2019 BC-ONCAIPS

Provincial Child & Adolescent Inpatient Psychiatry Standards

BC Children's Hospital
Provincial Health Services Authority

Prepared for the BC Child and Youth Mental Health & Substance Use Care Advisory Network

The BC standards were adapted from the original ONCAIPS 2015 Standards.
ONCAIPS (2015) 2015 ONCAIPS Collaborative Provincial Child & Adolescent Inpatient Mental Health Standards. Ontario Network of Child and Adolescent Inpatient Psychiatry Services.

Authors:

Jana Davidson, Psychiatrist-in-Chief, BC Children's Hospital Head, Division of Child & Adolescent Psychiatry

Andre Picard, Provincial Director, Youth Forensic Psychiatric Services, Ministry of Child & Family Development

Colleen McEwan, Manager, Adolescent Psychiatry Unit, Interior Health Authority

Jennifer Begg, Executive Lead, Child and Youth Health Program, Northern Health

Jordan Cohen, Manager, Regional Carlile Youth Concurrent Disorders Centre and North Shore Child and Youth Mental Health and Substance Use Services, Vancouver Coastal Health

Maureen Mackinlay, Director, Tertiary Acute and Rehab Mental Health, Interior Health Authority

Mike Kenyon, Manager, Child, Youth & Young Adult Mental Health & Substance Use Services, Fraser Health Authority

Sandy da Silva, Health Services Administrator, Tertiary Mental Health, Mental Health and Substance Use, Interior Health Authority

Shannon Vogels, Project Manager, BC Children's Hospital

Susan Gmitroski, Manager, Child, Youth and Family Mental Health and Substance Use, Vancouver Island Health Authority

Tanis Evans, Manager, Mental Health and Substance Use Strategic Initiatives, Vancouver Coastal Health

Tom Jensen, Director, Maples Adolescent Treatment Centre and Complex Care Programs, Ministry of Child & Family Development

BC Children's Hospital Contact:

Jana Davidson, MD, FRCPC
Psychiatrist-In-Chief
Child, Youth and Reproductive Mental Health Programs
BC Children's Hospital
Box 141, 4500 Oak Street Vancouver, B.C. V6H 3N1
jxdavidson@cw.bc.ca

Suggested Citation:

BC Children's Hospital (2019). *2019 ONCAIPS-BC Provincial Child & Adolescent Inpatient Mental Health Standards.* BC Children's Hospital, Child and Adolescent Psychiatry.

Table of Contents

Background

There is a strong desire among the leadership of the various child and adolescent psychiatric inpatient units in BC to provide consistent access and high quality, evidence-informed care to the children and youth admitted to their services. Following the development of the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS) standards in 2015, and in the context of discussions with the ONCAIPS network leads in Ontario, representatives from the BC Child & Youth Mental Health and Substance Use Care Advisory Network began work on adapting the ONCAIPS standards to the BC context in 2017. There was agreement that use of similar standards across the country would not only ensure delivery of high quality, standardized care, but would also facilitate national benchmarking in psychiatric inpatient care for children and youth.

Purpose of Standards

- To promote high quality care
- To promote safety
- To improve effectiveness
- To reduce unacceptable variations in care
- To improve efficiency
- To safeguard the rights and dignity of children, adolescents and families
- To integrate emerging best practices and evidence
- To promote child and adolescent inpatient research
- To provide guidance for what should be measured and benchmarked
- To encourage comparison against standards identified in the literature and provincial benchmarks
- To encourage collaborative comparisons and learning across inpatient units
- To identify areas for improvement in inpatient clinical and managerial practices
- To inform children, adolescents, parents, and professionals about the types and quality of services to expect

Focus

The BC adaptation of these standards is intended to align with and supplement relevant standards set by Accreditation Canada and the Council on Accreditation. It is expected that individual units will meet the standards of their accrediting bodies, and will refer to these as additional standards developed specifically for child and adolescent inpatient psychiatry.

