

ONTARIO NETWORK OF CHILD & ADOLESCENT INPATIENT SERVICES

Standards Self-Audit Checklist

February 19 2019 Version

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Name of Unit:

Date of Self-Audit:

All Standards Partial Audit Limited to Following Standard(s) _____

ONCAIPS Standards refers to qualities of inpatient care that should be aspired to.

Refer to the *Guide, Standards & Literature Review* for additional detail, supporting literature, and rationale. Please feel free to add detail and comments that can improve the self-audit and standards or add to the literature review.

The ONCAIPS Self-Audit Checklist can be used in its entirety or the checklist can be used in smaller sections to assess any discrete area of particular interest at a particular time.

The Checklist indicators and its separate sections can be used for surveys of the state of provincial and national inpatient care and to promote the development of provincial and national data bases focusing on child and adolescent inpatient and related services.

The Checklist on the website is pdf and can only be completed using a pen, but plans are to eventually make it so it can be completed electronically. Look forward to your feedback (jpersi@cyberbeach.net)

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1.0 SAFETY. The unit monitors, assesses and assures the safety of patients, visitors, and staff.

1.1 The unit monitors, manages, and reduces risk of suicidal behaviour. Yes No

1.2 The unit monitors and reduces risks of harm to others from aggression, bullying, and intimidation. Yes No

1.3 The unit monitors and assures sexual safety for all and with an awareness of the specific needs of youth who identify as gay, lesbian, transgender and intersex. Yes No

1.4 The unit monitors and helps youth reduce and stop non-suicidal self-injurious behaviours and habits. Yes No

1.5 The unit monitors and works to prevent other types of risks, near misses, and incidents. Yes No

1.6 The unit engages patients and parents/caregivers in the completion and evaluation of written admission, pass, and discharge safety and risk management plans. Yes No

INDICATOR: SAFETY PLAN & PROCESS	Yes	No
1. Patients and whenever possible, parent/caregivers, collaborate with inpatient staff to develop a safety plan to address the most severe risks.	<input type="checkbox"/>	<input type="checkbox"/>
2. The safety plan is a companion document to the inpatient care plan and details how risks will be managed on the unit, during passes home, and after discharge.	<input type="checkbox"/>	<input type="checkbox"/>
3. Risk and safety are and the safety plan reviewed by youth, parents/caregivers and community partners prior to every pass and discharge.	<input type="checkbox"/>	<input type="checkbox"/>
4. The plan helps identify antecedents and warning signs of impending risk or crisis.	<input type="checkbox"/>	<input type="checkbox"/>
5. The plan identifies actions that can reduce likelihood of risk.	<input type="checkbox"/>	<input type="checkbox"/>
6. The safety plan includes cautions about the disinhibiting risks of drugs and alcohol, need to check that means to suicide such as firearms and drugs are safely stored or removed, that a follow-up appointment has been scheduled.	<input type="checkbox"/>	<input type="checkbox"/>
7. The plan lists a primary contact as well as secondary family members, friends, mental health professionals, agencies, and crisis responders who the youth can use for support in case of impending risk.	<input type="checkbox"/>	<input type="checkbox"/>
8. The plan lists any other actions that parents/caregivers and others can take to a) help manage emotional distress and other risks, and 2) reduce access means of serious self-harm (e.g., restriction on access to firearms).	<input type="checkbox"/>	<input type="checkbox"/>

1.7 The unit provides, monitors, and minimizes need for seclusion and restraint. Yes No

INDICATOR: RESTRAINT USE & REDUCTION	Yes	No
1. The unit with referral/transfer sources engage patients, parents/caregivers, & professional partners in prevention of need for seclusion/restraint at referral/transfer & point of admission.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit management and staff complete a written review of seclusion and restraints in order to help prevent needs and address antecedents and factors which contribute to restraints	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit notifies substitute decision makers and/or parents/caregivers as soon as possible after any incident of seclusion/restraint.	<input type="checkbox"/>	<input type="checkbox"/>
4. Post-restraint debriefs which occur not only with staff but also with the patient and parents/caregivers; findings are used to improve functional assessment, care plan,	<input type="checkbox"/>	<input type="checkbox"/>

and prevent future occurrences.		
5. Use of restraints is monitored and evaluated for its appropriateness of use, effectiveness, and maintenance of patient dignity; a report is reviewed, and improvements made by the unit staff and management minimally on a yearly basis.	<input type="checkbox"/>	<input type="checkbox"/>
6. Types and prevalence of restraints are monitored, reviewed, and improvements proposed in the annual unit report.	<input type="checkbox"/>	<input type="checkbox"/>
7. % admissions (versus unique patients) secluded/restrained _____ <i>Average and median numbers of patients restrained by any method per unit based on ONCAIPS units which tracked data were <9% and <8% respectively.</i>	<input type="checkbox"/>	<input type="checkbox"/>
8. % of all seclusion/restraints by type (numbers restraints by type/total numbers of restraints x100) Seclusion _____ Physical _____ Mechanical _____ (Pinel etc.) Chemical _____ <i>Can be >100% as one restraint may involve medication, physical restraint and seclusions</i>	<input type="checkbox"/>	<input type="checkbox"/>
9. % of patients (not admissions) restrained. _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Total # seclusion/restraints per 1000 bed days. _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Total # of seclusion/restraint hours per 1000 patient hours. _____		
12. Comparisons against the previous year(s)...describe trends or make other comments here:		

1.8 The unit monitors and works to reduce involuntary admissions and to promote voluntary ones. Yes No

INDICATOR: INVOLUNTARY ADMISSIONS	
1. % Admitted involuntarily = (# admitted involuntarily/total admissions) x 100 = _____%	
2. % Made Involuntary after Admission = (# of admissions whose status changes from informal and voluntary to involuntary/total admissions x 100) = _____%	
<i>Provincial Benchmarks for general crisis and extended stay general units: Avg ~65%, Mdn ~68%</i>	

1.9 The unit monitors, evaluates, and improves all other safety procedures. Yes No

1.10 The unit identifies and redirects referrals/transfers which are not able to be managed safely on the unit. Yes No

INDICATOR: REDIRECTING UNSAFE ADMISSIONS	
1. # of admissions redirected, delayed, or excluded because they represented a level of risk the unit could not manage because of an unacceptable risk of injury to staff or patients _____	
2. # of admissions on the unit which resulted in harm to the patient, co-patients or staff that were admitted not because the unit was an appropriately safe setting but because there was no more secure place for the patient to access _____	

1.11 The unit routinely provides postvention and incident analysis. Yes No

1.12 The unit provides a balance of restrictive measures and reasonable risks essential for recovery. Yes No

DETAILS, COMMENTS, & NOTES:

2.0 DIGNITY, RIGHTS & ENGAGEMENT. The unit respects, protects, and promotes dignity, rights, identity, and participation in care

2.1 The unit protects personal rights and freedoms. Yes No

2.2 The unit protects is aware of the stigmatizing potential of hospitalization and mental illness and has procedures in place to reduce the likelihood of such outcomes. Yes No

2.3 The unit protects the dignity of its patients, staff, and visitors. Yes No

2.4 The unit provides a climate for recovery (not just a climate of control and safety). Yes No

2.5 The unit provides trauma informed care. Yes No

INDICATOR: TRAUMA INFORMED CARE		Yes	No
1.	All individuals are screened for trauma at admission.	<input type="checkbox"/>	<input type="checkbox"/>
2.	The care and discharge plans document stress and trauma histories, and inpatient trauma-linked behaviours for each patient.	<input type="checkbox"/>	<input type="checkbox"/>
3.	All staff on the unit understand and are able to assess trauma avoidance and other behaviours associated with past stressful and traumatic experiences.	<input type="checkbox"/>	<input type="checkbox"/>
4.	All staff on the unit understand the traumatizing and disempowering potential of mechanical restraint, seclusion, and other similar restrictive measures and strive to reduce these.	<input type="checkbox"/>	<input type="checkbox"/>
5.	All staff on the unit understand that watching other youth act out emotional distress, watch seclusion and restraints, and watch other youth hurt themselves or others can be very stressful and potentially traumatizing.	<input type="checkbox"/>	<input type="checkbox"/>
6.	All individuals continue to be monitored for trauma recall and reactions from admission to discharge.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Supervisors, consultants, and nurse educators provide documented training, monitoring and supervision specific to assuring trauma informed care and reducing reliance on coercive practices	<input type="checkbox"/>	<input type="checkbox"/>
8.	The unit has formal procedures to prevent bullying, stigmatization, and threatening behaviours among co-patients.	<input type="checkbox"/>	<input type="checkbox"/>
9.	Nurses, child and youth workers and allied staff provide sessions to address and prevent traumatic harm and re-traumatization to themselves	<input type="checkbox"/>	<input type="checkbox"/>
10.	The hospital explicitly supports trauma informed care and assures that staff resources and supporting procedures are available and implemented	<input type="checkbox"/>	<input type="checkbox"/>

2.6 The unit provides attachment supportive care. Yes No

INDICATOR: ATTACHMENT SUPPORTIVE CARE		Yes	No
1.	All staff on the unit have the capacity to understand, distinguish, and assess secure, insecure-ambivalent (anxious-preoccupied), anxious-avoidant (dismissive-avoidant), and disorganized/disoriented (fearful-avoidant) behaviours.	<input type="checkbox"/>	<input type="checkbox"/>
2.	All staff on the unit understand that separations from significant others and their attachment support can be very stressful and can aggravate problematic self-harming behaviours and risks to others, and that their behaviour can aggravate or reduce such distress	<input type="checkbox"/>	<input type="checkbox"/>
3.	The admission, care, and discharge processes discuss and document attachment styles and behaviours that are important for the care for each patient.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Supervisors, consultants, and nurse educators provide training specific to promoting attachment supportive care.	<input type="checkbox"/>	<input type="checkbox"/>

5. Nurses, child and youth workers and allied staff integrate their intervention approaches so as to prevent and reduce harms related to attachment.	<input type="checkbox"/>	<input type="checkbox"/>	
6. The hospital explicitly supports attachment supportive care and assures that staff resources and attachment supporting procedures are available and implemented.	<input type="checkbox"/>	<input type="checkbox"/>	
STAFF PROVIDE ATTACHMENT BALANCE TO INSTITUTIONAL CARE PRESSURES:			
Staff Provide Attachment Supports by:		Staff are Aware of needs to limit and balance:	
a. Doing with	<input type="checkbox"/>	a. Doing to and for	<input type="checkbox"/>
b. Making the therapeutic relationship and attachment support the focus	<input type="checkbox"/>	b. Making mental illness and service the focus	<input type="checkbox"/>
c. Being supportive and catching patients being good/successful	<input type="checkbox"/>	c. Monitoring infringements of the rules	<input type="checkbox"/>
d. Being most aware of antecedents and using antecedent control to minimize and prevent acting out	<input type="checkbox"/>	d. Being most aware of problems and providing logical negative consequences for inappropriate behaviour	<input type="checkbox"/>
e. Minimizing or eliminating need to use time-out, prn medication, and seclusion and restraint	<input type="checkbox"/>	e. Promoting use of time-out, loss of privileges, prn medication and seclusion and restraint as the most important components of safety	<input type="checkbox"/>
f. Paying attention to children and appreciating what they have to say	<input type="checkbox"/>	f. Making children listen, so they do what they are told	<input type="checkbox"/>
g. Connecting, and then correcting	<input type="checkbox"/>	g. Correcting, then connecting	<input type="checkbox"/>
h. Enjoying rewarding activities together	<input type="checkbox"/>	h. Giving handouts and assuring written assignments are complete	<input type="checkbox"/>
i. Individualizing rules, demands, and expectations	<input type="checkbox"/>	i. Subjecting all children and adolescents to the same rules, demands, and expectations	<input type="checkbox"/>
j. Focusing together on a few important and mutually known rules	<input type="checkbox"/>	j. Having many rules to assure order on the unit	<input type="checkbox"/>
k. Encouraging discussions and assessment of rules	<input type="checkbox"/>	k. Assuring rules are rules and are not open to discussion	<input type="checkbox"/>
l. Providing opportunities for making it up to injured parties	<input type="checkbox"/>	l. Providing consequences to teach children they have made a mistake	<input type="checkbox"/>
m. Providing opportunities for children to be leads in their own recovery	<input type="checkbox"/>	m. Telling children what they should do	<input type="checkbox"/>
n. Working and learning together 1:1	<input type="checkbox"/>	n. Leaving children with instructions or telling them what to do	<input type="checkbox"/>
o. Increasing time to care (spending most of the nursing time with patients outside the nursing station)	<input type="checkbox"/>	o. Spending most of the time on the nursing unit observing patients and doing paperwork	<input type="checkbox"/>
p. Prioritizing the designing of shifts to assure consistency and continuity of staff-patient relationships	<input type="checkbox"/>	p. Prioritizing shift designs around the budget	<input type="checkbox"/>
q. Rewarding youth exploration & reasonable risk taking as essential for developing capacity & motivation	<input type="checkbox"/>	q. Taking few and no risks and punishing risk taking	<input type="checkbox"/>
r. Exploring and individualizing approaches with each patient and parents/caregivers on how best to meet attachment needs	<input type="checkbox"/>	r. Providing the same level and type of attachment support to all youth	<input type="checkbox"/>
2.7 The unit respects culture, protects minorities and their identities, and values the diversity of children and adolescents, parents/caregivers, professional partners, and staff. Yes <input type="checkbox"/> No <input type="checkbox"/>			

