Service Guide, Standards, Benchmarks, & Literature Review:

Standard 3: Physical environment

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3. PHYSICAL ENVIRONMENT

The unit physical environment is not only safe but also supports the therapeutic, cultural, developmental, and special needs of patients.

Q & A SUMMARY

This ONCAIPS submission about child and adolescent psychiatry physical environment begins with commonly asked questions and answers. It is followed by a literature review, and then by indicators in the form of self-audit checklists for the 16 core standards and a separate and more detailed one for Standard 3 alone.

- Why are standards for the physical environment of child and adolescent mental health units important?
    - *Standards are important because the physical environment is a key contributor to inpatient experiences and mental health outcomes and because the standardization of best practices helps units assure that units have the best evidence-informed environmental designs, structures, materials, and equipment. Environmental standards can help reduce accidents, opportunities for suicide, and other problems that are costly for health care system, and diminish trust for patients, families, and inpatient staff. It us important that standards consider the population units serve which in this case is the group of youths with assessed or suspected mental disorders.*

- Are the standards suggested by ONCAIPS prescriptive?
    - *At this time, the standards recommended by ONCAIPS are <u>not</u> meant to be prescriptive. They are aspirational. They are intended to promote self-reflection and self-audit, discussion, and research. ONCAIPS recognizes that the standards need to change across time. They are meant to be flexible appreciating and not ignoring local resourcing constraints, organizational priorities, and opinions and research.*

- Should ONCAIPS standards replace provincial safety standards, building codes, and hospital policies?
    - *Not they should not. The suggested standards are intended to be aligned with policies and procedures, building codes, and workplace safety legislation. When they*

are not, units should follow defer to legislation and regulations they have in place. But units should nevertheless consider the implications when they cannot be aligned.

- Should ONCAIPS standards primarily focus on physical safety?
    - *The current submission is an enhancement providing guidelines based on literature reviews that go beyond a focus on physically safety. The suggested standards emphasize the need to consider the impact of the physical environment on the psychological well-being and mental health of children and family. The standards are meant to help units reflect on what they have and what they might need to improve in the physical environment to optimize it for the mental health of children and adolescents.*

- What is the primary purpose of a child and adolescent inpatient mental health unit's physical environment?
    - *The primary purpose of the physical environment is and should be to support mental health recovery in a physically and psychologically safe way.*

- Is a typical inpatient environment physically and psychologically safe, and a contributor to recovery?
    - *Although all units are, and perceive themselves to be, generally safe and supportive of recovery, all units also have some structural, design, and equipment problems. Some of these problems impact physical safety in brief and intermittent ways, whereas others are more psychologically harmful and lasting.*

- What are common environmental problems that threaten patient physical or psychological safety?
    - *Inpatient physical environments are harmful when they are overly controlling and restrictive; insensitive to the needs and rights of certain user groups; too noisy, stressful, and crowded; lacking good lighting; providing too many opportunities for self-harm, aggression, accidents, and infection; failing to balance needs for calmness with needs for activity; and lacking ability to separate patients who pose risks to each other*.

- What aspects of the inpatient physical environment contribute to better mental health outcomes?
    - *Physical environments are best when they flexibly support the physical and psychological care needs of its diverse inpatient population groups. These groups include children and adolescents of different ages and sizes, cultures, religions, gender, gender identity and orientation, thought disturbances, personalities, language groups, and intellectual and physical disabilities.*

- What are the sources of the greatest risks of physical injury to patients?
    - *Although there are always risks of accidents, the most serious risks are posed by environmental structures and items that provide opportunities for suicide and assault.*

- Should physical environments be safe but still allow opportunities for some risky behaviours?
    - *Yes. The main purpose of admissions is not to restrict and control young patients so that all risk of any kind is eliminated but to help them recover by protecting their dignity and rights while providing some challenges essential for recovery. This includes providing some risk that young people can learn how to better address. An environment that provides some risks that are likely to be faced after discharge promotes learning more effective self-management and coping habits prior to return to the community.*

- What are the essential rooms and spaces?
    - *All units should have a secure monitored entrance, single-occupancy bedrooms, bathrooms, kitchens and dining area, spaces for individual, group, and family therapy, study spaces or classroom, spaces for recreation, opportunities for relaxation and exercise, space for visits, access to greenspaces and natural light, a padded and safe seclusion room if the unit uses seclusion, staff rooms and nursing/staff station, adequate storage including for storage of medication and potentially harmful items, and ability to separate patients during periods of aggression and infection.*

- Should the physical environment be built, operated, and renovated in socioeconomically and environmentally responsible ways?
    - *Units should be cost-efficient and whenever possible, they should use local materials in building and operation, and materials with the smallest possible negative environmental impacts. The unit should have a conservation and recycling program. Modifiable multi-purpose rooms that can be shared with other parts of the hospital or the community should be considered as cost-efficient options.*

- How many beds should a unit have?
    - *Units are most efficient when they have between 8 and 12 beds. Some large rural areas with dispersed populations may be better to have smaller units and more local access despite the decreased cost-efficiency.*

- Does the location of a unit matter?
    - *The location should be one that is most likely to be accessible to users, and most likely to be an integral part of the local mental health system.*

- Does a unit have to be in hospital?
    - *Currently there is no compelling evidence from outcome studies to conclude that units outside of hospitals are less effective. Units can be off-site, often provided at lower cost, and still supported by nearby hospital resources for medical needs.*

- Should the physical environment of units be evaluated?
    - *Monitoring of the environment should be ongoing. In addition, the unit should publish an annual report about the problems and assets of the physical environment for its users and partners. The evaluation should focus on the ability of the environment to support recovery, to protect dignity and rights, and to maintain physical and psychological safety. The evaluation must include the expressed opinions of children and adolescents who are the most affected group by the environment, as well as the opinions of staff, parents/caregivers, and partner agencies that visit the unit. It would be highly desirable for the information in annual reports to be standardized provincially and nationally in ways that describe the state of inpatient care across all units.*

- Why is it so important to ask children and families their opinions?
    - *Because they are the principal users for whom the unit was designed. Their opinions are as if not more important than the opinions of administrators, manager, and inpatient care professionals. The points of view of those for whom the service is intended should be a routine part of every admission and discharge. If you were a child patient or you had a child who was a patient would you not like to be asked about whether the environment is psychologically and physically safe and what it contributed to mental health?*

- How confident can we currently be about the information we have on the best physical designs?
    - *It is important to appreciate that the benchmarks/indicators in this paper are based on limited available research. Mich more research is needed. The relationships among designs, cost-efficiency, and clinical outcomes must be better researched particularly for child and adolescent inpatient units. There is a much larger evidence base supporting design in other sectors such as long-term care and adult units than what is available for child and adolescent inpatient psychiatry (e.g., Wrublowski, 2018).*

INTRODUCTION

Standard 3 builds on prior ONCAIPS standards. Standard 1, discussed physical safety and Standard 2 discussed rights, dignity, inclusion, and participation. Standard 3 focuses upon desirable aspects of the physical environment, compiles literature and research findings, and provides a self-audit checklist. Like other ONCAIPS standards it is provided to help reduce gaps in knowledge from the recurring loss of knowledge that occurs because of turnovers of staff, and lack of time available to units and professionals to stay updated on research and literature specific to child and adolescent inpatient mental health care.

The physical environment and its architecture should be standardized to assure they make the best possible contributions to inpatient mental health assessment, stabilization, and treatment. Well structured physical environments can help reduce risks of harm to self and others, provide calmness, safeguard privacy and dignity, enhance assessment, and protect the unit social and emotional climate (Cardell, Bratcher, & Quinnett, 2009; Dahl, Thomas, & Holmes, 2013; Jovanovic, Campbell, & Priebe, 2019; Liddicoat, Badcock, & Killackey, 2020; Lieberman, Resnik, & Holder-Perkins, 2004; Nederkoorn et al., 2016; Trzpuc et al., 2016; Woodruff, 2020). Alternatively, they can provide misleading assessment findings and get in the way of recovery. It is essential that units use evidence-informed architectural designs and renovations that promote mental health rather than harm it.

Knowledge about what works and what does not in designs and structures is continuously improving. Although there are significant differences in opinions about what the best environment should look like, there are convergent opinions as well (e.g., Hunt & Sine, 2012; Health Care Investment Branch, Ontario Ministry of Health & Long Term Care, 2017; International Health Facility Guidelines, 2017; Liddicoat et al., 2020; Ulrich et al., 2008; Wrublowski, 2018). The Center for Health Design for example, has measures, guides, standards, and a knowledge repository for most hospital environments (see https://www.healthdesign.org/knowledge-repository) and research on unit designs for subspecialty designs such as for anorexia is increasing (e.g., Basinger, 2011).

While the purpose of the physical environments on all inpatient units is to improve mental health in a safe context, all environments are not equally capable of fulfilling this role. Fiscal constraints, incomplete knowledge bases, and outdated beliefs about what units should look can lead environments that are unsafe, institutional in their look, excessively controlling and confining, stressful, fear and anxiety provoking, and without good ability to prevent accidents, and self harm (Jovanovic, et al., 2019; Nederkoorn et al., 2016). They may have poor natural light and lighting patterns, poor air circulation, and lack of access to greenspaces, and age-appropriate socialization. They may have excessive noise and poor temperature control, lack of space for therapeutic activities, ligatures and ligature points that increase risk of suicide, signage and art that marginalize vulnerable minorities, furniture and fixtures that are inappropriate for the size of children, and insufficient barriers for prevention of infection or bullying or assault.

Although some general design principles for physical safety including prevention of suicide, assault, and accident proofing have been better identified, less attention has been paid to whether a similar level of physical and psychological safety and health outcomes could be provided outside of hospitals. It is not clear if units would be more effective, better integrated with community services, and less costly if located in the community with hospital liaison and support than in hospitals themselves. Ontario does have one inpatient unit located in a residential unit outside of hospital. This unit is supported by psychiatric resources from the hospital and operated under the same legislation as other hospital-based units. It also remains unclear whether the clinical needs of younger children and adolescents are best met by Ontario's blended age units or if children and adolescents should have their own separate age-appropriate units in which to recover.

Standard 3 of ONCAIPS integrates and summarizes literature about the physical environment and offers standards and indicators for evaluation and further development. The standards and indicators are offered to provide information to help new units as well as to help existing units who may be looking assess their physical environment with a view to making improvements. The information about the physical environment is discussed under the following headings:

1. *Being clear about the purposes of the physical environment*
2. *Balancing safety and recovery needs*
3. *Providing essential rooms & spaces*
4. *Reducing risks of suicide and self-harm*
5. *Providing visibility & monitoring*
6. *Reducing accident risks*
7. *Reducing opportunities for assaults & harm to others*
8. *Reducing environmental stressors (e.g., light, air quality, noise, crowding).*
9. *Designing bedrooms*
10. *Designing bathrooms*
11. *Designing kitchen & dining spaces*
12. *Designing therapy rooms*
13. *Designing of classroom, learning, & study areas*
14. *Providing sensory/calming spaces*
15. *Assuring access to natural light & greenspaces*
16. *Assuring access to exercise equipment & space*
17. *Providing recreation & play space*
18. *Assuring sufficient storage*
19. *Providing spaces for family & visitors*
20. *Assuring well designed staff rooms & nursing stations*
21. *Designing a seclusion room*
22. *Providing infection control*
23. *Providing space and equipment for communication (e.g., teleconferencing)*
24. *Providing an age-appropriate physical environment*
25. *Promoting dignity, inclusion, and engagement*
26. *Having the right unit size*
27. *Considering the best unit location*
28. *Engaging in continuous improvement & completing an annual evaluation*

References and a self-audit checklist of qualitative benchmarks/indicators for the environment are provided at the end of Standard 3. Self-audit checklist can help units to better identify and address problems and risks, and frequency and severity of incidents (Watts et al., 2012).

PURPOSIVE DESIGN

3.1 The physical environment is purposed to improve mental health while providing physical and psychological safety in an environmentally and culturally responsible manner.

The physical environment is not intended to solely be a place to detain children safely and securely. Safety is essential but is not the defining purpose of mental health units. There are other types of confining environments that can provide security and safety without promoting mental health improvements. ***The purpose of the physical environment is to promote improvements to mental health of children and adolescents while keeping them safe and secure.*** *The primary user or consumer in inpatient care is not the hospital, the unit, the management, or the professionals but the children and adolescents who are admitted. The physical space should be therapeutic and facilitate the achievement of clinical goals that are associated with better mental health outcomes (Cotton & Geraty, 1984). Ideally, the physical environment should make some identifiable and lasting contributions mental health outcomes.*

Consequently, the physical environment should have a design, rooms, spaces, and equipment that promotes accurate assessment as well as effective stabilization and treatment. The environment should not instigate temporary institutional behaviours that can then be inaccurately assumed to be representative of behaviours in a community setting. Inpatient environments can too easily come to resemble "fake worlds" rather than realistic normalizing environments (Gill, Butler, & Pistrang, 2016). Accurate assessment and generalizable outcomes need the unit to be sufficiently like environments to which children are returning. This means having home-like and classroom-like environments on the unit. This includes having a living room and dining room to promote socialization with staff and co-patients, a kitchen for food and drink preparation, a classroom to continue schoolwork, and bedrooms that provide privacy and promote good sleep.

Stabilization and recovery require that the environment be physically and psychologically safe while also providing nourishment, security, and shelter. All unit environments should be designed to minimize opportunities for risks of suicide. They should be able to provide barriers and spaces that separate patients from each other whether from risks of infection or risks of bullying or physical assault. They should also be designed to minimize unhealthy stress. Unhealthy levels of light, temperature, ventilation, and noise can stress patients and staff. Stress on the unit also increases from overcrowding, threats and conflicts, and excessive loss of contact with family attachments, friends, community groups, and school supports.