The original ONCAIPS inpatient standards apply to crisis as well as assessment and treatment units that are 'general' or 'generic' in type. In BC, the adapted standards are intended to apply to all units, including specialized forensic, eating disorder, and concurrent disorders units.

Influences

Similar to the original ONCAIPS Standards Development working group process, BC engaged in a collaborative adaptation of the Ontario standards. ONCAIPS is part of a national body which may permit opportunity to further expand the provincial initiatives on standardization to a national stage; it was with this in mind that BC adapted the ONCAIPS standards to ONCAIPS-BC.

For the background information on influences on the development of the ONCAIPS (2015) Standards please refer to the original standards (Appendix 1).

Process

In 2017, consensus was reached among members of the CYMHSU Care Advisory Network that the ONCAIPS standards should be adapted to the BC context to enable both provincial and national standardization and benchmarking. An inpatient subcommittee was formed to collaboratively review and adapt the ONCAIPS standards to produce this document.

Contextual Assumptions

The standards are meant to be sensitive to cultural and special needs of children and adolescents, their families, and their communities, to be consistent with existing government legislation, hospital, professional and partner standards and policies[1], and to be responsive to recommendations from those with lived and living experience (see Figure 1).

[1] BC's Mental Health Act, Heath Care Consent Act, PHIPPA, PIPEDA, and all other pertinent acts, professional practice standards, hospital policies and procedures, government policies, and standards of partner agencies and services

Figure 1 ONCAIPS-BC Provincial IP Standards in Context

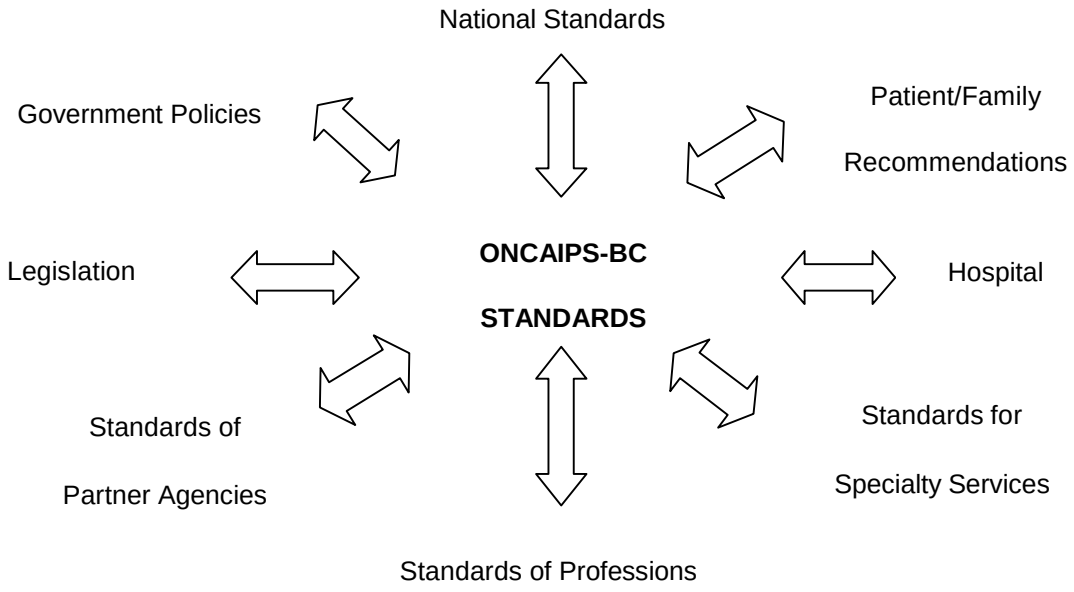

Figure 1. ONCAIPS-BC Provincial IP Standards in context * adapted from ONCAIPS Standards 2015

Provincial inpatient standards are expected to need updating across time as they reciprocally influence, and are influenced by their context.

