

CASE STUDY

Counseling Caregivers on Restricting Access to Lethal Means

How Seattle Children's Hospital improved its process for addressing dangerous self-harm and suicidality

Seattle Children's Hospital was one of eight hospitals that participated in the 12-month Pediatric Hospital Care Improvement Project's (P-HIP) Mental Health Collaborative. The collaborative sought to improve documentation of counseling on how to restrict the child/adolescent's access to potentially lethal means of suicide.

Seattle Children's started with high scores on the measure but still had some areas for improvement. The team focused improvement efforts on standardizing the documentation template in the electronic health record (EHR), and offering safety classes to patients outside the psychiatry and behavioral medicine unit (PBMU) and inpatient psychiatry unit. The team's stepwise approach to rolling out these interventions proved to be a successful strategy.

Hospital Context for Quality Improvement Focus

The hospital had a strong foundation to build on: a high level of organizational support, a standardized process of daily huddles with clinicians and the pediatric mental health staff, and a safety meeting curriculum for patients admitted to the

PBMU. In addition, the organization had a pediatric mental health staff member available 24/7 who was responsible for meeting with patients to develop and review individual crisis prevention plans and offering a group safety class.

The team also had a few challenges to overcome. Psychiatrists who were not permanent staff were unfamiliar with the standardized process and sometimes discharged patients without proper safety plans in place and documented. In addition, the safety classes were only offered to patients admitted to the PBMU. Patients on other medical inpatient units for whom self-harm and suicidality was a concern were not offered the same support.

Goals for Improvement

Goal 1: To implement a standard documentation template for crisis prevention plans and safety classes to easily identify the completion of these across all inpatient units.

Goal 2: To expand PBMU safety curriculum and get participation from 70% of the patients on other inpatient floors who receive psychiatry consultation.

Hospital

Seattle Children's Hospital

Lead Project Staff

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Quality Measure

Children/adolescents admitted to the hospital for dangerous self-harm or suicidality should have documentation in the medical record that their caregivers were counseled on how to restrict their child's/adolescent's access to potentially lethal means of suicide prior to discharge.



Improvement Process

The first major accomplishment for Seattle Children's was to initiate group safety classes on the PBMU. The change from the individual safety planning session to group safety classes freed up therapists' time for more one-on-one counseling time with patients. The new process required all patients admitted to the PBMU to be scheduled for a safety planning meeting during the first 24 hours of admission. Up to five families attended the group safety meeting where safety recommendations were reviewed and instructional handouts provided. At the end of the class, a crisis prevention planning worksheet was given to caregivers to complete prior to their one-on-one meeting with the dedicated pediatric mental health staff member.

The team worked with the hospital's parent advisory council to determine the best timing for safety counseling during a child's hospitalization. The council's feedback was that waiting until discharge to share the safety planning information was too stressful; the caregivers had to quickly track down all of the potential lethal means in the home before the patient could return. Scheduling the safety planning class at admission for the next day gave the family time to plan for discharge.

To address the goal of standardizing the documentation template and expanding the intervention's reach, the team worked with the IT department to implement a safety planning note template into the EHR. While Seattle Children's had a mental health staff member available 24/7 to counsel patients on the PBMU, the other inpatient units did not have a standardized process or dedicated staff member. Therefore, the EHR template served a dual purpose—to provide a standardized means for capturing the data and serve as a guide

to other inpatient unit staff on what should be discussed with patients who present with dangerous self-harm or suicidality.

Once team members tested the group safety class strategy and curriculum in one unit and had the EHR template in place, they were ready to expand their reach to include patients on other units that presented with self-harm or suicidality. The team shared the safety planning curriculum with staff in another unit. The team also met with unit leadership to ensure alignment regarding the importance of the safety curriculum and what it entails, and explore possible avenues for patients to be taught this information. The PBMU staff nurses, who are deployed to other units to support with behavioral needs, reviewed the safety planning curriculum with the patients admitted to the medical unit and offered to include patients in the safety planning classes on the PBMU.

Impact

When the collaborative began, Seattle Children's original mean score was 77%. The team worked to improve on every key driver in the Key Driver Diagram, and their comprehensive, stepwise approach proved to be a successful strategy.

At the end of the 12-month collaborative, the team improved their score to 93% and sustained that improvement over time (see team results chart below). Standardization of the safety planning curriculum, dissemination and training of other unit nurses, and the implementation of the safety planning note template were strategies with the biggest impact on their scores. However, the team's real-time data review and data feedback loop to providers was also a major contributor to their success.

Team Results