INDICATOR: INCLUSIVENESS		Yes	No
1.	All staff on the unit have the training and understanding of the importance of inclusion and validation all vulnerable or marginalized groups and identities.	<input type="checkbox"/>	<input type="checkbox"/>
2.	The unit has explicit processes and activities that accommodate the different developmental needs of very young children including optional rooming in for parents/caregivers when required, and accommodations for different gender identities.	<input type="checkbox"/>	<input type="checkbox"/>
3.	The unit makes a point of celebrating holidays that have specific value and meaning for patients including those of different minority groups and cultures.	<input type="checkbox"/>	<input type="checkbox"/>
4.	The hospital explicitly supports inclusion for all minorities and assures that staff resources and supporting procedures are available and implemented.	<input type="checkbox"/>	<input type="checkbox"/>
5.	The unit applies principles of inclusiveness to both patients and staff.	<input type="checkbox"/>	<input type="checkbox"/>
6.	The unit has ongoing regular initiatives to combat stigma and prejudice.	<input type="checkbox"/>	<input type="checkbox"/>
7.	The unit recognizes youth who have been marginalized by their social experiences and past service placements and takes steps to accommodate for these experiences	<input type="checkbox"/>	<input type="checkbox"/>
2.8	Unit staff assess and work with youth motivation and goals.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.9	Children and adolescents are informed, given a voice, and are engaged in a working alliance that includes involvement in decision-making and planning.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.10	The unit engages parents/caregivers in collaboration from the beginning to the end of care.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.11	The unit assesses alienation and encourages re-engagement and reconciliation among youth, parents/caregivers, and mental health service providers.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.12	The unit protects privacy and confidentiality and respects and empowers the process of informed consent.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.13	The unit respects and empowers the process of informed consent.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.14	The unit monitors, reports, and responds to youth and parents/caregiver satisfaction, feedback, and complaints.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.15	The unit collaborates with youth, parent/caregivers and community partners to identify unmet needs and advocate for service improvements.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
INDICATORS: CONFIDENTIALITY, CONSENT, FEEDBACK & ADVOCACY		Yes	No
1.	The unit informs young people and parents/caregivers about the costs and benefits of inpatient care, about confidentiality, and limits to confidentiality for purposes of consent and engagement.	<input type="checkbox"/>	<input type="checkbox"/>
2.	The unit collects, reports, and utilizes youth, and parents/caregiver satisfaction ratings. If yes the percentages of satisfied youth is _____% and of parents _____%	<input type="checkbox"/>	<input type="checkbox"/>
3.	The unit collects, reports, and utilizes youth, and parents/caregiver feedback. If yes, the main most frequent and important qualitative themes and findings are (list):	<input type="checkbox"/>	<input type="checkbox"/>
4.	The unit has a formal complaints process that is well known to children and adolescents and their parents/caregivers.	<input type="checkbox"/>	<input type="checkbox"/>
5.	All inpatients and parents/caregivers are aware of the unit complaints process which allows them to address problems as soon as they occur.	<input type="checkbox"/>	<input type="checkbox"/>

6. The unit has a patient advocate. The percentage of youth which made use of the unit patient advocate _____% Primary themes (list):	<input type="checkbox"/>	<input type="checkbox"/>
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DETAILS, COMMENTS, & NOTES:

DRAFT

3.0 PHYSICAL ENVIRONMENT. The unit physical environment is safe, therapeutic, culturally and developmentally appropriate, and able to meet the special needs of all its patients

3.1 The physical environment is safe

Yes No

INDICATOR: SAFE PHYSICAL ENVIRONMENT	Yes	No
1. The unit can be locked down in cases of emergency	<input type="checkbox"/>	<input type="checkbox"/>
2. There are clear lines of sight) to monitor patients when they are out of their bedroom (includes video if necessary and no blind spots).	<input type="checkbox"/>	<input type="checkbox"/>
3. Windows are made with Plexiglas or shatter proof glass.	<input type="checkbox"/>	<input type="checkbox"/>
4. Ligature points are regularly assessed and minimized or eliminated including hooks and handles on doors, door frames, beds with posts or any other areas ligature points, hangers clothing rods in closets, high risk patients may require mattress on the floor without bedframe.	<input type="checkbox"/>	<input type="checkbox"/>
5. Bathrooms have breakaway fixtures in showers/bath tubs and sinks, breakaway shower curtains (if shower curtains are present), faucet are designed to minimize hanging risk, bathroom doors have locks removed, safety features are around plumbing fixtures, such as a stainless steel box that removes hanging risk, there are "plates" to grab bars that permit functionality but minimize hanging risk.	<input type="checkbox"/>	<input type="checkbox"/>
6. Objects that can be used as ligatures are assessed, eliminated, or minimized including removable pillow cases and bedsheets, call and light and electronics cords/TV cords, plastic bags.	<input type="checkbox"/>	<input type="checkbox"/>
7. Objects that can be used as projectiles or weapons for harming self and others are secured including kitchen utensils, televisions and electronics, and furniture.	<input type="checkbox"/>	<input type="checkbox"/>
8. The unit has a safe place for youth and visitors to store restricted objects which are personal property and for staff to store medication.	<input type="checkbox"/>	<input type="checkbox"/>
9. There are visual alarms on nursing stations when doors open at night.	<input type="checkbox"/>	<input type="checkbox"/>
10. All hazards are clearly marked for youth and staff.	<input type="checkbox"/>	<input type="checkbox"/>
11. The unit physical design allows for separation of youth who are risks to each other.	<input type="checkbox"/>	<input type="checkbox"/>
12. All equipment is regularly maintained and tested.	<input type="checkbox"/>	<input type="checkbox"/>

3.2 The unit has access to a designated, safe seclusion room.

Yes No

INDICATOR: SECLUSION ROOM		Yes	No
1.	The seclusion room has no falls and ligature hazards (e.g., no opportunity to access electrical wiring or receptacles, grab objects on shelves, fall on sharp corners or edges, fall on slippery floor (replaced with slip resistant material), no other hardware, nails, nuts, bolts, or screw heads	<input type="checkbox"/>	<input type="checkbox"/>
2.	Doors swing out rather than in.	<input type="checkbox"/>	<input type="checkbox"/>
3.	The seclusion room is located as far as possible from elevators, stairs, exits, bedrooms, patient living and activity areas.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Capacity for continuous observation and verbal communication among patient and staff.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Lock types facilitate rapid and safe entry and exit	<input type="checkbox"/>	<input type="checkbox"/>
6.	Protective blanket or protective cushioning material covers walls and floor to protect against self-injurious behaviors and falls.	<input type="checkbox"/>	<input type="checkbox"/>
7.	If there is a bed in the seclusion room it can be moved out if needed.	<input type="checkbox"/>	<input type="checkbox"/>
3.3 The physical environment is therapeutic.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
INDICATORS: THERAPEUTIC ENVIRONMENT		Yes	No
1.	The unit has a separate designated space for individual and family therapy that supports engagement and confidentiality (not a child's bedroom).	<input type="checkbox"/>	<input type="checkbox"/>
2.	Children and adolescents have their own (unshared) bedroom which they can use as a place of comfort, safety, and without worry about having their privacy compromised by co-patients or visitors.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Youth have access to a calming or sensory room outside their bedroom and in addition to the seclusion room that can be used to be away from staff and co-patients to calm down. (A sensory cart with relaxation supplies can be an adjunct)	<input type="checkbox"/>	<input type="checkbox"/>
4.	Levels of lighting, heat, noise, and ventilation are comfortable and not impediments to sleep and recovery.	<input type="checkbox"/>	<input type="checkbox"/>
5.	There is sufficient access to computer, internet and other health care media to access social and mental health knowledge and supports for recovery.	<input type="checkbox"/>	<input type="checkbox"/>
6.	The unit has access to a gym or exercise area that invites group yoga and vigorous therapeutic exercise,	<input type="checkbox"/>	<input type="checkbox"/>
7.	Art, signage, and posters are contributors to a healthy therapeutic climate.	<input type="checkbox"/>	<input type="checkbox"/>
8.	Children and adolescents have access to designated outdoor spaces for therapeutic walks, fresh air, sunlight, gardening, and physical activities.	<input type="checkbox"/>	<input type="checkbox"/>
9.	Children have access to self-help reading materials.	<input type="checkbox"/>	<input type="checkbox"/>
10.	The unit utilizes computers, internet, cell phones, and/or tablets to link youth with self-help apps and resources.	<input type="checkbox"/>	<input type="checkbox"/>
11.	Surveys of inpatient youth predominantly support the view that the unit environment is therapeutic and not only custodial, safe, and secure.	<input type="checkbox"/>	<input type="checkbox"/>
3.4 The physical environment is normalizing.		Yes <input type="checkbox"/> No <input type="checkbox"/>	

INDICATOR: A NORMALIZING ENVIRONMENT	Yes	No
1. The unit has a clean looking and welcoming appearance.	<input type="checkbox"/>	<input type="checkbox"/>
2. Children and adolescents can personalize their bedroom.	<input type="checkbox"/>	<input type="checkbox"/>
3. Young people have some control over comfort including ventilation, heat, and noise	<input type="checkbox"/>	<input type="checkbox"/>
4. There is a separate space for the privacy of family and other visitors.	<input type="checkbox"/>	<input type="checkbox"/>
5. There is a kitchen and dining area for food preparation and meals.	<input type="checkbox"/>	<input type="checkbox"/>
6. Children and adolescents have a place to do schoolwork.	<input type="checkbox"/>	<input type="checkbox"/>
7. There is space to make and receive telephone calls in private where appropriate	<input type="checkbox"/>	<input type="checkbox"/>
8. There is access to laundry and food preparation facilities.	<input type="checkbox"/>	<input type="checkbox"/>
9. The unit has a place where patients and staff can socialize.	<input type="checkbox"/>	<input type="checkbox"/>
10. The unit has sufficient bathrooms and shower facilities that do not require waiting in discomfort or having to be concerned about privacy	<input type="checkbox"/>	<input type="checkbox"/>
11. Children and adolescents are encouraged to contribute to unit design.	<input type="checkbox"/>	<input type="checkbox"/>

3.5 The physical environment is inclusive, culturally safe, values diversity, and accommodates special needs. Yes No

INDICATOR: AN INCLUSIVE ENVIRONMENT	Yes	No
1. The unit design, signage, furniture and equipment are appropriate for all age groups admitted	<input type="checkbox"/>	<input type="checkbox"/>
2. All youth have access to space for prayer and religious and cultural practices.	<input type="checkbox"/>	<input type="checkbox"/>
3. Posters, signage, and decorations are able to inform and welcome youth of different ages, with different levels of reading abilities, different cultural background, and differing interests	<input type="checkbox"/>	<input type="checkbox"/>
4. Door knobs, kitchen tables, games tables, and other unit equipment are accessible to all patient ages and groups.	<input type="checkbox"/>	<input type="checkbox"/>
5. Posters, signage and decorations reflect and celebrate the cultural, linguistic, LGBT2SQ and other diverse groups on the unit.	<input type="checkbox"/>	<input type="checkbox"/>
6. The unit is accessible and accommodates the needs of individuals with disabilities.	<input type="checkbox"/>	<input type="checkbox"/>
7. Children and adolescents inform unit design and changes	<input type="checkbox"/>	<input type="checkbox"/>

3.6 The unit size is large enough to support a social milieu, but not so large that individualized care is compromised. Yes No

INDICATOR: UNIT SIZE (# of Beds)
Numbers of beds per unit as indicated in MOHLTC health data branch web portal https://hsim.health.gov.on.ca/ or if unavailable there from the 2017 ONCAIPS Annual Directory. Your unit size in terms of numbers of beds is _____ beds Recommended unit size is between 6 and 12 beds.

DETAILS, COMMENTS, & NOTES:

4.0 STAFFING. The unit has the numbers of staff, types of disciplines, processes, and training to provide the best possible inpatient care.

4.1 The unit provides a description of its interdisciplinary staffing model in a publicly available document or section of a document. Yes No

4.2 The unit publishes an annual staffing plan. Yes No

INDICATOR: STAFFING MODEL & PLAN	Yes	No
1. The unit interdisciplinary team minimally includes psychiatry, psychology, social work, nursing, child and youth work (CYW), and a teacher.	<input type="checkbox"/>	<input type="checkbox"/>
2. The staffing model is clearly linked to the unit's model of care.	<input type="checkbox"/>	<input type="checkbox"/>
3. The staffing model provides clear descriptions of the roles of each of the disciplines and the tasks which are discipline specific.	<input type="checkbox"/>	<input type="checkbox"/>
4. The staffing model provides clear descriptions of the tasks which are common (shared) among disciplines.	<input type="checkbox"/>	<input type="checkbox"/>
5. The staffing model identifies who is the most responsible physician responsible for admission, care, and discharge decisions.	<input type="checkbox"/>	<input type="checkbox"/>
6. The staffing model identifies the most responsible manager for staffing decisions, supervision, and evaluation.	<input type="checkbox"/>	<input type="checkbox"/>
7. The staffing model and annual staffing complement is supported by a budget which is known to the public and sufficient to maintain the required numbers and types of staff.	<input type="checkbox"/>	<input type="checkbox"/>
8. The annual staffing plan describes the recruitment and retention goals.	<input type="checkbox"/>	<input type="checkbox"/>
9. The annual staffing plan describes how it plans to address gaps in staffing caused by terminations, absences, and other problems.	<input type="checkbox"/>	<input type="checkbox"/>
10. Youth, parents/caregivers and partner agencies provide formal feedback on the staffing model and plan on at least a yearly basis.	<input type="checkbox"/>	<input type="checkbox"/>

4.3 A child and adolescent psychiatrist is the most responsible physician who leads the interdisciplinary team, makes admission and discharge decisions, provides diagnosis, completes medication review, and integrates the overall plan of care. Yes No

4.4 The team includes a child and adolescent clinical psychologist who provides psychological assessment and psychotherapy, supports behavioural stabilization, consults to psychiatry and staff, trains, contributes to program development, and leads outcome evaluations. Yes No

4.5 The team includes a social worker who is responsible for leading the maintenance of evidence informed family and larger systems work and collaboration, including transitions to and from the unit. Yes No

4.6 The team includes nurses who help assure a safe environment, a climate for recovery, provision of medically required procedures, health care education, and development of a working alliance with the youth around healthy lifestyle choices. Yes No

4.7 The team includes child and youth workers who lead the provision of relational and behavioural interventions, milieu programming and recovery activities from a client centred holistic point of view. Yes No

4.8 The team is supported by a teacher who assesses current academic capacity, helps youth keep up with school work, and provides educational liaison with the community schools and resources. Yes No

4.9 The team is supported on an as needed basis by students, volunteers and interdisciplinary staff beyond those in the core team. Yes No

INDICATOR: STAFFING NUMBER & TYPES

- 1. The unit knows and can report all its full time equivalents (FTEs) for all its staff. Yes No
- 2. The team is supported by a teacher from the local school board. Yes No
- 3. The most responsible or attending physician is a Child and Adolescent Psychiatrist
 General Psychiatrist , Pediatrician , General Practitioner
 Other _____

What is the number of FTEs (35 to 37.5 hours per week for unit specific work) for each of the following core clinical disciplines on your unit?