The environment and its operation should of course be efficient, cost-effective, and culturally and environmentally responsible while not losing focus first and foremost on its impact on client outcomes. At the same time, there is no reason why the environment should not be expected to be environmentally responsible. It should be a contributing part of its community by buying locally whenever possible, by considering the life cycle of materials and equipment used in building and renovations, by making design and operation choices that minimize environmental pollution, and by engaging in recycling (Onaran, 2009)

BALANCING PHYSICAL SAFETY & RECOVERY NEEDS

3.2 The environment provides and balances physical safety with opportunities for recovery and mental health.

Physical safety is essential for psychological safety. It is important that all spaces and equipment are physical safe. Entrances should be able to allow screening of visitors before they enter the unit. Having a secure entrance and waiting area can help. Although doors need not always be locked in low-risk periods, the ability to lock the main doors is essential and can help prevent absconding of involuntary patients and prevent entry of dangerous visitors (Desai, 2009; Van der Merwe, et al., 2009).

Windows should secured and made with safety glass that does not shatter and that is treated protective film to ensure glass is held together if it should be broken although non-glass polycarbonate to let in natural light can be used where scratching and loss of visibility are not important (International Health Care Facilities Guidelines, 2017). All units should have emergency medical resuscitation equipment which should be maintained and checked weekly and after each use. Staff should have access to alarms using panic buttons, strip alarms, or personal alarms that work best for their activities (International Health Care Facilities Guidelines, 2017; Lucas, 2019). Youth too should have the means to alert staff to emergencies.

But a balance is needed between control and freedom to experience normal life risks. Excessive fear of possible physical injuries can lead to the creation of an overly restrictive environment that paradoxically increase feelings that the environment is unsafe and the belief of patients and staff that all patients dangerous. Units should be safe and secure but not so much so that they come to overly resemble restrictive and controlling carceral institutions and promote stigma. Overly controlling environments can take on an institutional look with cold lights, hard cold surfaces, white colours, and spaces dedicated to observing patients for risks and breaches of rules. An excessive focus on safety and security can lead to a barren demoralizing institutional type of environment that increases likelihood of stigmatization, dissatisfaction, acting out, and diminished ability to support recovery (Cotton & Geraty, 1984; Mullen,2009; Muller, Schlosser, Kapp-Steen, Schanz, & Benkert, 2002; Reavey et al., 2017; Lucas, 2019; Van der Merwe, et al., 200). Young people, like their caregivers do value safety, but not to an extent that makes them young people feel controlled and or treated as if they were not persons (Biering et al., 2011). Young people need an environment that allows them to express themselves and to engage in rewarding and familiar activities that have some level of risk.

However, units should also focus on providing spaces and materials to promote improved emotional, behavioural, and social adjustment. A comfortable, home-like environment is important to develop for recovery and improved likelihood of generalization of outcomes after discharge. Environments should have rooms that provide opportunities for healthy socialization, exercise, and therapy. Furniture and materials in use should be appropriate for all youth on the unit regardless of age and size, and for their visitors (International Health Care Facilities Guidelines, 2017). The unit should have comfortable home-like furniture, warm inviting colour

schemes, art, comfortable beds and pillows, access to soft music and pleasant olfactory sensations as opposed to barren walls, locks, and antiseptic smells which reflect intense preoccupation with safety, rules, and observation (Muskett, 2013). The environment should be one that conveys a friendliness, warmth, and acceptance rather than panic, despair, or fear, spaces that promotes rather than erodes opportunities for autonomy and self-control (Cotton & Geraty, 1984). The environment needs to support social integration for all patients at all levels of functioning, to provide opportunities for constructive peer relations and private times, and to have spaces that support formation of more adaptive alternatives to maladaptive behaviours (Cotton & Geraty, 1984). A blend of common areas like dining and recreation rooms, and private areas like bedrooms and sensory rooms can add to the home-like welcoming quality (Jovanovic et al., 2019). Patients as much as staff can be valuable informants about what changes to the setting are likelier to assure the best balance among safety and recovery (Trzpuc, et al., 2016).

ESSENTIAL ROOMS & SPACES

3.3 The unit has all the types of rooms and spaces to assure the best mental health outcomes.

There is some agreement in the literature about the types of rooms and spaces that are essential for mental health inpatient settings (e.g., Lucas, 2019; Sharma & Kommu, 2019). Certain rooms and spaces have been identified as important across units. These spaces include private spaces for each patient (e.g., bedrooms and bathrooms), spaces for caregivers (nursing unit, lunch area, meeting rooms), and semi-private spaces for staff and young people. These shared semi-private spaces for staff and patients include therapy and activity rooms, classrooms or study areas, kitchen and dining areas, and recreation areas. Units also need public spaces that are open to visitors such as a living room and a family rooms for visitors. All public spaces need not be on the unit. Some spaces can be shared with other services or the public. This can include scheduled access to exercise and recreation areas such as cafeterias, gyms pools, access to a library, access to the outdoors and greenspace, and access to space for cultural and religious observance.

Although some standardization of required spaces is important, so too is flexibility given that different units admit different age groups and have different lengths of stay. Treatment units that house children for weeks and months clearly require more rooms and spaces than ultra-brief stay crisis units. Having a unit with its own kitchen, classroom, and recreation spaces for youth on brief stay units could be argued to be neither necessary nor cost-effective since children are not likely to fall too far behind in school or lose social contacts for longer periods of time. But in Ontario all crisis units tend to have some of their inpatients who can stay for weeks and months. This means having to occasionally meet the needs of longer-stay youth by providing home-like spaces and classrooms like those available on longer stay units. Longer stay treatment units also need to consider what additional spaces they require to provide sub-specialty forensic, eating disorders, developmental disabilities, and concurrent disorders inpatient services. Most units in Ontario are blended-age units which admit both children and adolescents. This requires

considering the needs of youth with different mental disorders as well as the needs of different age groups. There are no units designed for separate male and female patients in Ontario, although recommendations for separate units have been made in other countries (e.g., Sharma & Kommu, 2019).

SUICIDE & SELF-HARM

3.4 The physical environment minimizes opportunities for suicide and self-harm.

Risk for suicide is the leading reason for admission to child and adolescent crisis units in Ontario and is also common on treatment and subspecialty (aka sometimes as tertiary care) units (Greenham & Persi, 2014). Completed suicide of a child or adolescent in the care of a hospital, is a terribly tragic and traumatizing event for families and caregivers. The family's emotional pain can be further compounded by a sense of betrayal because admission was supposed to prevent suicide. Legal action can follow because of failure of the unit to provide a safe physical environment (Ahn, Lee, & Song, 2020; Bongar et al., 1993). Athough other measures such as supportive monitoring and hope promoting activities, and therapeutic interventions are also needed (Cardell, Bratcher, & Quinnett, 2009),safe environments are an essential part of inpatient suicide prevention (Lieberman et al., 2004; Ontario Hospital Association, 2017; Wall et al., 2012),

The physical environment should minimize opportunities for strangulation, asphyxiation, poisoning, overdose, and cutting are eliminated (Ontario Hospital Association, 2017; Roberts, Monferrari, & Yeager, 2008; Wall et al., 2012). Prevention of strangulation one of the central goals because strangulation is the most common type of suicide attempt on inpatient units (Cardell et al., 2009; Farberow, Shneidman, & Leonard, 1961). Commonly used 15-minute checks and continuous monitoring though helpful, are not sufficient to prevent suicide by strangulation or asphyxiation because continuous monitoring is often stopped when patients appear to be safe and because death by strangulation is so rapid. Environmental safety proofing can provide additional risk reduction.

Environmental interventions include removal of items that can be used for suicide as well as redesigning the environment to eliminate ligature points. Items which pose ligature risks include bedsheets, pillowcases, curtains, neckties, shoelaces, shirts and tops with long sleeves, hoodies and pants with drawstrings, intravenous tubing, pull cords on lights, electrical cords, electronic wiring, panty hose, suspender belts, long socks, handkerchiefs, headbands, and scarves (Ahn, Lee, & Song, 2020; Cardell et al., 2009). Items which pose asphyxiation risk include garbage bags including liners, plastic bags, and latex gloves (Lieberman et al., 2014).

Units should eliminate potential ligature points such as support bars ("grab bars"), exposed heating and water pipes, kitchen drains, bed posts, high mounted door stops, heating and cooling grills, plumbing fixtures in showers and bathrooms, clothing hooks, ceilings with tiles that can be moved to expose pipes, hooks for hanging pictures or posters, and fire sprinkler heads. Prevention includes not only removing high ligature points but also low ones that pose hanging or twist risk from a sitting, kneeling, or event a semi-lying position (Yeager et al., 2005). Fixed support bars can be replaced with breakaway ones that easily pull away from the wall and doors

can be redesigned to make hanging more difficult (Cardell et al., 2009). Clothes can be folded rather than hung or kept in a secure area. Showerheads can be flush mounted, and shower controls can be push-button, or utilize a rounded design that will not support a cord (Lieberman et al., 2004). Windows with integral between-the-glass blinds eliminate the need for curtain rods, and curtains/drapes.

Doors in public and semi-private spaces should be eliminated unless essential for the functioning of the unit. Doors to bedrooms should allow staff ease of entry for emergencies and should not present physical safety risks but should provide privacy from other patients. Admittedly providing the best balance between safety and privacy can be difficult. Suicidal patients do not always communicate they are at risk and can hide behind doors to conceal self-harm or suicide attempts. Consequently, storage and closet doors are best removed as these are not essential for privacy. Some units have also removed ensuite bathroom doors. In single occupancy rooms as the bedroom door is considered to provide sufficient privacy.

Door that cannot or should not be removed should be free of ligature points. Patients should not be able to tie a knot using a bed sheet or clothing and then place the item on top of a door and use the other end as a ligature. Door hinges can be the continuous piano style extending from the top of the door to the bottom in an unbroken manner (Lieberman et al., 2004). Doors can be designed to swing in and out, so they allow staff access and prevent blocking of doors by patients from the inside. Pressure sensitive devices that mount on door edges, connect to a central alarm system, and sound alarms when they are compressed by the presence of an object, such as a ligature can be used to alert staff. Other potential modifications include a slanted tops and gaps on the bottom that can prevent wedging objects to hang from (Joint Commission Resources, (2007). Doors can have a rubber edge that makes it impossible to wedge objects between the edges (Joint Commission Resources, 2007).

Suicide by ingesting poisons or through overdose pose a less frequent but nevertheless important risk. Handwash, alcohol and illicit drugs bought on pass, prescription and over the counter medications, herbal or naturopathic products mouthwash, acetone (fingernail polish remover), cleaning chemicals on trolleys or other accessible areas, alcohol-based hand cleaners, and any available toxic substances pose risks. should never be left unattended (Lieberman et al., 2004) and medication should be stored in a secure place, in line with the organisation's medicine management policy (Lucas, 2019). It is important for units to be aware that locking medications is insufficient to assure safety and that units need to take other measures to prevent patients stockpiling their medication or giving their medication to other patients.

It is rarer but nevertheless possible also for youth to jump to their death. It is therefor important that safety take precedence over aesthetics of design. There should be no accessible spaces in hospitals where individuals could jump or fall to their death. This is important for all patients and not only those on the unit. Access to rooftops or to high walkways that pose risks for suicide attempts should be restricted and structural designs altered if necessary (Farberow et al., 1961). Installation of plexiglass barriers along walkways where jumping is possible reduces risk of both impulsive and planned suicides.

Self-injury using cutting implements or items is common on inpatient units. Although in most cases cutting does not result in death or serious injury, there are occasions when it does. Sharp objects like knives, scissors, razors, mirrors, kitchen utensils, popcans, wood, plastic, or steel items that can be sharpened (Cardell et al., 2009). Because self injuries can include ingesting, headbanging, punching walls, or kicking it is important to replace furniture with sharp edges and add padding to seclusion rooms, as well as limit access to glass bottles or jars.

Parents/caregivers should be invited to partner in reducing risks at home on visits and should be asked not to bring items or gifts to the unit that can be used to attempt suicide or for non-suicidal self-harm. Patients, parents/caregivers, and visitors can provide useful feedback about features or items of the unit that could use to commit suicide, which staff points of view may have missed (e.g., Benensohn & Resnik, 1973). Working in partnership can lead to discussions that reduce likelihood that young patients will see safety measures as punishing or petty. Although the physical environment is important for preventing opportunities for suicide it is as important to appreciate that one of the best ways to prevent suicide is to provide an environment that is supportive and engaging and not sterile, punitive, humiliating, or overcontrolling.

VISIBILITY & MONITORING

3.5 The unit has minimized the risks posed by lack of visibility.

The physical environment should provide a level of visibility necessary to identify risky patient behaviours as early as possible. Environmental designs should allow staff to have clear lines of sight to monitor patients, at least when they are out of their bedroom. Lack of visibility can make it difficult for staff to monitor for self harming behaviours, aggression, sexual exploitation, bullying among patients, patient wandering, and patient inactivity. Nursing stations should have visual alarms that notify staff when bedroom doors open at night. Close captioned television cameras should be used to help address any blind spots particularly in areas where possibility of suicide attempts, elopement, or assaults may occur.

Visibility is also important for the entrance to each unit. Staff should be able to see who is coming and going to and from the unit. The entrance to the unit should be observable from the nursing station/office and should incorporate a greeting/ waiting area for family, friends and others which is separated from all other functional areas on the units. These may include electronic locking, intercoms, and video surveillance (CCTV). Staff should be able to welcome visitors or block entrance or exit in cases of significant risk.

ACCIDENTS

3.6 The physical environment minimizes accident risks.

Any design issues or causes of accidents on the unit that have contributed or that could contribute to accidents should be identified, formally recorded, reported, and addressed. Youth in inpatient

care include those with various neurodevelopmental and psychiatric vulnerabilities that increase accident risk (Engqvist & Rydelius, 2006; Park et al., 2013). Units also must ensure that risks of visitor and staff accidents are minimized. Environmental designs that minimize likelihood of accidents from falls, frail furniture, overhangs, and edges and are important for everyone.

Patient falls though rare on most child and adolescent units, relative to units for older patients can occur and should be prevented. Thresholds, and exposed wires and screws on floors can cause trips and falls. Ideally floor material should be of the non-slip good grip type, and the unit should be free of clutter. Risks increase when floors are wet or there are spills. Any hazards such as wet floors should be clearly marked for patients, staff, and visitors. Ideally floor should be made from or covered by slip-resistant material. Young people taking sedating medication or with impaired mobility, and young people with conditions or illness affecting balance, a history of falling, and/or a history of disorientation are at greatest risk (Razmus et al., 2016). Children and adolescents should be screened for fall risk at admission, and individualized safeguards including needed wheelchairs or crutches should be put in place as soon as possible.

