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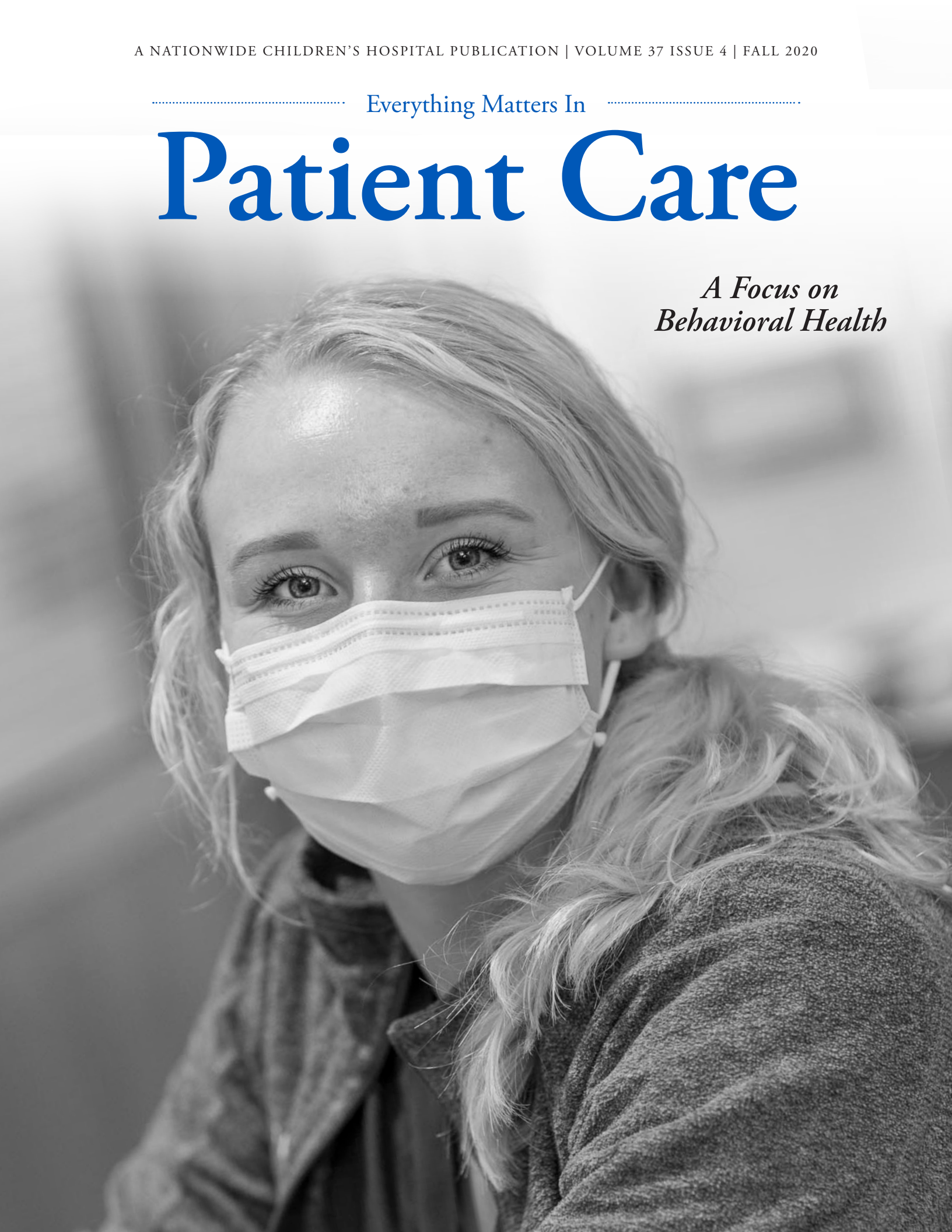
Everything Matters In

Patient Care

A Focus on Behavioral Health



At Nationwide Children's Hospital, we're breaking boundaries and changing the stigma around mental health.

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Where Passion Meets Purpose

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Passion Meets Purpose is truly a reflection of our Nationwide Children's Hospital Behavioral Health team. In 2018, they cared for 34,889 patients, providing more than 234,000 visits at 10 different locations. Also that year Nationwide Children's launched our *On Our Sleeves*® campaign, because we know kids don't wear their thoughts on their sleeves. One in five children lives with a mental illness, and we wanted to create a network of support around the millions of families struggling with mental illness, breaking stigmas associated with these diagnoses. In March 2020 we opened the Big Lots Behavioral Health Pavilion, America's largest and most comprehensive center, dedicated exclusively to pediatric behavioral health. We believe a child's mental health is just as important as their physical health.

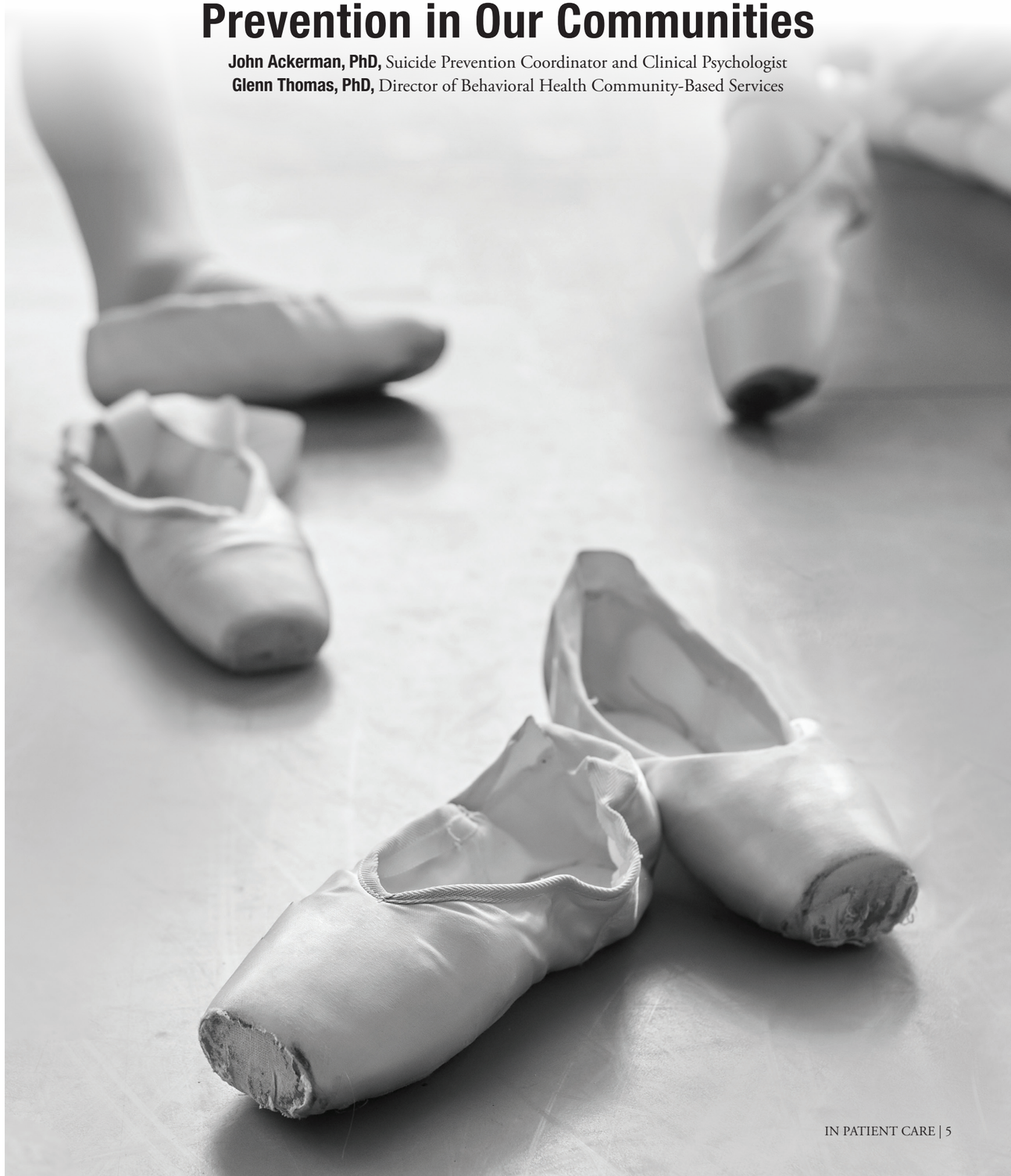
To promote children's mental health, our Behavioral Health team provides a variety of services for patients ranging from early childhood to adolescence. These services focus on five key areas: inpatient, outpatient, crisis services, research and improving partnerships with our community providers.