Discipline	Your Unit FTEs (x hours/37.5 hours) May includes on-call, follow-up, and other organization duties				Suggested Minimal Desirable Staff for Crisis or Treatment ...for Discussion
	On-site		Off-site: Telehealth		
	Core Team <i>(part or full time)</i>	Contracted <i>(accessed if & as needed)</i>	Single consistent consultant <i>(regular tele-consultant)</i>	Varied consultants <i>(e.g., from single or multiple organizations)</i>	
Psychiatrists <input type="checkbox"/> Child & Adolescent <input type="checkbox"/> Other					.5 to 1.0 per 8 bed unit
Psychologists					Minimal .4 to 1.0 per 8 bed unit
Social Workers					.4 to 1.0 per 8 bed unit
Nurses (R.N)					Minimal 1 FTE per 8 or 12 hour day shift
Nurses (R.PN)					To complement RNs
CYW					Minimal 1 FTE per 8 or 12 hour day shift
Students/Volunteers					
Other (Describe):					
Comments & Details:					

4.10 The unit ensures there are sufficient staff numbers per patient to assure a safe and therapeutic milieu. Yes No

INDICATORS: MILIEU STAFFING RATIOS

- 1. The unit has a publicly available description of its staffing ratios per shift Yes No
- 2. The unit staffing plan describes how the unit will sufficient milieu staffing for high risk or high occupancy periods. Yes No
- 3. The staffing plan assures the milieu is not overstaffed in periods of low occupancy. Yes No

Discipline	Actual Milieu Staffing Ratio (Unit Size as in Number of Beds_____)						Desirable Milieu Staff-Patient Ratio
	<input type="checkbox"/> 8 hour shift			<input type="checkbox"/> 12 hour shift			
	Day	Evening	Night	Day	Night		
RN						Days & Evenings: 1 staff per 3 patients for typical admission increasing in ratio depending on the severity of aggression, risk and dependency to 1 to 1	
RPN							

CYW						or 2 to 1 staff per patient <u>Night & Days:</u> Minimally 2 staff on the unit for a unit up to 12 beds
Others						
TOTALS						
Comments:						

4.11 The unit has processes that promotes effective and efficient interdisciplinary communication, integration of care, and knowledge exchange. Yes No

4.12 The unit provides opportunities for the development and maintenance of staff well-being and morale. Yes No

INDICATOR: TEAM PROCESS & MORALE		Yes	No
1.	The unit has a shift-change process that leads to accurate and effective care information exchanges among incoming and outgoing milieu staff.	<input type="checkbox"/>	<input type="checkbox"/>
2.	The unit schedules case conferences at intervals that best allow the most responsible physician and all other staff to exchange information on an ongoing basis about what is needed and how to work together as a team to best meet the care needs of the patient.	<input type="checkbox"/>	<input type="checkbox"/>
3.	The patient and parents/caregivers are provided with ongoing opportunities to attend case conferences and minimally after admission, before discharge, and as needed to review proposed changes to care and treatment	<input type="checkbox"/>	<input type="checkbox"/>
4.	The unit schedules regular safety and quality improvement sessions which is attended by all staff including the most responsible physician and the manager.	<input type="checkbox"/>	<input type="checkbox"/>
5.	The unit schedules meetings for team development that provide opportunity for all staff including the most responsible physician and the manager to appreciate what they as a team are doing well, and also to help identify stressors, threats to staff safety, and threats to the emotional climate of the unit and morale.	<input type="checkbox"/>	<input type="checkbox"/>

4.13 The unit monitors and assures staff have the time to develop and maintain therapeutic alliances and direct therapeutic interactions with patients. Yes No

INDICATORS: TIME TO CARE						
Workload Measurement: What is the number of hours from date _____ to date _____ that each of the staff engaged in the following activities? (suggest sampling one typical week) Time should add up to the total time worked in the week. Can be completed by staff or manager with staff.						
Discipline	Activity					
If there is more than one staff member of a discipline sample one or more depending on the roles; for example a nurse educator may have a different way in which they spend their time.	Direct Interactive, face-to-Face In-the-room or tele			Indirect Writing notes, checking beds, ordering medication, preparing handouts, scoring or completing checklists or reading patient notes or diaries	Non-Patient Work required by the hospital on WHMIS, codes and responses, hand washing, falls etc. as well as personal development, education, receiving or providing supervision to staff & consultation etc.	Total Time
	<i>Patient Change</i> <i>Psychotherapy, Behavior Therapy, Therapeutic Activities Medication Review</i>	<i>Patient Observation, Assessment, Supervision</i> <i>Diagnosis, behavioural assessment, observations</i>	<i>Caregivers & Partners</i> <i>Interactive Time with significant others without the patient present</i>			
Medical Psychiatrist <input type="checkbox"/> Pediatrician <input type="checkbox"/> Physician <input type="checkbox"/>						
Psychologist						
Social Worker						
Nurse (R.N)						

Nurse (R.PN)					
CYW					
Students/Volunteers					
Other (Describe)					
Comments & Details:					

4.14 The unit has protected time for supervision, education, and training to assure staff have the competencies and supports to provide the safest and most effective services. Yes No

4.15 The unit annually evaluates its staffing model, plan outcomes, and staff. Yes No

INDICATORS: STAFF EDUCATION, TRAINING, SUPERVISION & EVALUATION	Yes	No
1. The unit formally evaluates and provides feedback about their performance to all staff on the interdisciplinary team on a yearly basis with a view to maintaining quality of care, improving the staffing model, and identifying education and treatment needs.	<input type="checkbox"/>	<input type="checkbox"/>
2. All staff are trained to not only to physically manage of out-of-control risky behavior, and de-escalate but also to use knowledge of antecedents and functions of behavior to prevent escalation.	<input type="checkbox"/>	<input type="checkbox"/>
3. Staff have the capacity to apply knowledge of human development, child and adolescent mental health problems, legislation and child protection, knowledge of child and adolescent mental health approaches across different cultures and marginalized populations, how to collaborate with one’s own team and other agencies, and how to best communicate and engage youth and parents/caregivers.	<input type="checkbox"/>	<input type="checkbox"/>
4. Inpatient mental health education and training for all staff is monitored and reported on an annual basis (not just hospital based requirements such as handwashing, falls prevention etc.).	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit has clear description of supervisory structures and a schedule of regular peer and line supervision to support the best possible performance for clinical and administrative tasks for all staff.	<input type="checkbox"/>	<input type="checkbox"/>
6. The unit provides staff with regular opportunity for peer and line supervision support at least once each month, and as needed	<input type="checkbox"/>	<input type="checkbox"/>
7. Effectiveness and outcomes of supervision are monitored and improved on an ongoing basis.	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS, COMMENTS, & NOTES:

5.0 MENTAL HEALTH SYSTEM. The unit works with its community partners to develop and maintain a complete, integrated, cost-effective mental health system that ensures children and adolescents receive the services and supports they need when they need them.

5.1 The unit and its partners are part of a complete, integrated, cost-effective mental health system that ensures children and adolescents receive the services and supports they need when they need them. Yes No

5.2 The unit and its partners employ a common standardized view of a complete system of care and its operation (see end of Yes No

INDICATORS: A COMMON SYSTEM		Yes	No
1.	The unit and its partner professionals and agencies have identified all of the essential service components required in the complete system.	<input type="checkbox"/>	<input type="checkbox"/>
2.	The unit and its partners have common shared descriptions of the service components.	<input type="checkbox"/>	<input type="checkbox"/>
3.	The unit develops and employs common criteria and common service pathways (beyond simple memoranda of agreement) with partners that prevent fragmentation and promote continuity of services across components of the system of care	<input type="checkbox"/>	<input type="checkbox"/>
4.	The unit and its partners have developed a common evidence supported view of which services are most effective and cost-effective for different problems and populations based upon their reading of the latest outcome research.	<input type="checkbox"/>	<input type="checkbox"/>
5.	When several services are similarly effective, the unit and partners agree on and assure the provision of the services which are least restrictive of youth personal rights and freedoms	<input type="checkbox"/>	<input type="checkbox"/>
6.	When several services are similarly effective, the unit and partners agree on and assure provision of the services which are least costly for the system and users.	<input type="checkbox"/>	<input type="checkbox"/>
7.	When several services are similarly effective and costly, the unit and partners and assure provision of the services which are closest to home.	<input type="checkbox"/>	<input type="checkbox"/>

INDICATORS: A COMPLETE SYSTEM

SERVICES CHILDREN & FAMILIES CAN ACCESS WHEN NEEDED ✓

(System Audit: Accessible means no waiting list, sufficient number of Evidence Supported sessions or contacts)

Mental health Crisis/Emergency	Mental Health Treatment (Tx)	Home & Housing	School Placement	Case Management	Forensic
Psychiatr. Intensive Care <input type="checkbox"/>	Secure Tx <input type="checkbox"/>	Residential High Dependency <input type="checkbox"/> Medium Depend <input type="checkbox"/> Low dependency <input type="checkbox"/>	Class in Inpatient or Residential Facility <input type="checkbox"/>	Wraparound <input type="checkbox"/>	<i>To be added in next update</i>
Inpatient Crisis <input type="checkbox"/>	Inpatient Tx <input type="checkbox"/>		Home Schooling <input type="checkbox"/>		
Non-Hospital Crisis Residential Crisis Unit <input type="checkbox"/>	Residential Tx Individual <input type="checkbox"/> Family Admissions <input type="checkbox"/>		Alternate School <input type="checkbox"/>		
Crisis Group Home <input type="checkbox"/>	Tx Group Home <input type="checkbox"/>	Regular Grp Home <input type="checkbox"/>	Intensive Case Management <input type="checkbox"/>		
Crisis Foster Care <input type="checkbox"/>	Tx Foster Care <input type="checkbox"/>	Regular Foster Care <input type="checkbox"/>			
Emergency Department <input type="checkbox"/>	Day Hospital <input type="checkbox"/>	Respite Care <input type="checkbox"/>	Day Treatment or Special Ed. Class <input type="checkbox"/>		

Mobile Crisis Mtl Health <input type="checkbox"/>	Intensive In-Home & Community Tx <input type="checkbox"/>	Supported Independent Living <input type="checkbox"/>	Regular Classroom Partial Withdrawal <input type="checkbox"/>	Agency Case Mgt While Open <input type="checkbox"/>
Mobile Emergency Serv. (Police, CAS, Paramedics) <input type="checkbox"/>	Office-Based Tx Primary Care <input type="checkbox"/> Outpatient <input type="checkbox"/> Childr. Mntl. Hlth. <input type="checkbox"/> School Mntl. Hlth. <input type="checkbox"/>	Living independently or with parents/ caregivers <input type="checkbox"/>	Regular Classroom Mild to intensive in class supports <input type="checkbox"/>	Broker/ Navigator Case Management <input type="checkbox"/>
Telephone Crisis Lines & Walk-In Crisis Services <input type="checkbox"/>	Self-help <input type="checkbox"/>		Regular Classroom No Supports <input type="checkbox"/>	Youth, Parents, Case Mangmnt <input type="checkbox"/>
Family, School, Community Crisis Int. <input type="checkbox"/>	Public Health & Community Supports <input type="checkbox"/>			

List significant service gaps here by: Age group, Disorder, problem type, individual versus family focus, Language, Culture, LGBT, geography, rural versus urban, vulnerable or marginalized special needs groups.

- 5.3 The system of care provides a complete, distinct, helpful, integrated, accessible, and cost-effective continuum of crisis/emergency services. Yes No
- 5.4 The unit is part of a system which provides a complete, helpful, integrated, accessible, and cost-effective continuum of treatment services and supports. Yes No
- 5.5 The unit is supported by an integrated psychiatric outpatient service which assures continuity of care before, during, and after hospitalization. Yes No

INDICATORS: INTEGRATED PSYCHIATRIC OUTPATIENT PROGRAM	Yes	No
1. The unit has its own affiliated Psychiatric Outpatient Program that assures all children and adolescents can access these services when they need prior to admission and after discharge to help assure continuity of care and to prevent readmissions	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit has an affiliated Psychiatric Outpatient Program but it cannot handle the volume and children and adolescents; which results in families needing to use Telepsychiatry, rely on local counselling services, or travel to another district	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit has no affiliated program and it relies on Telepsychiatry, local children’s mental health agencies, and/or travel to another district	<input type="checkbox"/>	<input type="checkbox"/>

For units who lack Psychiatric Outpatient Services or lack sufficiently resourced psychiatric services (who answered “No” to number 1. above):

The lack of outpatient services is resulting in

- a. A very few
- b. A concerning number of admissions and extended lengths of stay that could have been prevented had outpatient services been available and provided in a timely way.

- 5.6 The unit and community partners monitor housing and admit no children and adolescents nor leave them in hospital because they lack a home or home type placement that best meets their long term living and attachment needs. Yes No
- 5.7 The system of care provides a complete, distinct, helpful, integrated, accessible, and cost-effective continuum of school mental health services. Yes No
- 5.8 Children, adolescents, and their families are supported by a case management continuum which assures continuity and integration of care across involved services.

Yes No

INDICATORS: CASE MANAGEMENT INTEGRATION, & CONTINUITY OF CARE

1. What percentage of children and adolescents with enduring mental health or neurodevelopmental problems had an identified system case manager (not just an inpatient case manager for the duration of the admission or a case manager for a single community service) _____%

INTEGRATION

1. What is the number (or percentage) of admitted patients who had been receiving step up treatment (not just triage, assessment, case management, waiting list, or registration) prior to admission? _____%

2. What is the number (or percentage) of admitted patients who had a session with their family or individual therapists during their admission (preferably conjoint with inpatient providers _____

CONTINUITY OF CARE

1. What is the number (or percentage) of admitted patients who were admitted with an integrated multiservice (i.e., children’s mental health, child welfare, school mental health, and outpatient) plan of care? _____

2. What is the number (or percentage) of patients (or parents/caregivers) who had scheduled session with post discharge providers early in the admission and prior to discharge? _____

5.9 The unit with its partners provide accessible services for all children and adolescents regardless of age, problem type and other special needs.

Yes No

INDICATORS: SYSTEM INCLUSIVENESS/UNIVERSALITY

Yes No

1. The system of care provides all needed (i.e., crisis, treatment, and case management) services for all ages.

If the answer is ‘No’, list the affected age groups and the services and supports they need but have been unable to receive:

2. The system of care provides all needed services for all mental health problems and diagnoses.

If the answer is ‘No’, list the problems and diagnostic groups and the services and supports they need but have been unable to receive:

3. The system of care provides services not only for individual children and adolescents, but also for parents/caregivers and family problems.

If the answer is ‘No’, list services and supports that are lacking for parents/caregivers:

4. The system of care provides all essential services for all user groups regardless of culture, language, religion, immigrant status, or orientation/identity.

