NOVA SCOTIA
Health and Wellness

Standard:	Mental Health Inpatient Services Standards
Originating Branch:	Mental Health, Children's Services, and Addictions
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Standards for Mental Health Services in Nova Scotia

In Canada mental illness is the second leading cause of human disability and premature death. $51 billion is the estimated annual cost of mental illness to the Canadian economy, in terms of health care and lost productivity. On any given week, at least 500,000 employed Canadians are unable to work due to mental illness, including approximately 355,000 disability cases due to mental and/or behavioral disorders plus approximately 175,000 full-time workers absent from work due to mental health issues. Mental Health is the number one cause of disability in Canada, accounting for nearly 30% of disability claims and 70% of the total costs.

System-level standards for mental health services in Nova Scotia has been drafted by the Core Programs Standards Working Group of the Mental Health Steering Committee. Numerous system stakeholders were involved in reaching consensus on standards based on the best available information regarding effectiveness and/or best practice, balanced by the perspective of consumers, expert practitioners and educators. Input will continue to be sought and revisions will take place every five years to keep pace with best practice evidence.

Generic and core program standards form the foundation for long-term improvement in mental health services. An overarching set of generic standards represent the preferred conditions relevant to all mental health service delivery. The core program standards define the key service components to be achieved within each of the core programs. Core programs are accessible to all Nova Scotians as part of a comprehensive mental health system. Nova Scotia's core programs, as referenced in the work of the Federal/Provincial/Territorial Advisory Network on Mental Health (2001), are:

- Promotion, prevention and advocacy
- Outpatient and outreach services
- Community supports

- **Inpatient services**
- Specialty services

The standards are intended to provide guidance for quality service delivery and reduce variations across the province, while maintaining flexibility to adapt approaches to unique district, community and organization conditions.

Guiding Principles

Standards for acute psychiatric inpatient units' services must address the following:

- clear evidence of a patient centred /family centred philosophy
- the physical environment of the service
- the provision of care by interdisciplinary teams
- the promotion of a wellness lifestyle and a rehabilitative approach
- the provision of a full range of medical care
- the collection and analysis of outcome measures
- the special needs of differing cultures and vulnerable populations
- the initiation of discharge planning at the point of admission to the service
- clear accountability for the efficacy of services
- the provision of a continuum of care for patients both within the mental health service and with partner services in the community at large
- standards must be measurable, and targets, benchmarks and/or thresholds must be set and those must be met
- least restrictive and respectful environment

Development Process & Methodology

To inform the IP Standards development process, a situational analysis of current Inpatient Services and Supports provided by mental health and addiction services in NS was conducted, as well as a cross-jurisdictional review of relevant policies, guidelines, and standards was completed. Using this information as a foundation, as well as key references from the literature regarding promising and emerging practices, a set of IP Standards was developed by representatives of mental health and addictions services staff from across the province.

Effective intervention for mental illness requires close collaboration between DHW mental health branch and DHAs and the IWK. These standards aim to improve service delivery of mental health services in the DHAs and the IWK, through the establishment of a DHW framework which sets expectations of activity and performance in the health system through the development and monitoring of standards.

The standards include a specific set of indicators contained within a monitoring report. A baseline assessment will be done following approval of the standards and then in conjunction with the DHAs/IWK Accreditation survey a full self-assessment will be done, collated at DHW and visits made to the locations to do spot checks and discuss their non-compliance and other issues identified in the self-assessments. In the interim years a brief questionnaire will be sent to identify if any significant changes and progress on recommendations from the site visit. The indicators will enable the DHAs and the IWK to monitor the extent to which progress is being made towards meeting the System Standards for Inpatient Services. However, it must be noted that the indicators are generic in nature until such time as we have a provincial data collection system to capture very specific data and allow for very specific indicators. At present we will be using a template to monitor compliance for the DHAs and the IWK to report on and will visit the stakeholders to ensure their audited responses are accurate and to make recommendations on areas they are having difficulty with.

Inpatient Services- Overview

Acute psychiatric inpatient services provide interdisciplinary care for those of all age groups who cannot be effectively cared for in a less restrictive environment. Every district must have access to acute inpatient care. This can be achieved through reasoned geographic placement and formal arrangements (including bed management processes) among health districts to ensure equitable access. Inpatient services are located within a facility as defined by the *Hospital's Act* and are governed by that Act and by the *Involuntary Psychiatric Treatment Act*.