Other sources of accidents include cuts on sharp corners or exposed screws, poisoning, cuts from breaking glass or ceramics, injuries from falling objects, and electrical shocks and fires. All wiring, electrical, and electronic equipment should be regularly checked and maintained. It is best that windows and other items be made from non-breakable materials. Heavy items like television sets or other equipment that could fall or be pushed over should be secured in ways that prevent the equipment from falling over. Exercise equipment that could cause injuries in several ways should be supervised and locked when not in use. The unit should be able to be "locked down" when there are external threats such as from toxic spills and to prevent wandering that may result in accidents.

AGGRESSION & ASSAULT

3.7 The environment minimizes opportunities for patients to harm or be harmed by others.

The unit environment should help prevent injuries caused by patient impulsive or planned behaviours directed at others. Many of the same items that could be used to harm self can also be used to harm others. This includes objects such as pencils and other items that can be used as weapons or projectiles. Contraband drugs and toxic substances can also be used by some patient to harm others. Ligatures can be used in assaults and matches and lighters can start fires or be used to burn others. Although fire-setting is rare, there are children and adolescents who are admitted specifically for risks related to fire setting or who have fire setting as a secondary problem (Kolko, & Kazdin, 1988). Units are best to monitor and to reduce access to flammables and means of ignition and to secure any objects that can be used to harm staff or other patients.

The environment must be able to protect potential victims of violent behaviours. It must have the space to separate individuals who are at significant risk of hurting others or each other. Physical and sexual assault, and harassment can severely harm and destabilize both those harming and those being harmed. The ability to close off or separate spaces reduces the need for staff themselves to act as physical barriers between acting-out patients. When a unit is in the same hospital as an adult one it is important to provide a level of separation that can keep younger people safe (Lucas, 2019). The ability to use space and barriers to protect younger children who have been or are vulnerable to being victimized by older adolescents is similarly important.

STRESSORS (NOISE, LIGHT, AIR QUALITY, TEMPERATURE ETC.)

3.8 The unit is free of significant environmental stressors involving noise, lighting, air quality, cleanliness, temperature, and uncomfortable furniture.

Physical stressors that can hinder recovery include excessive noise, excessive light at night and not enough natural light in the day, inadequate ventilation, poor air quality, humidity or dryness, unpleasant smells, uncomfortable temperature, lack of cleanliness, complicated wayfinding and signage, and crowding (Dahl et al., 2013; Karlin & Zeiss, 2006; Lucas, 2019; Sharma & Kummu, 2019; Tham et al., 2020; Ulrich, Bogren, & Lundin, 2012; Yakov et al., 2018; Zhou et al., 2020). Stress from crowding results from more frequent invasions of personal space, inability to withdraw to a calm place, and recurring exposure to arguments, social pressures, threats and bullying (Baum & Valins, 1979; Stokols, 1972; Ulrich et al., 2012). Larger spaces with moveable seating can help young patients maintain more comfortable interpersonal distances in common areas (Ulrich et al., 2012).

Survey information suggests that children and adolescents find some units to be too hot, too noisy, with irritating lighting and uncomfortable furniture (Haines et al., 2015), and overly bright lights at night (Battrick & Glasper, 2004). Ergonomically and developmentally designed seats, tables, and beds can help reduce discomfort (Hariwidagdo & Sahroni, 2019). Many inpatients have levels of noise exceeding recommended World Health Organization guidelines. Irritating and confusing noise can and should be reduced through improved acoustic design of equipment and unit spaces (Shield, Shiers & Glanville, 2016). Given the difficulty many patients have with reality orientation, Karlin and Zeiss (2006) recommended designs without long corridors or highly echoic space that can contribute to perceptual distortions and fear. It is helpful if study and rest areas are distanced from noisy meeting rooms. Yakov et al., (2018) reported that sensory reduction in the environment during a high-stress time was associated with a reduction in assaults and restraints.

Reducing light and noise levels at night and increasing natural light during the day can help with diurnal rhythms and help reduce aggression, irritability stemming from insomnia, and agitation (Allen et al., 2002; Dahl et al., 2013; Harvey et al., 2015). Chronobiologically informed lighting that reduces circadian rhythm disruptions is best (Drews et al., 2020; Platt, Bosch, & Kim, 2017).

Units should ideally have window(s) that increase natural light during the day (Lucas, 2019), and reduce it at night. Intrusive lights from nursing stations, hallways, and outside intrusions such as from streetlights should be minimized at night.

BEDROOMS

3.9 Bedrooms are safe, private, and promote healthy sleep.

Bedrooms are arguably one of the most important spaces because they a space for youth to take a break from stressful interactions, to be themselves, to relax, to reflect, and to sleep (Kopec (2006). It important that bedrooms not only be safe, but also that they provide a home-like comfortable environment that promotes recovery. Young people should be permitted and encouraged to personalize bedrooms to make them more home-like. Bringing personal belongings and displaying them on alcoves can help children maintain a connection with their identity outside of hospital and their regular place in the world (Kopec, 2006). Being able to bring items like teddy bears (so long as they are screened for safety) can be important for younger children. Bringing familiar items like photographs or music can be similarly important for older children or adolescents with attachment vulnerabilities or difficulties coping with transitions and unfamiliarity.

Bedrooms should minimally have a comfortable bed, a desk, a chair, a door, and a window that lets in natural light in the day that block light at night. Doors to closets or areas which create unnecessary barriers to observation/assistance should be removed. Entrance doors to the bedroom should be designed to be free of ligature points and ligatures as discussed in the section on suicide prevention. Windows should be designed with between-the-glass lights and shades that can manage light without concerns about ligatures and ligature points from curtains and curtain rods whenever possible. Furniture should be fixed in place in tamper resistant ways and should be sturdy enough that it cannot be dismantled or broken into shards. The room should be free of furniture or shelving with sharp edges, rugs or thresholds that could lead to slips and falls, and items that could fall on patients. To minimize wandering and intrusions on co-patients, bedroom doors should have visual alarms that alert staff on nursing stations when doors open at night.

Single-occupancy bedrooms are best. Creating homelike personal and safe spaces is usually more challenging when bedrooms are double occupancy. Single-occupancy rooms tend to be preferred by most patients, they provide more privacy, they improve infection control, and to provide safety from bullying, harassment, and physical assault (Shepley et al., 2016; Ulrich et al., 2012; Watts & Wilson, 2009). Several ONCAIPS units have indicated that physical and sexual assaults, bullying, as well as sexual contact are more likely to occur in shared bedrooms particularly at night. On occasion, vulnerable children who have had past experiences with abuse and cultural, racial, or religious discrimination can be re-exposed to similar types of bullying from co-patients they share a room with. Lyons et al., (2015), for example, described survey reports of bullying and harassment from youth identifying as LGBT2SQ who shared a room.

Unfortunately, not all units have the space or funding to provide single occupancy rooms. Tulloch et al., (2008), for example, reported 59% of bedroom were singles and 41% were shared in the UK CAMHS units. In Ontario, most of rooms are singles although there are units with shared bedrooms as well. When a bedroom is shared, an opportunity for discussion should be provided about decorations, drawings, music, and poetry as one individual may prefer certain things that may offend the other.

There are a few patients who indicate a preference for shared bedrooms. because of their hope that having a peer in the bedroom will provide a deterrent to their suicide attempts and self-harm (Shepley et al., 2016). But sharing a bedroom can increase risk if the roommate is also suicidal or has self-harming intentions they wish to enact. Furthermore, allowing patients to "supervise" other patients places them in monitoring roles that typically only increases their stress, their own potential for guilt and trauma, and the perception that they are being unjustly expected to do the work of inpatient staff. Although some children may feel less lonely with a roommate, current opinions are that there are greater benefits for children and adolescents on crisis and treatment units should have single (private) bedrooms (Lucas, 2019).

On units with shared bedrooms, the question of who should be roomed with who, arises. Choices should first consider physical and psychological safety, and the capacity of the rooming relationship to be an asset rather than a liability. Miller, Friedman, and Coupey (1998) suggested that it is important to not ignore expressed patient preferences when allocating bedrooms, without discounting the opinions of parents/caregivers, and of staff and administrators. Preferences and risks are important to balance. Fears that a patient would be more likely to act out sexually or be victimized because of their group membership should be replaced by considering personal histories and current risks at an individual and not on negative and inaccurate homophobic or other stereotypes (e.g., Deacon, Rea & Largey, 1991). It is important that some time be taken to consider rooming needs from the individual's perspective and to weigh parent/caregiver opinions more heavily for younger children. Discussion among staff, patients, and parents/caregivers is important. There are often complex linguistic, religious, cultural, gender, gender identity and developmental differences to consider along with vulnerabilities that can inform if and how to allocate youth to shared bedrooms. For example, the rooming of younger children with an older adolescent may present more challenges than having similar aged patients sharing a room.

The unit should provide younger children with the sleeping space to have parents/caregivers 'bunk in'. Younger children are more likely to be emotionally harmed by separation from family (Churven & Durrant, 1983). This can be essential sometimes in preserving the child's attachment and engaging parents more effectively as partners in care.

There were no inpatient family units in Ontario at the time of writing, but it is recommended that all health care jurisdictions have a unit or minimally a space attached or affiliated with the unit for family admissions. The ability to provide family admissions is important given the relationship among problems of parents and children. Serious problems of parents that destabilize children are not always due to abuse. Problems like mental illness of parents, parenting problems, chronic marital conflicts, and addictions can cause admissions although admitting children will typically

be unable to make a significant or lasting difference when only the children receive treatment. Findings suggest that family admissions may be likelier to produce better mental health outcomes for certain problems such as anorexia nervosa (e.g., Nilsen et al., 2019).

BATHROOMS

3.10 There are enough bathrooms for the size of the unit and their design assures safety and protects dignity.

Children and adolescents as well as staff should have easily accessible, private, and safe toileting facilities, and showers. It has been recommended that every bedroom should have their own bathroom for toileting (Lucas, 2019). Lucas (2019) recommended a minimum of one shower room for every three patients. A bathroom in a bedroom is most convenient and comfortable for patients. But because bathrooms are one of the most common sites for suicide attempts by hanging, there may be benefits if bathroom entrances and exits, are located outside the bedroom where they can be visible from a nursing station.

Bathrooms and showers should have privacy or 'in use' signs. The same level of care should be take when designing bathroom doors as described for bedroom doors. Bathroom and shower doors and hinges should be suicide proofed in ways described for bedrooms. Bathroom doors should be unlockable or easily accessible from the outside (Cardell, et al., 2009). Doors should swing out rather than in and be free of barricade risk.

Mirrors should be rigidly fixed to walls with tamper proof hardware, made of safety glass or other appropriate impact resistant and shatterproof construction, and fully glued to prevent availability of loose fragments of broken glass (International Health Care Facilities Guidelines, 2017). Bathrooms and showers should allow easy access for a wheelchair and 1 caregiver.

There should be sufficient and separate showering facilities for staff.

KITCHEN & DINING AREA

3.11 The kitchen and dining areas are safe, promote healthy eating, and support social and psychological well being.

Every unit which has at least a few children and adolescents who stay for more than three days should have its own kitchen and dining spaces. These spaces are no less important tin hospital than at home. They provide places for celebrating holidays, birthdays, and for varied recovery activities. Kitchen and dining areas also provide opportunities for enjoying food., for learning skills such as cooking, setting and clearing tables, and for positive therapeutic interactions among patients and staff. Kitchen and dining areas are often used as contexts for developing healthier eating habits such for all patients including those with anorexia, bulimia, diabetes, or obesity. Meal preparation and dinnertime socializing can provide relief from boredom, interrupt anxiety,

increase social and other problem-solving skills, distract from rumination, focus mindful attention to tasks, and increase frequency of reinforcing pleasant anti-depressing experiences.

For these spaces to be assets it is important they be safe and comfortable. As is the case at home, the kitchen should have a dining area. The dining area should minimally be large enough to accommodate all patients and staff. Components should include refrigerator, stove or microwave, sink and hand hygiene sink, and dishwasher. There should be a commercial grade hood over the stove, and light commercial grade dishwasher which can achieve proper sterilization temperature. The area must be accessible for wheelchairs and facilitate participation of youth with hearing and visual disabilities. Patients at risk of harming themselves or others should typically be supervised and supported by staff while in the kitchen. Because not all patients require proximal constant supervision, it is best that kitchen and dining spaces be visible from the nursing station (e.g., plexiglass walls on one side or large windows). The unit should have secure spaces to store dishes and utensils. Locked pantries may be incorporated for storing cutlery, and other food stuffs.

Food that is served should always be fresh, healthy, and sufficient in quantity. The admission process should identify food allergies, food aversion, and dietary needs. According to Lucas (2019) young people should be provided with some food choices and meals that are do not conflict with their cultural and religious eating practices. The unit should then provide a nutritional/balanced diet that is safe and appropriate for specific dietary needs (Lucas, 2019). The unit should provide ongoing access to water and fluids and patients should be encouraged to keep hydrated throughout the day. There should be reasonable access to snacks like fruits and vegetables.

Although kitchen and dining are important and an essential components of residential mental health care, it is not unusual for fiscal and time constraints to set limits on what can be provided. There are units which receive meals from a central kitchen or supplier in a pre-prepared way on trays in ways that limit and sometimes eliminate opportunities to incorporate the joy of cooking, food preparation skills. Tray service is less costly and less time consuming. Unfortunately, it is more likely to promote an institutional conveyer belt atmosphere that may be less than ideal for those with stays longer than a couple of days. In settings that lack a kitchen or food preparation area it is still common for those units to discourage eating alone and invite patients to bring trays to a common area to eat and socialize.

It is important for units to support community efforts to reduce, recycle, re-use and compost. Ideally every unit should do its part and have recycling bins in the kitchen.