If the answer is ‘No’, list services and supports that are lacking and for which groups:

INDIVIDUAL SERVICE PROFILE & EVALUATION

Client Name:

Date:

Mental health Crisis/Emergency	Mental Health Treatment (Tx)	Home & Housing	School Placement	Case Management (CM)	Forensic
Psychiatric Intensive Care <input type="checkbox"/>	Secure Tx <input type="checkbox"/>	Residential High Dependency <input type="checkbox"/> Medium Depend <input type="checkbox"/> Low dependency <input type="checkbox"/>	Class in Inpatient or Residential Facility <input type="checkbox"/>	Wraparound <input type="checkbox"/>	<i>To be added in next update</i>
Inpatient Crisis <input type="checkbox"/>	Inpatient Tx <input type="checkbox"/>				
Non-Hospital Crisis Residential Crisis Unit <input type="checkbox"/> Crisis Group Home <input type="checkbox"/> Crisis Foster Care <input type="checkbox"/>	Residential Tx Individual <input type="checkbox"/> Family Admissions <input type="checkbox"/> Tx Group Home <input type="checkbox"/> Tx Foster Care <input type="checkbox"/>		Regular Grp Home <input type="checkbox"/> Regular Foster Care <input type="checkbox"/>	Alternate School <input type="checkbox"/>	
Emergency Department <input type="checkbox"/>	Day Hospital <input type="checkbox"/>	Respite Care <input type="checkbox"/>	Day Treatment or Special Ed. Class <input type="checkbox"/>		
Mobile Crisis Mtl Health <input type="checkbox"/>	Intensive In-Home & Community Tx <input type="checkbox"/>	Supported Independent Living <input type="checkbox"/>	Regular Classroom Partial Withdrawal <input type="checkbox"/>	Agency CM - while case is open <input type="checkbox"/>	
Mobile Emergency Serv. (Police, CAS, Paramedics) <input type="checkbox"/>	Office-Based Tx Primary Care <input type="checkbox"/> Outpatient <input type="checkbox"/> Com.Mental Health <input type="checkbox"/> School <input type="checkbox"/>	Living independently or with parents/ caregivers <input type="checkbox"/>	Regular Classroom, in-class supports <input type="checkbox"/>	Broker/ Navigator CM <input type="checkbox"/>	
Telephone Crisis Lines & Walk-In Crisis Services <input type="checkbox"/>	Self-help <input type="checkbox"/>			Youth or Parents CM <input type="checkbox"/>	
Family, School, Community Crisis Intervention <input type="checkbox"/>	Public Health & Community Supports <input type="checkbox"/>				
No Crisis Service Needed <input type="checkbox"/>	No Tx Needed <input type="checkbox"/>	No Housing Needed <input type="checkbox"/>	Regular Classroom No supports needed <input type="checkbox"/>	No CM Needed <input type="checkbox"/>	
Cr Response harmful <input type="checkbox"/>	Tx Harmful <input type="checkbox"/>	Placement Harmful <input type="checkbox"/> <small>(e.g., culture. displacement, emotionally abusive)</small>	School Placement is Harmful <input type="checkbox"/> <small>(e.g., culturally harmful, target of stigma bullying)</small>	CM is Harmful, Disruptive or Fragmenting <input type="checkbox"/>	
Cr Response excessive or inappropriate <input type="checkbox"/> <small>(unneeded, leading to excessive service, adult not child in crisis)</small>	Tx not least restrictive not evidence support <input type="checkbox"/>	Inappropriate <input type="checkbox"/> <small>(e.g. stuck in hospital, no place to go)</small>	Inappropriate <input type="checkbox"/> <small>(e.g. not the best setting, could be in a more helpful placement if available)</small>	CM is Unhelpful or Excessive <input type="checkbox"/>	
Cr Response not timely or too late <input type="checkbox"/>	Tx Ineffective or insufficient dose <input type="checkbox"/>	Placement Unstable Breakdown Risk <input type="checkbox"/>	Enrolled not attending <input type="checkbox"/> <small>(e.g., avoidance, suspension)</small>	CM is Insufficient <input type="checkbox"/>	
Cr Response needed but absent <input type="checkbox"/>	No Tx <input type="checkbox"/> <small>(Tx refused, or waiting list)</small>	Homeless <input type="checkbox"/> <small>(e.g, couch surfing)</small>	Not enrolled <input type="checkbox"/>	No CM <input type="checkbox"/>	

Services are well integrated and continuous with ongoing communication among service providers, family and individual

Services lack continuity as reflected in the lack of a common service plan and multiple competing opinions

Different service providers in schools, children’s mental health, hospital, and other services lack regular integrative communication and sufficient contacts for common planning and progress assessment

5.10 The unit has ongoing contacts with all its partners to monitor, evaluate, and improve integration and continuity of care, and to advocate for missing services and supports.

Yes No

INDICATOR: SYSTEM INTEGRATION & COLLABORATION

Yes No

1. The unit identifies gaps and shortcomings in the identified essential components of care with its partners.	<input type="checkbox"/>	<input type="checkbox"/>
2. The collaboration identifies and reduces obstacles that delay or block access to the right service at the right time	<input type="checkbox"/>	<input type="checkbox"/>
3. The requests that telepsychiatrists, private practitioners, and other involved agencies communicate with the unit and exchange information that will prevent fragmentation of care and that will promote continuity of diagnosis, medication, and therapy.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit and its partner professionals and agencies meet at least once per year with youth, caregivers/parents to identify gaps in services, and address problems with integration, lack of continuity of care across all component services in the system of care.	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit has formal agreements/protocols in place with its community partners that assure integrated and continuous of care before, during, and after hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
5.11 The unit exchanges information and works with other inpatient units in the province (and if possible nationally) to standardize systems and best practices. Yes <input type="checkbox"/> No <input type="checkbox"/>		
5.12 The unit works with its partners locally and provincially to formalize, assess, monitor, and improve the completeness, integration, inclusiveness, helpfulness, and cost-effectiveness of the system of care and all its components. Yes <input type="checkbox"/> No <input type="checkbox"/>		
5.13 The unit collaborates with the private sector providers and agencies in ways that benefit children, adolescents, and families. Yes <input type="checkbox"/> No <input type="checkbox"/>		
DETAILS, COMMENTS, & NOTES:		



6.0 BEDS & UNIT TYPES. There are sufficient numbers of beds and types units to best meet the needs of children and adolescents.

6.1 The unit and its region have the right number of beds to best meet inpatient service needs. Yes No

INDICATOR: NUMBERS OF BEDS	Yes	No
1. There are more demands/requests for admission than the number of beds can accommodate resulting in high occupancy and overflow.	<input type="checkbox"/>	<input type="checkbox"/>
2. There are more beds than demands/requests for admission resulting in overall low occupancy (<85%).	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit has the right numbers of beds for the numbers of demands/requests.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit has too many beds relative to actual needs (versus demands).	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit has too few beds relative to actual needs.	<input type="checkbox"/>	<input type="checkbox"/>
6. The unit has the right number of beds to meet actual needs.	<input type="checkbox"/>	<input type="checkbox"/>

Number of child and adolescent inpatient beds/100,000 per LHIN area _____/100, 000. This is the number of beds as listed on the MOHLTC health data branch web portal <https://hsim.health.gov.on.ca/> or if unavailable there from the ONCAIPS Annual Directory divided by estimated population of children and adolescents aged 0-17 (under age 18) <https://www.ontario.ca/data/population-projections> provincially. Unfortunately the hsimi data base was missing several crisis/emergency units and several treatment ones at last review.

6.2 Children and adolescents have access to a balance of brief crisis and longer stay general and specialized treatment beds. Yes No

6.3 Children and adolescents have access to developmentally appropriate inpatient services. Yes No

6.4 The unit or the unit’s system of care have the capacity to admit entire families whenever needed. Yes No

6.5 Children and adolescents with problems including eating disorders, autism, substance use, concurrent disorders, and substance use, have access to the specialty units they need. Yes No

6.6 The unit and its region have all of the types of units that are essential to best meet the needs of children and adolescents. Yes No

INDICATORS: ACCESSIBILITY TO INPATIENT UNIT TYPES v

(Units that are funded and accessible to the unit and its catchment)

Secure Treatment	Crisis/Emergency	General Treatment	Specialized by Disorders and Problem
Adolescent Unit <input type="checkbox"/>	Children’s Unit <input type="checkbox"/>	Children’s Unit <input type="checkbox"/>	Eating Disorders <input type="checkbox"/>
	Adolescent Unit <input type="checkbox"/>	Adolescent Unit <input type="checkbox"/>	Autism & Intellectual Disabilities <input type="checkbox"/>
Transitional Age Unit <input type="checkbox"/>	Transitional Age U. <input type="checkbox"/>	Transitional Age Unit <input type="checkbox"/>	Detox Unit <input type="checkbox"/>
Psychiatric Intensive Care PICU	Blended Child & Adolescent Unit <input type="checkbox"/>	Blended Child & Adolescent Unit <input type="checkbox"/>	Concurrent Disorders <input type="checkbox"/>
Adolescent Unit <input type="checkbox"/>	Blended Adolescent & Transitional Age <input type="checkbox"/>	Blended Adolescent & Transitional Age U. <input type="checkbox"/>	Psychosis Unit <input type="checkbox"/>

Transitional Age Unit <input type="checkbox"/>	Family Admission	Family Admission	Mood Disorders Unit <input type="checkbox"/>
Admissions to Adult Units <input type="checkbox"/>	Family Unit <input type="checkbox"/>	Family Unit <input type="checkbox"/>	Eating Disorders U. <input type="checkbox"/>
		Parent-Infant	
		Perinatal Unit <input type="checkbox"/>	Forensic Unit <input type="checkbox"/>
Other Unit Types That Are or Should Be Available:			

6.7 The unit is adequately funded and resourced for the service expectations. Yes No

DETAILS, COMMENTS, & NOTES:

DRAFT

7.0 ADMISSIONS. The unit has the criteria and process to assure timely access for children and adolescents best helped by inpatient care.

7.1 The unit works with partners to develop and apply common criteria and processes that assure timely access for youth whose needs are best met by inpatient care. Yes No

INDICATOR: COMMON ADMISSION CRITERIA/PROCESS DEVELOPMENT & IMPLEMENTATION

1. Percentage of referrals to a crisis unit that experienced delay or blocked bed and had to be admitted to a less appropriate setting _____% compared to provincial, international, or ideal benchmark of tbd %
2. Median _____hours, and 90th percentile time_____ to transfer to an inpatient bed after triage (Controlling for travel times which would be quite different for rural and remote feeder hospitals) Compared to CAEP targets of 2 hours and 8 hours.
3. Median _____hours, and 90th percentile time_____ for community services to see a patient after referral or triage.
List of Reasons for delays: _____

7.2 The unit collaborates with partner agencies to reduce overuse and underuse of inpatient care. Yes No

7.3 The unit utilizes admission criteria and process which are developed with system partners and are supported by the best available evidence. Yes No

INDICATOR: CRITERIA DEVELOPMENT & IMPLEMENTATION	Yes	No
1. The admission process and criteria have been jointly developed, are well known by partners and the public, and are implemented in collaboration.	<input type="checkbox"/>	<input type="checkbox"/>
2. The admission criteria and process are regularly reviewed and improved in collaboration with partner agencies.	<input type="checkbox"/>	<input type="checkbox"/>
3. There is a larger system mechanism that is routinely used to address problems in the joint use of the admission process and criteria across the system of care, not just bilaterally.	<input type="checkbox"/>	<input type="checkbox"/>

7.4 The unit and partners share and utilize the same checklist of admission criteria to help reduce variability of admission decisions. Yes No

7.5 The admission criteria are accompanied by explicit exclusion/redirection criteria. Yes No

INDICATORS: CHECKLIST TO SUPPORT ADMISSION DECISIONS

ADMISSION CRITERIA	Yes	No	Not Sure
1. The problem and/or risk is severe enough to warrant admission.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Inpatient care is the least restrictive of the effective options that are available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. The health benefit of inpatient care is likely to be greater than what could be provided by other services (according to the available research evidence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. The problem is primarily due to a diagnosed or suspected mental disorder (problem is not mainly psychosocial, environmental or parental in nature).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. The youth is medically clear (without medical needs that the unit cannot safely manage).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. The unit will be able to manage the level of aggression and all other risks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. The admission will be close enough to allow family visits, and collaboration with community services from admission to discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Inpatient care will be able to provide a developmentally appropriate social milieu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Inpatient care will be able to be provided in a culturally responsible manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Services will be linguistically appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. The problem is <input type="checkbox"/> severe and imminent requiring stabilization in an inpatient crisis/emergency care unit or <input type="checkbox"/> urgent and temporary requiring treatment in a treatment unit or <input type="checkbox"/> chronic and enduring requiring residential treatment				
EXCLUSION-REDIRECTION CRITERIA			Consider Overflow or Redirection	
1. There is no bed available on the unit	<input type="checkbox"/>			
2. The child is better served by a hospital closer to his/her home	<input type="checkbox"/>			
3. The admission is not primarily to house the child for respite or to hold the child until a home or placement is found	<input type="checkbox"/>			
4. The is not primarily for the purpose of avoiding or escaping incarceration, school exams, or similar situations	<input type="checkbox"/>			
5. The unit does not have the capacity to address the service needs of the child (parenting capacity, forensic assessment, capacity to address admissions for neurodevelopmental problems). Describe:	<input type="checkbox"/>			
6. The case mix on the unit will present an unacceptable level of risk for the youth or co-patients.	<input type="checkbox"/>			
7. The child is not admitted for an educational or intellectual assessment or for assessment to access other services.	<input type="checkbox"/>			
8. The child is not admitted for medication reviews that can be and should be completed in the community.	<input type="checkbox"/>			
9. Percentage of referrals/transfers excluded/redirected instead of admitted _____% compared to provincial benchmark of <u> tbd </u> %.				
SUPPORT: Admission is Supported <input type="checkbox"/> Admission is not Supported <input type="checkbox"/>				
COMMENTS:				
7.6 The unit has explicit criteria and process for transferring to other units when the unit is full and for accepting transfers from other units. Yes <input type="checkbox"/> No <input type="checkbox"/>				
INDICATORS: OPTIONS AVAILABLE TO THE UNIT FOR CRISIS/EMERGENCY OVERFLOW			Yes	No
1. A treatment bed on the unit (if the unit has separately funded treatment beds)	<input type="checkbox"/>	<input type="checkbox"/>		
2. Unfunded bed attached to the unit I (extra out of service bed that is only activated to deal with emergency/crisis overflow)	<input type="checkbox"/>	<input type="checkbox"/>		
3. Holding beds attached to an emergency department or feeder hospital	<input type="checkbox"/>	<input type="checkbox"/>		
4. Pediatric beds for age 15 and under	<input type="checkbox"/>	<input type="checkbox"/>		
5. Pediatric beds for age 17 and under	<input type="checkbox"/>	<input type="checkbox"/>		