Evidence driven practice indicates that treatment for children and adults who have mental disorders or who face mental health conditions are provided in an inpatient setting when other services are not able to provide the level of intensive, safe, secure, effective care of the patient in the community. Thus, less restrictive alternatives to inpatient hospitalization must be considered prior to the decision to admit.

Inpatient stays should be as short as possible without harming patient outcomes. Evidence indicates that once the illness has stabilized, patients recover more quickly when they return to an independent level of living arrangements and functioning as possible.

Patients, their families and their other caregivers are provided services with respect for their culture, unique needs and rights. Patients and families are as fully involved in setting the parameters of care and treatment as they wish to be and are able to be.

Inpatient Services Standards

Purpose

Inpatient (IP) Services Standards outline a very clear direction on how mental health Inpatient services respond to those clients requiring an inpatient admission. Implementation of these standards will provide a roadmap for DHAs and the IWK with respect to how mental health and addictions services may work together in a more collaborative way.

Background

Historically Mental Health systems in Nova Scotia have been underfunded and struggled to provide an acceptable level of service. The medical model has failed to ensure services is client centred and involved significant others in the treatment process. The system has prescribed what they see as the best for the client and not what the client considers to be an integral part of their recovery. Keeping the client and his or her concerned significant others at the center of system planning is vital.

The 2000: Bland-Dufton report. *Mental Health: A Time for Action* was a consolidation of all previous reports as well as broad stakeholder input. All 72 recommendations of the report were accepted by the government in 2001. A Mental Health Steering Committee was struck and mandated for the development of minimal system standards and this involved over 200 professionals including front-line staff.

Nova Scotia was the first province to develop mental health standards in Canada. In 2003 the first set of standards approved by the government were; Inpatient, Outpatient, Community Support, Prevention & Promotion, Eating Disorders, and Early Psychosis with a price tag of $30m. The IP Standards were approved for a cost of $998,000.

System-level standards for mental health services in Nova Scotia have been drafted by the Core Programs Standards Working Group of the Mental Health Steering Committee. Numerous system stakeholders were involved in reaching consensus on standards based on the best available information regarding effectiveness and/or best practice, balanced by the perspective of consumers, expert practitioners and educators. A guideline was established by the Steering Committee that all standards would be reviewed and revised every 5 years for best practice and emerging evidence.

The June 2010 Auditor General (AG) Report “A Summary of the Current State of Mental Health and Addictions Services in Nova Scotia” recommended the revision of standards for the treatment of people with mental illness in Nova Scotia. The revision of the System Level Standards for Inpatient Mental Health Services (Acute IP Services & Rehab Children & Youth) responds directly to the AG Recommendation # 4.6, “The Department of Health should review the mental health standards to ensure each standard is measurable, specific and can be evaluated.” The previous IP Standards from July, 2009 was a minor revision from the 2003 version.

A further review of the mental health IP Standards began in 2012 with a removal of those standards that are currently well embedded in practice, those that were more guidelines and to make them more succinct. Indicators in most cases are those that can be audited as there is currently no data collection system to assist in this area. The plan is to have more benchmarks and percentage type indicators when a data collection system is in place.

Legal Authority:

The NS DHW is responsible for setting the strategic direction in establishing and monitoring Provincial System Level Standards, for the delivery of mental health services in Nova Scotia. The duties and powers for the development and implementation of health policies and standards are legislated under the *Health Authorities Act, 2000*.

Policy and Standards Framework:

An overarching policy called: "The Mental Health and Addictions Service Delivery Standards Policy" was developed in 2012 for the NS health care system, to improve service delivery of addiction and mental health services and to revise and update existing Provincial Standards for the delivery of mental health services.

Standard Statements and Indicators

Standard D1- Acute Psychiatric Inpatient Services
Goal Statement: All acutely ill Nova Scotians who require admission have timely access to acute psychiatric inpatient services. **Description:** The purpose of acute psychiatric inpatient services is to provide safe, secure, active, energetic, comprehensive interdisciplinary assessment, stabilization, treatment initiation and service linkage back to the community, of those whose acute psychiatric condition cannot be managed in a less intrusive fashion. The goal is to ensure that the patient can resume normal community living as soon as feasible, thereby maintaining independence. The service: ➢ Provides the highest quality patient care that is achievable within available resources, knowledge, skills and technology; ➢ Maintains an organizational culture that respects and values diversity, cultural competence, promotes collaboration and teamwork, encourages professional and personal development of staff, and commits to providing the highest quality of service achievable; ➢ Proactively responds to change, improving existing services, and developing new programs to meet the needs of the patients served; ➢ Shares knowledge and expertise and provides education, training, and services to meet the unique needs of the health care community and the public; ➢ Collaborative processes with other health and human service providers and with hospital and health authority departments are used to maximize treatment and discharge planning.