COUNSELING & PSYCHOTHERAPY SPACES

3.12 The unit has access to spaces for family, group, and individual counseling and psychotherapy.

Every unit should have access to spaces that optimize assessment and individual, family, and group psychotherapy processes and outcomes. It is important of course to appreciate that not all patients are willing or able to profit from therapy (e.g., severe psychotic states, therapy-refusing). But for those who are ready and able, it is important that they participate in therapy in spaces that are clean and uncluttered, comfortable, that feel safe, and that promote disclosure and communication. All therapy rooms should provide privacy for the process and look like the unit values the therapeutic conversations and process. All therapy spaces should communicate that talking together to improve mental health is one of the most important activities of inpatient admission, no less important than medication and protective hospitalization

Group therapy and mental health education can occur in comfortable, safe, and quiet classrooms meeting, and dining rooms. These places and those for individual therapy should have finishes and flooring that are smooth, damage resistant, and easily cleaned (International Health Care Facilities Guidelines, 2017). Group family and individual sessions should all have sufficient space, good lighting, warm decoration, and provide choice over seating and interpersonal spacing (Pearson & Wilson, 2012).

Individual and family sessions require additional considerations. The environment must ensure that conversations cannot be overheard by other patients in hallways or adjoining rooms. Rooms should have a soundscape that minimizes confusing or anxiety-provoking background noises or echoes for individuals with hearing impairments and those who are easily startled. Noise suppression equipment can in many cases help protect confidentiality and cancel out irritating external noise. Providing individual or family therapy in bedrooms or dining areas confuses visits with therapy and suggests that assessment and counseling processes are not that important. It is also important for bedrooms to be protected as places of rest and sleep, and dining room as places to eat and socialize. Doing so protects these places as places of relaxation, rest, and positive reinforcement by limiting strong association with stressful recall emotionally difficult situations.

A therapy room can be used by multiple programs and need not be on the unit if space is limited. Whether on site or off, the individual therapy room should be modifiable for different therapies, different age groups, and different activities (e.g., use of role play and movement or exposure work). It is important to be sensitive to how lighting, art, or wall colouring affects different participants. Younger children will often better engage through therapeutic music, art, clay modelling, miniatures and doll houses, and sand and water play. Older adolescents will have different reactions than children to therapy materials, space, art, and lighting. Staff will not always be able to determine how comfortable or safe a patient feels in the therapy room. Art that a therapist or some patients like may offend or make others uncomfortable. Feedback from patients about the degree to which a room design is an asset rather than liability should be used to monitor and improve design.

Therapists no less so than patients prefer designs and equipment that helps them trust and feel safe. Many therapists will feel more comfortable having access to two exits as well as a panic button or personal alarm. Sometimes this will not be enough and a second staff in the room may

be required to help protect a therapist when there are concerns about aggressive behaviour or false allegations.

It is most helpful if therapy rooms are used as extensions of community care and are open for starting or continuing collaborative work with community mental health professionals. Inpatient therapy is much more likely to be better informed when collaboratively completed with a patient's existing or past counselors. Community-based therapy should not be interrupted or terminated simply because a child has been admitted. It should be continued and modified in recognition of new crises or stresses. Parents/caregivers should continue family therapy. They need not wait until children are stable and able and willing to engage. Past community counselors and newly assigned ones that are invited to sessions are better informed about inpatient care and better able to contribute to the course of care and discharge. Discharge is also much more likely to result in successful post-discharge engagement if children and adolescents and their parents/caregivers have sessions with their community therapist prior to discharge. Tele-therapy equipment should be available for families and community counselors to participate if they are unable to come to the unit in person.

CLASSROOM & STUDY AREAS

3.13 The unit has a classroom or study area which is safe, quiet, and appropriate for learning.

Children and adolescents need space and equipment to continuing their education while they are on the unit and away from their school (e.g., computers or tablets, paper and pencils, access to information) (Lucas, 2019). Classroom space improves the likelihood that children will keep up with schoolwork by providing academic supports, and opportunities improve classroom social skills and habits (Marcia, 1980). Opportunity to keep up with schoolwork is helpful on brief stay units but essential for units which have some children staying longer than a few days.

Classroom space provides a unit with the ability to assess and treat in ways that are not possible on other parts of the unit for young inpatients whose school problems are intertwined with their mental health symptoms (Ogilvie et al., 2019). Classroom milieus provide excellent contexts for assessments and treatment of school-linked problems. The spaces can be used to inform to develop classroom safety plans, and to assess medication impact on learning (Savina, Simon, & Lester, 2014). Children's reaction to being asked to go to class can help identify avoidant or rebellious patterns and potential interventions (Oner, et al., 2014). Low pupil-teacher ratios allow for individualized attention and better discharge plans.

Classroom spaces should be free from noise and other distractions, have good lighting, have adequate space, have sufficient equipment and supplies, and have a qualified special education teacher. There should be a computer for every two young people and access to e-learning and library books (Lucas, 2019; Sharma & Kommu, 2019). The classroom space should accommodate younger children and older adolescents as well as all youth with special needs or

disabilities. Special education teachers are important as they have the essential knowledge to assess academic performance and learning history, as well as the knowledge to best develop appropriate plans for school reintegration. Teachers can provide supportive interactions and relational interventions in their role, beyond what clinical staff can provide (Lesinskiene et al., 2008).

SENSORY ROOMS & MATERIALS

3.14 The unit has therapeutic sensory rooms and materials that can be used for self-calming.

There are many types of sensory rooms known by many names including names like comfort rooms, optimal stimulation rooms, calming rooms, and sensory modulation rooms. These rooms are found on many inpatient units (Bobier et al., 2015; Seckman et al., 2017; Sivak, 2012). The primary use of the rooms and their calming materials is to prevent agitation, to help patients stay in control, to calm, to prevent acting out and need for restraint, and to assess for sensory strengths and problems associated with different disorders. The rooms can be used to teach patients how to cope with sensory difficulties, how to improve concentration, and how to reduce vulnerability to distraction (Bailliard &Whigham, 2017). Sensory-based approaches and rooms can also be valuable for trauma-related sensory problems (Champagne & Stromberg, 2004). Although there are risks that therapy can harm their primary calming function, sensory rooms have at times been productively used as places for individual and small group therapy (e.g., Smith & Jones, 2014). Therapy in sensory rooms can include conditioning of new more positive cognitive-sensory associations as well as extinction of maladaptive fears and aversions.

Many inpatient children and adolescents suffer from agitation, hyperarousal, hypervigilance, restlessness, anxious distress, social discomfort, and other problems that make it difficult for them to calm down in other parts of the unit. Although some patients will calm in other areas such as bedrooms, some will not. Some will find their bedroom lacking optimal stimulation, boring, traumatic memory evoking, or anxiety provoking. Many will look for types of stimulation and calming experiences that are unavailable in their bedroom. Sensory rooms are spaces that can provide planned optimal stimulation that may help patients learn new ways to manage their arousal, emotions, cognitions, and behaviours (Bailliard &Whigham, 2017; Cummings, Grandfield, & Coldwell. 2010; Seckman et al., 2017; Sharma & Kommu, 2019; West, 2017). There are promising findings suggesting that inpatient sensory rooms and calming materials can reduce stress, arousal prior to sleep, irritability, aggression, and need for seclusion and restraint as well as improving staff sense of safety (Andersen et al., 2017; Bobier et al., 2015; Champagne & Stromberg, 2004; Cummings, et al., 2010; Seckman et al., 2017; West, 2017

The literature suggests that a sensory room should include or have safe comfortable furniture, ball chair, therapy ball, a large screen for relaxing videos, soothing colors, coloured glasses or virtual reality equipment, soft lighting, noise suppression capacity, gentle music, calming nature

sounds, textures like sand and silks, choices of calming scents/aromas, pleasant snacks for tasting, plants, pleasing art, stress balls, and a weighted blanket (Andersen et al., 2017; Becklund, Rapp-McCall, & Nudo, 2020; Knight, Adkison, & Kovach, 2010). A recessed large screen can play calming music, show calming scenes, and guide meditation. For some patients who calm down by doing things the space can also provide opportunity for drawing or painting, yoga, scrapbooking, and other hobbies. It is important that the presence of a sensory room not distract from the need to consider sensory stressors that may be reduced in the rest of the unit (Yakov et al., 2018). Noise, crowding, and other stresses in other parts of the unit will not be eliminated by a sensory room. Recent pandemic concerns have made it more important to assure the room and materials are easily cleaned and disinfected after use.

Given the many individual differences in what patients find irritating, fearful, and pleasant, the room should provide a broad range of sensory options. It should be able to be modified to accommodate all patients regardless of age, sensory problems, culture, disabilities, and preferences. Getting patient feedback about the design and materials can help with alterations that can optimize design (Trzpuc et al., 2016).

It is ideal for both safety and therapy that patients and staff use the space and materials together. Not only will being with patients help inform assessment, but it will usually strengthen positive staff-patient alliances and engagement (Seckman et al. (2017). It is also important to assure that calming rooms do not reinforce maladaptive behaviour. They should not become places for naps for those who have circadian rhythm problems, not a place to ruminate for obsessing patients, and not a place to hide for the socially anxious.

NATURAL LIGHT & GREENSPACES

3.15 Patients and staff have access to natural light, green spaces, and the outdoors.

It essential for mental health that child and adolescent inpatient units provide access to an outdoor green space and natural light, so long as it is reasonably safe for them to do so (Lucas, 2019; Ulrich et al., 2012; Watts & Wilson, 2009). One of the prominent beliefs underlying the development and operation of early asylums was a belief in the healing power of nature as reflected in asylum gardens and natural landscapes (Verberden, 2018). This aspect of mental health design has been overtaken by the focus on the power of medication and the need to use inpatient care for brief stays rather than longer ones. But the value of natural light and greenspaces has not disappeared, and many hospitals are acknowledging the health benefits of greenspaces and outdoor gardens (e.g., van Kessel, 2012) and greenhouses (e.g., Curtis et al., 2007).

Outdoor access to natural light, views of nature, and walks in greenspaces have come to be valued for their benefits for both patients and staff (Boyce, Hunter, & Howlett, 2003; Edwards & Torcellini, 2002; Jovanovic et al., 2019; The National Association of Psychiatric Intensive Care

Units, 2014). Greenspaces and natural light not only help to reduce an institutional look. They can also be used to help improve circadian rhythms and sleep, promote alertness, and reduce fatigue, and contribute to self-calming (e.g., Alimoglu, & Donmez, 2005; Flouri, Papachristou, & Midouhas, 2018; Ulrich et al., 2004; Ulrich et al., 2012).

There are many possibilities that can be used to enhance natural light and access to greenspaces. Larger windows that optimize exposure to natural light and views of green areas in the daytime hours provide a more calming lightscape. An outdoor shaded garden space on hospital grounds in a fenced area, or an interior courtyard, permits increased exposure to natural light and plant life while maintaining a high level of security for patients at risk of wandering or absconding. The availability of staff to supervise individual patients or small groups of patients outdoors on walks or garden visits to gardens or courtyards can be reassuring for patients and enjoyable for both patients and staff. Having plants on the unit may also be helpful so long as the plants are in safe locations and plants are not toxic or allergenic. Having nature art or landscape wallpaper may be an improvement over abstract paintings or evocative or complex messaging that can cause agitation (Ulrich et al., 2012).

EXERCISE SPACES & EQUIPMENT

3.16 The unit has exercise areas and equipment that patients (who are cleared for exercise) and staff can use.

Addressing physical inactivity and lack of exercise have historically been challenges for inpatient units despite well known findings that exercise is important to mental health, and inactivity is harmful. Positive associations among better mental health and exercise have been found for many activities including team sports, cycling, resistance, and gym activities, especially for more vigorous exercise over 45 minutes three to five times per week (Carter et al., 2016; Lee et al., 2012). Exercise can help to improve glucose metabolism in children who are overweight (Bailey et al., 2018; Broadney et al., 2018), to prevent and reduce depression, anger, rumination, anxiety, psychomotor agitation, muscle tension and sleep disturbances (Anderson et al., 2014; Brand et al., 2018; Schuch et al., 2018; Tomasi & Gates, 2019), to reduce fatigue, improve attention, and increase physical strength (Brand et al., 2018), and to improve social skills in group exercise settings (Stanton et al., 2017).

Inpatient environments seeking to promote mental health should have spaces that provide opportunities to 1) interrupt inactivity such (e.g., sitting or lying down in bed for long periods), 2) promote fitness, and 2) engage young people in enjoyable physical activity with others (e.g., Carney et al., 2020; Faulkner & Biddle, 2002; Fruhauf et al., 2020; Jones & O'Beney, 2004; Lederman, et al., 2017; World Federation for Mental Health, 2004). Spaces and equipment that meets the needs of all inpatient ages and types of disabilities. There is no reason why this type of health promotion should not be a part of all units including crisis and sub-specialty treatment (aka teriary care).

It is important to appreciate that while some patients may resist exercising that there will be some who will tend to exercise excessively. It is increasingly accepted that eating disorders units, still have exercise spaces available although the utilization of such spaces requires closer supervision and a plan of care that considers the need for a healthy amount of exercise (Bratland-Sanda, et al., 2009). More work is needed to develop common best practices on eating disorders units as a variety of approaches to exercise are used although most do not eliminate exercise focusing instead on making exercise a healthy activity (Davies et al., 2008).

Having access to a gym is highly desirable as it allows for a wider range of activities than is possible on the unit. These activities can include strength training, gymnastics, as well as group activities like volleyball and basketball (Mittleman, Iuchtman, & Yatzker, 2018). Some hospitals are fortunate in having access to a pool area that allows children who like to swim or like to be in water to exercise in their favourite medium. Pools also allow patients who cannot readily exercise because of skeletal or other injuries or problems the ability to exercise in a safer way. Access to exercise opportunities in greenspaces also may have additional motivating and calming properties beyond what is provided by exercise on concrete or building interiors (Barton & Pretty, 2010).

Units who do not have access to a hospital gym, courtyard, or swimming pool still should find space for physical activity and exercise. Units can use multi-purpose recreation spaces or hallways, in bedrooms, or in nearby corridors of the hospital. Small spaces can accommodate small groups for hot yoga, tai chi, stretching, and aerobic in-place activities. Stair climbing and walks are other possibilities (Stenling et al., 2019). Some units have smaller designated spaces for stationary bicycles, treadmill, and other types of exercise equipment.