6. Adult beds for 16 and 17 years of age	<input type="checkbox"/>	<input type="checkbox"/>
7. Another unit in the same LHIN geographic area	<input type="checkbox"/>	<input type="checkbox"/>
8. Another unit elsewhere in the province	<input type="checkbox"/>	<input type="checkbox"/>
9. Total number of children and adolescents in the preceding year that used any of the above _____#		
10. Total number of children and adolescents that needed to be sent out of LHIN _____#		

7.7 The unit collaborates with partner agencies and communities to identify, monitor, and report harmful, ineffective, preventable, and low benefit admissions. Yes No

INDICATOR: IDENTIFYING & TRACKING INAPPROPRIATE ADMISSIONS		
IDENTIFYING: After admission and prior to discharge the unit has completed its assessment and has concluded that this admission was inappropriate because the admission was for a child or adolescent whose problems were	Yes	No
1. Too LOW SEVERITY/RISK too require inpatient care either because the problems remitted by point of admission or because screening/triage overestimation severity	<input type="checkbox"/>	<input type="checkbox"/>
2. Severe by point of referral/transfer, but were PREVENTABLE by standard community care in the period preceding referral/transfer to inpatient care.	<input type="checkbox"/>	<input type="checkbox"/>
3. Severe but not needing a more secure or specialized setting than the unit which was the WRONG TYPE OF SERVICE.	<input type="checkbox"/>	<input type="checkbox"/>
4. Severe but for whom inpatient care was of LOW OR NO BENEFIT.	<input type="checkbox"/>	<input type="checkbox"/>
5. Severe but for whom the admission was more HARMFUL as indicated by deterioration in care, cultural displacement, placement stability, or family attachments.	<input type="checkbox"/>	<input type="checkbox"/>
6. Severe but NOT THE LEAST RESTRICTIVE or COST-EFFECTIVE option for the problems (i.e., could have been addressed in a less restrictive and costly program has one been available and accessed)	<input type="checkbox"/>	<input type="checkbox"/>

TRACKING: What number of admissions to your unit (or separations) were inappropriately redirected (not admitted) and what percentage were admitted but were assessed to be systemically inappropriate?		
Type of Inappropriate Admission (From chart reviews at discharge)	Number For the Year	Don't Know
1. Too LOW SEVERITY/RISK		<input type="checkbox"/>
2. PREVENTABLE		<input type="checkbox"/>
3. WRONG TYPE OF SERVICE		<input type="checkbox"/>
4. LOW OR NO BENEFIT		<input type="checkbox"/>
5. HARMFUL		<input type="checkbox"/>
6. NOT THE LEAST RESTRICTIVE or COST-EFFECTIVE		<input type="checkbox"/>
The unit, emergency departments, and partner community services collaboratively identify the overall percentage of admissions whose needs were not best met by admission, and work together to improve access to more appropriate available or needed alternatives. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes _____% compared to provincial benchmark of <u>td</u> %		

7.8 The unit and its system of care have clear and distinct pathways for crisis/emergency and treatment services. Yes No

DETAILS, COMMENTS, & NOTES:

8.0 CARE. Care is guided by a single plan of care and a process that addresses the reason for admission.

8.1 The unit focuses its care around the problematic behaviour that precipitated referral or transfer to inpatient care. Yes No

8.2 The goals for each patient clearly target assessment and reduction of the problematic behaviour and contributing factors that led to admission. Yes No

8.3 The unit has a standardized admission and orientation process. Yes No

INDICATOR: ADMISSION & ORIENTATION		
Staff review and discusses with all youth and all parents/caregivers the	Yes	No
1. Patient and parent/caregiver brochure and handbook that contains the orientation information (and which should be available to all youth and caregivers prior to admission)	<input type="checkbox"/>	<input type="checkbox"/>
2. Behaviour problem, risk, or low functioning which precipitated the admission.	<input type="checkbox"/>	<input type="checkbox"/>
3. Likely costs and likely benefits of inpatient care in addressing the behaviour and functioning of concern.	<input type="checkbox"/>	<input type="checkbox"/>
4. The roles of the Most Responsible Physician and the roles of other staff on the interdisciplinary team.	<input type="checkbox"/>	<input type="checkbox"/>
5. Unit rules.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient and parent/caregiver rights (highlighting commonalities & differences)	<input type="checkbox"/>	<input type="checkbox"/>
7. Primary lines of communication for the patient (e.g., milieu nursing staff) and the parents/caregivers (e.g., social worker).	<input type="checkbox"/>	<input type="checkbox"/>
8. Availability of patient advocate.	<input type="checkbox"/>	<input type="checkbox"/>
9. Complaints process.	<input type="checkbox"/>	<input type="checkbox"/>
10. Youth responsibilities and code of conduct.	<input type="checkbox"/>	<input type="checkbox"/>
11. Parent/caregiver responsibilities and code of conduct.	<input type="checkbox"/>	<input type="checkbox"/>
12. Collaborations with community agencies and professionals.	<input type="checkbox"/>	<input type="checkbox"/>
13. Process of care from admission to discharge including milieu activities and any other specific stabilization or treatment to be provided.	<input type="checkbox"/>	<input type="checkbox"/>
14. Anticipated or likely outcomes of stays (for the problems or on average)	<input type="checkbox"/>	<input type="checkbox"/>
15. Likely or average unit length of stay.	<input type="checkbox"/>	<input type="checkbox"/>
16. Discharge and transition planning and discharge process, including the role of youth, parents/caregivers, community partners, and unit staff.	<input type="checkbox"/>	<input type="checkbox"/>
17. Role of the unit staff, if any, after discharge.	<input type="checkbox"/>	<input type="checkbox"/>

8.4 The goals for each patient are the reduction of the problematic behaviour or increase in the level of functioning in the specific areas of concern that led to admission. Yes No

8.5 The goals for each patient and the plan and course of inpatient are informed by collaboration with family and other services and supported by an existing community plan of care when it is available. Yes No

8.6 A single integrative interdisciplinary admission, care, and discharge plan of care guides service provision from admission to discharge. Yes No

INDICATORS: THE WRITTEN SINGLE INPATIENT CARE PLAN		
The Care Plan clearly identifies the reason for admission and contributors including	Yes	No

1. The Precipitating Problem (i.e., This is the risky or problematic behaviour or sets of behaviours of concern; in Emergency/Crisis Transfers this is described on the Form 1)	<input type="checkbox"/>	<input type="checkbox"/>
2. Contributing Diagnostic Factors (i.e., Diagnoses thought to have contributed to the precipitating problem)	<input type="checkbox"/>	<input type="checkbox"/>
3. Contributing Parenting, Family, and/or Community Factors	<input type="checkbox"/>	<input type="checkbox"/>
4. Contributing School & Peer Group Factors	<input type="checkbox"/>	<input type="checkbox"/>
5. Other contributing problems or stresses	<input type="checkbox"/>	<input type="checkbox"/>
6. History of the problem and contributors (i.e., Including developmental history)	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient voice at admission (including understanding and acknowledgment of disagreements about the precipitating problem and need for admission, the goals, and the plan)	<input type="checkbox"/>	<input type="checkbox"/>
8. Caregiver voice at admission (including understanding and acknowledgment of disagreements about the precipitating problem and need for admission, the goals, and the plan; under conditions of consent)	<input type="checkbox"/>	<input type="checkbox"/>
9. Legal disposition (i.e., Involuntary – form 1,2,3 etc. Informal, Voluntary)	<input type="checkbox"/>	<input type="checkbox"/>
10. History of all previous Psychotherapy and Psychosocial Interventions and their outcomes	<input type="checkbox"/>	<input type="checkbox"/>
11. Medication at Admission and History (i.e., Including medication history before more recent regimens)	<input type="checkbox"/>	<input type="checkbox"/>
The Care Plan clearly describes services to be provided including		
1. Specification of whether the admission is for brief emergency assessment and stabilization versus treatment	<input type="checkbox"/>	<input type="checkbox"/>
2. The service goals to address the precipitating problem	<input type="checkbox"/>	<input type="checkbox"/>
3. The assessment, stabilization, and treatment services and milieu activities to be provided	<input type="checkbox"/>	<input type="checkbox"/>
4. Any other risks not related to the reason for admissions that have to be managed	<input type="checkbox"/>	<input type="checkbox"/>
5. Anticipated length of stay and criteria for discharge	<input type="checkbox"/>	<input type="checkbox"/>
6. How progress and outcome will be evaluated	<input type="checkbox"/>	<input type="checkbox"/>
7. Who will receive a copy of the care plan	<input type="checkbox"/>	<input type="checkbox"/>
N.B. The care plan should ideally be one part of the discharge summary, with the rest of the discharge summary including recommendations for post-discharge care.		
8.7 Every admission includes a care planning session at admission for crisis and before admission for treatment with the youth, parents/caregivers, and community partner professionals. Yes <input type="checkbox"/> No <input type="checkbox"/>		
8.8 The unit has a clear series of steps it follows in providing care from admission to discharge. Yes <input type="checkbox"/> No <input type="checkbox"/>		
8.9 The unit has case conferences that engage patients, parents/caregivers, and professional partners in collaborating in the implementation of the plan from admission to discharge. Yes <input type="checkbox"/> No <input type="checkbox"/>		
INDICATOR: COLLABORATIVE PROGRESS REVIEWS & PLANNING		
1. The unit provides youth with an opportunity to participate in their own case conferences and progress review at least once per week.	<input type="checkbox"/>	<input type="checkbox"/>
2. Parents/caregivers are provided an opportunity to participate the case conferences and progress review for their child or adolescent at least once per week	<input type="checkbox"/>	<input type="checkbox"/>
3. Partners are provided opportunities to continue care they were involved in and to provide family and individual therapy, and to participate in regular case conferences and progress review.	<input type="checkbox"/>	<input type="checkbox"/>
4. Planning for care and discharge and summary recording engages youth and parents/caregivers at referral/transfer and continues throughout admission	<input type="checkbox"/>	<input type="checkbox"/>
8.10 The unit provides children and adolescents with passes back to their homes and schools as appropriate to inform and support assessment, stabilization, treatment, and transition back home. Yes <input type="checkbox"/> No <input type="checkbox"/>		

DETAILS, COMMENTS, & NOTES:

DRAFT

9.0 MILIEU ACTIVITIES. The unit milieu provides patients with the health promotion activities that can best support stabilization and longer term change.

9.1 The unit provides a complete range of evidence-supported, health-promoting milieu activities Yes No

INDICATOR: MILIEU PROGRAMMING OVERVIEW (Sleep & Exercise have their own sections with more detailed indicators)		
Milieu staff provide patients with the following on a daily basis:	Yes	No
1. Mindful meditation, breathing exercises, body scan meditation, progressive muscle relaxation, yoga and tai chi, or other forms of relaxation.	<input type="checkbox"/>	<input type="checkbox"/>
2. Healthy meals with healthy socializing breakfast, lunch, and dinner routines.	<input type="checkbox"/>	<input type="checkbox"/>
3. Support for spiritual, religious, and cultural practices	<input type="checkbox"/>	<input type="checkbox"/>
4. Routines to develop or maintain personal care and hygiene.	<input type="checkbox"/>	<input type="checkbox"/>
5. Opportunities to develop and maintain social skills & to socialize with co-patients.	<input type="checkbox"/>	<input type="checkbox"/>
6. Opportunities to meet with and socialize with families or visitors.	<input type="checkbox"/>	<input type="checkbox"/>
7. Exercise.	<input type="checkbox"/>	<input type="checkbox"/>
8. Sleep Hygiene.	<input type="checkbox"/>	<input type="checkbox"/>
9. Free time.	<input type="checkbox"/>	<input type="checkbox"/>
Milieu staff also provide opportunities, lead, support &/or participate with patient in the following activities on a regular basis:	Yes	No
1. Cooking or meal preparation.	<input type="checkbox"/>	<input type="checkbox"/>
2. Youth mental health education sessions.	<input type="checkbox"/>	<input type="checkbox"/>
3. Parent/caregiver mental health education sessions.	<input type="checkbox"/>	<input type="checkbox"/>
4. Opportunities for therapeutic art, crafts, music, expressive writing, gardening and/or other similar activities	<input type="checkbox"/>	<input type="checkbox"/>