Our comprehensive inpatient services allow intensive treatment for those who cannot be treated in outpatient clinics. We offer a wide range of outpatient therapies, including innovative telehealth visits. These visits enable children and families to have an outpatient visit from their homes which is a more natural and less stressful environment. Our outpatient therapy programs include specialized care for eating disorders, family support focusing on child maltreatment and domestic violence, mood and anxiety disorders, substance abuse treatment and THRIVE. The THRIVE program specializes in care for differences of sexual development (DSD), gender development and complex urological conditions. These wide range of programs are provided by a multidisciplinary team which includes specially trained psychiatrists, psychologists, neuropsychologists, advanced practice nurses, child development specialists, social workers and registered nurses.

Children's mental health is often overlooked and underfunded in regards to pediatric health care and research. We are breaking those boundaries at Nationwide Children's. We are committed to changing the stigma around mental health while making an impact on our children and youth during critically important and formative years. Through our research, we hope to better understand the causes and identify the most effective treatments for these conditions and address the rising rate of youth suicide. We are committed to improving the mental health of the more than 175,000 children in our service area who need our care.

Advances in Promoting Suicide Prevention in Our Communities

John Ackerman, PhD, Suicide Prevention Coordinator and Clinical Psychologist
Glenn Thomas, PhD, Director of Behavioral Health Community-Based Services



Suicide is a critical yet under-recognized public health issue, particularly in children and adolescents. Nationally and in Ohio, suicide is the second leading cause of death for youth and young adults. Rates of youth suicide have increased nearly 60% from 2007 to 2016 and rates of suicide among 10- to 14-year-old girls nearly tripled in that same timeframe. Of concern, the suicide rate among African American youth has been found to be increasing faster than any other racial/ethnic group. Moreover, data from the 2017 Youth Risk Behavior Survey indicate that 17.2% of high school students seriously considered suicide in the previous 12 months, 8.6% reported attempting suicide and 2.2% reported receiving medical care for a suicide attempt. Recent data collected from 49 U.S. children's hospitals indicate that from 2008 to 2015 hospitalizations for suicidal ideation and suicidal encounters doubled among children 5 to 17 years of age. Closer to home, Franklin County has also experienced a concerning rise in youth suicides. In an effort to turn the tide, Nationwide Children's Hospital established the Center for Suicide Prevention and Research (CSPR) in 2015, as an innovative partnership between Behavioral Health and The Research Institute. Below we outline some of the CSPR's initiatives aimed at slowing and reversing the rate of pediatric suicide.

The Importance of Prevention

Nationwide Children's Behavioral Health has committed significant resources to support youth with acute needs, including suicidality, in response to the increasing need in the community. However, there is also a need for upstream universal prevention programming to increase awareness of depression and suicide risk in youth and proactively identify those at risk before there is a need for emergency care. Ideally, this upstream work involves partnerships with families, schools and communities and meeting their needs in a culturally sensitive manner. Furthermore, by its very nature universal prevention programming is provided to all youth in a given setting, thereby limiting the impact of social disparities. The CSPR is committed to providing best practice suicide prevention that breaks stigma, starts critical conversations, teaches core prevention skills to all members of our community and reduces the burden on those most vulnerable to suicide.

School-Based Suicide Prevention

One of the first major undertakings of the CSPR has been the dissemination of a nationally recognized program, Signs of Suicide (SOS), to middle and high schools in central and Southeastern Ohio at no cost to the schools. SOS is an evidence-based program that teaches students how to identify signs of depression and suicide in themselves and their peers, while training school professionals, parents and community members to recognize at-risk students and take appropriate action to access support. The program is based on the **ACT** acronym: 1) **Acknowledge** a friend's distress; 2) Show you **Care**; and 3) **Tell** a trusted adult. Additionally, a brief depression and suicide screening is administered to identify students with potential mental health needs. The SOS program is supported by three randomized control trials that demonstrate a 40 to 64% reduction in student self-reported suicide attempts in schools delivering this program. After the delivery of the SOS program, the CSPR serves in a training and consultation capacity to support school suicide prevention activities throughout the year. Our experience shows that over the course of two to three years of partnership, schools can deliver SOS and youth screening independently and with confidence.

The CSPR has now provided training and support to 2,020 classrooms in 142 schools in 18 Ohio counties. School staff have educated 43,227 students in the warning signs of suicide and how to respond. Screening and follow-up led to nearly 2,400 referrals for mental health services; many of these youth were previously unknown to have symptoms of depression or thoughts of suicide by school staff or parents. Additionally, the CSPR has developed strategies for both on-site and virtual training of school staff in risk assessment and safety planning which can increase a school's ability to manage risk in collaboration with families. Identification is only effective when there is a plan to meet the needs of youth who need support.

Expanding to Out of School Spaces

Of course, schools are not the only places where youth spend time with peers and trusted adults. The CSPR also provides trainings to camps, recreation centers, clubs, faith-based communities and other out-of-school spaces to meet youth where they are. In 2019, the CSPR partnered with the Boys and Girls Clubs

of Columbus (BGCC) to develop a "Next Big Safety Idea" project identifying emotional wellness needs in Columbus area clubs. This led to a collaboration among the CSPR, BGCC and national youth suicide prevention leaders from the American Association of Suicidology (AAS) to develop a gold standard suicide prevention program for staff and club youth with an emphasis on connection, skill-building, and mental health and suicide awareness. BGCC staff have now been trained over each of the past two summers to look for warning signs of suicide and how to respond to at-risk youth through a trauma-informed lens. The program has been piloted successfully and there is a plan to expand throughout the state with grant support from the Ohio Suicide Prevention Foundation.