Standards Statements	Measure/Indicator Target/benchmark/ threshold 100% for all
D1.1 Assessment of the need for admission is available twenty-four (24) hours per day, seven (7) days per week.	• Protocols which ensure this are developed, approved by relevant bodies within the DHA/IWK, available to all staff/physicians. • A regular review process for the protocols is in place. • Inter-district protocols, regarding movement of those requiring admission when the particular DHA/IWK has no beds, are developed, in place, approved by all the DHA's /IWK and signed off by and tabled with DHW. • Staff/physicians are trained in the protocols. • Protocols are reviewed regularly. • Admissions are appropriately documented. • There is an audit process and results are documented**- checklist.**
D1.2. Patients meet established, evidence driven admission criteria at admission and throughout their acute psychiatric inpatient units stay. *Criteria for admission are:* a) Requirement of Involuntary Psychiatric Treatment Act (IPTA) b) The individual's medical state is acute and is the primary reason for the psychiatric presentation. c) The patient has a medical clearance . d) There is a comprehensive preadmission mental health assessment by a mental health clinician(s). e) There is an expectation the individual is likely to benefit from an acute psychiatric inpatient unit	• Medical and mental health assessment protocols in place & approved by relevant bodies in the DHA and the IWK • Documentation on the chart reflects that the protocol(s) have been followed. • Required documentation of the whole admission process. • Screening/assessment process complies exactly with the **checklist.** • There is a regular audit process and the results are used to inform changes and improvements.

admission. f) The individual is currently mentally ill according to accepted criteria (e.g. DSM-IV, ICD -10) or there is a need for a period of intensive monitoring of the individual's mental status and symptoms to clarify an uncertain diagnosis. g) Management of the patient in a less intrusive setting is inappropriate, inefficient or likely to be ineffective in addressing the presenting problem and the individual's medical needs can be safely managed on a psychiatric unit. *Criteria for exclusion are:* a) Intoxication with alcohol or other psychoactive substances will not be a primary reason for admission. b) Straight forward dementia is the only psychiatric diagnosis. c) Delirium is the only diagnosis. d) Aggressive behavior not related to primary psychiatric illness.	
D1.3. There is a clear referral path to the medical and surgical services.	• Established protocols; these protocols to be reflected in the **checklist.**
D1.4. The IWK responds within one hour (1 hour) regarding the process for emergency assessment of the child in question, between itself and other DHAs.	• The IWK in conjunction with the DHA's have a telephone log, capturing all such conversations and time frames both at the IWK and the referring DHA. • An audit is maintained for all requests by the IWK and DHAs. • 100% compliance on a trailing six-month average basis.
D1.5. Acute Psychiatric Inpatient Units collaborate with Emergency Departments in ensuring that admissions from ED to the unit take place within one	• Processes to rectify problems will be in place and documentation maintained – **checklist.**

hour of admission decision if a bed is available; and excluding such issues as transportation (e.g. if the emergency room is in one building and the unit is in another).	
D1.6. Clinical direction of the acute inpatient unit is provided by a psychiatrist.	• There is documented evidence that this exists and that the service is provided by a psychiatrist.
D1.7 There is a designated nursing position responsible for the ongoing continuity and coordination of patient care.	• There is documented evidence that this exists and that the service is provided by a registered nurse.
D1.8 A written care plan exists. The appropriateness of the care plan is overseen and revised weekly or more frequently. Patients have access to a treatment plan that includes a range of treatment/rehabilitative/psychosocial programming throughout each day.	• Plans and updates to plans are documented in a **checklist.** • Documented evidence patient and/or substitute decision maker were involved in plan of care.
D1.9. The unit design minimizes the risk of suicide/self-harm. A process exists to evaluate that the physical environment is conducive to the safety and well-being of both patient and staff and attends to issues identified.	• Evidence of evaluation for risk from the evaluation of the physical environment • Evidence that recommendations are followed up by the metal health director.
D1.10. Risk assessment of harm to self/others begins from the moment assessment indicates admission is called for and continues throughout the admission. An initial screening is completed within one hour of the patient arriving on the unit and is documented. Full risk assessment is carried out/documented within 48 hours and updated at critical decision making points (e.g. admission, transfer).	• A protocol for risk assessment exists. • Documented evidence of risk on chart – **checklist.**
D1.11. Policies and procedures exist to address issues that offer a full ranges of treatment options such as aggression, restraints, suicide and absconding.	• There is evidence of readily available appropriate protocols, procedures responsive to needs of mental health clients. • There are annual reports on new protocols, procedures prepared and available.

	• There is a review and evaluation on all codes (white, blue, yellow) called on the acute psychiatric inpatient units, as well as of all other serious adverse events.
D1.12. All staff (clinical, physician, clerical**,** security and other) are educated and trained in the recognition, prevention and de-escalation of potentially violent situations, and have regular updating of these skills.	• There is evidence that all staff have been trained and kept current to program requirements.

Standard D2 - Acute Psychiatric Inpatient Units - Children and Youth Mental Health Rehabilitation

Goal Statement: Nova Scotia children and youth between the ages of 5 and the 19, have timely access to mental health acute psychiatric inpatient rehabilitation services to help them attain optimal functioning.

Description: The Rehabilitation Program for Children and Youth provide mental health services to patients between the ages of 5 and the 19 to attain/retain optimal functioning in psychological, social and education/occupational spheres. This includes ongoing treatment of the primary disorder and any functional decline that may occur as a result of that disorder. Optimal length of stay necessary to attain treatment goals set on admission should be less than 12 months.

Standards Statements	**Measure/Indicator** **Target/benchmark/threshold 100% for all**
D.2.1. Where possible, prior to admission, a comprehensive mental health assessment is completed to demonstrate that the patient meets all admission criteria.	• % of assessments documented on chart and **checklist.**
D.2.2. DHAs ensure that referral paths within districts follow established protocols (i.e. referrals are accepted from intensive community-based team where they are in place and, where they have yet to be established, from the district's formal mental health system). The IWK follow their established protocols for referrals to	• % of referrals that followed established protocols documented on chart and **checklist.**

intensive community-based team.	
D.2.3. The following admission criteria for the residential treatment/rehabilitation unit must be met: a) Chronic and persistent mental disorder (DSM-IV ICD-10) with serious/profound functional impairment. b) Evidence that treatment/intervention requires rehabilitation within the program setting, i.e., the patient cannot be managed within a less restrictive setting c) Evidence that residential treatment will contribute to the patient's reintegration into the community. d) Family/care giver/referring service commit to participating in the admission, treatment and discharge planning process. e) The patient is a resident of Nova Scotia. f) Evidence that, intensive work to manage the child/youth in a community setting was ineffective.	• Documented evidence of a social network to provide ongoing follow-up care. • Documented evidence of functional impairment and progress on plan of care and progress notes. • Documented evidence individual requires a more restrictive environment. • Evidence that referral source accepts responsibility for follow-up care. • Evidence discharge discussed and introduced to transition worker documented on chart and **checklist.**
D.2.4. At admission and throughout the patient's rehabilitation treatment, the treatment team will collaborate with the patient's caregivers, referring service and other relevant agencies/services in treatment and discharge planning. Continued inter-agency cooperation is expected.	Chart documentation that identifies: • Phone contact with GP • Phone contact with teacher • Phone contact with referral source
D2.5. Treatment will be provided by an interdisciplinary team and may be comprised of but not limited to social work, occupational therapy, psychology, psychiatry, education, nursing etc. This team will work alongside the child/youth and family with each allocated specific tasks and goals.	• Care plan as documented on chart.

D.2.6. The rehabilitative process consists of a comprehensive assessment, intervention plan and patient progress review considering all domains of child/adolescent/family life.	• Care plan as documented on chart.
D.2.7. a) The treatment plan clearly outlines mutually established goals and expected outcomes for the patient and/or family, where appropriate, as well as a time frame for goal attainment.	• Weekly updated documentation on chart
b) The goals and/or outcomes of treatment are to be reviewed, evaluated and revised as necessary following the establishment of the treatment plan.	•
D.2.8. Discharge planning from the rehabilitation /residential program, which is Initiated at the time of admission, will include: a) Notice of anticipated discharge date at time of admission with referral to most appropriate agency/community-based team for post-discharge support. b) Transition planning. c) Communication/conference with mental health team expected to follow up will continue throughout admission. d) Preliminary discharge summaries are sent to primary therapist and attending physician within seventy-two (72) hours of discharge. e) Discharge summaries are received by referral agency within four (4) weeks of patient discharge.	• Documentation on chart.
D.2.9. The interdisciplinary team is accountable for ensuring that at discharge: a) Specific rehabilitation goals have been evaluated. b) Discharge and follow up plans are in place, the	• Documented on Discharge Checklist and Transitional Care Plan.

first appointment date offered is within (10) ten working days following discharge as stated in the agreed transition plan. c) A process is in place to monitor the completion of the transition plan.	

Glossary

Interdisciplinary:

"A group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, they create "formal" and "informal" structures that encourage collaborative problem solving. Team members determine the team's mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalize on disciplinary differences, differential power and overlapping roles. To accomplish these they share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration."Drinka (2000).

Multidisciplinary:

A group of care providers with shared values and goals, however, each individual sees the task from his or her own perspective, and depending on the task, from their own unique worldview.Dan Dangler *(*2005).

Functional Impairment:

Any loss or abnormality of psychological, physiological, or anatomical structure or function .Anthony (1993

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DHA:		
Inpatient Checklist Mental Health Inpatient Unit:		
TASK	**DATE – TIME (YY/MM/DD – 24 hr time)**	**INITIALS**
Pre-Admission		
1. A complete mental health assessment has been completed indicating that admission is the indicated disposition		
2. A medical clearance/ stabilization including discontinuation of any external lines, IVs, catheters, O2, etc.		
3. In-patient unit physician accepts the patient or Charge Nurse accepts patient on behalf of the attending physician		
4.Transfer of Accountability (e.g. Report) to assigned nurse with particular emphasis on any immediate needs or safety concerns		
5. Complete admission orders written		
Admission		
6. Transfer of accountability (ED to unit)		
7. Physical search		
8. Baseline risk assessment with immediate plan (suicide, physical harm, aggression) within X hours from #6		
9. Initial nursing assessment		
10. Orientation of patient to the unit including an explanation of status, rights and responsibilities; explanation/ reassurance re: availability of assistance and what to expect during admission		

On Unit		
11. Full psychiatric assessment within 24 hours		
12. Interdisciplinary/interprofessional team assessment		
13. Full hospitalist assessment		
14. Patient and family orientation including rights and responsibilities		
15. Collateral info. from relevant support networks (family, friends, primary care, other agencies, etc)		
16. Care plan/treatment plan with goals objectives and responsibilities		
17. Care plan indicates discharge plan is under development		
18. Care plan update at least every 48 to 72 hours, or more frequently as required		
19. Final discharge plan developed/shared with patient/relevant support networks		
Discharge/Follow-up		
20. Preliminary sharing of discharge plan with relevant support networks		
21. Plan shared with relevant supports, as appropriate		
22. Explicit primary care follow-up plan with medications/plans regarding decompensation, etc. sent to primary care physicians		
23. Alerts to other relevant organizations provided – police, mobile crisis, emergency departments, etc		

Transfer to Another Unit		
24. Bed Manager or designate informs nursing unit of availability and charge nurse/ patient nurse assigned gives telephone/ verbal report to accepting unit. Fax information as needed.		
25. Transfer orders written		
26. Transport arranged		
27. Patient and family informed re: transfer. Reassurance provided.		

Inpatient Services – Adult, Children & Youth

Inpatient Services (D)				
Standard	**Indicator**	**Yes No**	**Evidence**	**Barriers to compliance**
Acute Inpatient Services(D1)				
D1.1 Assessment of the need for admission is available twenty-four (24) hours per day, seven (7) days per week.	**P**rotocols which ensure this are developed, approved by relevant bodies within the DHA/IWK, available to all staff/physicians.			
	A regular review process for the protocols is in place			
	Inter-district protocols, regarding movement of those requiring admission when the particular DHA/IWK has no beds, are developed, in place, approved by all the DHA's /IWK and signed off by and tabled with DHW			
	Staff/physicians are trained in the protocols			
	Protocols are reviewed regularly			
	Admissions are appropriately documented			
	There is an audit process and results are documented- **checklist**			
Standard	**Indicator**	**Yes No**	**Evidence**	**Barriers to compliance**
Children & Youth Rehabilitation (D2)				
D2.1. Where possible, prior to admission a comprehensive, mental health, assessment is completed to demonstrate that the patient meets all admission criteria.	% of assessments documented on chart and checklist			

Interim Self-Assessment of Mental Health Standards

Year _____ DHA/IWK _____

1. Do your priorities remain the same as the previous fiscal year?? ☐ Yes □ No

If no what are your three top priorities:

a)

b)

c)

2. Are there any significant changes to the last full self-assessment (fiscal year _____) you completed? ☐No ☐ Yes (If yes, document the changes)

3. Describe the progress made on the areas that were identified for further work.

Signature: _____ Date: _____