Consultation from accredited exercise physiologists with experience in programming for children and inpatients can help with designing motivating enjoyable exercise spaces and programs, and purchasing the best equipment (Fibbins et al., 2019). Engaging patients and staff to consider and determine types of exercise and intensity levels is important as well as information that is obtained can lead to activities that are more likely to improve motivation to participate (e.g., Stanton et al., 2017). Ideally, as with many other activities, better outcomes are more likely when staff and patients exercise together or when staff are with patients during exercise. Exercise and reducing sitting time, is important not only for patients, but also for staff.

RECREATION & PLAY EQUIPMENT & SPACE

3.17 The unit has space, equipment, and supplies that encourage individual and group recreation and play.

Although some restrictions in types or amount of play are necessary when there are immediate risks of infection and risks of harm to or from self or others, children and adolescents have a fundamental right to play and socialization regardless of age, gender, culture, and disability (Graber et al., 2021). Recreation and play can help them work through their stresses, help them relax and socialize, help reduce their boredom and sense of isolation, and help increase

opportunities for choice and independence (Lambert et al., 2014; Reavey et al., 2017; Sharma & Kommu, 2019). Recreation and play areas can also be used for observational assessment and therapeutic intervention using games and art supplies. Socializing play and recreation can be particularly important for youth without visitors and social supports and for all youth at times such as quarantine when visiting is restricted (e.g., Graber et al., 2021).

Recreational and play spaces should be safe and developmentally appropriate. Adolescents for example should have a lounge type of room where they can socialize with other teenagers (Kari et al., 1999; Smith, 2004). Younger children should have a place to play, preferably a playroom with age-appropriate toys and activities.

Units should avoid having unsupervised social media or gaming. Unrestricted gaming and obsessive searches on the internet may only reinforce existing overuse or addiction (Frolich et al., 2016; Fuchs et al., 2018). Misuse or addiction of game play are associated with conduct and emotional problems, suicidality, identity development, and higher rates of peer victimization (Frolich et al., 2016; Fuchs et al., 2018). Problems can also arise when screen time is used by youth to avoid other healthy activities and social contacts (Topor et al., 2011). Because youth with emotional and behavioural difficulties tend to gravitate to gravitate to screen time it is important to use the opportunities provided by admission to help explore and improve participation in non-digital recreation (Kostyrka-Allchorne, 2020).

But video games and internet activities are not all bad. Some gaming activities are socially important and some rehabilitative. Supervised computer and internet use can help maintain children's social connectivity to home, school, and significant others. Television and movie players, music apps, computers, and biofeedback apps can teach mindfulness skills and promote access to mental health sites for children and adolescents (Lucas, 2019; Steadman et al., 2014). Use of cell phone also has potential for self-monitoring and communications during pass or after discharge.

Although designated recreation and play spaces are most desirable and easiest to structure for desired process and outcomes, hospital courtyards and gardens, play and games rooms, sensory rooms, gyms, bedrooms, and dining areas can also be used. Larger recreation rooms or larger spaces can be split into separate ones for different age groups by manipulating room dividers and arranging furniture and materials.

STORAGE

3.18 The unit provides sufficient storage spaces for staff and patient personal property, and hospital equipment and items.

A child and adolescent inpatient unit should have storage spaces to reduce accident risks from clutter or to secure hazardous materials. Young people and staff should also have storage space for their personal property (Lucas, 2019). Storage spaces should be lockable to reduce risk of

theft and to keep risky or prohibited items in storage (Bowers et al., 2007). Staff should supervise and manage storage space access and use.

SPACE FOR FAMILY & VISITORS

3.19 The unit has space and resources that allow children and adolescents to privately visit with family and visitors.

Parents/caregivers, families, and other visitors should find the environment a welcoming one when they visit (International Health Care Facilities Guidelines, 2017; Isobel et al., 2015). A welcoming environment increases the likelihood of parent/caregiver engagement and the positive engagement of parents/caregivers in the mental health of their children increases satisfaction and the likelihood of more lasting outcomes (Ingoldsby, 2010; Jovanovic et al., 2020).

A space neutral space like a lounge or family room for private visits is important. Visitors with no other available space often use child and adolescent bedrooms. This may be unavoidable on units where there are no other visitor spaces but risks invading the young person's privacy and seeing the young person as sicker than they are. Bedroom visits also create additional tensions and inconveniences for both occupants of shared bedrooms (Curtis & Northcott, 2017).

A unit needs to consider the age of young patients when considering visits. Children may be ok with visits to their bedroom whereas adolescents on the other hand may wish to keep their bedroom private and visit in a space that reflects their greater need for autonomy and privacy. Children will generally have more frequent visits and greater need for parent and attachment support compared to adolescents. Ideally, units should be able to accommodate parents of attachment vulnerable young children who need to room-in when this is helpful and safe. This can be achieved by having a family admission room with two beds or an ensuite (International Health Care Facilities Guidelines, 2017; Kahan, 1992; Sharer, 2002).

Children and adolescents who are in foster care as well as those who are alienated from parents may have fewer or no visitors. These individuals should be supported by encouraging visits from foster parents, child welfare workers, and any other supports. It is important to encourage supportive visits from foster parents and not only caseworkers when possible, to maintain or improve attachments and for pre-discharge planning. Professionals from community mental health service can also use the space for visits if they have no access unit therapy rooms.

Some parents, caregivers, and community professionals may lack time, transportation, live too far from the hospital, to visit. It is important that these supports to be able to visit with children and adolescents through planned telephone calls, video calls, or videoconferencing.

NURSING STATION & STAFF ROOM

3.20 The unit has separate spaces for staff including a staff (nursing) stations and a staff room.

The unit needs to provide private and shared spaces to accommodate the needs of not only patients but also of staff (Jovanovic et al., 2019). Most units appreciate the needs for both a central space for interprofessional and patient communications as well as a private space for staff to recoup after acutely stressful and traumatic experiences. A place is helpful when completing important paperwork and other administrative tasks. UK standards expect that environments include both a nursing station, as well as a staff room (Lucas, 2019). A staff room can help staff socialize, have snacks or lunch when not eating with children, engage in team building, and resolve interprofessional tensions and disagreements.

The extent to which nursing stations should open to promote interaction versus closed and reserved for observing patients remains open to discussion (Jovanovic et al., 2019). Extremely open and extremely closed units each have their problems. Choices relating to open and closed designs can depend on patient to staff ratios, and levels of risk. Units with lower staff per patient ratios and with higher and more unpredictable risks tend to have centralizing nursing stations that focus more on patient monitoring or risks and rapid crisis intervention. On such units, staff may spend relatively more time in the nursing station observing patients while at the same time completing notes. Units with higher patient to staff ratios and patients with less frequent crises, on the other have tend to have staffing patterns that are more active in many more spaces and with many more patients. On such units the nursing station is less central and work is more dispersed.

All units should be aware the purpose of their nursing station and what walls and other barriers can communicate about hierarchy, power, respect, and dignity. Jeremy Bentham's 'panopticon carceral' environment which promoted the idea that individuals under constant observation are less likely to act in dangerous ways, likely contributed to the design of modern centralized nursing stations (Curtis et al. 2013; Foucault 1975). It is true that centralized nursing stations more easily support observation and control. Observation of patient activity from a nursing station can be helpful while allowing staff to simultaneously divide attention to report writing and staff discussions (International Health Care Facilities Guidelines (2017). But this type of design can also be problematic when it creates ongoing distractions or communicates a controlling message at the expense of a therapeutic one. Units that watch patients from behind the safety of plexiglass can unintentionally communicate fearful and stigmatizing message. These are messages that the environment is meant to detain and control dangerous patients who cannot be trusted and that staff are afraid of the patients and need to hide behind walls and barriers. Too much control and separation of patients from staff can undermine staff confidence and compound staff fears of patients while minimizing positive supportive and preventive staff-patient interactions that can contribute to both staff and patient safety and well-being.

THE SECLUSION (AKA TIME-OUT) ROOM

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

Units that use seclusion should have safe and helpful rooms designed for that purpose. Seclusion rooms are also known as "secure rooms", "quiet rooms", "safe rooms", "environmental restraint rooms", "time-out rooms", and "isolation rooms". Seclusion separates patients from the rest of the milieu and in this way reduces opportunities for harm to self and others. Seclusion is an environmental restraint that is supported by legislated mental health acts in Ontario and many other jurisdictions internationally (e.g., Lucas, 2019; Sharma & Kommu, 2019). Seclusion prevents children and adolescents from leaving the room by locking the door and the presence of staff who deny the young person the freedom to exit (Mayers et al., 2010). Seclusion is more restrictive than voluntarily remaining in a bedroom or having restrictions on access to other parts of the milieu. It should not be forgotten that getting a patient into seclusion sometimes involves physical immobilization, prn medication, and physically assisted transport. Seclusion is less restrictive than mechanical straps that immobilize limbs and head, and 4-point restraints that tie a patient to a bed. The seclusion process was discussed in greater detail under the previously published Standard 1. Physical safety and readers should refer to that Standard for additional reviews and discussion.

The review and discussion in Standard 1 notes that seclusion is not without its own problems. Seclusion poses risks of patient and staff physical and psychological injuries during transport, inconsistent utilization, infringements on dignity, stigmatization, inadvertent social reinforcement of aggression, and reduction of opportunities for patients to develop self-control. Despite a desire for common best practices, surveys completed by ONCAIPS indicated that designs and practices were highly variable. Inter-unit variability in seclusion use, and seclusion room design is also common in other countries (e.g., Rydelius, 2007). Although seclusion is intended to provide time out from reinforcement it is not always successful. Sometimes the social attention and emotional reinforcement experienced by patients during the process can increase rather than decrease likelihood of future incidents. Although seclusion and associated physical restraints may temporarily suppress/prevent violence against co-patients and staff, they certainly do little on their own to help patients learn self-control during a period of escalation.

As discussed in Standard 1, prevention of escalation and incidents is always preferable to seclusion. This involves units engaging patients as partners in preventive problem solving when they are calm, reducing stresses, providing calming spaces, avoiding harsh or insensitive staff-patient encounters, and reducing opportunities for patient-patient conflicts (Bobier et al., 2015; Seckman et al., 2017; West et al., 2017). Although the relative risks and benefits of seclusion, the need for such rooms, and best designs continue to be a focus of study and discussion (e.g., Finke, 2001), it is generally agreed that seclusion should occur only in well-designed rooms that best assures the physical safety of patients and staff, while also protecting dignity and minimizing psychological injury and stigmatization (e.g., British Columbia's Ministry of Health, 2012a; British Columbia's Ministry of Health (2012b). General guidelines include those provided in "The Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated

Mental Health Facilities under the B.C. Mental Health Act" (British Columbia's Ministry of Health, 2012a) and its accompanying literature review (British Columbia's Ministry of Health (2012b).

Seclusion rooms in Ontario, for example, differ in how visible the patient is (some have small windows, others have full wall plexiglass), presence or absence of protective padding on walls, presence, or absence of toilets in the room, and presence, or absence of potentially accessible light and plug fixtures.

There are several published guidelines for seclusion rooms (e.g., International Health Care Facilities Guidelines, 2017; Lucas, 2019). These include the expectation that rooms should be lockable, have padded floors and walls, have ceilings without accessible wires, pipes, or other dangerous materials, have a visible clock for patients and staff, be well lit preferably have natural light, have good air flow and be comfortable in temperature, have the capacity for continuous patient observation, provide access to toileting and washing facilities without needing to traverse the unit, have no furnishings that can be used to harm self or others, have no apps, electronics, games or other activities that could make the seclusion room a desired setting, have the ability for two-way communication with the team, have a transitional space for exit and entry into the seclusion room (e.g., courtyard, or safe unlocked safe transitional area), be located in a location that best assures privacy and reduces disruptions to the milieu and co-patients (e.g., at end or the unit rather than near bedrooms or kitchen or elevators), and provide safe and easy access for police or staff to enter if support is needed. Glod et al., (1994) reported that changing the quiet room from bare white walls and cold hard floors textures and to warmer paint tones, visually interesting murals, and more comfortable floor material was associated with reductions in agitation and aggression.

INFECTION-CONTROL

3.22 The unit has designated, safe, infection control spaces, and equipment.

Unit physical designs must be able to help prevent and effectively manage contagion and infection. The concern about child and adolescent inpatient infection risks increased dramatically during the recent COVID-19 pandemic (e.g., Tilmanne et al., 2020). Inpatient units during this period experienced significant decreases in admissions because of concerns related to the pandemic and the potential that units might not be able to well-manage contagion (e.g., Abdallah, 2020; Ougrin, 2020; Ougrin et al., 2020; Mourouvaye et al., 2020).

Although the level of concern is new, the concern about transmission of infections in hospitals is not new. There were previous concerns during outbreaks of Clostridium Difficile, Vancomycin Resistant Enterococcus (VRE), Methicillin Resistant Staphylococcus Aureus (MRSA), and Severe Acute Respiratory Syndrome (SARS). The Provincial Infectious Diseases Advisory Committee (PIDAC) (2018) provided guidance about best hospital practices in Ontario for cleaning,

prevention, and control of infections. The Ontario Agency for Health Protection and Promotion (2013) additionally provided a companion guide for higher level disinfection and sterilization.

None of the earlier outbreaks were as concerning to inpatient care as the more recent pandemic. Units were surprised by how infectious the new virus was and how widespread the infections were. Some units coped with the risks posed by the COVID-19 pandemic by reducing bed numbers, some by closures that allowed them to redirect resources to other physical medicine units, although most ONCAIPS units remained open. Those that remained open reported significant challenges in providing care while at the same time preventing and managing infections. Challenges arose because units had been designed to encourage social interactions among patients and staff and now had to socially distance and mask up. Additional challenges arose from findings that children and adolescents were more likely to be asymptomatic and showed less severe symptoms which made it more challenging diagnose. Early in the pandemic, some of these children were at high risk to infect staff and other patients particularly. Discussions among ONCAIPS inpatient units included sizes of masks, the impact of isolation from parents/caregivers for younger and more vulnerable children, and the costs-benefits of admission for different groups of children and problems. The perceived cost-benefits of admission appeared to change as the pandemic waxed and waned.

