PRACTICE PARAMETERS
CHILD and ADOLESCENT INPATIENT PSYCHIATRIC TREATMENT
A Publication of the Association of Child and Adolescent Psychiatric Nurses
A Division of International Society of Psychiatric Nurses (ISPN)

Introduction

Child and adolescent inpatient psychiatry is a subspecialty in nursing requiring a definable set of skills and abilities. In the inpatient setting, practice centers on the provision of a safe, structured, and supportive environment for seriously ill young people. Their needs are diverse and complex. Care to this vulnerable population is provided by a multidisciplinary team. These practice statements are meant to be broad parameters for defining performance expectations in various aspects of inpatient treatment.

This document describes parameters on assessment, milieu management, cultural considerations, discharge planning, care of special populations (e.g. suicidal, aggressive, maltreated youth) and guidelines on specific practices such as use of seclusion and restraint. These parameters were developed from clinical expertise and a review of the literature and are offered as a supplement to the American Nurses Association (ANA), Scope and Standards of Psychiatric-Mental Health Practice (American Nurses Association, 2000). The ANA document serves as the primary guide for clinical nursing practice with these child and adolescent inpatient parameters offering more specific guidance for child and adolescent subspecialty practitioners. This document is only a snapshot of knowledge to date, and practitioners are urged to use their research interpretation skills to critique and incorporate new knowledge into their practice throughout their professional lives.

We appreciate the work of ACAPN members in revising the existing practice parameters first written in 1995: Pamela Galehouse, Chris Hacker, Ellen C. Rindner, Judith Hirsh, Lois Powell, Edilma Yearwood. Thanks to Judith Coucouvanis, Edilma Yearwood and Elizabeth H. Erwin who assisted in the editing of the final product.

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American Nurses Association (2007). *Scope and Standards of Psychiatric- Mental Health Nursing Practice.* Washington, D. C.: Author.

These guidelines summarize data to inform nurses and mental health staff of the care of children and adolescents during inpatient psychiatric treatment. These guidelines are not intended to serve as the absolute standards of child/adolescent inpatient psychiatric care. Standards are subject to change as our evidence base grows. Adherence to these guidelines should not be interpreted as including all proper methods of care or excluding other acceptable methods.

ACAPN INPATIENT PRACTICE PARAMETERS

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ASSESSMENT OF THE CHILD AND ADOLESCENT DURING BRIEF INPATIENT PSYCHIATRIC TREATMENT

DESCRIPTION/OVERVIEW:
During inpatient hospitalization, psychiatric nurses are afforded a unique assessment opportunity by virtue of their 24-hour presence on the unit. They observe and interact with patients and significant others with the purpose of assessing behaviors, symptoms and responses to intervention in the milieu. Because of their continuous presence nurses have the opportunity to recognize patterns of behaviors, symptoms, deficits, thoughts and beliefs; and to communicate these to other members on the team. Inpatient units typically admit children with a variety of mood, behavioral and neurobiological disorders as well as children with significant physical or mental co-morbidities. Thus assessment must be holistic, and the data collected using reliable and valid methods.

DESIRED OUTCOME:
Assessment data will be compiled that reflects the child's current status, accurately determines symptoms, and describes how the child/adolescent functions in activities of daily living and in therapeutically designed activities. These activities will vary in structure and task demands. Nurses will assess for any difficulties with regulation of affect or behavior associated with situations such as transitions, activities of daily living (e.g. concentrating on homework), visiting with family members, peer interaction, or periods when the pace and noise level of the milieu increases or decreases. Responses to treatment are documented. The nurse also assesses how the child/adolescent views their illnesses and how effective adults are, as they interact, nurture, discipline and support them in managing their acute illness. Finally, assessment will include any potential barriers to discharge to a less restrictive environment and what services or referrals can increase the likelihood of a successful transition.

A. ASSESSMENT

Principle of Care	Practice
The child/adolescent and family can expect: A thorough assessment of current behavior, centered on issues that prompted admission. An opportunity to explain their perceptions of the behaviors and symptoms that prompted admission. A holistic assessment is conducted including physical and psychiatric issues. Any unstable medical conditions are monitored.	The nurse will: Be proficient in understanding developmental, cultural, spirituality and gender differences in the presenting patients. Utilize reliable and valid methods to collect data; synthesize findings and communicate these with other members of the team. Complete a review of systems as specified on the nursing admission data base.

The assessment reflects not only health behaviors or symptoms, but other factors integral to the child's functioning, such as strengths, affect regulation, support system, coping and stress response, information processing, relatedness and control. Assessment includes evaluation of the child's functioning within peer groups, the family, school, and the neighborhood/ community. There will be continuous assessment of any behaviors/thoughts that indicate a danger to self or others. When known risk factors are present anticipatory planning will be done. The plan of care that is developed is based on the assessment and reflects a synthesis of all relevant data. The plan of care reflects patient-centered goals and family involvement in establishing those goals. The patient, family and legal guardians will understand the unit policies about how assessment data is collected and will participate in the process. The assessment process will include a discussion of confidentiality, trust and the nature of the nurse-patient- guardian relationship.	Assess the child/adolescent for: -Current behavior, thoughts, mood and affect, and how they compare with parent/child report pre-admission -Review of medications: current, past years, side/adverse effects, dosage adjustments and response -Situational or relational variables that are related to increased or diminished intensity of problem behaviors -Any verbal or non-verbal signs of danger to self or others (See additional guidelines detailed in section on monitoring suicidal behavior) -Substance use: type, amount, frequency, context. Include legal, illegal, over the counter, and psychoactive substances -Legal involvement -Traumatic events (recent and remote) -Achievement of developmental milestones -Functional limitations that may impact discharge planning -Any co-occurring medical conditions. Obtain history of psychiatric treatment. Assess the family for ability to provide for the patient's needs post discharge. Assess for any potential barriers for discharge to the least restrictive environment.