THE TEN ONCAIPS-BC STANDARDS

1. SAFETY: The unit provides a safe environment for staff, children, and adolescents.

1.1. The unit utilizes documented policies and practice standards on safety-related practices

1.1.1. Assessment of medical stability on admission by a qualified health care provider

1.1.2. Clinical risk assessment to inform the plan of care

1.1.3. Regular mental status examination

1.1.4. Regular suicide risk assessment as required, with supporting documentation

1.1.5. Assessing and documenting risk of aggression towards patients/staff

1.1.6. Regular site-wide safety risk assessment (as per Worksafe BC violence risk assessments (Appendix 2))

1.1.7. Search of belongings

1.1.8. Personal searches only as required to ensure safety, as per trauma informed guidelines

1.1.9. Restraint and seclusion procedures (see Appendix 2)

1.1.10. Camera use for observation only as required to ensure safety, as per seclusion room standards, organizational privacy policies, and trauma-informed guidelines

1.1.11. Environmental/room and unit safety checks/rounds and documentation in alignment with BC Provincial Violence Prevention Curriculum

1.1.12. Standardized Hospital Color Codes (see Appendix 3)

1.1.13. Visitors

1.1.14. Passes, transfers, and discharges

1.1.15. Required staff competencies and training for safety, risk reduction and de-escalation

1.1.16. Medication error prevention (e.g., medication reconciliation)

1.2. The unit endorses a trauma–informed least restraint model of care

1.2.1. Including staff training and education on restraint prevention

1.2.2. Patient validation and de-escalation strategies

1.2.3. Patient engagement in risk reduction, preventive programming, and activities

1.3. The unit provides the patient/client and family/caregivers written information regarding safety and risk management

1.3.1. Unit expectations and responsibilities

1.3.2. Restricted items and associated procedures related to the search of belongings and persons

1.3.3. Items allowed on the unit and procedures governing the storage of belongings

1.4. The unit tracks, reports, and reviews risks, incidents, and restrictive safety measures and makes improvements based upon the available information

1.4.1. Risks that precipitate referrals

1.4.2. Serious incidents/sentinel events

1.4.3. Safety occurrences/near misses

1.4.4. Percentage of youth admitted on an involuntary basis

1.4.5. Percentage of youth that are certified as involuntary patients after admission

1.4.6. Percentage of patients and percentage of incidents per total admissions

involving physical, mechanical, environmental and chemical restraints

2. ACCESS & DISCHARGE: Timely inpatient care is available to all who would benefit.

2.1. Numbers of and types of beds, and access to these beds, is sufficient to meet needs

2.1.1. Beds and admissions per 100, 000 are similar across geography and appropriately reflect the Child and Youth Mental Health Tiers of Service module (Appendix 4)

2.1.2. In an effort to assess and prevent bias, the units tracks demographic data including age, culture, gender, and diagnosis

2.1.3. For crisis units, beds remain open whenever possible to accommodate emergency admissions, and there are no significant delays as measured through their own data sources or national reporting bodies

2.2. When the unit does not admit the patient, it redirects patients to other programs in the continuum of care that would best serve them

2.3. Referral criteria distinguish appropriate/inappropriate referrals by

2.3.1. Diagnosis of a psychiatric disorder requiring hospitalization

2.3.2. Age

2.3.3. Whether and under what conditions transitional age 17 and 18 year-old adolescents should be admitted to the unit as opposed to an adult mental health inpatient unit or a Psychiatric Intensive Care unit

2.3.4. Geography; boundaries are well defined

2.3.5. Services. Whether and under what conditions children and adolescents should be admitted to child and adolescent inpatient unit versus psychiatric-intensive care, non-hospital residential, therapeutic foster care, specialized community programs and similar