9.2 The unit provides routines and activities for the development and maintenance of good sleep habits Yes No

INDICATOR: SLEEP HYGIENE (UNIT PROMOTION OF HEALTHY SLEEP)			
The unit provides	Yes	Partly	No
1. Consistent rising time (unless there is a medical reason not to). Allowing children to sleep in can perpetuate sleep difficulties and contribute to social isolation, continuity of the sick role, passivity and depression and school refusal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consistent bedtime appropriate for age and needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Consistent bed-time routine (structured calming attachment promoting, and appropriate for age and needs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Arousal reducing activities before bedtime (e.g., yoga, slow breathing, relaxing music or colouring; sensory overload for certain populations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Scheduled opportunities to engage in daily stress reduction activities, relaxation, calming mindfulness, or calming spiritual and cultural practices at different points in the day, not just prior to bedtime.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Routines that assure that the bedroom and bed are for sleep and <u>not</u> for homework, therapeutic handouts, a place for psychotherapy, a place for games, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

a setting in which to safely worry, ruminate, avoid school, or obsess.			
7. Minimization of light, noise, overly hot temperature, uncomfortable beds and bedrooms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Protection of privacy and psychological safety (stressful intrusions by other patients, visitors, family and staff are prevented and youth are encouraged to meet with visitors in rooms for this purpose and not in the bedroom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Help rescheduling stressful problem solving prior to bedtime to the next day (if these arise on their staff reschedule to tomorrow if possible and help children and adolescents to put the worry aside until tomorrow; if the raising of problems is to avoid feared sleep or get attachment supports then the fear and need for attachment have to be acknowledged and provided but the problem solving can be deferred to tomorrow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Help in avoiding overly arousing types of activities including exercise, game play, movies, screen time, and social interactions within three to four hours of bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Help in preventing daytime napping .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Help to adopt good eating habits prior to sleep (e.g., not going to bed too hungry or too full), and avoiding drinking beverages or foods likely to keep them awake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Scheduled daily physical exercise during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Psychoeducational sessions on sleep that promote good understanding of sleep problems and interventions (individual, group, and family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Individualized sessions during the day to identify and address emotionally conditioned emotions that may getting in the way of sleep including a) anxious rumination and worry cued by bedtime b) fears of being abandoned or assaulted during sleep, c) fear of nightmares and intrusive images after sleep, d) fear of having interrupted sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Individual sessions during the day to identify and replace maladaptive pre-sleep behaviours such as a) active attempts to calm down and sleep that increase rather than decrease agitation, b) watching the clock, c) commanding self to go to sleep, or d) catastrophizing anticipated consequences due to lack of sleep (e.g. If I don't sleep tonight...).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.3 The unit reduces sedentary behaviours and provides developmentally appropriate opportunities for vigorous exercise. Yes <input type="checkbox"/> No <input type="checkbox"/>			
INDICATOR: EXERCISE (UNIT PROMOTION OF HEALTHY EXERCISE/ACTIVITY)			
The following are the recommended aspirational standards	Yes	Partly	No
1. Staff and patient, assess the individual's prehospitalization exercise in order to identify motivation, preferences, and patterns of excessive or insufficient exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The hospital and unit recognize healthy exercise as a core milieu activity, and they have provided staff with the time required to lead and participate in exercise activities with unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Staff individualize exercise in order to permit all youth regardless of age, disabilities, medical conditions, or special needs to exercise daily to the extent that is most desirable and possible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Staff typically provide all children and adolescents with 60 minutes per day of vigorous exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. The 60 minutes of vigorous exercise daily include at least 30 minutes of aerobic exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The daily 60 min. should include muscle and bone strengthening exercises such as resistance training, core strength development, or weightlifting at	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

least 3 times per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Staff lead activities and exercise with patients to model positive exercise behaviour for children and adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Opportunities to exercise outside and in a green area are available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The vigorous daily activities are supported by light exercise opportunities such as slow walks, stretches, and other less intense movement activities every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Recreational screen time is limited to less than 2 hours per day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Staff provide a minimal 5 minute activity break for patients who have been inactive, sitting or lying in bed for an at least 50 minutes to an hour (including watching television, playing video games, sitting in school, and completing educational and self-help handouts provided by staff)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Staff set limits on the amount and type of maladaptive exercise (e.g., excessive or compulsive exercise in eating disorders, risky exercise activities in excitement seeking groups)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The staff lead and participate in exercise with youth in a motivationally enhancing, trauma informed and attachment supporting way that is aware of individual emotional and motivational challenges, and the need for an encouraging but not overly demanding or punitive approach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Staff choose and develop activities with patients that are motivating, reinforcing, and most likely to be continued after discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Staff choose and develop activities with patients that they have the means and equipment to continue after discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.4 The unit staff lead, and whenever possible, model and participate in the activities with youth. Yes No

9.5 The unit provides children and adolescents, and parents/caregivers with a copy of the daily or weekly activity schedule. Yes No

9.6 Children and adolescents on the unit are provided an opportunity to evaluate the activities and care they receive and to make suggestions about programming. Yes No

INDICATOR: PATIENT EVALUATION OF ACTIVITIES				
Youth Name _____		Sampling Period: _____		
Time (When?)	What did you do?	Who with?	Was it helpful?	Suggestions?
Add rows as needed				

10.0 ASSESSMENT. The unit provides reliable and valid assessments that inform stabilization and treatment, and contribute to improved outcomes.

- 10.1 The purpose of inpatient assessment to inform stabilization and treatment in order to improve youth outcomes (i.e., not simply to label, describe, or diagnose).** Yes No
- 10.2 The focus of assessment is the behavioural problem, functional disability, and/or risks that precipitated admission.** Yes No

INDICATORS: ASSESSMENT OF THE PRECITATING PROBLEM(S)	True	False
1. Assessment focuses on the problems that precipitated the admission.	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessment does not focus upon or extend stays for secondary problems that are not reasons for admission (e.g., once suicidality is stabilized further and ongoing assessment of contributing depression or eating disturbance should be provided on a community or outpatient basis before or after discharge).	<input type="checkbox"/>	<input type="checkbox"/>
3. Assessment continues to track progress on the assessed precipitating problems throughout the admission.	<input type="checkbox"/>	<input type="checkbox"/>
4. Recipients of assessment information are informed of the limitations and potential for unreliability and invalidity of inpatient assessment.	<input type="checkbox"/>	<input type="checkbox"/>
The unit has the capacity to as reliably and validly as possible assess the most common precipitating problems including:		
5. Nature and severity of suicidal thoughts, behaviours, and risks.	<input type="checkbox"/>	<input type="checkbox"/>
6. Nature and severity of aggressive and homicidal thoughts, behaviours, and risks of aggression and harm to others.	<input type="checkbox"/>	<input type="checkbox"/>
7. Nature and severity of impairments in functioning that pose significant risks to self and others, and their related contributing factors (e.g., functional disabilities associated with psychosis, eating disorders, substance use and other)	<input type="checkbox"/>	<input type="checkbox"/>
8. The unit is a specialized services eating disorders unit, concurrent disorders unit, forensic units or a unit specializing in developmental or other disorders. True <input type="checkbox"/> False <input type="checkbox"/> . If True (go to 9.)		
9. The unit provides a specific assessment process (not limited to diagnosis) that is specific to the type of problem in which the unit specializes.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

- 10.3 The unit provides the most efficient, least restrictive, and most cost-effective assessment measures and processes.** Yes No

INDICATORS: ASSESSMENT OF EFFICIENCY, RESTRICTIVENESS, AND COST-EFFECTIVENESS	True	False
1. The unit gathers all of the information required for an accurate and helpful assessment as efficiently and cost effectively as possible including using and not duplicating prior assessments.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit does not admit for assessments that could be completed in the community simply used because of community waiting lists or lack of services.	<input type="checkbox"/>	<input type="checkbox"/>
3. Inpatient assessment is very intrusive and potentially harmful and is not used to provide second opinions to parents/caregivers who disagree with community assessment conclusions.	<input type="checkbox"/>	<input type="checkbox"/>
4. There are no processes/measures that require staff to gather and record information that then lies relatively dormant and does not significantly affect or improve client care.	<input type="checkbox"/>	<input type="checkbox"/>
5. The restrictiveness of equally helpful assessment processes and measures is always considered and the least restrictive and most cost-effective of similar options is always chosen.	<input type="checkbox"/>	<input type="checkbox"/>

6. The cost-effectiveness of equally helpful assessment processes and measures is always considered and the most cost-effective of similar options is always chosen (<i>e.g., similarly valid and reliable public domain measures at no cost versus high cost measures with copyright</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

10.4 The unit assesses personal characteristics, diagnoses and environmental factors that contribute to the precipitating problem, risk, or functional disability. Yes No

INDICATORS: ASSESSMENT OF CONTRIBUTING FACTORS		
The unit has the competencies and always assesses and identifies....	True	False
1. The diagnosis which makes the greatest contribution to the problems that precipitated the admission (<i>i.e., primary of most responsible diagnosis</i>)	<input type="checkbox"/>	<input type="checkbox"/>
2. Comorbid disorders (<i>e.g., for disorders such as Major Depression, Psychosis, Post Traumatic Stress etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3. Individual characteristics, habits and lifestyle behaviours that may contribute to problems.	<input type="checkbox"/>	<input type="checkbox"/>
4. Personal strengths that can support recovery and change.		
5. Motivation for change (<i>e.g., stage of change</i>).	<input type="checkbox"/>	<input type="checkbox"/>
6. Motivation to collaboration or therapeutic alliance (<i>e.g., willingness and capacity to collaborate with therapists and physicians</i>)	<input type="checkbox"/>	<input type="checkbox"/>
7. Attachment needs and style	<input type="checkbox"/>	<input type="checkbox"/>
8. Family problems and strengths.	<input type="checkbox"/>	<input type="checkbox"/>
9. Social, community, and peer relational problems and strengths.	<input type="checkbox"/>	<input type="checkbox"/>
10. School problems and strengths	<input type="checkbox"/>	<input type="checkbox"/>
11. The history of past services and their outcomes, including past medication and psychotherapy use and effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>
12. Cognition including beliefs, automatic thoughts, and ways of thinking.	<input type="checkbox"/>	<input type="checkbox"/>
13. Emotional functioning, and capacity for self-regulation, and distress tolerance.	<input type="checkbox"/>	<input type="checkbox"/>
14. The antecedents, functions, and reinforcement maintaining the precipitating problems and behaviours of concern.	<input type="checkbox"/>	<input type="checkbox"/>
15. Global functioning or disability.	<input type="checkbox"/>	<input type="checkbox"/>
16. Special needs including but not limited to cultural ones.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

10.5 The unit utilizes standardized, reliable, and valid measures to inform inpatient stabilization and treatment. Yes No

INDICATORS: RELIABLE & VALID MEASURES IN USE		
	True	False
1. The unit routinely utilizes a measure for suicidal thinking, behaviour and contributing factors for all patient presenting or suspected to be at risk for suicide.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit routinely utilizes a measure for aggression and contributing factors for all patient presenting or suspected to be at risk of harming others.	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit has specific measures for some <input type="checkbox"/> most <input type="checkbox"/> all <input type="checkbox"/> of the diagnostic contributors and diagnostic inpatient groups is admits (<i>e.g., measure of depression, measure of psychosis etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
4. Measures used are culturally appropriate and available in French and English.	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit routinely utilizes a psychometric measure of global functioning and functional disability for some <input type="checkbox"/> most <input type="checkbox"/> all <input type="checkbox"/> patients. If the answer is True the measure(s) used are	<input type="checkbox"/>	<input type="checkbox"/>
CAPI <input type="checkbox"/> , CGAS or GAF <input type="checkbox"/> , RAI- ChYMh <input type="checkbox"/> , CAFAS <input type="checkbox"/> , HoNOSCA <input type="checkbox"/> , BPRS-C <input type="checkbox"/> , CANS-MH <input type="checkbox"/> , CBCL <input type="checkbox"/> ,		

Other Global Measure (s) Please list:

Comments:

10.6 The unit and the community partners develop and use common and continuous integrative assessment processes and measures. Yes No

INDICATORS: SYSTEMIC APPROPRIATENESS & INTEGRATION OF ASSESSMENTS	True	False
1. The unit uses the same assessment measures for the precipitating problems, global functioning, and contributing factors as community based child and adolescent mental health services.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit uses the same assessment measures for the precipitating problems functioning, and contributing factors as school based child and adolescent mental health services.	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit uses the same assessment measures for the precipitating problems functioning, and contributing factors as other units in the province.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit has agreements with other services that establish that the unit does not accept admissions for assessments that can be and should be provided by less restrictive and more cost effective services in the community.		
5. The unit does not accept admissions for assessments that can be as reliably and validly be provided in the community.	<input type="checkbox"/>	<input type="checkbox"/>
6. The unit does not extend lengths of stay for assessment of problems which should be provided on a community or outpatient basis after discharge.	<input type="checkbox"/>	<input type="checkbox"/>
7. The unit always accesses all available prior assessments in order to reduce duplication and be optimally informed in its care planning.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

DETAILS, COMMENTS, & NOTES:

11.0 STABILIZATION & THERAPY. The unit selects stabilization and/or psychotherapy components with the best current evidence for the precipitating problem and contributing factors.

11.1 The unit focuses its stabilization and/or psychotherapy on the behaviour, risk, or problematic functioning that precipitated admission. Yes No

11.2 The unit extends its stabilization and/or psychotherapy to the factors that contributed to the precipitating problem(s). Yes No

11.3 Patient history of treatment and the best evidence from research findings are utilized to inform stabilization and/or psychotherapy components. Yes No

INDICATORS: APPLYING THE BEST CURRENT INFORMATION & EVIDENCE	True	False
1. The unit targets the precipitating problems, risks, or disturbed functioning that are to be for change.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit also considers the diagnostic and environmental contributors in developing its stabilization and/or psychotherapy plans.	<input type="checkbox"/>	<input type="checkbox"/>
3. Stabilization and/or psychotherapy are individualized for each patient's precipitating problems and contributing factors (<i>i.e., patients do not receive the same therapy regardless of presenting problem, but receive the therapy with the best supporting evidence in the literature for the precipitating problems, risk or functional disability</i>).	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit selects the stabilization and/or psychotherapy components with the best current research evidence support.	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit utilizes information about the patient's treatment history responses to stabilization and/or psychotherapy to understand likely costs and benefits of different approaches and components.	<input type="checkbox"/>	<input type="checkbox"/>
6. The unit assesses and reports the process and outcomes of stabilization and psychotherapy for each patient and makes changes to stabilization and therapy based upon the evidence provided by observation and inpatient measurement.	<input type="checkbox"/>	<input type="checkbox"/>

11.4 The unit has published a clear definition of stabilization that distinguishes stabilization from the relatively longer processes of therapy. Yes No

INDICATORS: STABILIZATION	True	False
The unit provides <input type="checkbox"/> does not provide <input type="checkbox"/> crisis/emergency stabilization. If it does...		
1. Stabilization is described as a return to typical functioning and levels of risk.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit providers, youth, and parents/caregivers are clear about the difference between crisis/emergency stabilization and longer psychotherapies.	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit selects and individualizes the least restrictive stabilization interventions with the best evidence support for a patient's precipitating crisis problems and contributing factors.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit monitors, evaluates, and reports outcomes of stabilization activities for each patient in ways that improve outcomes.	<input type="checkbox"/>	<input type="checkbox"/>
5. Children and adolescents are asked to routinely provide feedback to inform stabilization.	<input type="checkbox"/>	<input type="checkbox"/>

11.5 The unit provides the most effective psychotherapy or combination of evidence supported psychosocial therapy components for the precipitating problems and contributing factors. Yes No

INDICATORS: TYPES & MODES OF PSYCHOTHERAPIES & COMPONENTS	True	False
The unit provides <input type="checkbox"/> does not provide <input type="checkbox"/> psychotherapy. If it does,		