While the CSPR had already begun to develop virtual prevention offerings, the COVID crisis has highlighted the importance of being able to provide suicide prevention flexibly in the absence of face-to-face interactions. Fortunately, the CSPR have just been awarded grants from Columbus Public Health and the Ohio Suicide Prevention Foundation to continue the important work of developing virtual trainings and programming. Staff have been adding trainings to address the specific suicide prevention needs for youth of color, foster children, families of first responders, youth in rural communities, as well as a wide range of faith-based communities. In communities where a disproportionate number of risk factors are encountered by youth, awareness and action of many caring adults is needed to address the public health problem of youth suicide.

Zero Suicide and Caring Contacts

The CSPR has also helped drive the implementation of the Zero Suicide initiative in Behavioral Health and its expansion across other service lines at Nationwide Children's. Over the past 12 months, all Behavioral Health providers and clinicians have received advanced training in identifying and responding to suicide risk and Epic has been optimized to support this endeavor. Zero Suicide, as was outlined in an Everything Matters in Patient Care article in 2019, is a comprehensive set of best practices designed to improve care for patients at risk for suicide, prevent them from slipping through the cracks, and support the clinicians who identify and work with these patients. Elements include screening for suicide risk, comprehensive assessment, safety planning (including lethal means restriction), referral to care where necessary and effectively managing transitions in care from a hospital-based level of care to the community.

For patients admitted for suicide risk, the month post-discharge from inpatient care is a high-risk period. Supportive, validating communications to patients during this transitional period have been shown to reduce risk of suicide. Initially taking the form of letters and cards, these "Caring Contacts" are a simple and effective means of reducing risk intended to be supportive and encouraging while not placing any demands on the patient. Funded by a grant from the Ohio Suicide Prevention Foundation, the CSPR has developed several series of texts containing esthetically pleasing and emotionally rich images combined with encouraging messages. These texts were developed in collaboration with Crisis Services and incorporated feedback from patient focus groups and our lived experience representative (e.g., a young adult with a history of suicide attempts previously treated at Nationwide Children's) to the Zero Suicide Implementation Team. A series of Caring Contacts texts are sent directly to patients over a period of four months following discharge. Initial responses to the texts have been very positive.

In conclusion, the scope of suicide prevention is necessarily broad, from early education and identification, to follow-up during transitions of care after a suicide-related crisis. Nationwide Children's is fortunate to have an impressive continuum of suicide-related care, including Crisis Services, Inpatient and Crisis Stabilization, and intensive treatment programming. While the CSPR takes seriously its role in helping to prevent suicide among those already demonstrated to be at a significant level of risk, its main focus is to provide and disseminate effective and innovative early universal prevention services so that fewer youth and families ever experience the level of distress and crisis requiring more intensive services. This in turn will spare all schools and communities we serve the trauma of such tragedies and reduce the demand for acute services at a time when access to care has become a significant issue.

Big Lots Behavioral Health Pavilion Pharmacy: Providing Care with Nationwide Children's Hospital Vision in Mind

Meredith McCauley, PharmD, BCPP, Behavioral Health Patient Care Pharmacist
Lauren Leiby, PharmD, Behavioral Health Patient Care Pharmacist

Nationwide Children's Hospital is rooted in our vision of working toward Best Outcomes in everything we do. With this in mind, the Behavioral Health pharmacy team is motivated to work toward best medication outcomes for children admitted to the Big Lots Behavioral Health Pavilion and beyond. Through our pharmacy team expansion, transitions of care services, and virtual education efforts we continue to strive toward this vision.

In 2018, the first pharmacist dedicated solely to inpatient behavioral health started at Nationwide Children's.

With the opening of the Behavioral Health Pavilion, the Behavioral Health pharmacy team has grown to include four pharmacists, most having completed post-graduate training in psychiatric pharmacy. This expansion, combined with our team's agility and innovativeness, has allowed for increased clinical pharmacy presence throughout the Behavioral Health Pavilion. We are able to provide therapeutic drug monitoring, assist in the development of protocols to ensure safe, evidence-based use of medications and increase medication education efforts.

Care transitions are an important aspect in ensuring optimal patient care, with accurate medication reconciliation during the admission process being a vital component. For the Behavioral Health Pavilion, we adapted the pharmacy intern-led medication history process from Nationwide Children's Emergency Department to meet the unique needs of the Behavioral Health patient population while ensuring staff safety. By training both pharmacy technicians and interns, we hope to better assist patients, families and providers in navigating medication questions during the admission process.

An additional effort to enhance transitions of care involves our discharge medication dispensing process. Nationwide Children's outpatient pharmacy offers a Med-to-Beds service, where discharge prescriptions are delivered and medication counseling is offered at bedside to ensure patients leave with their medications in hand. Our Zero Hero attitudes reminded us to exercise caution when dispensing medications on Behavioral Health units, as medications that are not stored in a locked location or staff supervised area could potentially be found by patients and used in an attempt to self-harm via intentional ingestion. The Behavioral Health pharmacy and Meds-to-Beds teams are continuing to develop a process that ensures patients have access to their medications while emphasizing secure medication tracking and storage throughout the discharge process.

As virtual health care and education platforms are expanding, opportunities for community outreach have surfaced. The Extension for Community Healthcare Outcomes (ECHO) team is a virtual education initiative that facilitates sharing knowledge from local specialists to surrounding community healthcare providers. One of our Behavioral Health pharmacists plays an active role on the Nationwide Children's Behavioral Health ECHO team where Behavioral Health medication information, such as important adverse effects, monitoring parameters and counseling points, is shared on a weekly basis. The goal is to empower these providers with Behavioral Health medication knowledge to enhance patient outcomes.

The Nationwide Children's Behavioral Health pharmacy team is excited to have the opportunity to expand pharmacy services, improve patient outcomes, and help break mental health stigmas with the opening of the new Behavioral Health Pavilion. As we aim to provide the best medication outcomes for the Behavioral Health patient population, we will continue to adapt our processes and develop innovative ways to meet the needs of our patients.

The Spirit of Inquiry: An Update on Nursing and Patient Care Services Science

Micah Skeens, PhD, RN, CPNP, Nurse Scientist

"Were there none who were discontented with what they have, the world would never reach anything better."