- Emergent
- Elective

2.3.6. Safety & Security

- Medical stability
- Capacity to admit involuntary patients
- Crisis/emergency versus longer assessment treatment focus
- Capacity/incapacity to address high risk safety situations

2.4. There are clear criteria and processes describing how the following are managed, (including collaborative care planning across agencies/units):

2.4.1. Exclusions and redirections to more appropriate services

2.4.2. Delays because of unavailable inpatient beds

2.4.3. Overflow to and from other inpatient units, beds, programs, and facilities

2.4.4. Frequent readmissions

2.4.5. Discharge

3. ENVIRONMENT & DIGNITY: Units are designed and managed so that child and adolescent rights, privacy and dignity are respected.

3.1. The child and adolescent unit should be separate from the adult unit. Ideally, children should receive inpatient services on child units, and adolescents on separate adolescent units rather than adult units

3.2. The unit adopts BC's Seclusion Room standards, using seclusion and restraint as last resort interventions

3.3. The unit adopts BC's Trauma Informed Practice Guide approach (Appendix 5/6)

3.4. The unit provides culturally responsive and safe services

3.5. There is a formalized process for patients and their

families/caregivers to provide their feedback and input into the unit design, programming and evaluation

3.6. The unit provides services that are culturally sensitive, trauma informed, and gender-affirming to all children, adolescents, and families/caregivers

4. ENGAGEMENT: Children, youth and their families/caregivers are effectively engaged partners in the process of care, from referral to follow-up.

4.1. An orientation process prior to or upon admission (also in Standard 1 for safety) informs children/adolescents and their families/caregivers about inpatient care to be provided. Orientation topics include:

4.1.1. Confidentiality

4.1.2. Rights of voluntary and involuntary patients under the BC Mental Health Act (Appendix 7)

4.1.3. Visits

4.1.4. Opportunities and expectations for participation in care

4.1.5. Typical inpatient care process

4.1.6. Availability of peer support for youth and families

4.1.7. Outcomes of care (See also Standard 6)

4.2. An integrated care plan is available to guide care throughout the admission

4.2.1. The care plan includes a description of the problem precipitating the referral and services to be provided

4.2.2. Patients, families/caregivers and community partners are provided

opportunities to participate in and contribute to care planning (with appropriate consent)

4.3. An integrated discharge summary with recommendations is available at point of discharge

4.3.1. The discharge summary and plan summarizes services provided, outcomes, and recommendations for continuity of care

4.3.2. Patients, families/caregivers and community partners are invited to participate (ideally at a discharge and planning session), as appropriate and with consent.

4.3.3. A copy of the discharge summary and plan is available to be shared with patients, families/caregivers and community partners

4.4. Patients, families/caregivers and community partners are provided the opportunity to provide feedback about the quality of care received

4.4.1 The unit provides youth and caregivers with the opportunity to complete satisfaction and feedback measures

4.5 Unit staff will inform families of safety events witnessed by patients in a timely manner, as per adverse event disclosure policies

5. ASSESSMENT & TREATMENT: The unit provides assessments and treatments that have the best evidence and research support

5.1. The unit uses one or more useful, standardized, developmentally appropriate, reliable, and valid measures or indicators of risk, functioning and/or symptom severity for all patients to support:

5.1.1. Diagnosis and diagnostic clarification

5.1.2. Treatment selection, planning, and side effect monitoring (as appropriate)

5.1.3. Outcome evaluation (changes in risk, function, and symptoms from admission to discharge)

5.2. The unit distinguishes whether it is providing interventions aimed at 1) Crisis stabilization and rapid return to the community for treatment, and/or 2) Assessment, diagnosis and stabilization with recommendations for care in community follow-up, and/or 3) Mandated care (e.g. forensics)

5.3. Length of stay is appropriate for the required assessment and treatment/interventions (i.e. not too brief and not beyond the point where benefits plateau)

5.4. The unit informs and educates patients, families/caregivers and community partners about the process and outcomes of the inpatient treatments/interventions

5.4.1. The unit identifies the primary presenting problems, symptoms, and diagnoses responsible for the admission

5.4.2. The unit describes the expected outcomes of inpatient stay for the reasons for admission and inpatient services to be provided, and the limitations therein (e.g., typically for this diagnosis and service, the length of stay ranges from…to…)

5.4.3. The unit describes the costs, limitations and benefits of different medication and psychosocial treatment/intervention options on discharge

5.5. The unit provides evidence-supported treatments/interventions including:

5.5.1. Interventions targeting factors important for change that are common across most admissions. These include:

- Trauma Informed Practice
- Therapeutic alliance
- Motivation
- Skill building (e.g. emotion regulation, relaxation, mindfulness)
- Modelling healthy living (structuring the day)

5.5.2. Interventions targeting symptoms, problems, or diagnoses that differ from individual to individual, and which require specific treatment processes

5.5.3. Treatment modalities which are offered include individual and family, as well as group and milieu therapy, and psychotropic medication

6. HEALTH PROMOTION: Activities that help maintain and improve mental health are available to all patients

6.1. The unit provides flexible health promotion activity schedules across units, while maintaining predictability. Opportunities include:

- Exercise
- Nutrition
- Sleep hygiene
- Personal care
- Socialization with peers on the unit
- Socialization with families and relevant others
- School work
- Recreation & Arts (e.g., music, dance, art)
- Relaxation (e.g., breathing, muscle relaxation, yoga)
- Work (e.g., gardening, food preparation)
- Free time

6.2. The schedule is available to patients, families/caregivers and community partners

7. STAFFING & TRAINING: Staff are appropriate in number and type to provide safety and care, are well trained, and function within an interdisciplinary model

7.1. Numbers and types of staff and disciplines are appropriate to ensure the safety and care needs of inpatients

7.1.1. Staffing models are formally identified and evaluated on an ongoing basis

7.1.2. The common tasks and distinct roles of each discipline in the model of care are available to all staff

7.2. Competencies are formally identified, needs are evaluated, and training is provided:

7.2.1. For roles and skills common to all staff around safety and care

7.2.2. For roles and skills specific to each discipline

7.3. The unit has formalized processes for addressing, optimizing and evaluating team interdisciplinary functioning and development

8. INTER-SYSTEM COLLABORATION: The unit has a well-defined distinct and valuable role within a complete continuum of care that includes collaboration with other partner mental health services, and mechanisms to assure good transitions and continuity of care

8.1. The unit identifies gaps in its continuum of care with its patients and their families/caregivers and community partners, and collaboratively addresses them when possible

8.2. The unit works within the continuum of care, including children,

youth and families to:

8.2.1. Improve access and prevent unnecessary inpatient admissions

8.2.2. Redirect admissions that should be seen at higher or lower levels of care, as per BC's Child and Youth Mental Health Tiers of Service module

8.2.3. Eliminate obstacles that delay or block discharge (e.g., non-psychiatric residential, housing, wraparound, intensive services at home, family preservation, outpatient psychiatry)

8.3. The unit reviews criteria, processes, and protocols in place with service partners to assure ease of transitions and continuity of care

8.3.1. The unit participates in the BC Child and Youth Mental Health & Substance Use Care Advisory Network and/or Inpatient subcommittee, and uses quarterly meetings as an opportunity to discuss barriers, therapeutic approaches, and improved service alignment

8.3.2. Referral and post-discharge partners are engaged in collaborative care with the unit across referral, care, and discharge processes

8.3.3. Those in the child/youth's circle of care are routinely invited to sessions and participate in care and discharge planning

8.4. The unit is engaged in provincial and national collaborations that aim to improve and standardize best practices for child and adolescent inpatient care and mental health services for children, adolescents, and their families. Collaborators include:

- ONCAIPS & its national partners
- BC Child and Youth Mental Health Care Advisory Network
- Child Health BC
- BC CYMHSU Physician Community of Practice

9. CONSMER & PUBLIC INFORMATION: Information about the unit and its services are easily available to children, youth, families/caregivers, community partners and the general public

9.1. Children and youth, families/caregivers, community partners and other referral sources can access information about the unit prior to admission

9.2. Appropriate information (electronic or print) is available in the emergency department and in other referral settings

9.3. The unit has a user-friendly public website that provides accurate, up to date information. Information on the public website should include at least the following:

- The range of services provided
- How to access inpatient services and alternatives
- Admission and exclusion criteria (see also Standard 1)
- Typical length of stay and outcomes
- When the information was last written or updated

10. ACCOUNTABILITY: Information about utilization and performance is publicly available to users, providers, funders, and communities of practice

10.1. The unit collects, retains, and reports reliable and valid information about its services, and completes all required Ministry of Health reporting. Utilization and performance measures include:

- Numbers of beds per capita, types of beds, and locations in each region
- Problem precipitating admission
- Gender, age and ethnicity
- Primary (most responsible) diagnosis
- Setting discharged to (e.g. home versus out of home placements)
- Occupancy by month (or admissions by month)
- Average and median length of stay
- Alternate levels of care
- 30 day re-admission rates
- Delays in accessing a bed
- Implementation of these Standards

10.2. The unit participates in providing information and making use of existing data bases to monitor its services, including:

10.2.1. Own hospital data bases

10.2.2. CIHI data including Discharge Abstracts Database, and data in the National Ambulatory Care Reporting System (NACRS)

10.3. The unit provides information and participates in cross sector Performance Benchmarking and Standards Development, including but not limited to ONCAIPS-BC

10.4. ONCAIPS-BC collaborates in benchmarking and standardizing best practices for mental health inpatient care, and advocating for changes and improvements to the mental health system with key partners such as:

- Canadian Child and Adolescent Psychiatry Inpatient Network

- ONCAIPS
- BC CYMH Care Advisory Network
- Child Health BC
- Children's Health Care Canada (formerly CAPHC)
- BC CYMHSU Physician Community of Practice

10.5. Developing appropriate and usable outcome measures

10.6. ONCAIPS-BC standards align with existing provincial legislation, policies, standards and protocols, including:

- BC Mental Health Act
- BC Infants' Act (Appendix 8)
- Acute to Community Transition Protocols
- CYMH Tiers of Service Module
- Seclusion and restraint standards

10.7. ONCAIPS-BC standards align with existing national accreditation standards, including:

- Accreditation Canada
- Canadian Organisation Accreditation

Appendices

1. 2015 ONCAIPS Collaborative Provincial Child & Adolescent Inpatient Mental Health Standards (http://oncaips.ca/ONCAIPS_Standards_June_2015.pdf)

2. BC Provincial Violence Prevention Curriculum (http://www.heabc.bc.ca/Page4270.aspx#.XBF4d4dKiUk)

3. Standardized Hospital Colour Codes (https://www2.gov.bc.ca/assets/gov/health/keeping-bc-healthy-safe/health-emergency-response/standardized-hospital-colour-codes.pdf)

4. BC Restraint and Seclusion Standards (https://www.health.gov.bc.ca/library/publications/year/2012/secure-rooms-seclusion-guidelines-lit-review.pdf)

5. BC Child and Youth Mental Health Tiers of Service Module (http://www.childhealthbc.ca/tiers-service/mental-health-services-children-and-youth)

6. BC's Trauma Informed Practice Guide (http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf)

7. Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families (https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf)

8. BC Mental Health Act (http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01)

9. BC Infants Act (http://www.bclaws.ca/civix/document/id/complete/statreg/96223_01)

References

Evidence to support these standards can be found in the 2015 ONCAIPS Provincial Child & Adolescent Inpatient Mental Health Standards (see Appendix 1).