The unit has the capacity and flexibility to provide psychotherapies in the following ways		
1. On an individual basis.	<input type="checkbox"/>	<input type="checkbox"/>
2. On a peer group basis.	<input type="checkbox"/>	<input type="checkbox"/>
3. On a family and parent/caregiver training basis on the unit or in partnership with community agencies that may provide these services in the community while the child is on the unit.	<input type="checkbox"/>	<input type="checkbox"/>
4. On a milieu basis.	<input type="checkbox"/>	<input type="checkbox"/>
The unit has the capacity to apply the following psychotherapy treatment components		
1. Behavioural types of therapy &/or components (<i>e.g., antecedent control procedures, exposure & desensitization, appetitive and aversive conditioning, modeling & rehearsal</i>)	<input type="checkbox"/>	<input type="checkbox"/>
2. Cognitive types of therapy &/or components (<i>often paired with other components and variants such as collaborative problem solving and mentalization types</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3. Emotionally targeting therapy &/or its components (<i>e.g., distress tolerance, emotional self-regulation</i>)	<input type="checkbox"/>	<input type="checkbox"/>
4. Interpersonal skills training &/or its components	<input type="checkbox"/>	<input type="checkbox"/>
5. Mindfulness and acceptance therapy &/or its components	<input type="checkbox"/>	<input type="checkbox"/>
6. Attachment therapies &/or components (including those focusing on parent attachment)	<input type="checkbox"/>	<input type="checkbox"/>
7. Motivational therapies &/or components	<input type="checkbox"/>	<input type="checkbox"/>
8. Family and larger system therapies &/or components	<input type="checkbox"/>	<input type="checkbox"/>
The unit evaluates outcomes of its psychotherapy activities and sessions		
1. Patients are routinely asked for feedback about the helpfulness of a session and components and their feedback is recorded	True	False
2. The unit assesses progress and reports the outcomes of its psychotherapy activities for each patient in terms of patient ratings of its helpfulness and measures of change in the precipitating problem and contributing factors.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		
11.6 The unit has a process for assuring and documenting that youth and substitute decision makers are adequately informed and able to make knowledgeable decisions about therapy. Yes <input type="checkbox"/> No <input type="checkbox"/>		
INDICATORS: INFORMED CONSENT		
The unit provides <input type="checkbox"/> does not provide <input type="checkbox"/> psychosocial therapies. If it does the unit accurately informs patients or substitute decision makers	True	False
1. About the process of the planned inpatient psychotherapy.	<input type="checkbox"/>	<input type="checkbox"/>
2. Of the potential harms and benefits of the specific planned course of inpatient psychotherapy.	<input type="checkbox"/>	<input type="checkbox"/>
3. The relative costs and benefits of different options.	<input type="checkbox"/>	<input type="checkbox"/>
4. About its own past psychotherapy outcomes so that it can more accurately inform young people and families.	<input type="checkbox"/>	<input type="checkbox"/>
5. Of the opportunity and desirability of understanding and discussing psychotherapy directions	<input type="checkbox"/>	<input type="checkbox"/>
11.7 Staff who provide stabilization and/or psychotherapy have the necessary competencies, time, supervision and consultation. Yes <input type="checkbox"/> No <input type="checkbox"/>		
INDICATORS: COMPETENCIES, TIME, RESOURCES		
1. Staff without training and experience are not placed in situations of provided stabilization and/or psychotherapy they are not competent to provide (<i>e.g., part time staff borrowed from surgical or adult units without child and adolescent mental health</i>)	<input type="checkbox"/>	<input type="checkbox"/>

experience)		
2. All staff keep informed about key theories, research findings, and comparative outcomes of the application of different therapies and components of therapies on inpatient units (<i>important if staff are to communicate information essential to obtaining informed consent.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit has a process of scheduled weekly or monthly supervision (<i>peer or from a more experienced and credentialed staff</i>).	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit staff have access to specialist consultation for rare or difficult cases.	<input type="checkbox"/>	<input type="checkbox"/>
5. Staff psychotherapy time is protected and monitored to assure staff provide the required frequency and numbers of sessions and milieu care contacts.	<input type="checkbox"/>	<input type="checkbox"/>
11.8 The unit works with the community to assure continuity and integration of stabilization and psychotherapy activities. Yes <input type="checkbox"/> No <input type="checkbox"/>		
INDICATORS: INTEGRATION & CONTINUITY	True	False
1. The unit build upon its knowledge of community psychotherapy approaches to continue what worked well in therapy and improve upon what did not.	<input type="checkbox"/>	<input type="checkbox"/>
2. Community psychotherapists and counselors are collaboratively engaged by the unit to continue to provide individual or family psychotherapy inpatient care across the admission (<i>e.g., through telephone or other media, visits for conjoint sessions on the unit, or therapy sessions on passes</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3. Community psychotherapists starting or continuing care after discharge are well informed about what happened on the unit so that they can provide continuing and integrated care.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit provides opportunities for youth and parents/caregivers to discuss psychotherapy process and progress across admission, across care, and at discharge.	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS, COMMENTS, & NOTES:		

12.0 MEDICATION. The unit assesses medication needs and provides pharmacotherapy that is supported by the best current evidence.

12.1 The unit works with primary care providers and community services to assure medication reviews and pharmacotherapy services are provided in the least restrictive setting. Yes No

12.2 Inpatient prescribers work to develop a therapeutic alliance that promotes patient collaboration in pharmacotherapy. Yes No

12.3 The unit uses the best possible available evidence to support its prescription practices. Yes No

INDICATORS: OBTAINING & USING THE EVIDENCE	True	False
1. Unit providers follow pharmacotherapy guidelines and pathways for the precipitating problems and contributors.	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit gathers the history of pharmacotherapy and the outcomes and adverse reactions associated with the past uses of medication (<i>i.e., not just the best possible (recent) medication at admission</i>).	<input type="checkbox"/>	<input type="checkbox"/>
3. The unit uses direct observation to monitor the costs and benefits of prescribed medications and their interactions.	<input type="checkbox"/>	<input type="checkbox"/>
4. The unit uses standardized measures of targeted symptom changes.	<input type="checkbox"/>	<input type="checkbox"/>
5. The unit uses standardized measures for side effects and adverse reactions.	<input type="checkbox"/>	<input type="checkbox"/>

12.4 The unit is aware of address placebo and nocebo problems and implements procedures to reduce misleading impressions of providers and patients. Yes No

12.5 The unit providers use the most cost-effective medications. Yes No

12.6 The unit monitors, manages, and assures medication safety. Yes No

INDICATORS: MEDICATION SAFETY
1. % of medication errors = medication errors/# of admissions _____%
2. % of adverse medication events = adverse events/# of admissions _____%

12.7 The unit monitors, reports, and evaluates use of polypharmacy. Yes No

12.8 The unit monitors, reports, and evaluates off-label medication use. Yes No

12.9 The unit monitors and annually reports medication use. Yes No

INDICATORS: PHARMACOTHERAPY USE & OUTCOMES				
Medication	Target Symptom(s)	Outcomes & Adverse reactions	Date	Patient ID
Annual Indicators				
1. Percentage of admissions prescribed treatment medication for a mental health reason at admission _____ % at discharge _____ %				
2. Percentage off patients receiving off-label prescriptions at admission _____% at discharge _____ %				
3. Percentage by type at admission antipsychotic _____% antidepressant _____% stimulant _____%				
Other:				
4. Percentage of patients receiving polypharmacy at admission _____ % at discharge _____ %				
12.10 The unit tracks changes to admission patient medication status. Yes <input type="checkbox"/> No <input type="checkbox"/>				
12.11 The unit monitors, reports, and evaluates use of prn type medication for restraint, managing of agitation, and other purposes. Yes <input type="checkbox"/> No <input type="checkbox"/>				
12.12 The unit promotes continuity of pharmacotherapy across transitions into and out of inpatient care. Yes <input type="checkbox"/> No <input type="checkbox"/>				
INDICATORS: MANAGING TRANSITION FROM & TO THE COMMUNITY			True	False
1. There is a clear written plan of pharmacotherapy that informs the unit at admission about what was provided in the community and a clear plan that informs primary care physicians and specialists at discharge (ideally this should not be restricted to a simple list but should include a rationale and contingencies)			<input type="checkbox"/>	<input type="checkbox"/>
2. The unit identifies most involved and responsible community prescriber			<input type="checkbox"/>	<input type="checkbox"/>
3. The inpatient unit has a direct contact with the most responsible primary care provider prior to or just after admission and before discharge to promote ongoing uninterrupted continuity of pharmacotherapy.			<input type="checkbox"/>	<input type="checkbox"/>
4. The unit protects the roles of the most involved direct care providers by alerting peripherally involved specialists, consultants, and telepsychiatrists who may be unaware of the unit's role and of the more involved roles of primary and secondary care in the community.			<input type="checkbox"/>	<input type="checkbox"/>
12.13 The unit evaluates and reports the short term outcomes of the medication it prescribes and collaborates with community providers to evaluate and report longer term ones. Yes <input type="checkbox"/> No <input type="checkbox"/>				
INDICATORS: MEDICATION OUTCOMES			True	False
The unit an partners track				
1. The number of patients still on the medication prescribed on the inpatient unit within 1 month and 3 months after discharge			<input type="checkbox"/>	<input type="checkbox"/>
2. The extent to which medication prescribed on the unit is associated with a reduced 3 month readmission rate			<input type="checkbox"/>	<input type="checkbox"/>

3. The extent to which medication prescribed on the unit is associated target symptom reduction or increase at 3 months post-discharge	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

DETAILS, COMMENTS, & NOTES:

DRAFT

13.0 DISCHARGE. The unit and partner services employ a commonly developed, efficient and effective discharge process to facilitate transition back to community and school.

13.1 The unit has explicit criteria for discharge which are linked to the outcomes of the services provided for precipitating behavioral risk/problems and contributors.

Yes No

INDICATORS: DISCHARGE CRITERIA		
The unit utilizes the following discharge criteria:	Yes	No
1. The child or adolescent is not at imminent risk of harm to self and others if discharged	<input type="checkbox"/>	<input type="checkbox"/>
2. The individual's precipitating problem or risk has been successfully addressed as per the goals in the plan of care.	<input type="checkbox"/>	<input type="checkbox"/>
3. The individual's precipitating problem or risk has not been successfully addressed as per the goals in the treatment plan but <ul style="list-style-type: none"> a. The youth will not profit from continued hospitalization b. The youth will be harmed more than helped by continued hospitalization c. The youth or the Substitute Decision Maker withdraws consent 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. A necessary condition for transfer to a more secure, longer stay (non-acute), or more specialized setting is that the individual is at imminent risk of harm to self and others by virtue of a mental disorder if discharged. But the unit is unable to provide required safety or treatment; the youth must be transferred to another setting	<input type="checkbox"/>	<input type="checkbox"/>
5. Identification and engagement or contact with a most responsive post-discharge care provider, case manager, or agency that will continue care (necessary in most cases)	<input type="checkbox"/>	<input type="checkbox"/>
6. Discharge session with medication reconciliation, service summary, and recommendations reviewed with youth, parents/caregivers and community mental health services	<input type="checkbox"/>	<input type="checkbox"/>
7. Aftercare plan completed by most responsible community provider with support from the inpatient team.	<input type="checkbox"/>	<input type="checkbox"/>

13.2 The unit has a discharge planning process that engages patients, parents/caregivers and partner professionals no later than admission.

Yes No

INDICATORS: DISCHARGE PROCESS		
The Discharge Process assures that	Yes	No
1. Patient, parent/caregivers and post-discharge community professionals are engaged in the process of post-discharge planning and care at admission or shortly after.	<input type="checkbox"/>	<input type="checkbox"/>
2. A final copy of the discharge summary and plan is available to inform all youth and their post-discharge community care providers no later than point of discharge.	<input type="checkbox"/>	<input type="checkbox"/>
3. The discharge summary includes or is accompanied by a discussion of safety needs including a jointly developed safety plan.	<input type="checkbox"/>	<input type="checkbox"/>
4. The written plan/summary and discharge session review outcomes of reasons for admission, medication needs and changes, recommendations and community post-discharge plans.	<input type="checkbox"/>	<input type="checkbox"/>
5. A knowledge exchange and planning discharge sessions occurs at or prior to discharge with youth, parents/caregivers post-discharge community care providers	<input type="checkbox"/>	<input type="checkbox"/>

13.3 The unit provides a single interdisciplinary discharge summary/plan that patients, parents/caregivers and partner professionals can use to further develop their future community care plan.

Yes No

INDICATORS: DISCHARGE SUMMARY		
The Discharge Summary includes	Yes	No
1. Outcome of the behavior and risk that precipitated admission	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient voice about the positive and negative experiences during their stay and their view of the outcome		
3. Changes to any contributing factors.	<input type="checkbox"/>	<input type="checkbox"/>
4. Changes to legal status.	<input type="checkbox"/>	<input type="checkbox"/>
5. Opinions and information provided by parent/caregivers and community partners and recommendations.	<input type="checkbox"/>	<input type="checkbox"/>
6. Summary of psychosocial therapies and interventions provided and their outcomes	<input type="checkbox"/>	<input type="checkbox"/>
7. Identification of primary and supporting post-discharge care providers (e.g., children's mental health agency, private psychotherapist, school mental health providers, mental health and addiction nurses in the schools)	<input type="checkbox"/>	<input type="checkbox"/>
8. Summary of medication changes and medical procedures provides	<input type="checkbox"/>	<input type="checkbox"/>
9. Identification of primary and supporting medical providers (e.g., outpatient psychiatry program, pediatrician, family health team, primary care physician, nurse practitioner)	<input type="checkbox"/>	<input type="checkbox"/>
10. Recommendations	<input type="checkbox"/>	<input type="checkbox"/>
11. Who is to get copies and any restrictions	<input type="checkbox"/>	<input type="checkbox"/>

13.4 The unit monitors, evaluates, and works with its partners to prevent delays in discharges. Yes No

INDICATORS: DELAYED DISCHARGES				
Reasons for Delayed Discharges: 1= almost all delayed discharges, 2= many, 3=some, 4= very few delayed discharges	1	2	3	4
1. Lack of transportation to discharge environment	<input type="checkbox"/>			
2. Lack of access to specific community services/supports at discharge				
3. Refusals or reticence in accepting the patient back in the home or group home				
4. School refusal or reticence in accepting a return to school				
5. The child or adolescent refuses to leave and wants to stay against medical need/advice				
6. The patient was without a placement at discharge				
7. Other (Describe):				
Reporting Delayed Discharges	Yes	No		
1. The unit identifies and reports all delays and their causes.	<input type="checkbox"/>	<input type="checkbox"/>		
2. Percentage of admissions with blocked bed days = Delayed Admissions/Total Admissions _____%				
3. Percentage of total blocked bed days = Blocked/lost bed days = Blocked bed days/Total bed days _____%				
4. Annual ALC statistics submitted to CIHI: _____				
5. Rank Order Reasons for Delayed Discharged from most prevalent as 1 (list here from above)				

13.5 The unit works with home, school, and community to facilitate transitions back to home and school.	Yes <input type="checkbox"/> No <input type="checkbox"/>
13.6 The unit and adult services collaborate to assure the best possible transitions to the adult service system.	Yes <input type="checkbox"/> No <input type="checkbox"/>
13.7 The unit and community stay in contact to assure continuity of care and support for patients after discharge.	Yes <input type="checkbox"/> No <input type="checkbox"/>
DETAILS, COMMENTS, & NOTES:	

DRAFT

14.0 UTILIZATION. The unit monitors and ensures helpful, fair, and cost-effective utilization of inpatient resources.

14.1 The unit monitors, reports, evaluates total numbers of admissions. Yes No

14.2 The unit monitors, reports, and evaluates numbers and types of admissions by age and gender. Yes No

INDICATORS: TOTAL ADMISSIONS & AGE X GENDER

How many discharges (i.e., separations) did your unit have? If you have only totals without age and/or gender please include what you have.