B. <u>DIAGNOSES</u>

Assessment could result in any number of nursing diagnoses, including but not limited to:
Impaired social interaction
Altered role performance
Altered growth and development
Risk for injury/Risk for violence self directed or other
Self-care deficit
Ineffective coping

C. PLANNING

Principle of Care	Practice
A complete assessment of the patient's behavior requires planning for the on-going assessment of milieu behavior. This milieu assessment of behavior demands: Observing and interacting with the child/adolescent in a variety of milieu settings that includes different levels of stimulation and task demands. Obtaining parent/guardian perceptions of milieu behavior. Scheduling times to discuss staff observations of milieu behaviors with the parent/guardian. Assuring that sufficient numbers of appropriately trained staff are assigned to detect variations in behaviors, affects, functioning and response to treatment. Providing continuity of staff to promote trust and rapport and enable ongoing assessment. Inclusion of knowledge deficits that will inform both treatment and discharge planning.	The nurse will: Plan opportunities to assess functioning in a variety of situations (e.g. with peers, doing structured an unstructured tasks) and determine if variation exists. Include a plan for systematically engaging with primary guardians. Allow multiple staff to assess behavior in a variety of situations. Plan staffing to ensure consistency with patient assignments, facilitate the development of the therapeutic relationship and thus enable assessment of changes in response to treatment. Consult with the literature when necessary to ensure that all relevant factors are assessed. Communicate and collaborate in developing this plan with the multidisciplinary team. Integrate assessment findings and prioritize.

D. IMPLEMENTATION

Principle of Care	Practice
Implementing the assessment process requires the nurse has knowledge of all of the psychiatric disorders, and of the physiological illnesses that have associated psychiatric symptoms.	The nurse will: Identify patterns of behaviors over time and identify antecedents or consequences of behavior. Utilize assessment tools as appropriate to gather quality data.

In assessing youth the nurse acknowledges: The number of stressors prior to admission is related to child's presentations and adjustment in the hospital. Assessments will be individualized to the needs of the child, and will be conducted using therapeutic tools, reliable and valid methods. Therapeutic interactions for the purpose of assessment will take into consideration the nature of the stressors and symptoms, as well as gender or cultural issues that may impact disclosure.	Observe the patient in a variety of milieu and group situations. Discuss incidents and behaviors with patient to ascertain their perceptions and attributions. Discuss observations with parent or guardian to compare and contrast milieu behaviors with home behaviors. Provide constant supervision so that behaviors indicative of danger to self or others can be observed. (See additional guidelines on suicidal patients) Consider the relative impact of stressors in school, peer group and neighborhood on adjustment.

E. <u>EVALUATION</u>

Principle of Care	**Practice**
Assessment of behaviors is an ongoing process that provides information useful to diagnosis, treatment, and discharge planning. Inpatient facilities that experience optimal outcomes use a systematic process of risk management, independent auditing of programs and policies, and evaluating their practices against 'best evidence' in the literature.	The nurse will: Communicate staff's assessment of patient's milieu behavior to the treatment team. Conduct and participate in discussions among nursing staff to reach common understanding of the child or adolescent. Refine assessment as new data emerges and/or behaviors or symptoms change. Consult the literature as needed.

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PRINCIPLES Of THE THERAPEUTIC MILIEU APPIED TO PSYCHIATRIC HOSPITALIATIZATION FOR CHILDREN AND ADOLESCENTS

DESCRIPTION/OVERVIEW:
Inpatient psychiatric nurses are the "gatekeepers of the milieu." They assume responsibility for the milieu's tone, pace and activity level. They assure that the milieu is safe, structured and supportive. Further, they assure the milieu is engineered so that the child/adolescent succeeds and begins to build a sense of control in their lives. A therapeutic milieu consists of five components: safety, structure, support, involvement and validation. Inpatient units are typically locked and the young person's movements about the space are restricted (e.g. visitation between patients in their rooms). Containment limits a child/adolescent's autonomy and freedom of will and separates them from sources of support such as parents and peers. Also, adults possess control that can be intimidating or anxiety provoking for many young patients, especially those who have been victimized. For many youth, the issue of containment is extremely stressful and impacts their coping and behavior on the unit.

Structure in the milieu comes from unit policies and procedures, the practice behavior of the staff, and from incorporating existing knowledge about therapeutic activities into nursing practice. It is based on meeting the developmental needs of the patients. Increasingly structure is informed by principles of family-centered care. The structure provides the backdrop for the nurse to assess responses to hospitalization.

Support, involvement and validation comes from adult staff as well as peers, other participants in unit activities (e.g. parents in a family group) and other visitors to the physical space (e.g. housekeeping staff). Children and adolescents have a right to feel safe and respected, have personal boundaries protected, be reliably and consistently responded to and experience trust in the milieu staff. Staff will collaborate to provide a balance between support, structure and containment.

DESIRED OUTCOME:
Each child or adolescent's mental and physical health is fostered during their inpatient stay. Through participating in the structured activities of the milieu, the child or adolescent learns coping skills and experiences being efficacious at self-regulation. They will identify unhealthy thoughts and behaviors as they occur and, with the assistance of the nursing staff, modify these behaviors and/or replace them with effective coping skills. The child or adolescent uses peer, parental and staff feedback and teaching from staff to modify maladaptive behaviors. These activities, which often mimic typical activities of daily living, present opportunities for the young person to demonstrate their progress in areas such as impulse control. When participating in milieu treatment, the nurse intervenes in problem areas identified in the plan of care. Nursing staff will build a therapeutic alliance with patients and their families; and serve as a patient advocate. It is important for the environment to be carefully structured to meet both the needs of the individual and the needs of the group. Often, children who are hospitalized have been traumatized. Their emotion regulation and stress responses are often impaired. A critical outcome for these children is that the milieu does not precipitate re-traumatization.

A. ASSESSMENT

Principle of Care	Practice
The milieu will be constructed to meet the requirements for safety, structure, support, involvement, and validation. Young people who have been maltreated or are victims of violence are at high risk for acute stress disorder and require a therapeutic milieu for healing and safety. The child/adolescent and family will experience respect and have his/her needs for safety, personal boundaries and trust assessed and met from the point of admission through discharge. The child/adolescent and family can expect the nursing staff to assess and control the milieu's pace, tone and activity levels from the point of admission through the point of discharge. The structure of the milieu will be targeted to the developmental, physical and psychological needs of the youth who are admitted. Individual expectations will be kept in line with the child's ability to reason, perform and regulate. The unit lives by sensible rules that elicit the child's cooperation and, in as many instances as possible, afford the child choice. Milieu guidelines include includes clear rules and consequences for antisocial actions.	The nurse will: Continuously assess patients' safety needs. Continuously monitor the milieu's tone, pace, activity level. Provide a schedule and list of activities for children and review it with them. Seek patient input on activities and unit guidelines. Assess and respond to boundary conflicts between milieu and therapy staff. Collaborate with the patient and family on patient's needs and how the milieu might address them. Conduct assessments that consider both the needs of the individual young person and the needs of the milieu. Be mindful of any child's history of violence or victimization and its elaboration in milieu behaviors. Detect and prevent periods of group contagion and milieu escalation. Assess the patient group needs and staffing numbers to assure sufficient staff is available to respond to and address youth's needs. Assess the needs of the individual youth against milieu expectations.

B. DIAGNOSIS

Assessment could result in any number of nursing diagnoses, including but not limited to:

High risk for violence, self or other-directed
Ineffective individual coping related to child abuse or neglect
Self-esteem disturbance related to unmet dependency needs
Impaired social interaction related to negative role modeling
Defensive coping related to low self-esteem
High level of anxiety related to treatment in a setting other than home or school

B. PLANNING

Principle of Care	Practice
The child/adolescent and family can expect: Members of the treatment team will maintain the safety of the milieu and promote success in coping and functioning with milieu expectations. Planning will be done in the five areas of milieu: safety, structure, support, involvement and validation. The nurse will assess the milieu regularly and intervene to maintain safety and structure, and engage in anticipatory problem solving with other staff to avoid crises. Planning will assure integration of family-centered goals.	The nurse will: Collaborate with the child/adolescent family and treatment team to determine the proposed interventions/strategies for treating the client's basic identified needs, i.e., safety needs and containment of behaviors that are dangerous to self or others. Collaborate with unit management to assess milieu acuity, determine therapeutic activities, and adjust staff levels to assure a safe, structured and supportive milieu, and one where patients succeed in meeting the demands of hospitalization. Adjust staffing numbers to assure sufficient staff is available to respond to and address patient's needs. Assure clinical structures and resources are in place such that all milieu functions (safety, structure, support, involvement, validation) can be consistently enacted.

C. IMPLEMENTATION

Principle of Care	Practice
Youngsters who are hospitalized because they posed a serious danger to self or others require a safe, structured environment which supports their regulation of emotions and behavior. Hospitalized youth who have experienced trauma or maltreatment may have additional problems with arousal patterns, stress response, sleep/rest cycles, memory and attachment. They heal and learn best in an environment of sensible rules where respect and shared decision making support autonomy and reduce stress. In staff's efforts to create order and structure, the child learns that staff is dependable, responsive and predictable. Many hospitalized youngster have social cognitive skill deficits, personal space and boundary limitations, and react strongly to peer rejection, or other interpersonal stressors. The milieu is structured such that staff step in and bolster faltering function so the child succeeds. The youngsters can expect that they will receive positive reinforcement when they behave in a safe manner, follow expectations and participate in treatment activities. The child/adolescent/family can expect to interact with nurses in the milieu and receive on-going, individualized client and family education related to diagnosis, treatment approaches, and psychotropic medications.	The nurse will: Establish a trusting relationship with the child/adolescent/family in a way that conveys interest, respect, and support. Inform the child/adolescent and family of the unit structure, rules and expectations during the course of treatment. Provide a balance of structure and unstructured or quiet time. Strategize with others to maintain a calm, organized milieu. Maintain a positive tone to the environment. Continuously assess the milieu for safety by performing random and routine checks for safety. Maintain staff visibility at a maximum level. Maintain awareness of the child's particular deficits and needs and reliably step in and provide support to the child's regulation or cognitive functions. Reinforce positive/adaptive changes in the client's coping and attempt to increase positive interactions with the child/adolescent. Use milieu interactions and developmentally appropriate teaching tools to provide the child and family education on interventions, diagnoses, and medications.

E. EVALUATION

Principle of Care	Practice
Child/adolescent/family can expect ongoing, timely evaluations of their responses to expressed safety, personal boundary, and trust needs from point of admission to unit through the discharge phase of treatment. Outcomes are evaluated by patient, family and staff to increase satisfaction with services. Staff continually monitor the safety of the milieu and examine any lapses in safety that occur. Staff monitor their response to milieu situations and evaluate the individual's or group's response to the approach.	The nurse will Monitor/evaluate the client/family's response to treatment on an ongoing basis and document this evaluation of responses. Review (at shift report) which milieu management strategies have been effective and which have not and revise strategies appropriately. Engage in anticipatory problem solving (e.g. separating peers with a history of conflict) to increase success in activities. Monitor and evaluate responses to treatment on an ongoing basis and share evaluation with multidisciplinary team members. Review and integrate patient/family perceptions of care including discharge satisfaction data. Collaboratively identify client/family/community support systems following discharge to promote the continuation of behavioral change.

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GUIDELINES FOR THE USE OF RESTRAINT AND SECULTION DURING CHILD AND ADOLESCENT INPATIENT TREATMENT

DESCRIPTION/OVERVIEW:

Restraint means restricting the freedom of movement or normal access of a person to his/her own body by means of a manual method or physical or mechanical device (Health Care Financing Administration [HCFA], 1999). Seclusion is the involuntary confinement of a patient to either a room or area such that the person is physically prevented from leaving (HCFA, 1999). Potential and actual dangerous behavior requires immediate evaluation and intervention to prevent and manage harm to self and/others. Restraint and seclusion have not been found to be useful as interventions for modifying behavior. However, the literature does support the use of restraint and seclusion as safety interventions. Restraint and seclusion shall be non-punitive and non-coercive and used only in situations that pose a significant danger to the patient or others. Types of restraint include: 1). Mechanical restraints-body movements are contained, restricted or restrained by use of a mechanical device; 2). Physical restraints - body movements are contained or restricted or restrained by the physical actions of a staff person. 3). Chemical restraints-use of a drug or medication that to control behavior or restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychiatric condition.

Following restraint/seclusion incidents it is important to process the event with the patient to understand how it is perceived by him/her; and to determine what other interventions could have been attempted and thus avoid restraint in the future. A comprehensive interdisciplinary team approach should be utilized to identify alternate interventions, reduce restraint/seclusion and ensure safety of clients. Restraint and seclusion must be utilized within the guidelines or policies of each agency and also meet the requirements of accrediting and licensing organizations.

Guidelines and standards of practice concerning the use of seclusion and restraint during inpatient hospitalization have been created by Center for Medicaid and Medicare Services (CMS) (formerly HCFA), State Mental Health Acts, and professional organizations such as the International Society for Psychiatric Mental Health Nurses and the American Psychiatric Nurses Association. When applicable, child inpatient nurses should be aware of and comply with the content of these regulations. The guidelines presented here are intended as a supplement to these more extensive parameters and regulations.

DESIRED OUTCOME:

The client will cease injurious behavior and be able to maintain control without the use of restraint or seclusion. The client will learn alternative ways to respond to intense emotions such as anger or frustration; and process experiences that prompt emotional arousal. The staff will be successful in assessing potential situations that may result in restraint or seclusion and receive ongoing training and supervision around the use of restrictive measures and alternative approaches.

A. ASSESSMENT

Principle of Care	Practice
The child/adolescent and family can expect that: A thorough assessment of the child/adolescent's ability to control his/her behavior and motivation for harming self and others will be done prior to the decision to use restraints or seclusion. The welfare and safety of the child/adolescent will be the prime consideration. Nursing staff will assess any situations that may trigger aggression and act to interrupt escalation. Feedback on effective de-escalation methods will be collected during the assessment period.	The nurse will assess the child or adolescent for: Current and historical potential for violence to self or others. Response to less restrictive interventions or to medications that have been helpful in the past. De-escalation methods that have been used successfully in the past. Contraindications or special considerations in using restraint or seclusion. History of trauma, including potential triggers to aggression towards self or others. Any injuries following restraint or seclusion. A clinically privileged nurse will communicate assessment findings to the physician prior to restraining/secluding, when possible, and follow all state, federal and regulatory guidelines concerning physician and LIP notification and responsibilities.

B. DIAGNOSIS

Assessment could result in any number of nursing diagnoses, including but not limited to:

Potential or high risk for violence toward others
Potential or high risk for violence toward self
Potential or high risk for explosive behavior
Potential or high risk for poor impulse control

C. PLANNING

Principle of Care	Practice
The child/adolescent/family can expect to: Participate collaboratively in planning responses to aggressive behaviors. Be informed of the procedure used to restrain or seclude clients. Be informed, within a reasonable period of time when the child/adolescent is placed in restraints, locked seclusion, or chemical restraint. Staff will be trained on alternative interventions that will decrease levels of patient stress and frustration, and avoid group contagion. Administration will consult with specialists in changing the physical environment to increase safety and monitoring. Administration will review policies and practices to determine any ways to make them less restrictive to staff and patients. Staff will support family involvement in care and in their decisions of how to help their child regulate.	The nurse will: Collaborate with the child/ adolescent/ family by explaining the potential need for restraint or seclusion. Explain behaviors that would result in restraint or seclusion and assess understanding. Describe the restraint/seclusion process and show the patient/family the seclusion room. Ask the family preferences if emergency measures are needed for safety of patient or others. Collaborate with the child/adolescent and family to develop a milieu approach to prevent behavioral and/or affective dyscontrol. Develop a plan with the client to avoid or cope effectively with environmental and internal triggers. While calm, provide options for patients to select as their preferred method of handling lack of control, including time out, verbal interactions with staff, PRN medications, and relaxation techniques. Track behavior to identify any patterns to an individual patient escalation. Assure that all staff involved in restraining or secluding a patient are trained and certified in the use of restraints/seclusion according to agency requirements. As clinically appropriate, follow the family wishes regarding the use of restraints or seclusion.

D. IMPLEMENTATION

Principle of Care	Practice
While in restraints or seclusion, the child/adolescent can expect: To be treated in a safe and respectful manner. To be constantly observed. To receive food, water and toileting opportunities at least every 2 hours. To be evaluated by a licensed independent practitioner within one hour That all hospital, state and regulatory guidelines on restraint procedures will be adhered to. Many alternatives exist to manage behaviors that have been shown to be effective. Nursing staff behavior will consistently utilize these interventions. Restraint and seclusion are never initiated/conducted simultaneously. Institutions will support a 'restraint free' environment, including the use of alternative behaviors and consulting with others and the literature on ways to change policy and practice.	The nurse will: Follow the agency's procedures for restraints and seclusion, as stipulated in JACHO, CMS (formerly HCFA) guidelines, and the State Mental Health Codes. Use less restrictive interventions prior to the use of restraint or seclusion. Give clear expectations to the patient about the expected behavior. Assure that all restraint and seclusion episodes are initiated and terminated in a safe and therapeutic manner by trained staff. Use sufficient numbers of staff with crisis management training to move the child/adolescent into seclusion or restraint. Clearly communicate to the client the behaviors required of them to end the restraint or seclusion episode. Maintain constant observation of the client and document at least every 15 minutes the client's behavior and response to restraints or seclusion. Remove the client from restraints/seclusion immediately when he/she meets the criteria. When the youth regains control, develop with them a consistent, step-by-step plan for reintegration into milieu activities.

D. EVALUATION

Principle of Care	Practice
The child/adolescent/family can expect to participate in the evaluation of the use of restraints or seclusion. The institution will support an aggression task force to look at practices, staff training and supervision, perceptions, and alternative interventions. Staff should understand that when young people are restrained or secluded there can be negative effects, such as physical injury, psychological distress, and damage to the nurse-patient relationship. Unit management recognizes that instances of restraint and seclusion are also potentially traumatizing for the staff, (physically and emotionally), and for the other patients. Institutional support should exist for research that identifies nurse and patient behavior and beliefs before, during and after restraint/seclusion incidents. The institution will assure a process for on-going quality assurance review of all episodes of restraint or seclusion.	The nurse will: Continuously monitor/evaluate the client's response to restraints or seclusion. Following the restraint or seclusion incident debrief with the client to identify and review behavioral problems, biologic precipitants and environmentally specific triggers that led to restraint. Assess if any injuries occurred during the incident and identify contributing factors. Explore feelings and perceptions with the intent of minimizing potential negative effects of the restraint or seclusion and to restore the nurse-patient relationship. Structure debriefing to facilitate the recognition of earlier symptom recognition and de-escalation; to improve affect regulation, impulse control and motivation for safety; and to promote problem-solving and conflict resolution skills. Debrief with other patients as needed (e.g. witnesses to the event). Participate in quality assurance review of the use of restraint and seclusion by collecting specific data about the clinical endpoints of restraint in order to identify patterns of use. Data collected will include the child/adolescent and family's perception and reaction to restraint or seclusion.

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GUIDELNES FOR THE MANAGEMENT OF AGGRESSION DURING CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC TREATMENT

DESCRIPTION/OVERVIEW:
Aggressive behavior is a common presenting problem with children and adolescents that are referred for psychiatric treatment and is the result of many factors. Among these factors are mental illness; environmental influences; genetic predisposition; and situational variables such as anxiety, fear and affect dysregulation. All acts of aggression are critical communication from children/adolescents. However, it is important to distinguish the motivating factors. There is a difference between reactive aggression, often the result of affect dysregulation or internally driven agitation, and proactive aggression which is often purposive and violent. Interventions for reactive aggression are very different from interventions for proactive aggression. Successful treatment plans to help children/adolescents manage aggressive behavior begin with a thorough assessment of potential and actual aggressive or dangerous behavior at admission. Triggers to escalation are identified as well. It is important to recognize the role of milieu stimulation in escalating situations.

DESIRED OUTCOME:
The child/adolescent will be able to express feelings including negative emotions such as anger and aggression. Moreover they will learn to express these feelings in a socially acceptable manner. During times of anger or aggression the child/adolescent will be free from injury and prevented from harming others. Over the course of hospitalization they will learn self-management /self-soothing techniques. Finally, the child/adolescent will be able to process his/her feelings and perceptions with staff after an episode of aggression.

A. ASSESSMENT

Principle of Care	Practice
At admission and throughout the course of treatment the child/adolescent/family can expect to participate in an assessment of their child's coping responses in various situations, including aggressive behavior and of situations that prompt dyscontrol. Reactive aggression will be managed with a calm milieu, and young people will learn and practice coping strategies to achieve successful affect regulation. Proactive aggression will be managed by the structure and containment of the	The nurse, in collaboration with the child/adolescent/family will assess the potential for aggression including: -Precipitants that may trigger aggressive behaviors -Type (self, other, property, verbal) -Intensity/Duration/Level (mild, moderate, severe) -Proactive versus reactive aggression -Frequency of episodes -Prior successful interventions (verbal, medication, external controls) -Aftermath of aggression on aggressor, victim and witnesses

milieu and reinforcement of expectations. Staff working with aggressive youth must recognize behaviors in themselves and during interactions with children that precede violent behavior. Recognition of such behaviors is the key to developing effective interventions. Staff should understand the principles of collaborative problem solving.	- Recognition of behaviors that would indicate to staff that patient is getting upset, i.e., pacing, isolating in room. The nurse's assessment of aggressive behavior will consider the developmental level of the child/adolescent. Assessment will include milieu factors that may produce escalating situations. The nurse will assess mental status regularly, monitor the milieu and intervene to maintain safety and structure, and engage in anticipatory problem solving with other staff to avoid aggression.

B. <u>DIAGNOSIS</u>

Assessment could result in any number of nursing diagnoses, including but not limited to:

Ineffective individual coping
Disturbed thought processes
Powerlessness
Anxiety related to knowledge deficit
Aggression directed at self or others
Impaired social interaction skills
Self-esteem disturbance

C. <u>PLANNING</u>

Principle of Care	Practice
The child/adolescent/family can expect to participate collaboratively in the plan of care regarding episodes of aggression and extreme affect dysregulation. For reactive aggression, a calm milieu with structure, personal space boundaries, decreased stimulation, reassurance and encouragement will be provided. Interactions occurring on the inpatient unit may closely resemble coercive	The nurse will: Collaborate with the child/adolescent/ family in developing the treatment goal and intervention strategies for treating aggressive or dysregulated behavior. Collaborate with the patient to develop a realistic plan to prevent and/or decrease the level of aggression. If indicated, include the child/adolescent/ family in selecting appropriate

patterns between adults and client, thus requiring staff sensitivity to the patients' reactions to limit setting.	medication for aggressive behavior. Anticipate milieu needs while planning a individual and group therapeutic activities.

D. IMPLEMENTATION

Principle of Care	Practice
The child/adolescent/family can expect to be treated in a safe, supportive and nonjudgmental manner.	The nurse will: Assure that all acts of aggression are managed in a safe and therapeutic manner and in accordance with agency policy.
The nurse will use the institutions' established methods of assisting children/adolescent with managing their behavior.	Utilize therapeutic communication skills when intervening with an aggressive youth.
Milieu stimulation is managed in a proactive and responsive manner.	Take into consideration trauma history and be gender sensitive.
The milieu should be structured to provide choice, eliminate threat and to help children achieve control.	Recognize and base interventions upon, the child/adolescents state of control using the least restrictive intervention.
Specific skills have been shown to be effective for people with proactive aggression. These include cognitive restructuring, relaxation training, modeling techniques, behavior therapy and collaborative problem solving.	Utilize redirection and empathy in the early stages of escalating behavior. Provide positive feedback to the patient for making reasonable choices in an escalating situation.
Skills are taught during periods of relative calm and openness to material and reinforced in interactions throughout the day.	Give the client choices and as broad a role in decision making as clinically appropriate.
The patient will learn to recognize aggression triggers, discuss typical responses to negative experiences and engage in problem solving to manage stress.	Recognize and assist patient with utilizing strengths to assist with management of affects, e.g. drawing, playing music.
In responding to escalating situations staff will intervene utilizing the least,	Utilize episodes of affect dysregulation to teach the client to identify and label

restrictive method that has the potential to decrease the tension/negative emotion. All staff should receive training in non-violent de-escalation techniques.	feelings, and more socially acceptable means of expressing anger. Process all aggressive episodes with the client to review precipitants, perceptions, and alternative coping strategies. Assure that adequate and appropriately trained staff are present during aggressive episodes. Proactively control the tone, pace and activity level of the milieu to keep stimulation in an acceptable range.

E. <u>EVALUATION</u>

Principle of Care	Practice
The child/adolescent/family can expect to participate in the evaluation of progress towards attaining treatment goal(s) relating to the management of aggressive behavior. There is consistent report of improved affect regulation, and no incidents of dangerous behavior to self or others. When stressors are experienced, the patient will utilize learned coping resources and experience behavioral and affective control.	The nurse will monitor, evaluate, and document client response to interventions for management of emotion dysregulation, including aggressive behavior. The team (including staff, patient and family) will revise approaches to management of aggression when indicated.

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GUIDELINES FOR THE ASSESSMENT OF SUICIDE RISK DURING CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC TREATMENT

DESCRIPTION/OVERVIEW:
In the United States, suicide is the third leading cause of death in youth ages 15-19. While the youth suicide rate in the US is decreasing in most age segments, the youth suicide rate is steadily increasing worldwide. Nursing care of the suicidal child or adolescent at the primary treatment level includes identification and referral to the least restrictive setting for acute crisis management. Secondary treatment consists of ensuring the youth's safety needs throughout the entire crisis period until suicidal impulses are diminished. Tertiary treatment includes ongoing case management of the child or adolescent post-discharge in the community setting.

Many adults and caregivers do not believe that younger children can become suicidal. Youth suicide risk assessment is conducted in a thorough clinical interview using multiple modalities. Once admitted to the inpatient unit the task is to monitor risk and be aware of and respond to any changes in the level of risk. Youth self report of suicidal ideation and imminence of suicidal actions are accurate indicators of suicidality. Professionals need to be aware of this and other risk factors for suicide e.g., history of mood disorders, substance abuse, self-harming behaviors, family discord, childhood abuse history.

DESIRED OUTCOME:
The child or adolescent will be assessed by the nursing staff throughout treatment for suicidal risk. During the course of hospitalization, the child or adolescent will feel safe and gain control over suicidal impulses. The child or adolescent will benefit from a therapeutic treatment environment and learn age-appropriate coping skills. There will be a reduction in the intensity of the youth's emotional distress. Discharge planning will assure that the child and adolescent will have access to appropriate interventions during times of crisis and during follow-up care in the community.

A. ASSESSMENT

Principle of Care	Practice
The child/adolescent and family can expect to have suicide risk (i.e., absent, mild, moderate, severe, extreme) continuously assessed from the point of admission through discharge.	The nurse, in collaboration with the child/adolescent and family, will: Assess the patient's suicide risk on a continuing basis according to the degree of depression and suicidal risk the child/adolescent exhibits. The nurse will consider using a standardized suicide risk assessment tool. Assess cultural norms around suicide.

	Assess spirituality in regards to suicide. Assess the patient for signs and symptoms of depression, including: -Sleep disturbance, appetite loss or increase, increased agitation or irritability -Helplessness/hopelessness/powerlessness -Morbid preoccupation -Self-mutilating behaviors (SMB) -Social withdrawal -Lowered self-esteem -Decreased school performance -Sad, depressed vocalizations Understand behaviors/factors that are considered dimensions of risk, these include: -Being in a high-risk populations (i.e., psychiatric co-morbidity, history of physical or sexual abuse, disrupted/poor relationships with peers or family, sexual identity crisis) -Low GAF for last six months (severity of cumulative stressors) -History of prior suicide attempts -Lethality of past suicide attempt -Access to means -History of substance abuse -History of impulsive behavior - Suicidal ideation -Strength of intent to die, motivation - Family history of suicide

B. <u>DIAGNOSIS</u>

Assessment could result in any number of nursing diagnoses, including but not limited to:
Risk for violence: Directed towards self
Hopelessness related to
Powerlessness related to
Alteration in emotional integrity related to feelings of despair
Ineffective individual coping due to emotional pain, altered thought-processes, altered self-concept
Self-Mutilation related to
Potential for self-injury related to depression and despair

C. PLANNING

Principle of Care	Practice
Child/adolescent and family can expect to participate in establishing goals for treatment.	The nurse will: Collaborate with the child/adolescent / family and treatment team to determine the goals of hospitalization. Document the ongoing process of planning around the child/adolescent/safety needs including the provision of safe milieu and the degree of required nursing supervision.

D. IMPLEMENTATION

Principle of Care	Practice
Child/adolescent and family can expect the nursing staff to provide on-going patient education and information related to suicide risk, diagnosis and treatment approaches. Child/adolescent and family can expect that the staff will implement all necessary procedures to assure a safe milieu.	The nurse will: Establish a relationship with patient that conveys sincere interest and caring and transfers the belief that help is possible. Discuss with child/adolescent ways to deal with suicidal ideations. Help child/adolescent strengthen existing coping skills. Provide group activities that allow patient to freely express their feelings and learn from others. Provide and promote education of child/adolescent and family regarding crisis intervention, diagnosis and medication. Assure patient is maintained at a suicide risk level commensurate with risk assessment. Follow institutional policy on monitoring patients on suicide risk or precautions.

E. EVALUATION

Principle of Care	Practice
Child/adolescent and family can expect ongoing responses to safety needs by nursing staff.	The nurse will: Monitor and evaluate response to treatment on an ongoing basis. Alter treatment approaches in order to achieve goal of strengthening coping skills. Assist the patient and family to identify support systems within the school and community following discharge.

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GUIDELINES FOR THE CARE OF CHILDREN AND ADOLESCENTS WITH A HISTORY OF MALTREATMENT DURING INPATIENT PSYCHIATRIC TREATMENT

DESCRIPTION/OVERVIEW:
The most recent data on child maltreatment indicate that in 2002, state child protective services received some 1.8 million referrals for possible maltreatment; approximately half of which, 900,000 children, were determined to be victims of abuse and neglect. Of these children about 60% were neglected, 20% physically abused and 10% sexually abused; children 0-3 years had the highest rate of victimization. Prevalence rates of maltreatment are primarily derived from adult accounts of their childhood experiences. In a large retrospective study of 13,500 HMO members, 43% of participants reported having been maltreated, either abused or witnessing abuse. Rates for different types of abuse vary. The prevalence rate for child sexual abuse is estimated to range from 16.8% for women and 7.9% for men. Recently one state report estimated that up to 84% of children hospitalized on inpatient psychiatric units had experienced some form of trauma. Thus inpatient units must take care to create milieus where children are not re-traumatized and afforded the opportunity to heal.

DESIRED OUTCOME
The child/adolescent will cope effectively with trauma-related symptoms. Discharge planning will include provision of services that will assist the child/adolescent in accomplishing developmental tasks and have an age-appropriate adjustment to social network. The child/adolescent will increase their ability to can identify emotions and express them in appropriate ways. If indicated the child/adolescent will establish a personal safety strategy. The child/adolescent will be future oriented in a positive way.

A. ASSESSMENT

Principle of Care	Practice
The child/adolescent can expect to have treatment needs assessed at the point of referral through the discharge phase of treatment. Assessment must include documentation of maltreatment and its aftermath.	The nurse, in partnership with the child/adolescent/family and members of the multidisciplinary treatment team will assess: If the child/adolescent wants to or is willing to share trauma history. Pre-trauma status including: age, developmental level, family structure, sociocultural factors, cognitive level, emotional issues and behavioral patterns. History of the maltreatment including occurrences, sexual activities, methods used and current status of perpetrator.

	Resolution of the maltreatment including sanctions imposed on perpetrator. Indications for mandated reporting of ongoing maltreatment. Coping and defensive methods employed by the child/adolescent following abuse. Symptoms of general anxiety. Behavior patterns post-abuse indicative of trauma which may be integrated or characterized as predominantly anxious, avoidant, disorganized or aggressive. Triggers related to abuse that may increase youths' difficulties, i.e., closed doors, presence of man or women, time of year. What has been helpful in past when the child/adolescent has experienced trauma related affects.

B. <u>DIAGNOSIS</u>

Assessment could result in any number of nursing diagnoses, including but not limited to

Rape trauma syndrome related to rape/repeated trauma
Coping, ineffective, individual related to…….
Coping, ineffective, family, disabling, related to abuse by family member, denial by family
Thought processes, alternation in, related to overwhelming anxiety
Self-concept disturbance, related to abuse
Sleep pattern disturbance, related to anxiety/fear/depression
Social isolation related to failure of significant others to protect or rescue
Violence, high risk for, self-directed (or directed at others) related to abuse
Body image disturbance related to trauma
Impaired social interaction related to…..
Parenting, altered, related to abusive behavior, denial of abuse or guilt.

C. **PLANNING**

Principle of Care	Practice
The child/adolescent/family can expect to participate collaboratively in their health care.	The nurse will collaborate with the child/adolescent and family and the multidisciplinary treatment team to: Determine short-term and long-term goals and interventions around processing the maltreatment that are realistic and empirically-based. Advocate for interventions that build on patient, child and community strengths.

D. **IMPLEMENTATION**

Principle of Care	Practice
The child/adolescent/family can expect: A psychological and physically safe milieu. The identification, recovery and strengthening of personal inner resources. When appropriate, support for the recall and processing of the traumatic experience. Education/information related to maltreatment and therapeutic treatment approaches. The child/adolescent/family can expect to receive anticipatory guidance. The child/adolescent with acute symptoms of trauma associated with the sexual abuse can expect support for the recall and processing of the traumatic experience.	The nurse will: Establish a safe, trusting relationship with the child/adolescent. Collaborate with the youth, treatment team and significant others to provide structure and maintain a safe environment. Use psychotherapeutic interventions that: -Offer relief from negative feelings -Develop self-control -Develop emotional regulation -Enhance self-esteem -Foster understanding of personal reactions to maltreatment -Develop coping skills for upsetting thoughts, feelings and behavior. Encourage use of previously identified and utilized coping skills. Provide education of the client and family/guardian regarding potential needs.

	For the child/adolescent with acute symptoms of trauma associated with abuse, the nurse will insure that the client has a circumscribed safe, accepting treatment environment in which the abusive traumatic experience can be discussed and the associated feelings freely expressed in order to: -Normalize experiences and symptoms -Decrease emotional distress -Decrease avoidance -Develop a safety plan -Practice skills and generalize in-session symptom reduction to real-life situations. Assure that the youth/family has continued access to support and treatment.

E. **EVALUATION**

Principle of Care	**Practice**
The child/adolescent/family can expect ongoing responses to progress in attaining desired outcomes.	The nurse will: Monitor or evaluate responses to treatment in an ongoing fashion. Collaboratively alter the treatment approaches in order to achieve the goal of optimum effective coping and healing.

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PRINCIPLES OF TRANSCULTURAL CARE WITH SPECIAL EMPHASIS ON APPLICATION TO INPATIENT PSYCHIATRIC HOSPITALIZATION FOR CHILDREN AND ADOLESCENTS

DESCRIPTION OVERVIEW:
Transcultural care is a dynamic process aimed at providing culturally sensitive and culturally congruent care that supports and promotes well-being in ethnically and culturally diverse individuals, families and communities. By practicing in a culturally competent manner, nurses can assist in minimizing client stressors and can incorporate cultural practices that support optimal coping behaviors. Cultural competence involves being aware of the other, having knowledge of the other, developing skills in working with the other, seeking encounters with the other and having a desire to learn about the culture of the other.

DESIRED OUTCOME:
The child / adolescent / family will be involved in and receive care / treatment that is sensitive to their cultural background and needs. The child / adolescent / family will leave the health care encounter feeling that their cultural values, beliefs and practices have been listened to, respected and wherever possible, maintained during the health care encounter. The health care provider will develop a repertoire of culturally competent skills that can be transferred and used as a template for each successive encounter with individuals from diverse cultures.

A. ASSESSMENT

Principle of Care	Practice
The child / adolescent / family can expect: To receive an assessment of cultural needs on admission and continuously throughout the health care encounter. To be an active participant in communicating their mental health needs from their cultural perspective. Nursing staff to advocate for the inclusion of the child / adolescent / family in the development of the plan of care which will be sensitive to client needs and cultural practices.	The nurse, in partnership with the child / adolescent and family will assess for: Significant historical events from culture of origin that may affect health care behaviors. Language barriers or misunderstandings that may affect health care behaviors. Cultural views about health, mental health and mental illness. Cultural values, beliefs and health care practices that may affect health care behaviors.

	Child / adolescent / family view of the health care encounter, recommended treatment and relationship with service providers. Encourage the child / adolescent / family to verbalize questions or discomfort with health care recommendations.

B. **DIAGNOSIS**

Assessment could result in any number of nursing diagnoses, including but not limited to:

Impaired communication related to cultural and / or language differences
Anxiety related to unmet needs
Noncompliance related to client and provider relationship
Noncompliance related to cultural dissonance
Powerlessness related to health care environment
Spiritual distress related to separation from religious / or cultural ties and practices
At risk for violence related to cultural distress
At risk for violence related to feelings of hopelessness or powerlessness
Coping, ineffective individual related to….
Coping, ineffective family related to…
Social isolation or impaired social interaction related to cultural dissonance

C. **PLANNING**

Principle of Care	**Practice**
The child / adolescent / family can expect to participate collaboratively in their health care.	In planning care, the nurse will promote: Respect and preservation of the client's cultural orientation. Accommodation to client culture within the treatment environment. Restructuring of care that innovatively meets the mental health needs of the individual and family without compromising their values.

The nurse in working with culturally diverse clients acquires the necessary knowledge about the health and mental health beliefs of the population.	The nurse will: Assess personal knowledge about the culture or ethnic group. Attend relevant seminars or workshops to learn more about the cultural or ethnic group. Seek cultural encounters with the cultural or ethnic group in order to enhance knowledge and understanding.

D. <u>IMPLEMENTATION</u>

Principle of Care	**Practice**
The child / adolescent / family can expect to receive on-going education related to diagnosis and various therapeutic treatment options.	The nurse will Listen to and ask questions of the patient to promote open and responsive communication. Provide and promote education of the child / adolescent / family in all aspects of mental health care. Assess youth's understanding of all information discussed. Utilize alternative methods of communication or resources in the event that the youth does not understand information conveyed.

E. EVALUATION

Principle of Care	Practice
The child / adolescent / family can expect on-going and timely responses to stated cultural mental health care needs	The nurse will Monitor and evaluate response to treatment in an on-going fashion. In collaboration with the youth and treatment team, revise interventions as necessary to achieve treatment goals while preserving cultural values of the child / adolescent / family.

RESOURCES

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DISCHARGE PLANNING DURING BRIEF INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC TREATMENT

DESCRIPTION/OVERVIEW:
Discharge planning will be based on established discharge criteria and on short-term and intermediate goals to be achieved by the child/adolescent prior to discharge from nursing care. These goals may serve as guidelines for development of long-term goals for the child/adolescent and family to work on after discharge. Discharge planning should begin almost upon admission. As treatment progresses the client and / or family members leaning needs should be assessed. They should have the opportunity to ask questions of the provider and may be given written information for later reference. They should be provided education about symptoms, medications, triggers, the disease process, anticipatory guidance and plans for intervening as well as facilitating early intervention before a crisis state evolves.

DESIRED OUTCOME:
The child/adolescent and family will be involved in discharge planning at the time of admission and throughout hospitalization. A discharge plan will be developed that matches the intensity of services with the intensity of the child/adolescent's needs. Discharge services will support family and child for optimal functioning in the least restrictive environment.

A. ASSESSMENT

Principle of Care	Practice
The child/adolescent/family can expect to undergo an assessment of discharge planning needs at the time of admission and throughout hospitalization.	The nurse, in collaboration with the family and multidisciplinary treatment team will assure that discharge criteria includes assessment of: The patient's level of functioning and the family's ability to meet his/her safety needs. The child/adolescent and family's learning needs. The child/adolescent and family's attitude toward after-care; and the ability to follow through with after- treatment regime. Cultural variables, personal, and socioeconomic factors.

	Educational needs including need for changes in educational services. Potential barriers to accessing services.

C. DIAGNOSES

Assessment could result in any number of nursing diagnoses, including but not limited to:

Noncompliance with treatment regimen
Management of therapeutic regimen
Knowledge deficit (specify)…..

C. PLANNING

Principle of Care	**Practice**
The child/adolescent/family can expect To have a discharge plan initiated at the time of admission. To have a discharge plan which reflects available support systems, cultural variables, personal and socioeconomic factors. The child/adolescent's discharge summary will reflect destination upon discharge, nursing interventions while in hospital, aftercare, prescriptions, and teaching.	The nurse will: Collaborate with the patient, family, out-patient providers (school where indicated) and multidisciplinary team to establish a discharge plan which will address immediate and future needs of the child/adolescent/family. Document the ongoing process of discharge planning. Write a discharge summary that reflects the child/adolescent's response to nursing interventions, teaching accomplished, goals, and destination upon discharge.

D. IMPLEMENTATION

Principle of Care	**Practice**
1. The child/adolescent and family can expect to receive sufficient explanation of the discharge plan such that they will verbalize understanding of the treatment recommendations.	The nurse in collaboration with the multidisciplinary team will: Initiate the discharge planning process beginning at admission. Discuss with the patient and family, anticipated learning needs related to discharge. Assure there has been adequate review of medications.

	Document the identified post discharge health care provider, the appropriate agency referrals and/or support groups. Share pertinent information with other disciplines and make recommendations regarding the youth's after care needs.

E. EVALUATION

Principle of Care	**Practice**
The child/adolescent and family can expect to participate in the evaluation of the discharge plan.	The nurse will evaluate the appropriateness of the child/ adolescent's discharge plan based on the child/adolescent's needs, socioeconomic status, support system, educational/vocational abilities, and community resources.