- FLORENCE NIGHTINGALE

Despite a multitude of events in 2020, the spirit of inquiry is strong in nursing and patient care services at Nationwide Children's Hospital. The spirit of inquiry can be defined as a "persistent sense of curiosity that informs both learning and practice." Staff focused on a spirit of inquiry will raise questions, challenge existing practices and pursue novel approaches to problem-solving. Inquiry encourages innovative thinking and fosters the possibility to develop unique solutions to patient care. Specifically, clinical inquiry is a constellation of research and research-related activities including evidence-based practice, quality improvement initiatives and innovation. Figure 1 depicts the components of Clinical Inquiry. At Nationwide Children's, nurses and many members of the Patient Care Services team participate in clinical inquiry as part of everyday practice.

This year alone several research studies, quality improvement projects, evidence-based projects and innovations have been conducted, developed and disseminated by nurses and other members of the Patient Care Services team including child life specialists, massage therapists and music therapists. Some of the projects and initiatives have been externally and internally funded, leading to almost $100,000 in funding this year to date. Table 1 provides examples of staff and the projects completed or underway. We know this is not an exhaustive list as many talented staff across the organization have projects underway. Now in our fifth journey to Magnet® redesignation, we will soon have a link on our intranet site for nurses to submit their work or seek a consult with the Nursing Research department. As a nurse scientist at Nationwide Children's I am proud of our strong culture of clinical inquiry and innovation and look forward to being a part of its growth in the future.

Figure 1. Clinical Inquiry Components

Table 1. Examples of clinical inquiry conducted by staff this year

Staff	Project
Ashley Dunaway, Carrese Stevens	Neonatal LPs in the ED
Stacy Whiteside	Fertility
Dorcas Lewe, Larissa Anglim	Simulation & Medication Errors
Gail Horner	Sexual Abuse in Children
Stacy Kuehn, Amanda Brown, Reena Patel & NEI Team	EPIC Virtual Classes
Brittany Mikuluk	Coping Plans and Botox Clinic
Lamar Love	Holistic Annual Care Plan for Children with Cerebral Palsy
Leslie Hoover, Crystal Seilhamer	Activity Restrictions and Spinal Fusion Outcomes
Janet Berry	Safety Culture
Kendra Skeens	Ambulatory Staffing
Jelila Agbemebia, Kim Regis	Early Lactation Program and Patient Outcomes
Brigid Pargeon, Jessica Bogacik	Music, Massage & Home-Based Palliative Care
Faye Willen	Outcomes in Hodgkin's Disease
Amber Pruett, Alyssa Baker, Mindy Bibart, Micah Skeens	Adherence in Stem Cell Transplant Patients *(DAISY funded)*
Summer Dougherty, Elizabeth Huenke, Marissa Larouere, Margot Ranney, Julie Gutentag, Leslie Thomas	Parent Beds in the NICU
Micah Skeens, Avery Anderson	Asherence App for Pediatric Oncology Patients *(Oncology Nurses' Foundation funded)*
Kate Busack, Paula Sanborn, Jennifer English, Amber Pruett, Mindy Bibart, Heather Bell, Micah Skeens	Parental Education Discharge Support Strategies in Children Newly Diagnosed with Cancer *(ANCC funded)*
Micah Skeens, Vicki von Sadovszky	Symptom Assessment App for Oncology Patients *(Johnson & Johnson funded)*
Rachel Chon	Nursing Attitudes and Beliefs About Clinical Research
Angela Blakenship	AHP Knowledge of EBP
Mindy Bibart	Partners in Practice

In Pursuit of Safe and High-Quality Care in Behavioral Health

Jahnavi Valleru, Manager of Quality Improvement Services

Nationwide Children's Hospital and the Behavioral Health program have a commitment to improving health outcomes in children and adolescents who interact with our health care system. Behavioral Health clinicians and providers, like all health care professionals, are engaged and working together to improve the quality of care and promote safety of vulnerable children who are seeking behavioral health care from us.

But, what does 'Quality' mean to us?

We recognize that patients and their families are the fundamental sources of the definition of quality: quality of medical care primarily refers to the degree of match between the needs of our patients and the healthcare services and products provided to them. Over the past six years, we built a robust Quality Improvement (QI) program in the Behavioral Health service line. We began by recognizing that our organization already had a robust QI system in place and a proven QI methodology that we followed – the Institute of Healthcare Improvement's (IHI) Model for improvement.

At the beginning of any QI work, we spend time and thought to gather the right amount of data and analyze that data to derive actionable knowledge. Lack of measurement can sometimes allow health care staff to not only live in an illusion that things around here are done well but can also underscore the quality and safety of patients by not painting a clear picture of gaps in our care. The data analysis helps us focus our efforts towards these gaps and support the improvement teams in ensuring that the improvements are sticking over time.

As in any other service line, Behavioral Health's QI work spans across all five pillars of Nationwide Children's Quality, Safety, and Strategic plan: Keep us well, Do not harm me, Cure me, Navigate my care and Treat me with respect. Few examples of our quality and safety efforts are summarized below:

In improving access to behavioral health services:

Timely pediatric diagnostic assessments and follow up care, especially in Psychiatry, therapy and Neuropsychology, promote child and family functioning, and improve long-term outcomes. Wait times to some of the outpatient services can be quite long, sometimes three to four months. Several clinics and programs within behavioral health used quality improvement projects and methods (e.g. Just-in-time scheduling) to reduce wait times and improve timely access to our patients.

In improving the safety of our patients:

Isolation and physical restraints are the most intensive interventions utilized in inpatient psychiatric units. Though necessary for patient safety, such interventions are rarely therapeutic and often increase the risk of physical and emotional injury in patients. We designed interventions to improve patient management and addressed staff training. Using several plan-do-study-act (PDSA) cycles, we carefully implemented interventions which led to a reduction in physical interventions by more than 50% within two years.

We continue to monitor these rates in the Big Lots Behavioral Health Pavilion as well and aim to reduce them further.

In improving the safety of our staff:

With the high volume of mental health patients on medical units, another QI initiative aims to improve nurse's safety. A focused QI project implemented interventions to address - education on the neurobiology of mental illness, the impact of trauma on symptom presentation, de-escalation skills, rapport building, and recognition and emotional support for suicidal patients. Interventions increased nursing knowledge and competence in caring for children with mental health disorders. The goal of these interventions is to reduce staff injuries over time.

In improving care for patients with suicidality:

Caring Contacts is an evidence-based intervention in which the patients' care providers provide short communications to their teenage patients to show support of their well-being and maintain a connection to their treatment following an inpatient stay at Nationwide Children's. Our Behavioral Health Zero Suicide team systematically implemented caring contacts phone calls and text messages to all 13 – 18 year old patients who were recently discharged from an inpatient stay for suicidality.

Conclusion:

For our health care system to cross the quality chasm, behavioral health should play a vital role in achieving the three dimensions of healthcare – health outcomes, value, and patient experience. A systemic approach (e.g., IHI Model for improvement) and organizational support are vital to improving healthcare processes and clinical outcomes. Our Nationwide Children's leadership support and staff buy-in are essential in improving the quality and safety of care, facilitate removal of barriers, and allocate resources to help teams on their journey of quality improvement.

Transforming Practice: Transitioning to Primary Nursing in Behavioral Health

Stacy C. Benton, MSN, RN NE-BC, Director of Clinical Services for Behavioral Health

Behavioral Health nursing is a developing field with many opportunities for growth. One key challenge is to determine the best evidence-based practice model that will support staff and follow scopes and standards of practice for mental health nursing. Research has shown that nursing practice grounded upon an evidence-based model improves patient and staff outcomes. The ideal model enhances the skill set of the psychiatric nursing staff while keeping them engaged as active members of the multidisciplinary care teams.

The Behavior Health Unit (T5A) opened in December 2015 as a beacon for patients with behavioral health needs. By April 2016, the need for broader services was evident. This increased demand ignited the concept for the Behavioral Health Program. With a vision in play, there were many expectations and responsibilities for the new leadership team. One of the greatest priorities was to get to know and listen to the multidisciplinary team. For the new director, it was vital to understand the program by watching the interactions, to learn the day-to-day processes and appreciate the complex job of caring for patients with behavioral health needs.

After the leadership team met with stakeholders, it became evident that a more extensive evaluation was required. The director reviewed engagement surveys and nursing documentation, asked questions and conducted rounds along with other members of the Behavioral Health senior leadership team. Next, the Behavioral Health senior leadership sat down with staff to gather direct feedback and better understand the team's perspectives and roles. Providers, clinicians and nursing staff consistently identified a clear disconnect. All agreed on the goal for the nursing staff to have a greater connection and involvement in the care of the patients and families, yet the nursing team felt they lacked the knowledge and confidence to speak to patients and families regarding the patients' care. Many staff identified feeling uneducated, ill-equipped and unsure of their participation in the patients' care. Nurses' engagement in the patients' plan of care was incomplete and even absent occasionally. Charge nurses represented the nursing team in rounds and often had limited information and input. Nurses were minimally contributing to the medical record. While the nursing team spent a significant amount of time providing vital care to patients, many saw themselves as observers more than contributors. Mental health specialists and nurses identified a desire to better develop and utilize psychiatric mental health nursing skills to provide direct care to the patients and families they were serving. In essence, they wanted to have a greater impact.

After the comprehensive review, it was clear that the unit was practicing team-based nursing. This nursing style is based upon a shared approach where different members of the team complete tasks associated with the patients' care but disperse the responsibilities. This approach led to confusion. The nursing staff had great role models such as medical nursing, therapists and practitioners but had very limited understanding of how to put psychiatric care concepts in action into psychiatric and mental health nursing practice. The multidisciplinary team needed clarification on which activities and responsibilities were in the nursing staff's scope of practice. The team needed to determine the party responsible for owning and coordinating the day-to-day psychiatric nursing care of the patients. This inquiry and review prompted the director to search for a better nursing care model for the Behavioral Health Inpatient Unit. The director had prior experience implementing a primary nursing care model in a behavioral health setting and felt confident that it would benefit the program.

What is Primary Nursing

Primary nursing is, "a care delivery system designed (1) to allocate responsibility for each patient's care to one individual nurse for the duration of the patient's stay, visit, or series of visits and (2) to assign to this nurse the actual provision of the patient's care whenever possible." Primary nursing is rooted in the concept of Relationship-Based Care. Primary nursing promotes a therapeutic relationship between the nurse and patient while supporting nursing professional practice, facilitating family and patient involvement in care planning and enforcing accountability for care. While some misperceive primary nursing as an indication of who has authority over the patient, the Primary Nursing Care Model stands on collaboration and inclusion of the nurse and the importance of a multidisciplinary team.

Implementation of primary nursing required a change in the coordination of the patient's care and a leveraging of the nursing staff's responsibilities. Information regarding the patient's day-to-day status would no longer be funneled up and reported out to the treatment team by the charge nurse. Instead there would be nurses assigned to a specific team of patients and representing that team in rounds. This also meant nurses and mental health specialists would be engaged in leading groups and documenting the outcomes of the groups. The nursing staff would contribute information regarding progress toward the goals on the patient's plan of care. The nursing staff would function to their full scope therefore supporting the patients, families and multidisciplinary team by being active and engaged collaborators.

As an HRO, the Primary Nursing model also aligns with the hospital's "One Team" philosophy. When well implemented, primary nurses not only build psychiatric nursing autonomy but support psychiatric nursing expertise at the bedside. Primary nursing allows managers to support the development of critical thinking for the nursing team and supports an environment of inquiry. Nursing managers become allies in the development of staff instead of an authoritarian of systems and processes.

What are the benefits of a Primary Nursing Care model?

Some may initially question the benefits of a primary nursing care model in a behavioral health setting. The benefits enjoyed in behavioral health settings are as abundant as any other nursing arena. Primary nursing offers consistency in patient care and has historically demonstrated improvements in patient outcomes. Primary nursing aligns with Magnet® principles by supporting nursing engagement and advocacy and supporting nursing professional practice. Nursing teams who adopt a primary nursing model demonstrate improvements in outcome measures such as readmission rates, falls and infections. As as result of the implementation of the Primary Nursing Care Model into Nationwide Children's Behavioral Health system, the team anticipates improvement in outcomes such as decreased seclusion and restraint rates, decreased staff injury incidents and improved staff satisfaction.

Another supportive component of the Primary Nursing care model is nurse-led rounds. Nurse-led rounds support patient care by assuring the nurse-perspective of the patient is shared and perceived concerns are highlighted. Nursing leadership is engaged in the management of trending concerns and customer recovery needs. Primary nursing also supports staff-led groups that promote the development of coping skills and medication awareness amongst other skills.By leading and facilitating groups, the nursing staff continue to nurture and build necessary relationships with patients.This rapport and understanding of the patients better support the primary nurses' ability to be informed and best advocate for the needs of the patients and families. All in all, the goal is to have members of the multidisciplinary team who spend a significant amount of time with the patients highly engaged in the patients' care.

Primary nursing has some specific benefits for families and caregivers as well. Parents and caregivers can have a specific nursing point of contact to minimize the need to retell their history. With primary nursing, parents and caregivers get to have a familiar face who knows their family and child; thereby creating broader connection to the nursing team that is providing care. Primary nursing can ease the stress for families when they see a familiar face that knows their needs.

What are the current challenges?

In the Behavioral Health Program, much work has been done to initiate primary nursing as the care model for our programs. There remain opportunities for growth. Work continues to enhance collaboration amongst the nursing staff and insure the responsibilities of the primary nursing team are leveraged across nursing staff roles and varying shifts. Another opportunity is increased engagement of direct care nursing staff in processes and practices related to the care provided on the unit. The aim is to increase staff participation in Strategic Partnership and other practice influencing committees. Educational lunch and learns regarding topics like psychiatric nursing scope and standards of practice and commonly utilized psychotropic are other efforts to empower nursing practice in the Behavioral Health department. By mitigating these challenges, the program anticipates increased confidence, knowledge and engagement of the staff who are providing direct care.

Although it has been less than a year since the implementation of the Primary Nursing Model in the Behavioral Health Program, the establishment of primary nursing as the nursing care model provides beneficial outcomes for all. Wessel and Manthey state, "By authorizing the nurse who delivers care to decide how that care will be delivered, the institution acknowledges that staff nurses are intelligent, educated people who are capable of deciding how to provide sensitive and sensible individualized care." The role of nursing in the Behavioral Health Program continues to grow and develop its practice. The vision is that the mental health programs function as a hallmark in the community for the development of psychiatric nursing skills. Recruiting, educating and developing a strong psychiatric nursing workforce is paramount to meeting the One Team goal of the Behavioral Health Program being a leader in the mental health community. It is also paramount in meeting the needs of our greater community.

How Do We Self-Care When Our Community Needs Care?

Kelly Papenfus, MSSA, LISW-S, YOU Matter Staff Support Clinician

We are living in unprecedented times. As the needs of our clients, patients and family members become greater, the emphasis on self feels less important. When we look back in history books, we want to be able to say: I was a helper; I led by example. As employees of Nationwide Children's Hospital, we know that now is the time to step up, and yet we might feel scared, fatigued and worried for the future.

As we continue to expect more of ourselves, we sacrifice our mental health, our physical well-being and our relationships. We feel selfish for spending an hour exercising, turning off the news or planning a well-deserved day of paid time off (PTO). But here is the irony: Without self-care, there can be no community care. Say it again. Without self-care, there can be no community care.

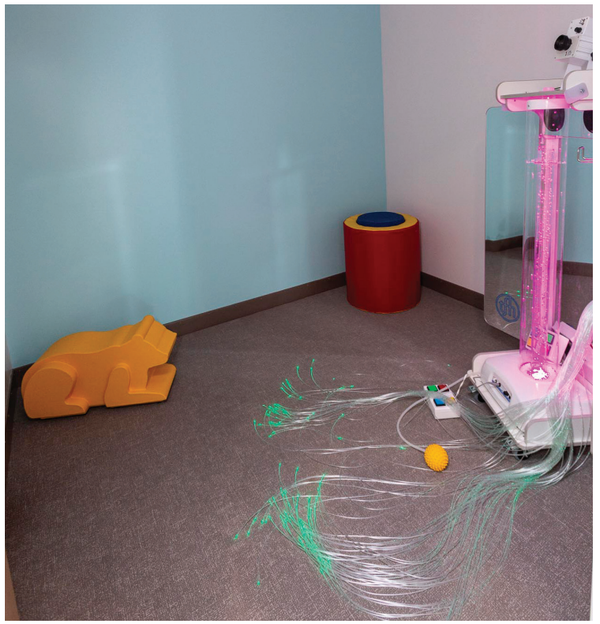
For those who have flown in an airplane, we know to put the oxygen mask on ourselves before a child. This action is to ensure that an adult does not faint before putting a mask on a child. We can apply this idea to our thoughts surrounding self-care: If I do not tend to my needs, I will not be able to tend to the needs of others. Self-care is not selfish; it is necessary to survive and evolve.

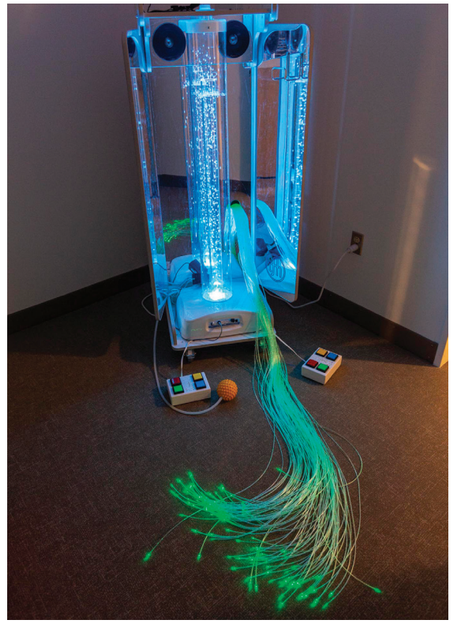
When we ignore our personal needs, our empathetic responses to the families we serve weaken, our views become jaded and our goals seem less important. How can we deeply love another if we choose not to love ourselves? Self-love can take on many forms. It is a mindful walk through the park, a sweat-filled cardio class, a coffee date on a patio and a long nap on the couch. Self-love requires deliberate action towards the self and for no one other than the self. When you engage in self-care, you know self-love.

If you are reading this, I encourage you to take this seriously. Find what brings you joy. To find your joy, consider what brings you to the present. Have you ever had an experience and thought: Wow, I feel so lucky to be alive and witnessing this moment? That is bliss, and I challenge you to reject all else as satisfactory until you feel this way. For me, it is creating art and it is yoga. It is listening to windchimes in my parents' backyard. It is reading a yummy book in the quiet. It is a hug from my grandma. It is writing to all of you.

Self-care looks like continuous acts of self-love. It is showing up for yourself so that you can show up for your community. Consider how you can incorporate daily practices into your routine and schedule it into your calendar. Remind yourself that you need these self-care rituals to keep moving forward. And as my program always says: YOU Matter.

"When you engage in self-care, you know self-love."





The Role of Comfort Rooms in Behavioral Health

Vonda Keels-Lowe, MSN, CPN, PMHNP-BC, CNP, Nurse Practitioner, Behavioral Health / T5A

Imagine a room where a child can go when they are feeling upset, worried, or angry. A room that will provide a source of calm. That room is referred to as a "Comfort Room." Comfort Rooms are considered an emerging practice in mental health treatment. A Comfort Room provides a supportive, therapeutic environment where patients can use self-help techniques to manage their behavior and emotions in a safe environment. It is a designated space that is intentionally designed to help calm an individual when they feel stressed or become overwhelmed. A Comfort Room provides a sanctuary from stress by temporarily limiting sensory stimulation and interpersonal interactions.

The Big Lots Behavioral Health Pavilion is fully dedicated to children and adolescents with behavioral health challenges and illnesses. Research and evidence support the use of comfort rooms as a part of behavioral health treatment, therefore; a Comfort Room was placed on every floor of the Behavioral Health Pavilion, including the Psychiatric Crisis Center. Each Comfort Room has been designed for specific use by the units to meet their individual patient needs.

Evidence has shown that Comfort Rooms have contributed to a reduction in seclusion and restraint, as well as a patient's stress or agitation level, and an increase in a patient's relaxation and cooperativeness. Each room includes space for relaxation and guided imagery. Furnishings are comfortable and pleasing to the senses. Music can be selected from an iPad and streamed into each room. Ambient lighting is also a unique feature and colors can be chosen by the patient. Another feature in most Comfort Rooms is the Comfort Cart, which is a sensory mobile unit with various features including aromatherapy, weighted fiber optics, and a bubble tower feature.

Success requires a multidisciplinary team approach and an understanding of trauma informed care principles. All Behavioral Health Pavilion staff are trained to recognize children and adolescents who may be struggling and assist by offering support and a sense of calm. Being able to provide a room designed specifically to meet that need, enables us to accomplish this goal on a daily basis.

Onboarding of the Psychiatric Nursing Team

Erica Konstand, MSN, RN-BC, Behavioral Health Program Manager – Nursing Orientation
Sue Orme, MSN, RN-BC, Clinical Educator, Big Lots Behavioral Health Services

Behavioral health services expanded to provide much needed care to our community with the opening of the Big Lots Behavioral Health Pavilion. With the expansion of services, staffing needed to increase from one inpatient psychiatric unit to several. In the Behavioral Health Pavilion, there are five units open or opening this year: Psychiatric Crisis Department and Extended Observation Suite (BH1A), the Youth Crisis Stabilization Unit (BH3A), the Neurobehavioral Unit (BH7A), the Child Unit (BH7B) and the Adolescent Unit (BH8A)—slated to open October 2020. This necessitated additional staff and a way to onboard them.

Nursing onboarding can be challenging. Onboarding must accommodate staff of all skill levels, backgrounds and experiences. Nurses present with a variety of education and experiences in the field of mental health, from none to very experienced. Designing a program that is both educational and engaging is critical for learning and retention of essential content.

To meet the educational needs of such a varied group, Behavioral Health Nursing leadership provided a vision to onboard nursing staff. Guided by prior work in her development of a psychiatric residency program, Stacy Benton, MSN, RN, NE-BC, Director of Nursing in the Behavioral Health Pavilion provided the structure of onboarding and orientation to ensure newly hired nursing staff would develop competency and confidence in their roles. Every detail of the process from hiring through orienting and onboarding required special attention. Staff were hired in large cohorts. The cohorts allowed new hires to develop relationships with peers. This peer support fostered a team-based approach and allowed for the development of professional relationships and camaraderie on the units.

Education focused on mental health interventions and best practices for patients and families. Specific topics important to psychiatric nursing were identified by a multidisciplinary team of behavioral health leaders. Content was developed and presented by organization experts including nurses, psychiatrists, advanced practice providers, psychologists, clinicians, and other disciplines. These experts gave interactive presentations during Welcome Week. Welcome Week was a week-long, seminar-style orientation of behavioral health topics, such as “Psychiatric Emergencies” and “Direct & Vicarious Trauma.” These topics helped familiarize staff with situations seen in any health care setting but are commonplace to behavioral health.

After Welcome Week, staff were precepted on the Inpatient Psychiatric Unit and the Youth Crisis Stabilization Unit. New staff also rotated throughout the medical-surgical units to see how behavioral health needs present in different patients. Didactic Education Days were incorporated into the onboarding process to cover behavioral health topics, have a safe space to discuss experiences, and continue to build relationships with other members of the team.

Prior to opening of the Behavioral Health Pavilion, tours took place to familiarize staff with the building and equipment. Tours included viewing the Psychiatric Crisis Department and the Safe Car for transporting patients between buildings. Department trainings took place throughout the month of February 2020. Staff participated in simulations such as mock Code Violets and patient admissions. The Simulation Lab was instrumental in using video cameras to film the workflow processes in the departments. Various forms of simulation experiences provided staff opportunities to interact with the multidisciplinary team in the new space, a critical component to ongoing collaboration. On March 10, 33 patients were transferred successfully from Nationwide Children's main campus to the Behavioral Health Pavilion seamlessly thanks to the coordination of Behavioral Health staff working together.

To be responsive to the learning needs of future cohorts, changes to the orientation process were made to have smaller cohorts, update processes, and allow for orientation and onboarding during the COVID-19 pandemic. Virtual learning and in-the-moment adaptability have put our agility and innovation to the test. Nursing will continue to be at the forefront of orientation and ongoing education as the Behavioral Health Pavilion grows and serves our communities.

The Behavioral Health Family Advisory Council: Increasing Family Advocacy and Voice

Kayla Zimpfer, PCC, Community Liasion, Child Abuse Prevention Coordinator-Center for Family Safety & Healing
Samanta Boddapati, PhD, PAX Prevention Coordinator, Behavioral Health Wellness Initiatives

The Big Lots Behavioral Health Pavilion at Nationwide Children’s Hospital vastly expanded the mission, reach and services promoting mental health in children and adolescents. This has included several initiatives such as the *On Our Sleeves®* movement, a national campaign to break the silence surrounding children’s mental health.

The Behavioral Health Family Advisory Council (BHFAC) was established in May 2019 to represent patients and families’ voices in providing important behavioral health services and programs. The BHFAC is a collaboration between staff and family advisors. The composition of the council includes a small group of caregivers or guardians of children who have utilized behavioral health services at Nationwide Children's. Behavioral Health staff and leadership serve as coordinators and liaisons. Through advisory council activities, caregivers provide feedback to staff on a range of behavioral health-specific topics, including existing services, new programming, facilities, and family care issues. The Behavioral Health staff provide families with updated information on new behavioral health initiatives at Nationwide Children’s.

This special council is beneficial to both Behavioral Health staff and the families we serve. As noted by one of the family advisors, Katie Wion, “…I am deeply moved and fulfilled by the coming together of providers and families as we have had open conversations rooted in compassion; evoking real change.” Input from family advisors inform decisions about treatment and our care environment, such as separating the outdoor courtyard space to provide more privacy. In addition, key feedback from the advisory council provided to the On Our Sleeves marketing department has led to important changes in campaign website and how information is disseminated to others.

After an initial year of success, the BHFAC will continue to recruit advisors that represent a range of family experiences and behavioral health services. With the additional growth and visibility of the council and behavioral health programming, advisors will have ongoing opportunities to participate in committee projects and children’s mental health advocacy efforts throughout the hospital. Such opportunities include council members giving a variety of presentations for new behavioral health staff during orientation, mentoring families, and speaking at national conferences to advocate for children’s mental health. One of the parent advisors also presented at the opening of the Behavioral Health Pavilion in March 2020.

As the momentum behind this initiative continues to grow, both the behavioral health department and advisors are excited for new opportunities and continued collaboration to advocate for the best possible patient and family-centered care. As summarized by advisor, Katie Wion, “I look to the months and years ahead with immense hope as this dynamic group continues to give children with behavioral health conditions, and their families, a voice. It is a profound opportunity to simply do the right thing.”

Motivational Interviewing

Katherine Myers, MSN, APRN, PMHNP-BC, Behavioral Health Nurse Practitioner
Krista Sheridan, MSN, APRN, PMHNP-BC, Behavioral Health Nurse Practitioner

Motivational interviewing (MI) originated from the work of William Miller and Stephen Rollnick, who co-authored, "Preparing People to Change Addictive Behavior" which was published in 1991. According to Miller and Rollnick, "MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. The goal of MI is to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." MI is a collaborative process, which acknowledges that although the practitioner is an expert in helping people change, individuals are experts in their own lives. MI is a deviation from the age-old practice of using confrontation and shame to motivate people. The practitioner does not provide unsolicited advice, instructing, directing, or warning but fosters an environment of natural curiosity.

Curiosity is the core foundation of MI. This curiosity steers the practitioner to use such strategies as open-ended questions, affirmations and reflective listening to better understand the person's values and hopes. Such techniques also assist the practitioner with ascertaining where they fall within the circular stages of change model:**Precontemplation**: the individual does not believe a problem exists, is in denial or there may be a lack of knowledge, which could require psychoeducation **Contemplation:** the individual is reflecting upon the issue and where ambivalence surfaces. An individual can remain in contemplation for a long time. **Preparation**: stage approaching the end of contemplation and the individual is saying "I am ready to make a change." **Action**: where they try out the change. This is where the intervention should be carried out–not in preparation as it may be too soon. **Relapse**: part of the change process, not an exception. It is a test of change that didn't work. Important question to ask in this stage is, "where did they relapse back to?" **Maintenance**: where the change is supported and able to flourish.) It is the practitioner's role to identify where ambivalence exists within the person's goals, values, and their behaviors. The practitioner pulls together this information in a way that helps the person move forward in understanding and healing. It is the practitioner's role to identify where ambivalence exists within the person's goals, values, and their behaviors. The practitioner pulls together this information in a way that helps the person move forward in understanding and healing.

MI is a strategy for communication rather than a technique or intervention. In the clinical setting, MI can be effectively utilized during regularly scheduled appointments, as well as in shorter therapeutic appointments, to empower patients and families to begin the process of change. MI can be applied across different settings (i.e. health care, mental health, school), treatment modalities (i.e. individual, group, telemedicine), populations (i.e. age, ethnicity, religion, sexual, gender identity) and target different concerns (i.e. medical conditions, exercise, nutrition, mental health, trauma, substance use, illegal behaviors).

Ironically, the power of MI comes from the unique ability to dismantle the power imbalance in the practitioner-patient relationship. Rather than telling the person what is right and is expected, the practitioner asks the patient what the experience is like for them? This disruption in power creates a safe space where the patient feels heard and not judged. MI opens and not closes doors, creates possibilities not roadblocks and replaces shame with empowerment.

Nationwide Children's Hospital offers an informational course on MI. For course offerings, please visit The Learning Center on ANCHOR.

Below is a chart from the Nationwide Children's Hospital MI course, demonstrating some of the common communication techniques utilized for MI.

Desire	Ability	Reasons	Need
How badly do you want that?	How would you do that if you wanted to?	What concerns you about your...?	What needs to happen?
How would you like things to be changed?	What do you think you might be able to change?	What concerns do your family or friends have about your...?	How important is it for your to...?
How would you like things to be different?	If you did decide to do ___ what makes you think you could do it?	What has your ___ cost you?	How serious or urgent is this to you?
What would you enjoy about that?	What skills do you have that would make it possible?	What are some not-so-good things about ___?	What do you think has to change?
Tell me what you don't like about how things are now?	How have you managed this before?	What might be some good things if you no longer ___?	Complete the sentence: I really have to...

Behavioral Health Patients arriving by Police or EMS

Kenny Hoffman, MS, BSN, RN, CEN, Paramedic-Program Manager, Emergency Communications and EMS Outreach

Patients being brought into Nationwide Children's Hospital by Emergency Medical Services (EMS) or police agencies call by radio or phone into the Emergency Communications Center (ECC) located just inside the trauma room doors of the Emergency Department (ED). Report is given including the patient's age, gender, chief complaint, vital signs and estimated time of arrival. The report is then relayed to the Emergency Department Charge Nurse or Patient Flow Coordinator for bed assignment.

Prior to the opening of the Big Lots Behavioral Health Hospital in March 2020, the inbound patients all came into the main ED. Once opened, criteria needed to be established to identify whether patients would be brought to the main ED or Behavioral Health Pavilion's Psychiatric Crisis Department (PCD). The planning for this criteria began nearly a year prior to the opening of Behavioral Health Pavilion. Leslie Mihalov, MD, an Emergency Medicine physician, established a small team to identify the appropriate criteria which would direct the patient flow. Questions included:

- Is the chief complaint medical or injury related?
- Is there an abnormal vital sign (based on established age-related normal signs from the American Heart Association's Pediatric Advanced Life Support course)?
- Is there an abnormal physical finding?
- Did the patient intentionally take an overdose of medication?
- If the Behavioral Health Pavilion was open would you have directed EMS to that location?

Using the questions as a template, the Emergency Communications Center Specialists listed the routing for each behavioral patient that was brought in for six months. Dr. Mihalov reviewed each chart for retrospective accuracy. The results indicated that the ECC staff were 100% accurate in routing to the correct location.

Just prior to the Behavioral Health Pavilion opening, more specific criteria were identified for routing patients to that location.

Betsy Schmerler, MD, the Behavioral Health Pavilion PCD Medical Director, identified that if a patient needed any care beyond strictly behavioral health concerns, they needed to be routed to the main ED. This would include any injuries needed treatment, ingestions, unstable vital signs, etc. That information was rolled out to all area EMS and police agencies with the assistance of the Central Ohio Trauma System departmental database. This was further communicated by flyers mailed and presented at the Behavioral Health Pavilion EMS/Police open house, as well as frequent reminders provided by Laura Holdren MS, RN, the Nationwide Children's EMS Coordinator.

While a few tweaks have been required, the system is working well. The inbound agency calls the ECC with patient information, the destination is established according to the report received, and the EMS or police agency is directed to that location. The Charge Nurse of the destination department is notified by the ECC Specialist, and the patient is received.

With no template or guide to assist, the flexibility of the ECC staff, nurses and physicians from both locations, local EMS and police agencies and many others have made this new endeavor as seamless as possible and have, above all, kept the care and safety of our patients as our top priority.

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Daisy Award

Marissa Kabbaz, RN

The quarterly Nationwide Children's Hospital Daisy Award was presented to Marissa Kabbaz, RN, of the Emergency Department. The Daisy Award is given in appreciation of the important difference our nurses make in the lives of our patients and families at Nationwide Children's.

Marissa received the Daisy Award for her devotion to a patient and demonstrating extraordinary care. After a young patient did not survive a car accident, the patient's mother asked if Marissa could stay with her child while they were still in the Emergency Department.

Says Marissa's nominator: "Mom left the beside around 6 p.m. and although Marissa's shift ended at 7 p.m., she stayed at the bedside, provided post-mortem care and took the patient down to the morgue. She did not leave for home until after 9 p.m.… Marissa provided great emotional support to a mother who lost her spouse and young child in the same day. The trust that she established created a comfort in the mother leaving her child and she strived to go above expectations in her role."

To learn more about our Daisy winners, and read their full nomination, visit **NationwideChildrens.org/Daisy-Award**

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