	0 to 5	6 to 12	13 to 15	16 to 17	18+	Total
Female						
Male						
Trans						
Total						

Rates per 100,000 can be calculated from estimated population of children and adolescents aged 0-17 (under age 18) <https://www.ontario.ca/data/population-projections> provincially, and by LHIN, beds per unit can only be reported by raw numbers as population information per unit catchment is not available.

14.3 The unit with its hospital partners monitors and reports numbers of child and adolescent mental health admissions to adult and pediatric units. Yes No

14.4 The unit works with its community partners to reduce need for admission to inpatient care. Yes No

14.5 The unit and community partner out-of-home services report the number and types of admissions across the system including transfers out of region and transfers into region. Yes No

14.6 The unit monitors, reports, and evaluates geographic differences in the numbers of youth using of inpatient care. Yes No

14.7 The unit monitors, evaluates and reports utilization by admission status under the Ontario Mental Health Act. Yes No

INDICATORS: ADMISSIONS BY INVOLUNTARY STATUS

What is the percentage of admission with the following disposition under the Ontario Mental Health Act?	Percent
1. Voluntary (Individual with capacity who consent on their own behalf)	
2. Informal (Admission under consent of parents/caregivers)	
3. Involuntary Detention (Form 1 Applications for Psychiatric Assessment)	
4. Involuntary Treatment (Form 3, 4, etc.)	

14.8 The unit monitors, evaluates, and reports the prevalence of behaviors which precipitated referral/transfer and the admission. Yes No

INDICATORS: UTILIZATION BY PRECIPITATING PROBLEM

Which of the following behavioural risks (as identified by referral sources or in emergency department transfers) precipitate admissions to your unit. (For involuntary patients on crisis units, the precipitating risks as identified by the referral source are those listed on the Form 1 as the reasons for involuntary certification).

Precipitating risk for 1= almost all admissions, 2= many admissions, 3=some admissions, 4=very few/no admissions	1	2	3	4
1. Severe imminent risk of Suicide (e.g., on the Form 1 suicide is reported as self-harm)				
2. Severe imminent risk of Harm to Others (e.g., threats or incidents of aggression, violence)				
3. Severe imminent risks arising from Inability to Care for the Self or from severe problems in Functioning (e.g., severe imminent risk of serious: accidents, illness, malnutrition, social isolation, addiction, thought disturbance)				
4. Non-Suicidal Self-Injury				
5. Less severe risks (e.g., refusal to attend school, conflicts with others, rule breaking and oppositional behaviour, feeling stressed)				

14.9 The unit identifies, reports, and evaluates the number and balance of crisis/emergency stays versus longer term treatment services provided. Yes No

INDICATORS: ADMISSIONS BY CRISIS VS TREATMENT TYPES	Percent
What percentage of admissions were for the following service types?	
1. Unplanned crisis assessment and stabilization with rapid return to community (typically around 3 to 7 days)	
2. Planned General Treatment (typically 4 to 6 weeks)	
3. Specialized Treatment (e.g. eating or concurrent disorders) (typically 4 to 6 weeks)	
The unit and the system of care clearly describe the differences between crisis & treatment units and inpatient staff report there is no confusion or misunderstanding leading to attempts to use crisis units to provide treatment. True <input type="checkbox"/> False <input type="checkbox"/>	
Comments:	

14.10 The unit monitors, evaluates and reports utilization by contributing diagnoses. Yes No

INDICATORS: ADMISSIONS BY CRISIS VS TREATMENT TYPES	Percent of total admissions
Most Responsible Disorder or Condition Contributing to Admission	
1. Neurodevelopmental: Autism	
2. Neurodevelopmental: ADH	
3. Neurodevelopmental: Other (intellectual, FAS, Tics & Tourette's)	
4. Psychosis & Related	
5. Bipolar	
6. Depressive	
7. Anxiety	
8. OCD & Related	
9. Stress Related: PTSD	
10. Stress related: Other (Adjustment, Acute stress)	
11. Disruptive, Impulse-control, Conduct	
12. Feeding & Eating Disorders	
13. Substance Use	
14. Maladaptive Personality Traits (Personality Disorders and other)	
15. None (no diagnosis contributing)	

16. Other (Please describe if significant in numbers)	
Comments:	

- 14.11 The unit monitors, evaluates and reports inpatient care use by different cultural, language, and other groups. Yes No
- 14.12 The unit monitors, evaluates, and reports inpatient use by home and school contributors to the precipitating problem(s). Yes No
- 14.13 The unit monitors, evaluates, and reports inpatient use by level of global functioning. Yes No
- 14.14 The unit monitors, evaluates, and reports use by each of their partner services. Yes No
- 14.15 The unit monitors, reports, and evaluates use by length of stay. Yes No

INDICATORS: UTILIZATION BY LENGTH OF STAY	
What was the unit length of stay (LOS) in the preceding year? Not Tracked <input type="checkbox"/>	LOS in Days
1. Average	
2. Median	
3. Minimum	
4. Maximum	
Annual blocked beds. Not Tracked <input type="checkbox"/>	Blocked in Days
1. Number of Blocked Bed Days according to reported Alternate Level of Care Status	
2. Additional number of Blocked Bed Days By Other Delays not Captured by Alternate Level of Care Status	
Comments:	

- 14.16 The unit monitors, evaluates and reports bed days and occupancy. Yes No

INDICATORS: OCCUPANCY & BED DAYS													
OCCUPANCY													
	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Avg
%Occupancy													
BED DAYS													
Bed Days	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Total

DETAILS, COMMENTS, & NOTES:

15.0 OUTCOME. The unit monitors, reports, and evaluates its contribution to patient, family, and system outcomes.

15.1 The unit assesses and reports its outcomes and uses this information to improve its services. Yes No

15.2 The unit tracks and reports outcomes of the behavior problems, risks, and functioning that precipitated admission. Yes No

INDICATORS: PRECIPITATING PROBLEM	Yes	No
1. The unit measures the admission to discharge change in the severity of precipitating problem, risk, or specific functional problems for which children were admitted (e.g., suicidal ideation, aggression, severe weight loss, incapacitating substance use, thought disturbance)?	<input type="checkbox"/>	<input type="checkbox"/>
2. The unit uses the following measures for the following precipitating problems: Suicide: _____ Aggression/Violence: _____ Thought Disturbance: _____ Substance Use: _____ Weight Loss: _____ Other: _____		
3. Outcomes: _____		
Comments: _____		

15.3 The unit monitors and reports differences in outcomes across contributing diagnoses. Yes No

15.4 The unit monitors and reports outcomes related to individual factors which may contribute to the precipitating problem (i.e., outcomes for different groups, minorities, and vulnerable populations such as male versus female, age, cultures, rural versus urban) Yes No

15.5 The unit tracks and annually reports the degree and types of admission to discharge changes to the precipitating problems, risks, and functional concerns. Yes No

15.6 The inpatient unit partners with community agencies and professionals to track patient progress after discharge. Yes No

15.7 The unit monitors and reports changes to global functioning. Yes No

INDICATORS: GLOBAL FUNCTIONING	Yes	No
1. The unit measures global functioning for each patient and annually reports average unit global functioning levels. Measure(s) used: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Average global functioning at admission _____		
3. Average global functioning at discharge _____		
4. Average global function 12-months post-discharge _____		

15.8 The unit monitors and reports improvements to family and parent/caregiver factors which contributed to the precipitating problem. Yes No

15.9 The unit tracks and reports on increases and decreases in the need and use of more restrictive out-of-home placements and overall services. Yes No

INDICATORS: PLACEMENT OUTCOMES		
	Don't Know	% of Total Annual Admissions
Placement at admission		
1. Independent or supported independent living	<input type="checkbox"/>	
2. Single or two-parent/caregiver home	<input type="checkbox"/>	
3. Extended family or friends of family	<input type="checkbox"/>	
4. Foster-home	<input type="checkbox"/>	
5. Group home or residential treatment setting	<input type="checkbox"/>	
6. No Placement	<input type="checkbox"/>	
Placement at Discharge		
1. Independent or supported independent living	<input type="checkbox"/>	
2. Single or two-parent/caregiver home	<input type="checkbox"/>	
3. Extended family or friends of family	<input type="checkbox"/>	
4. Foster-home	<input type="checkbox"/>	
5. Group home or residential treatment setting	<input type="checkbox"/>	
6. No Placement	<input type="checkbox"/>	
Placement Change & Stability		
1. Changed Placements	<input type="checkbox"/>	
2. Changes to more Restrictive Placement (<i>likely reflecting greater severity</i>)	<input type="checkbox"/>	
3. Changes to less Restrictive Placement	<input type="checkbox"/>	

15.10 The unit monitors and reports impacts of admission on school problems. Yes No

15.11 The unit monitors and reports annual readmission rates. Yes No

INDICATORS: READMISSION RATES			Yes	No
1. The unit tracks and annually reports 30 day readmission rates. If so... The percentage of patients readmitted within 30 days is _____%	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. The unit tracks and annually reports other readmission rates. If so... The percentage of patients readmitted within 7 days is _____% The percentage of patients readmitted within 90 days is _____% The percentage of patients readmitted within 12 months is _____% The percentage of patients readmitted within 30 months is _____% The percentage of patients readmitted after 5 years is _____%	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

15.12 The unit annually compares outcomes its outcomes against other inpatient and residential services. Yes No

15.13 The unit annually compares its outcomes to less restrictive and costly community settings. Yes No

15.14 The unit collaborates and is currently involved with users, other units, and community services in outcome evaluation and research activities. Yes No

DETAILS, COMMENTS, & NOTES:

16.0 COMMUNICATION. The unit accurately and helpfully communicates information about its staffing, process, utilization, and outcomes.

16.1	The unit makes information about the unit available to the public and to potential users ahead of admission.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16.2	The unit provides accurate information and identifies and corrects misleading communications.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16.3	The unit disseminates data about its own process and outcomes to inform partner agencies and users.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16.4	The unit publishes a user handbook which answers all important questions asked by users of inpatient care.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16.5	The unit has a website that provides accurate, complete and user-friendly information about the unit and its services.	Yes <input type="checkbox"/> No <input type="checkbox"/>
16.6	The unit publishes its schedule of patient activities on the unit and in the handbook and on the website.	Yes <input type="checkbox"/> No <input type="checkbox"/>

INDICATORS: CONTENT CHECKLIST FOR WEB & HANDBOOK		Yes
1.	How to access inpatient services	<input type="checkbox"/>
2.	Admission and exclusion criteria	<input type="checkbox"/>
3.	Costs and benefits inpatient care relative to other service alternatives	<input type="checkbox"/>
4.	Risks that could arise from patients and the inpatient care process	<input type="checkbox"/>
5.	Safety measures including types of restraint and seclusion	<input type="checkbox"/>
6.	Voluntary, involuntary, and informal processes	<input type="checkbox"/>
7.	Crisis, treatment, or both types provided	<input type="checkbox"/>
8.	Staffing and roles	<input type="checkbox"/>
9.	Typical patient mix	<input type="checkbox"/>
10.	Pharmacotherapy process	<input type="checkbox"/>
11.	Psychotherapy and treatment process	<input type="checkbox"/>
12.	Milieu health promotion and school activities	<input type="checkbox"/>
13.	Schedule (i.e., a week at a glance)	<input type="checkbox"/>
14.	Risks and benefits of inpatient care including typical outcomes	<input type="checkbox"/>
15.	Typical unit length of stay	<input type="checkbox"/>
16.	Discharge criteria	<input type="checkbox"/>
17.	Rights and responsibilities of children, parents/caregivers, and partner agencies	<input type="checkbox"/>
18.	The handbook or equivalent is available to those who need the information when they need it, and it is accurate, culturally friendly, and easy to understand	<input type="checkbox"/>
19.	A handbook or equivalent is available to the public in both hard copy and electronic formats	<input type="checkbox"/>
20.	It is available in emergency departments and other referral settings	<input type="checkbox"/>
21.	It is easily understood by children as well as parents/caregivers	<input type="checkbox"/>
22.	Different versions of the handbook or equivalent are made or can be made available for	<input type="checkbox"/>

users with different needs including users from different language, culture, and age groups	<input type="checkbox"/>
23. The content is free of exaggeration, inaccuracies, and fear-based tactics that aim to influence the public and users to have a more desirable than more accurate view of inpatient care	<input type="checkbox"/>

16.7 The unit provides its own annual report on its operation and outcomes. Yes No

INDICATORS: CONTENT CHECKLIST FOR ANNUAL AUDIT & REPORT		Yes
1. Numbers of admissions by age and gender		<input type="checkbox"/>
2. Safety and risk indicators		<input type="checkbox"/>
3. Voices, opinions of youth		<input type="checkbox"/>
4. Voices, opinions of parents/caregivers		<input type="checkbox"/>
5. Voices, opinions of partner services		<input type="checkbox"/>
6. Voices, opinions of staff and managers		<input type="checkbox"/>
7. Utilization indicators		<input type="checkbox"/>
8. General funding & resourcing issues arising		<input type="checkbox"/>
9. Goals and progress		<input type="checkbox"/>
10. Goals for the coming year, and an action plan		<input type="checkbox"/>
11. Dissemination to website or publication		<input type="checkbox"/>

16.8 The unit promotes open and honest communication and addresses problematic inaccuracies, gossip, and rumours. Yes No

16.9 The unit participates in developing, gathering, and disseminating provincial and national performance benchmarking data and standards development information. Yes No

DETAILS, COMMENTS, & NOTES: