AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Principles of Care of Inpatient Care of Children and Adolescents

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This principle of care document was developed by AACAP's Inpatient, Residential and Partial Hospitalization Committee members.

Introduction

Inpatient psychiatric care is an essential part of the continuum of mental health care for children and adolescents. This most intensive treatment modality is designed to provide a safe environment for assessment, initiation of treatment, and stabilization for children and adolescents with psychiatric illness and severe emotional disturbance. Primary goals of inpatient treatment are to evaluate and understand underlying reasons for admission, and to engage the patient and caregivers in the development of a treatment plan both for the inpatient setting and after discharge.

Inpatient units play a particularly important role in serving children with mental illness in rural and underserved areas, where intermediate levels of care, such as partial hospital and intensive outpatient programs, are routinely less available. In such settings, it may be beneficial to admit a child to an acute unit even if they are not at an imminent risk of harm to themselves or others, but rather, need a comprehensive evaluation or intensive monitoring of treatment initiation and long-term treatment planning based on available resources.

The length of stay on an inpatient psychiatric unit should be determined by the treatment team based on child's acuity, time required for stabilization and readiness for discharge. This decision is also influenced by the family and community capacity for post-inpatient care. While responsibility for length of stay decisions rests with the inpatient team, a variety of entities, such as state agencies and insurance carriers, often make determinations regarding continued care. It is important that the inpatient treatment team have the authority to provide appropriate care without undue influence from outside agencies, with all parties being held accountable for evidence-based care. In some cases, due to the complexity and severity of a child's illness and the lack of appropriate resources in the community, a prolonged stay on an acute unit may be warranted.

This document outlines key principles for psychiatric inpatient care of children and adolescents, with attention to program development, leadership, staffing, and processes around provision of care. A specific section is dedicated to safety in inpatient settings,

including prevention of restraint and seclusion with the overarching goal of improving patient and staff safety.

I. Program Description

Inpatient psychiatric treatment programs for individuals under 18 years old are designed to be specialized and developmentally appropriate and represent the highest level of care. These programs operate under the leadership of child and adolescent psychiatrists and provide 24-hour nursing care. Youth under the age of 18 years old are best served by programs designed for children and adolescents which are physically distinct from adult psychiatric programs. Only in emergency situations and to ensure patient safety would it be appropriate for adolescents to be treated in adult psychiatric programs. All elements of care must meet accreditation requirements for hospital-based psychiatric treatment programs and must comply with State and Federal regulations. In addition to psychiatric evaluation and treatment, inpatient programs provide medical evaluation and monitoring for any additional or emerging medical concerns.

Children and adolescents are evaluated daily by psychiatrists and/or non-physician practitioners (e.g. nurse practitioners or physician assistants), or graduate level medical physicians (residents and fellows) under the supervision of child psychiatrists. The treating psychiatric team works in concert with a multi-disciplinary team, which includes nursing, social work/case management, psychology and affiliated counselors and therapists, as well as trained direct care staff. Some programs also include educational programs and staffing on their treatment teams for assessment, maintenance of educational gains, and recommendations for post discharge educational programming.

Key aspects of quality inpatient psychiatric programs include the following:

- 24-hour nursing care
- Interventions to ensure the safety of the patient
- Secure unit with necessary safety monitoring
- Evidence-based treatment; this may include medication management, psychotherapeutic interventions with a trauma-informed lens, digital therapeutics and/or neurotherapeutics
- Emphasis on nurturing the child's developmental, emotional, and educational needs
- Physical health care
- Inclusion of families as full partners during the assessment and treatment course
- Equitable care
- Culturally sensitive approaches addressing ethnic and spiritual needs

II. Leadership Structure and Staffing

Each patient's assessment and treatment program is under the direction of a qualified child and adolescent psychiatrist. Care is provided in collaboration with other disciplines as required by the patients' needs. Mental health care programming includes appropriate patient supervision, with safety as the foremost goal. Nursing staff oversee the health status of all patients. Nurses collaborate with physicians in medical management, medication administration, and monitoring.

All personnel who work in the inpatient treatment program must be appropriately trained and demonstrate competency in providing mental health services to children, adolescents, and families. Competencies include delivery of culturally sensitive, developmentally-informed care, adherence to family-centered care principles, appreciation and delivery of trauma-informed care and consistent use of evidence-based mental health interventions.

Staffing numbers must be appropriate to the number of patients and patient acuity levels so that the needs of patients may be met 24 hours per day in a safe environment for both patients and staff. In certain cases, one to one staffing or two staff for an individual patient may be necessary for more intensive monitoring than is typical on an inpatient unit.

III. Admission Process, Assessment and Treatment, and Discharge Planning

Admission Process:

The admission and diagnostic process should include:

- Engagement of child and caregivers in the evaluation and treatment process
- Comprehensive diagnostic assessment of the child including primary and co-occurring psychiatric conditions
- Thorough risk assessment and safety planning for prevention of harm to self/others
- Screening for any medical conditions by nursing staff at the time of admission and a follow-up medical assessment within 24 hours of admission by a licensed medical staff member
- Comprehensive assessment of the child's strengths and needs in the context of their family, home, and community resources
- Clear documentation of provisional or confirmed psychiatric diagnoses, and description of functional impairment
- Initiation of discharge planning

Treatment Planning:

Care should be patient-centered, culturally sensitive, and trauma-informed, while incorporating the patient's and family's views of the goals for treatment. Successful treatment programs consider patients and families as full partners during the treatment process. Collaborating with patients and families requires understanding and respecting each patient's and family's unique needs. Staff must be knowledgeable regarding various racial, ethnic, linguistic, special needs, disability, sexual orientation, and socio-economic differences.

Key elements of treatment planning include the following:

- Documented clear treatment goals and criteria for discharge
- Incorporation of collateral data from school, outpatient team and other community sources
- Inclusion of multi-disciplinary assessments and treatment recommendations
- Utilization of evidence-based approaches for medication management and psychotherapeutic approaches
- Usage of virtual platforms to facilitate more access to caregivers/community partners

An inpatient stay may be the initial encounter for mental health care for many patients and families. A crucial component of an inpatient stay is the comprehensive, biopsychosocial formulation crafted by the multidisciplinary team. The formulation of why the child is not successful in community settings is key for identifying and implementing interventions. This enhanced understanding of the child should be communicated clearly to caregivers and outpatient team, ensuring contact with the outpatient clinicians throughout the child's stay for optimal collaboration.

Therapeutic Environment of Care:

The therapeutic environment on an inpatient unit should be caring, welcoming, and developmentally appropriate. Staff should be curious, flexible, and engaged with the child. The team should be focused on understanding the reasons for the behavior of the patient. Assessment and treatment should focus on the child's strengths, while understanding their symptoms and challenges. Therapeutic environments should never be coercive or punitive.

Provision of Medical Care:

Medical concerns must be addressed at the time of admission. All medical concerns, including those that may arise from psychiatric treatment, must be evaluated and quickly managed. Physical examinations must be performed by a licensed medical practitioner (under

appropriate supervision if required) within 24 hours of admission. This comprehensive evaluation must identify medical risks and illnesses. All identified medical risks and conditions must be included in the individual treatment plan. Ongoing evaluation and risk identification is mandatory throughout the hospitalization and access to medical care must be maintained throughout the hospitalization.

For sub-specialty care, the inpatient program must develop a process of appropriate referrals to sub-specialists for consultation and management of individuals that require such care. Along with medical management of potential co-morbid medical illness, assessment and management must include aspects of nutritional status and pain management. Coordinating medical care at the time of discharge must be achieved with consultants.

Coordination of Care and Discharge Planning:

Inpatient treatment must be coordinated in collaboration with a child's system of caregivers outside of the hospital setting. Communication with caregivers and community supports should begin at the time of admission and should foster continuity of care between the hospital and community providers. Inpatient interventions should be selected with consideration for the capacity of aftercare providers to continue or complete treatment courses initiated during hospitalization. A summary of inpatient assessment of findings, treatments provided, and discharge recommendations must be given to aftercare providers at the time of discharge to support the next phase of care. Discharge planning must focus on safe transitions to clinically appropriate, less restrictive treatment settings. The inpatient team has the responsibility to continue to provide care on the inpatient unit until the patient is sufficiently stable enough to engage in outpatient aftercare or be referred to longer-term placement such as residential treatment centers or state hospital settings.

Utilization and Fiscal Responsibility:

Child and adolescent inpatient psychiatric care should adhere to the best clinical practice standards in a cost-efficient manner. There should be timely coordination of care between caregivers, the treatment team, and insurers to determine availability of and eligibility for necessary services. Healthcare plans should know and appreciate the cost impact of the treatment recommendations for patients and families. Costs for families may include the direct expense of healthcare such as insurance co-payments, professional fees, medication charges, as well as indirect costs such as missed work or school days, significant travel distances and competing caregiving responsibilities. Utilization reviews of inpatient psychiatric treatment recommendations should be conducted by individuals who have necessary qualifications in child and adolescent psychiatric care.

Care of Special Populations:

These principles serve as a basis on which specialized care can be determined for youth with specific conditions such as developmental disabilities, autism spectrum disorder, trauma-related conditions, eating disorders, substance use disorders, and conduct and/or legal problems. While detailed principles of care for each of these populations is beyond the scope of this document, reference to evidence-based practices such as the AACAP Clinical Practice Guidelines (www.aacap.org) is recommended in development of policies and programming.

IV. Safety As a Primary Goal

Inpatient psychiatric treatment of children and adolescents is typically reserved for those individuals whose illness or severe emotional disturbance has reached a level where they pose a risk of harm to themselves or others. Critical situations to be managed include self-injury, suicidality, homicidality, mania, psychosis, and severe emotional or behavioral dysregulation. The safety of the patient is the primary goal.

Organizational Culture:

Patient safety is maximized in inpatient psychiatric organizational cultures that promote the following:

- Leadership models that hold safety of both patients and staff as paramount
- Psychological and physical environments that are perceived as safe by all stakeholders
- Dissemination of best practices in patient safety via established quality improvement methodologies
- Family and patient-centered teamwork that optimizes communication and planning
- Adverse event analysis, based on a systems view that adverse outcomes are multi-factorial
- Constructive feedback and identification of opportunities for improvement that are embraced by team members and reinforced by leaders
- A “no blame and shame” dynamic that ensures errors or discrepancies in care are seen as a failure of the system of care, not an individual.

Child and adolescent psychiatry leadership should have access to data to support performance improvement efforts.

Safety Monitoring:

Patient safety monitoring should include an event reporting system to track and analyze high-risk events. High-risk event tracking and analysis should include adverse outcomes, "close calls" and effective harm prevention related to episodes of aggression, missing patients/elopements, suicide assessment and prevention, restraint and seclusion, child abuse or neglect, medication errors, falls and physical injuries to patients, staff and others on the unit. Clinical and administrative review, which includes medical leadership, should occur for each event. Periodic reviews of high-risk events and trends should be conducted by hospital and program leadership, with feedback provided to program staff on patient safety findings.

Patient care processes should be designed to maintain safety in high-risk scenarios involving care "hand-offs," admissions, transfers and discharges, medication administration and monitoring, suicide and self-injury, interpersonal violence, restraint and seclusion, and elopements. Restraint and seclusion events are particularly high-risk situations.

Effective communication and care coordination methods increase patient safety and should include:

- Initial and ongoing documentation of individual safety risk and level of monitoring/safety precautions
- Verbal and written sign-out reports
- Medication reconciliation performed on admission and discharge
- Involvement of families, referrers and aftercare providers throughout the inpatient hospitalization
- Clear discharge instructions on safety plans, medication administration, and aftercare appointment schedules

Safety and Staffing:

Staffing should include 24-hour availability of licensed clinicians authorized to prescribe medications and evaluate medical and behavioral emergencies, including restraint and seclusion events. Staffing should be adequate to ensure continuous monitoring of patients and the patient care environment, taking into account patient acuity, various levels of observation, special patient needs, volume, flow, and coverage for potential emergencies.

Staff training is guided by evidence-based approaches and aligns with recognized professional standards.

Staff training should be frequent enough to maintain knowledge and skills pertaining to relevant safety standards and include crisis and agitation management, aggression prevention, and restraint and seclusion reduction and prevention. Staff also must be trained in compliance with national and local regulatory standards, child protection reporting and intervention, and emergency evacuation clinical management plans.

Safety of the Environment:

The environment of the acute inpatient psychiatric treatment of children and adolescents plays a critical role in the quality of patient services to ensure safety for individuals served and the staff who provide care. Oversight of the care environment must focus on minimizing risks in the treatment setting that are associated with safety and security, hazardous material and waste, utility systems and emergency events such as fire. Along with environmental ("milieu") management, individuals must be familiar and adept at initiating processes for identifying, reporting, and acting on any risk found in the environment. Psychiatric inpatient treatment requires the environment to be designed and maintained to minimize any potential for self-injury, suicidal act, and/or aggression.

Specific features to be addressed in the care environment include:

- Security for individuals and their belongings
- Size and configuration of treatment space that allows for high quality treatment
- Appropriate space design utilization allowing staff supervision of patients while maintaining appropriate privacy
- Surroundings that support the dignity of the individual patient and permit ease of interaction
- Supervision and oversight of patients that is balanced with individuals' rights to privacy
- Compliance with accreditation regulations

The care environment should be under continual review, both internally and externally, to enhance ongoing safety. Unit leadership, including child psychiatrists, should be involved in this ongoing review.

Prevention of Restraint and Seclusion:

Restraint and seclusion prevention and elimination efforts should be integrated into the program's approach to patient care. Restraint and seclusion are not treatment modalities and should only be used as a last resort when there is imminent risk to the patient or others. Program elements that are helpful in restraint and seclusion reduction include, but are not limited to, the following:

- An overarching goal of prevention and elimination of restraint and seclusion
- A non-coercive treatment milieu
- Clinical leadership and administration commitment to the reduction/elimination of restraint and seclusion
- Detailed, ongoing data collection with the goal to reduce restraint and seclusion
- Sharing data with staff in real-time to inform clinical practice
- Use of appropriate medication to address a patient's underlying psychiatric symptoms
- Implementation of evidence-based prevention tools for reduction of restraint and seclusion
- Safety plans upon admission that include an overview of triggers, what works, and what does not work, for the individual child
- Involvement of the patient and caregivers in developing safety plans, reviewing restraint and seclusion episodes, and gathering ideas for how to manage the child's dysregulated behaviors

Staff training should emphasize the need to consider each child individually with attention to their personal histories, particularly those related to past trauma and abuse. Staff must also undergo annual certification in the facility's de-escalation program for managing behavioral crises. The organization should have a commitment to ongoing workforce development including initial orientation and regular training for prevention and management of aggression and reduction of restraint and seclusion.

Debriefing is another key intervention and should include both an immediate debriefing and follow-up debriefing at 48 to 72 hours to improve the general practice and address systems issues, with the goal of avoiding restraint and seclusion in the future. Debriefings should be done in a supportive, nonjudgmental way, acknowledging trauma issues for the patient as well as for the staff.

The program should have written policies consistent with national standards and regulations that address monitoring of all restraints, seclusions, and improvement program for reduction of both.

Data collection and ongoing analysis should include information on restraint/seclusion by unit, time of the day, day of the week, by gender and age; per thousand bed days and time spent in restraint/seclusion. Data on injuries during restraint and seclusion and intramuscular medications should be collected as well. Restraint/seclusion data should inform clinical practice and be shared at all levels with staff, including child psychiatry leadership, in real time.

Conclusion

In conclusion, inpatient psychiatric care is an important part of the continuum of care for youth with psychiatric challenges. This most intensive treatment modality is designed to provide a safe environment for assessment, initiation of treatment, and stabilization for children and adolescents with psychiatric illness and severe emotional and behavioral disturbance. Primary goals of inpatient treatment are to understand the underlying reasons for admission, potential causes of the child's current presentation, and to engage the patient and caregivers in the development of a treatment plan. Treatment on an acute inpatient unit should result in a treatment plan that will facilitate a better outcome for the patient and their caregivers.