ONCAIPS units coped in various ways depending upon their resources and other hospital pressures. Single occupancy rooms provided more protection (e.g., Watts & Wilson, 2009) and shared bedrooms were typically made into single occupancy ones. Some hospitals temporarily closed the unit and redirected staff to other services, some reduced beds, and some stopped admissions for children with less severe problems or those that were more psychosocial in nature. All ONCAIPS units reported implementing forms of social distancing, increased hand hygiene, use of masks and gloves, increased cleaning with disinfectants, reduction or elimination of passes home, and use of more time and resources to assure successful discharge. Some allowed patients to keep masks in their rooms so they could put them on when staff came in. Others requested that both patients and staff to be continuously masked. A few indicated limiting mask use initially because of concerns that patients would use them as ligatures for suicide attempts. It was agreed that masks should be of a type that easily breaks strings or comes apart. Some units had different requirements for family visitors than for patients and staff with negative screens. All units used screening at admission and some also provided testing for COVID prior to discharge. Units noted that they were all generally able to defer an admission if a youth was not medically clear. A common finding was that increasing outpatient psychiatry supports enabled units to address problems in ways that often diverted admission. This led to questions about why such diversions from inpatient care could not be utilized not only during pandemics but also at all other times.

Inpatient youth were not without risk of infection after admission (e.g., Krass et al., 2020). Tilmanne et al. (2020) describe a series of steps their unit took to manage a symptomatic individual. This included treating the infected patient's bedroom as a contaminated space, requiring health-care workers to wear a protection gown and gloves to go into the bedroom, restricting co-patient access and home visits, requiring the patient to wear a surgical mask outside

the bedroom, requiring hand washing with hydroalcoholic solution before exiting the bedroom, and after touching mask or face, and requiring social distancing (1.5 meters) was required between all inpatients and with the health-care workers. Tillmanne et al. (2020) reported providing the infected patient had an own bathroom and toilet not used by other patients, and cutlery and plates which were thrown away in a contaminated garbage can after use. Social distancing and masks were worn outside during group activities. Each patient had their own personal locker, craft material, pencils, and programmed interactive activities that included distancing and avoiding sharing items as in card games (although tablet to tablet games were allowed). Meals were taken together but at a two-meter distance among patients. Parents were each allowed to visit for a few hours each day with surgical mask, distancing, and hand hygiene.

ONCAIPS networking discussions during the COVID-19 pandemic promoted the view that the identification and common implementation of unit designs that could best promote infection risk would be helpful. Questions remain about whether hospital environments should give way to units in the community, about whether rapid access psychiatry will be supported and continue to reduce admissions after the end of the pandemic, and about which children may be better treated as outpatients or in alternative residential settings. Clearly much more collaboration among units in different hospitals will be required to standardize best practices in ways that can best address challenges.

COMMUNICATION & TELE-CONFERENCING

3.23 The unit has the space and equipment required for learning, communication, and tele-conferencing.

The inpatient care team, involved community care agencies, and patients need the means to reduce the information gaps and the psychological distances between the hospital, the home and community. This requires the ability to communicate to maintain patient attachments and relationships, to encourage information exchanges among hospital, home, and community, and to review together research and best practices. To accomplish this, units require sufficient teleconferencing space, and IT resources including wireless networks, computers, laptops, tablets, telephones, printers, security protected internet, and fax machines (International Health Care Facilities Guidelines, 2017).

Units should have access to a dedicated, fully enclosed room with appropriate power and communications cabling and sufficient size to allow hospital and community, hospital, and family consultations. Teleconferences allow units and community partners to share information and to develop and maintain collaborative working relationships and to jointly plan for inpatient care, discharge, and post-discharge care. They allow the team and service partners jointly review information, conclusions, care plans, and written reports together for accuracy and helpfulness. This is particularly important for parents/caregivers and community professionals who are unable to travel to the unit or participate in person. Teleconference spaces and equipment should be accessible although they can be shared with other parts of the hospital.

Units should also have mobile equipment such as laptops or pads that staff can use wherever they are when they need to access service and diagnostic history, treatment options, research findings, and unit performance (Lucas, 2019). Similarly, every patient should have access to computers, tablets, or cell phones albeit under supervision. Technology can increase patient access to government and self-help sites that can help them learn about their condition and treatments more independently, and that can reinforce what the care team has provided. Browsing and age-appropriate podcasts can complement and enhance consolidation of child and adolescent learning while reducing use of staff resourcing (although there should always be an element of supervision, support, and debrief after watching videos or reading articles on the web).

AGE APPROPRIATENESS

3.24 The physical environment is appropriate for all inpatient age groups.

Unit environments must meet needs of youth with different problems, disabilities, backgrounds, and cultures, and they must be age-appropriate (International Health Care Facilities Guidelines, 2017). Age appropriateness is more easily achieved by units designed for specific age groups such as are found on units for children and such as are found on units for adolescents (England Department of Health, 2011, Hazell, Sprague, & Sharpe, 2016). Age-specific environments provide better opportunities for developmentally appropriate social conversation, activities, peer support, and friendship (Smith, 2004). Admissions to units designed for other ages, such as admissions of older adolescents to adult units can occur for many reasons including lack of availability or access to adolescent units, as well as to prevention services (Worral et al., 2004). The fact these admissions occur should not detract from the goal of admitting children to child units, adolescents to adolescent units, and transitional age youth to transitional age units.

Ontario's units do not meet criteria for age-appropriateness outside of the units for adolescents only. The most common type of unit in Ontario is one that admits both children and adolescents. Such blended units result in the undesirable admission of children to units that are populated primarily by adolescents. In addition, many adolescents continue to be admitted to units which are predominantly populated by adults (e.g., Stewart, Kam, & Baiden, 2014). These types of admissions are generally regarded as age inappropriate (Worral et al., 2004).

Blended child-adolescent units in Ontario face significant challenges in adequately meeting the different levels of vulnerability, maturity, interests, and relationship needs of both age groups. This is because the child and adolescent groups have different problems (e.g., younger children are more likely to be admitted for externalizing problems), preferences for social and educational, art, music, and exercise activities. In addition, unit designs must consider that adolescents have a greater need for autonomy than children, greater concerns about privacy, greater concerns about going using the bathroom and having a shower, greater worries about confidentiality, and stronger desire for peer acceptance and support (Hutton, 2005). Children, on the other hand, have greater need for parent and attachment support and visits. Younger children admitted to

adolescent units are also more likely to feel intimidated and traumatized from exposure to out-of-control aggressive, sexualized, and suicidal adolescent behaviours.

Family units provide admit children, particularly younger children, with their adult parents and siblings. Although they lack ability for peer group activities, these units make up for this by reducing risk of harm from older adolescent co-patients, supporting attachment, and providing opportunities to treat contributing parental mental illness and parenting problems that cannot be well addressed by typical outpatient programs. Family units are an age-appropriate setting given they provide a similar environment as is available at home where younger children spend most of their time. These units are not available in Ontario.

A few units in Ontario have, however, reported providing parent 'rooming in' in the absence of family units. Excepting cases of harmful enmeshment or unremitting child abuse, "rooming in" can help inform assessment and protect attachment. Rooming in cannot well address contributing family problems like a family unit can, but can help to reduce separation anxiety, and improve comfort and communication for children from linguistic and cultural minorities.

Adolescents in Ontario who are admitted to predominantly adult units face some similar problems as children admitted to predominantly adolescent units. Witnessing and being the target of adult out-of-control, suicidal, and aggressive behaviors can be no less traumatizing for adolescents housed with adults than it is for children housed with adolescents. Ideally adolescents should also have their own units separate from both child and adult patients (Hutton, 2005: Worral et al., 2004). Ontario has fortunately developed several transitional age units to better accommodate the needs of transitional age older adolescents and young adults.

Ontario blended age units provide the best services possible in environments designed to meet the needs of younger children and adolescents. Units strive to provide signage, instructions and notices, and pictures that can be read and appreciated by both children and adolescents. This is important because what adolescents understand and relate to, is often puzzling and inappropriate for children. Children need signage, activities, handouts, books, toys, games, and movies that are designed for their capacities and interests. Proximity to a medical paediatric unit can allow children on both units to participate in shared spaces like play therapy rooms and shared activities when it is safe to do so.

Units should also be able to flexibly change the look of rooms by shifting furniture, transforming the room for age-appropriate therapy, and play activities as required. The ability to convert a room for the use of different age groups (e.g., having toy cabinets or children's books in cabinets that are separate from cabinets for adolescents that can be opened or closed to suit the needs of different age groups) makes for a more efficient use of space. For units that have the benefit of more available space, children and adolescents can have separate "zones" designed to cater for their differing needs (International Health Care Facilities Guidelines, 2017). Under conditions of consent, units can also consider shared spaces with community programs that care for the same ages so that children have opportunity to interact with their own peer group.

DIGNITY, DIVERSITY, & INCLUSION

3.25 The physical environment accommodates the needs of all its diverse patient groups in ways that protect and promote dignity, rights, and engagement for all.

It is important for unit designs to be culturally aware and to provide cultural safety (Iskander, Sherif, & Mansour, 2019). Units must protect child and adolescent dignity, rights, and inclusion regardless of patient group affiliation, identity, and capacity. Feelings of exclusion can lead to experiences of devaluation that aggravate existing depression, anger, and distrust. Many minority groups can feel excluded or disrespected if design and decoration does not represent and include them. Inclusion can be increased by diversifying the type of art on the walls, signage, brochures, books, movies, music, and foods on the unit.

Exclusion can be unit may have art and photographs of children with 'normal' or mainstream socially desirable characteristics on its walls and no pictures of minorities or individuals with disabilities. Lack of representation is a devaluing experience. For example, Lefrancois, (2013a, 213b) noted that units, and indeed the mental health system, are generally heterocentric failing to be respectful and inclusive of young people with non-normative sexual and cultural identities. Exclusion in the form of polite ignoring can also be a devaluing experience for many children and adolescents whose routines include less common religious and spiritual identities. In response to these needs, Lucas (2019) recommended that all children and adolescents have access to places for cultural or spiritual practices including access to a multi-faith room. The unit design and its pay and therapy materials should assure access to a range of resources for entertainment for minorities and different language groups (Lucas, 2019).

The unit design also needs to accommodate youth with mobility, vision, and auditory disabilities. All units should have assistive devices appropriate for each type of disability and the ability to access professionals or contracted interpreter agencies such as occupational therapists and audiology/speech/language services (Wax et al., 2019). Units should develop a working relationship with organizations and groups that can provide or lend the unit materials that are important for supporting the young person's existing or developing relationships with culture, religion, and other affiliation and support groups in the community.

All young people regardless of age, culture, or identity should be treated with dignity and accorded privacy to the extent that it is safe to do so. In non-emergent situations staff members should show respect for personal space, by knocking and waiting before entering private areas (Lucas, 2019). Privacy is also helped along by having acoustic separation between private places used to discuss confidential information and common areas. Private conversations should not be audible outside such spaces (international Health (International Health Care Facilities Guidelines, 2017). Similarly, if confrontation about rules or behaviour is to occur, it is best that the unit does so in a private space that will not expose a patient to embarrassment and shame.

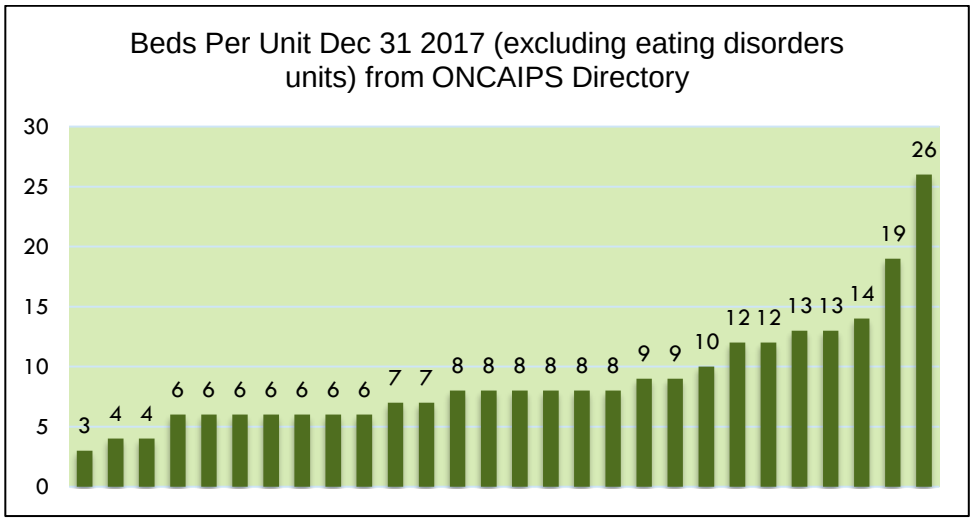
UNIT SIZE

3.26 The unit size is large enough to support a social milieu, but not so large that individualized care is compromised.

Units should have the right number of beds and rooms that most effectively contribute to stabilization and treatment outcomes. The lack of dining areas, sensory rooms, and space to separate aggressive patients from each other can hinder the unit's effectiveness. Units that are small with six or fewer beds, particularly if they admit different age groups may be unable to have enough patients at any time to provide age-appropriate group therapy and socialization. Smaller units of less than 6 beds are also less cost-efficient from a staffing perspective. The same minimal number of staff is required to provide services on small 4 to 6 bed unit as on a larger one 10 to 12 bed unit (York & Lamb, 2005). Ontario findings showed that number of front-line staff per bed was indeed significantly higher on smaller units than larger ones (Greenham & Persi, 2014).

On the other hand, units that are too large, can be more difficult to monitor, they can decrease frequency of caregiver contacts with patients, and they can result in unwieldly numbers for group activities. Larger units with greater staff to patient ratios have reported that it can be difficult to provide an adequate amount of patient contact (Cromwell & Maier, 2006). Larger units with more beds can also foster a poorer ward climate and outcomes (Tulloch et al., 2008). It has been suggested that units should be no larger than 10 to 12 beds. It has been suggested that a size of 10 to 12 beds provides a patient group size sufficient to support group recovery activities, while at the same time being cost-efficient from a staffing perspective (York & Lamb, 2005; Royal College of Psychiatrists, 2013).

ONCAIPS surveys and membership information in 2017 indicated that Ontario units ranged in size from three to four beds to twenty-six (although larger units were often subdivided into smaller sub-units). One of the largest units at that time was a general unit or program within a larger eating disorders program. Several other units had shared environments which made it difficult to clearly establish the boundary and therefor the size of such units. Two of the smallest units in 2017 were two 4 bed units in Northern Ontario. These were developed to decentralize services in a large geographic area with a culturally diverse and low-density population. Despite the loss of staffing cost-efficiency the health networks in those areas thought it was more important to provide smaller units that could provide closer and more culturally appropriate access for remote population groups. The smaller units were developed because of remote community complaints about travel distance to larger urban centres and the unfamiliarity of urban centres with Northern Ontario cultures, language groups, and service needs.



UNIT LOCATION

3.27 The unit is in a location that best assures access, safety, and recovery.

The location of a unit should assure easy access to needed services. Being close to the hospital has advantages for crisis unit access because of the proximity to the emergency department where most patients initially present. But advantages of proximity to emergency departments can be quickly lost after admission. After a crisis admission, emergency departments are no longer active, and the importance of family and community mental health services increases.

Crisis units and treatment units both need to accommodate supportive family visits, and those from community professionals. Units that are close to home help children and adolescents maintain connections to family, to therapists, to teachers, and to peers and culture. It helps if the unit can easily connect with day programs and outpatient mental health services. Day programs in hospital or community can help provide services to prevent lower risk admissions and can serve as a transitional support for higher risk discharges (International Health Care Facilities Guidelines, 2017). When units are not close to home and not supported by inexpensive public transport parents/caregivers face increased significant travel burdens. Travel is a significant problem for individuals in rural and remote parts of the province who need to travel large distances in inclement winter weather.

Services close to home are obviously much more difficult to provide in larger geographies with more dispersed populations without some increased cost and loss of efficiency. Many of these areas are underserviced and lack the kinds of supports available in urban centres. Nevertheless, links to existing services are essential as many families will have neither the means nor the motivation to travel long distances for continuing care. For such families, units should support whatever services are in place in the community and help the community build a more supportive and specialized locally accessible network that will optimize engagement and continuing care.

A location in hospital does not appear to be essential to service provision. Ontario has a unit that is in the community and supported by psychiatry in a nearby hospital. A community location can have advantages for continuity of care, costs, and normalization (Jovanovic et al., 2019). More research on costs-benefits of community versus hospital location needs to be completed to be completed for sure, as does research on centralized versus dispersed service models and hybrids (e.g., hub and spokes models).

EVALUATION & AUDIT

3.28 The unit annually audits the physical environment and its design with patients, families, and staff.

It is important for providers, managers, administrators, patients, parents/caregivers, and community partners to partner in the ongoing evaluation the physical environment. The assessment should evaluate whether the physical environment times supports the best possible access, care, connections with the community, and discharge. Evaluation should be ongoing as resources and architecture often change across time. Evaluation includes identifying shortcomings as well as the barriers to developing and maintaining the best possible environment. The evaluation should compare itself to ideal standards and other units while acknowledging its own special needs.

It is important for units to ask children and adolescents, staff, and visitors to indicate what aspects of the environment are assets and what aspects pose risks and problems. It is particularly important to reach out to youth and families who do not share the same language, culture, or group identity as staff as the opinions of minorities may otherwise remain unknown and unable to influence change (Pumariega et al., 2013).

The Joint Commission Resources (2007) recommends use the "environmental tours" to determine whether environmental and procedural safeguards are in place and effective to identify deficiencies, hazards, or unsafe practices. Ideally such tours should include patients and families, and the feedback should be used to affect helpful changes. In addition, root cause and similar analyses should be completed for close calls and incidents, and recommendations pertinent to improving the environment should be followed.

A formal audit of environmental risk should be conducted and reported at least annually. The annual audit should include patient and family consultations based on their direct knowledge of the unit physical environment and their experiences. Child and adolescent knowledge and viewpoints are essential to environmental design that strive to be user-friendly (Hutton, 2005. Giving patients some choice and control over the environment contribute to perceptions of calm during stay on the unit (Trzpuc et al., 2016).

In house, small sample studies of the impact of environmental changes should be completed whenever resources permit. This can include pre-post evaluation of significant changes on

mental health gains as well numbers of incidents or use of restraints per day associated with environmental changes (c.f., Ulrich et al., 2012).

Standardizing checklists to standardize have been found to reduce suicide rates in some adult settings (Watts et al., 2012, 2017). It is hoped that the self-audit checklist provided at the end of this paper can come to be similarly useful in supporting better safety and mental health outcomes for child and adolescent settings. The references and checklist can also serve to encourage the development of provincial and national common benchmarks. They can also be used to support research on how to improve physical environments so that they optimally contribute to the best possible mental health outcomes.

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THE 16 STANDARDS SELF-AUDIT CHECKLIST

The checklist below is for a broader audit of the 16 ONCAIPS core standards. A more detailed checklist is provided for indicators of compliance with Standard 3 on the physical environment.

Ontario Network of Child and Adolescent Inpatient Psychiatry Services

Unit Name_____

Date of Self-Audit: _____ for Fiscal Year April 1, 20 __ to Mar. 31, 20__

THE 16 ONCAIPS STANDARDS		
RATING	True	False
STANDARD 1: PHYSICAL SAFETY The unit assures the physical safety of patients, visitors, and staff.	☐	☐
STANDARD 2: Psychological Safety, Dignity, & Rights The unit assures and promotes psychological safety, dignity, rights, inclusion, and participation in care.	☐	☐
STANDARD 3: PHYSICAL ENVIRONMENT The unit physical environment is not only safe but also meets the therapeutic, cultural, developmental, and special needs of patients.	☐	☐
STANDARD 4: STAFFING The unit has the staff numbers, disciplines, processes, training, and morale to provide the best possible inpatient care.	☐	☐
STANDARD 5: 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.	☐	☐
STANDARD 6: BEDS & UNIT TYPES The (unit's) system of care has the right numbers and types of beds and units to best meet the needs of children and adolescents.	☐	☐
STANDARD 7: ACCESS & ADMISSIONS The unit and community services use joint admission criteria and processes to assure timely access for children and adolescents best helped by inpatient care.	☐	☐
STANDARD 8: CARE PLANNING Care is guided by a single interdisciplinary plan of care and an integrating planning process that addresses the reason for admission.	☐	☐

STANDARD 9: MILIEU & ACTIVITIES **The unit milieu provides patients with the health promotion activities that best support stabilization and/or longer-term change.**	☐	☐
STANDARD 10: ASSESSMENT **The unit provides reliable and valid assessments that inform stabilization and treatment, and that improve outcomes.**	☐	☐
STANDARD 11: STABILIZATION & THERAPY **The unit provides stabilization and therapy interventions which are supported by the best current evidence.**	☐	☐
STANDARD 12: MEDICATION **The unit assesses medication needs and provides pharmacotherapy that is supported by the best current evidence.**	☐	☐
STANDARD 13: DISCHARGE **The unit and partner services employ a commonly developed, efficient, and effective discharge process that facilitates successful transition back to home, community, and school.**	☐	☐
STANDARD 14: UTILIZATION **The unit monitors and ensures helpful, fair, and cost-effective utilization of inpatient resources.**	☐	☐
STANDARD 15: OUTCOMES **The unit monitors, reports, and evaluates youth, family, and system outcomes.**	☐	☐
STANDARD 16: PUBLIC INFORMATION **The unit accurately and helpfully communicates information about its staffing, care process, utilization, and outcomes.**	☐	☐
Comments:		

STANDARD 3 SELF-AUDIT CHECKLIST

The checklist for Standard 3 can be used annually as well as in pre-post evaluations. Units can audit only the 28 broader indicators, or they can use the complete and detailed items. There is no reason why users cannot add their own items. Feedback about the helpfulness of the checklist and about items that should be added or removed is of course much appreciated.

oncaips
Ontario Network of Child and Adolescent Inpatient Psychiatry Services

Unit Name_____

Date of Self-Audit: _____ for Fiscal Year April 1, 20 __ to Mar. 31, 20__

STANDARD 3: PHYSICAL ENVIRONMENT

The unit physical environment is not only safe but also supports the therapeutic, cultural, developmental, and special needs of patients.

Qualitative Indicators & Benchmarks		True	False
3.1	**The physical environment is purposed to improve mental health while providing physical and psychological safety in an environmentally and culturally responsible manner.**	☐	☐
3.1.1	The purpose of the physical environment which is "to support the best possible mental health outcomes" is understood by staff and patients	☐	☐
3.1.2	The physical environment and spaces accommodate the needs of all patients regardless of age, culture, and physical disability.	☐	☐
3.1.3	The physical design is efficient and cost-effective while maintaining the emphasis first and foremost on client care.	☐	☐
3.1.4	The rooms and spaces in the physical environment that are not in constant use are modifiable so they can be used for multiple purposes or shared with other programs in the hospital and community.	☐	☐
3.1.5	The physical environment is environmentally responsible in conserving resources, having recycling bins, and minimizing use of non-recyclable and polluting materials.	☐	☐
3.1.6	Whenever possible, the unit buys local materials for use in construction, meals, and maintenance.	☐	☐
3.2	**The environment provides and balances physical safety with opportunities for recovery and mental health.**	☐	☐
3.2.1	The physical environment looks like it promotes mental health rather than just control and security.	☐	☐
3.2.2	The physical environment promotes rather than erodes opportunities for autonomy and development of self-control.	☐	☐

3.2.3	The unit physical environment contributes to psychological comfort and feeling of safety by reducing feeling of panic, tension, stress, anger, distrust, and fear.	☐	☐
3.2.4	The physical environment looks welcoming and therapeutic and not harsh, stark, or institutional.	☐	☐
3.2.5	Walls and decorations have warm colours and are not an institutional white.	☐	☐
3.2.6	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly and after each use.	☐	☐
3.2.7	Any equipment including wheelchairs should be free of material that could be used to harm self and others.	☐	☐
3.2.8	For units that employ mechanical restraint, the mechanical restraint system provides a range of restrictive options that encourage the use of the least restrictive alternative (e.g., limb or chair versus bed mobilization).	☐	☐
3.2.9	For units that employ mechanical restraint, the mechanical restraint system fits and safely accommodates patients of all sizes, physical disabilities, and ages.	☐	☐
3.2.10	Young people and visitors have access to emergency alarms or panic buttons.	☐	☐
3.2.11	Staff are equipped with personal alarms.	☐	☐
3.2.12	Entrances and exits have electronic locking that can be used to restrict entry and exit in emergencies.	☐	☐
3.2.13	Corridors are sufficiently wide (e.g., minimal 3-person wide corridor) to allow patients to pass each other without tripping or confrontation.	☐	☐
3.2.14	Corridors are sufficiently wide to allow two staff to accompany an out-of-control patient to the seclusion room.	☐	☐
3.3	**The unit has all the types of rooms and spaces to assure the best possible mental health outcomes.**	☐	☐
3.3.1	The unit has enough bedrooms and bathrooms.	☐	☐
3.3.2	The unit has a kitchen for food preparation and a common dining area.	☐	☐
3.3.3	The unit has a living room or a recreation area.	☐	☐
3.3.4	The unit has a classroom or separate study area (outside the bedroom).	☐	☐
3.3.5	The unit has access to private places where youth can meet with families and visitors.	☐	☐
3.3.6	The unit has sufficient numbers and types of therapy and meeting rooms as well as equipment for video with families and providers who cannot attend in person.	☐	☐
3.3.7	The unit has access to a calming room, sensory room, or calming space (separate from the bedroom, or the time-out or seclusion room) and calming objects and equipment.	☐	☐
3.3.8	The unit has access to a gym, exercise equipment, and exercise spaces.	☐	☐
3.3.9	The unit has access to the outdoors.	☐	☐
3.3.10	The unit has access to spaces where children and adolescents can worship or engage in spiritual or cultural practices.	☐	☐
3.3.11	The unit has access to a room designed to provide seclusion.	☐	☐

3.3.12	The unit has access to an infection control space to separate youth with infection risk from those vulnerable to infection.	☐	☐
3.3.13	The unit has sufficient storage space.		
3.4	**The physical environment minimizes opportunities for suicide and self-harm.**	☐	☐
3.4.1	The unit can be locked to prevent suicidal patients from absconding.	☐	☐
3.4.2	The unit routinely assesses the physical environment for structures and items that could be used for suicide and self-harm.	☐	☐
3.4.3	The unit restricts or replaces unsafe items, or closely supervises use of ligatures that could be used to commit suicide including: ☐ electric/electronic cords ☐ curtains ☐ clothing with drawstrings ☐ shoelaces ☐ belts ☐ plastic bags ☐ sharps, mirrors, including objects that can shatter or be taken apart to produce pieces that could be used to harm self or others ☐ art on the unit is of the soft suicide type that or is securely fastened with tamper resistant screws and not hung using wire or hooks	☐	☐
3.4.4	Ligature points have been eliminated or designed to minimize likelihood of risk of suicide including: ☐ support bars (“grab bars”) eliminated where not essential and when essential are of the t and when essential are of the continuous type that does now have space for looping ligatures underneath ☐ high mounted door stops, ☐ lay-in-ceiling tiles set in grids ☐ protruding door latches and knobs ☐ heating and/or air conditioning grilles that are ligature points ☐ video cameras that protrude from the wall rather than being recessed	☐	☐
3.4.5	Light fixtures in patient areas are flush with the ceiling, protected by break resistant material	☐	☐
3.4.6	All patient area doors allow rapid access from the outside in case of emergencies (e.g., swing out so they can not be barricaded)	☐	☐
3.4.7	Fire sprinklers are flush rather than protruding or of a type that prevents use as ligature points.	☐	☐
3.4.8	Patients do no have access to roof or places in hospitals where they could jump to attempt suicide.	☐	☐
3.4.9	Objects that can be used for suicidal and non-suicidal self injury by cutting including kitchen utensils and scissors are secured and only used under supervision.	☐	☐
3.4.10	Toxic chemicals are locked in a secure location and cleaning carts are never left unattended.	☐	☐
3.5	**The unit has minimized the risks posed by lack of visibility.**	☐	☐

3.5.1	All public and socially shared spaces on the unit are visible to staff or monitored by close captioned television (CCTV) cameras.	☐	☐
3.5.2	Any furniture, screens, or barriers are removed or relocated to assure visibility.	☐	☐
3.5.3	Close captioned television cameras (CCTV) monitor high risk areas that are not otherwise visible.	☐	☐
3.5.4	The unit has a secure distinct entrance and greeting/waiting area for visitors.	☐	☐
3.5.5	Entrances and exits allow staff to see who is entering or leaving the unit (CCTV be used).	☐	☐
3.6	**The physical environment minimizes accident risks.**	☐	☐
3.6.1	The unit can be locked, and patients isolated and protected in case of external emergencies such as accidental release of industrial toxins, infectious outbreaks, or similar problems.	☐	☐
3.6.2	The unit keeps sharp objects, cleaning solvents, flammables, matches and lighters, and other potential hazards in locked areas.	☐	☐
3.6.3	Hand sanitizers with alcohol content are secured or in locations that can be safely monitored by staff.	☐	☐
3.6.4	Medication is securely stored.	☐	☐
3.6.5	Windows are made with Plexiglas or shatter proof glass.	☐	☐
3.6.6	There are no thresholds at doorways or between unit areas that can be the causes of tripping and falls.	☐	☐
3.6.7	Floors are made from slip resistant material.	☐	☐
3.6.8	The unit is free of clutter.	☐	☐
3.6.9	The unit restricts or supervises use of plastic bags and other items that could cause suffocation.	☐	☐
3.6.10	All equipment, including kitchen stoves and exercise equipment are regularly maintained and tested.	☐	☐
3.6.11	Objects that can fall, and cause injury, are safely secured.	☐	☐
3.6.12	The staff immediately informs co-workers, patients, and visitors about new or existing hazards from electrical outlets, wiring, nails, screws, toxic spills, loose cabinet hardware, and any other hazards that may contribute to falls or injuries	☐	☐
3.6.13	Hazards are always visibly marked.	☐	☐
3.6.14	Patients, staff, and visitors are encouraged to report hazards on the unit.	☐	☐
3.6.15	Repairs to potential sources of accidents are made within 24 hours and without extensive delays from paperwork.	☐	☐
3.7	**The environment minimizes opportunities for patients to harm or be harmed by others.**		
3.7.1	The unit has a camera or see-through door that allows identification of potentially unsafe visitors.	☐	☐
3.7.2	The unit can be locked to restrict access from risky visitors.	☐	☐
3.7.3	Objects that can be thrown or that can be used as weapons to harm others are not allowed on the unit or only used with close supervision in safe circumstances.	☐	☐

3.7.4 Tamper resistant screws are used to assure that items that could be sources of risk are secure.	☐	☐
3.7.5 Substances that can be used to poison or harm others are not allowed on the unit.	☐	☐
3.7.6 Patient matches, lighters, and flammables that could be used to intentionally set fires are not allowed on the unit.	☐	☐
3.7.7 Parts of the unit can be separated from other parts to keep patients apart who are likely to engage in or be victims of physical or sexual assaults, harassment, and bullying.	☐	☐
3.8 The unit is free of significant environmental stressors from noise, light, air quality, humidity, cleanliness, and temperature.	☐	☐
3.8.1 The unit is quiet and without echoes, or sources of irritating noises from nursing stations or other sites particularly during sleeping hours.	☐	☐
3.8.2 The unit is sufficiently bright for daytime activities and sufficiently dark at night.	☐	☐
3.8.3 Air quality and humidity are good (e.g., no dust, not too dry or humid).	☐	☐
3.8.4 The unit does not smell badly.	☐	☐
3.8.5 The unit is clean.	☐	☐
3.8.6 The unit is neither too hot nor too cold.	☐	☐
3.9 Bedrooms are safe, private, and promote healthy sleep.	☐	☐
3.9.1 All bedrooms on the unit are private/singles and not shared.	☐	☐
Although single rooms are physically and psychologically safest, there are units who have inherited shared rooms. These units should advocate for the development of single room environments and must take additional steps to assure psychological and physical safety until single room environments are developed.		
3.9.2 Children and adolescents who pose physical or psychological risks to each other are not placed in the same bedroom.	☐	☐
3.9.3 Roommates are chosen in ways that are likelier to promote healthier interactions, common interests, preferences, and the mental health of both.	☐	☐
3.9.4 The unit assesses and addresses patient fears and concerns about roommates	☐	☐
3.9.5 The unit strives to accommodate the personal preferences of children and adolescents for roommates (when there are no risks in their choices), in consultation with parents/caregivers.	☐	☐
3.9.6 The unit has a process to address conflicts and arguments, and to foster positive relationships among roommates.	☐	☐
3.9.7 Bedrooms have a home-like atmosphere.	☐	☐
3.9.8 Bedrooms provide a good balance of privacy and safety.	☐	☐
3.9.9 Children personalize their bedroom in ways that can help them feel safe and at home.	☐	☐
3.9.10 Bedrooms are open to outside lighting in the day and are dark at night (i.e., not just dark as in hospital dark but dark to promote sleep).	☐	☐
3.9.11 For units where exterior night-time light is a problem, the windows have between-the-glass blinds to minimize excessive outside light at night.	☐	☐
3.9.12 Bedrooms are not used as a place of punishment or isolation (quiet or sensory rooms should be available, as should seclusions rooms for emergencies).	☐	☐
3.9.13 Closet doors have been removed.	☐	☐

3.9.14	Closet spaces are free of ligature points and clothes hangers of any type.	☐	☐
3.9.15	Bedroom doors and their hinges are designed to prevent use of ligatures for suicide.	☐	☐
3.9.16	Bedroom doors cannot be jammed from the inside and can be rapidly opened from the outside by staff.	☐	☐
3.9.17	Doors are designed to swing out into the hall to prevent patients from barricading the door from the inside.	☐	☐
3.9.18	Furniture is low profile, secured to floor or wall, cannot be splintered or have handles that can be used as weapons, and is free of ligature points.	☐	☐
3.9.19	There are visual alarms on nursing stations or on doors that alert staff when bedroom doors open at night.	☐	☐
3.9.20	The unit has a bedroom or video equipment that can be turned on for patients who are in suicide crisis and at high-risk of harming themselves.	☐	☐
3.10	**There are enough bathrooms for the size of the unit and their design assures safety and protects dignity.**	☐	☐
3.10.1	There are sufficient numbers and locations of bathrooms for patients.	☐	☐
3.10.2	There is at least one shower available for every 3 bedrooms.	☐	☐
3.10.3	For privacy, sexual safety, and ligature risk, all bathrooms are single occupancy and there are no bathrooms or showers with multiple stalls with openings between stalls above and below	☐	☐
3.10.4	Visitors have access to bathrooms outside the unit (or on the unit if suicide proofed, locked when not used, and with separate access).	☐	☐
3.10.5	Bathrooms are safe having no ligature points, ligatures, or other materials that could be used to harm self or others. ☐ Bathrooms are equipped with soft suicide prevention doors or sentinel event doors ☐ Shower heads are institutional type that have no ligature points (e.g.,  or  ☐ Toilet paper holders are recessed in wall & without materials that could be used as a weapon or to self harm ☐ There are no locks on bathroom doors but there are occupied signs, appropriate scheduling and supervision, that can protect privacy ☐ Doors swing out and not in, or both ways to prevent barricading ☐ There are no shower curtains or shower curtain bars OR if the floor of the shower becomes slippery when wet and shower curtains are necessary, they are on a track, and designed to tear away at 5 pounds pressure ☐ Grab bars are ligature resistant do not provide spaces for ligature points having a continuous profile such as a rounded head  ☐ Towel holders break away or have a profile without ligature points	☐	☐

	 ☐ Door hinges are of types without ligature points ☐ Sinks, showers, and tubs have no ligature points (e.g., wall to wall vanities, minimal protrusion faucet design  ☐ There are no drainpipes or water pipes under the sink or elsewhere that could be used as ligature points ☐ Mirrors are shatter proof, provide no ligature points, and are fixed to the wall with tamper resistant screws or construction ☐ Electrical receptacles are removed, covered by a protective plate that can be removed when required, or GFCI protected		
3.10.6	Bathrooms and showers have push call buttons to alert staff in case of fall or another emergency	☐	☐
3.10.7	Bathrooms and showers have a sign to indicate whether they are occupied.	☐	☐
3.10.8	Toilets have integrated rather than removable seats	☐	☐
3.10.9	Bathrooms and showers can accommodate individuals in wheelchairs and with physical disabilities and have room to accommodate an attendant as well as the patient.	☐	☐
3.10.10	Staff have their own separate bathroom and shower facilities.	☐	☐
3.11	**The kitchen and dining areas are safe, promote healthy eating, and support social and psychological well being.**	☐	☐
3.11.1	The unit has a common dining space that encourages children and adolescents to socialize together and with staff at mealtimes.	☐	☐
3.11.2	The dining area is large enough to comfortably hold all patients and supervising staff at mealtime.	☐	☐
3.11.3	Food is fresh.	☐	☐
3.11.4	Patients should have food choices and meals that are respectful of their cultural/religious practices.	☐	☐
3.11.5	Potentially harmful eating and drinking problems (including allergies) are identified at admission and addressed by supervision or restrictions.	☐	☐
3.11.6	The kitchen and dining area are used to reinforce healthy eating habits.	☐	☐
3.11.7	Patients have ongoing access to water and drinks and the unit is mindful of promoting healthy hydration.	☐	☐
3.11.8	The kitchen contains a table, chairs, refrigerator, stove, microwave, sink, and dishwasher.	☐	☐
3.11.9	The unit kitchen can be used to help patients learn and enjoy food preparation skills.	☐	☐

3.11.10 The kitchen and dining area are accessible to and can accommodate all youth in wheelchairs or other disabilities.	☐	☐
3.11.11 In cases of need, the entrance to the kitchen can be opened or locked down from the nursing station (e.g., to limit access during periods of multiple patient aggressive acting out or physical restraint).	☐	☐
3.11.12 The inside of the kitchen/dining area are visible from the outside (glass window type walls) or there is video capacity to provide observation.	☐	☐
3.11.13 The door to the kitchen is visible from the nursing station.	☐	☐
3.11.14 All appliances such as refrigerator, microwave, or stove are secured to the wall or far and cannot be tipped.	☐	☐
3.11.15 Electrical outlets to the stove and other appliances can be turned off and on from the nursing station in case of risk.	☐	☐
3.11.16 The kitchen/dining space has doors or entrances that patients cannot lock or barricade from the inside (e.g., open out or swing both ways).	☐	☐
3.11.17 Potentially unsafe items and equipment are secured and only used under staff supervision. ☐ The area us free of ligatures and ligature points ☐ All supply and waste plumbing concealed and inaccessible ☐ Appliance cords are not accessible and appliances with cords are securely stored when not in supervised use ☐ The sink is secured to the wall with tamper resistant screws ☐ Cutlery and any sharps that could be used for self-harm is locked when not in supervised use ☐ All outlets are inaccessible, or safety proofed for possible shock potential ☐ Entrances/exits swing outwards and cannot be barricaded	☐	☐
3.11.18 The kitchen/dining area has recycling bins.	☐	☐
3.12 The physical environment has access to spaces for family, group, and individual counseling and psychotherapy.	☐	☐
3.12.1 The unit has a designated space for individual and family therapy (not a bedroom or common area but could be a clinician's office attached to the unit).	☐	☐
3.12.2 Individual and family therapy rooms, and case conference rooms are appropriately sound proofed to protect confidentiality and trust.	☐	☐
3.12.3 The unit has a large enough space to provide group therapy (could be an area that is also used for other purposes such as a classroom).	☐	☐
3.12.4 All meeting, individual, family, and group therapy rooms have two exits and panic alarms for staff (alarms could be portable personal alarms).	☐	☐
3.12.5 Therapy rooms and spaces can be flexibly modified to accommodate different types of therapies, special needs, and ages.	☐	☐
3.12.6 Therapy room art and materials reflect diversity and minimize likelihood of offending patients from different cultures, marginalized groups, and special needs.	☐	☐
3.12.7 The unit has a play therapy or activity therapy room or space for younger children, individuals with verbal and language disabilities, and those who are more likely to be helped by music, art, dance, and other similar therapies.	☐	☐

3.12.8	Walls, floors, ceiling, and materials are easy to clean and resistant to damage.	☐	☐
3.12.9	Therapy rooms are accessible to community mental health and outpatient service providers for collaborative work and continuity of care.	☐	☐
3.12.10	Tele-therapy is an available option for community counselors, and parents/caregivers that cannot attend in person.	☐	☐
3.13	**The unit has a classroom or study area which is safe, quiet, and appropriate for learning.**	☐	☐
3.13.1	There is designated classroom space or study area on or attached to the unit.	☐	☐
3.13.2	The classroom is large enough to minimally accommodate all patients as well as a teacher and another staff member who can be an educational assistant, a child and youth worker, a nurse, or a clinician.	☐	☐
3.13.3	The classroom is as safe as all other spaces on the unit, free of ligatures, ligature points, objects that could be used for suicide, or to harm others.	☐	☐
3.13.4	The classroom has a desk for every student which is safely fixed in place and cannot be broken or thrown.	☐	☐
3.13.5	The classroom has a computer for every student and supervised wifi access.	☐	☐
3.13.6	The classroom has access to needed reference books, e-books, and educational materials.	☐	☐
3.14	**The unit has therapeutic sensory rooms and materials that can be used for self-calming.**	☐	☐
3.14.1	The room has a warm inviting appearance (not an institutional look).	☐	☐
3.14.2	The room is on the unit or elsewhere in hospital and accessible to patients (it may also be used at other times as a therapy room, art and music room, or playroom).	☐	☐
3.14.3	The sensory room is free of ligatures, ligature points, potential barricading, and materials that could be used to harm self or others.	☐	☐
3.14.4	Patients are accompanied by staff when using the room, and staff engage with patients for alliance building, assessment, and skills development.	☐	☐
3.14.5	The unit assesses and prevents use of the sensory room for maladaptive purposes such as task avoidance, escape from staff and routines, or obsessional rumination/worry.	☐	☐
3.14.6	The materials following can be considered: ☐ large screen for playing calming scenes, sounds, or meditations ☐ sampler of scents (nontoxic and safe) ☐ material with different types of textures ☐ tasty food bits (e.g., chocolate). ☐ comfortable seating ☐ stress balls or similar ☐ weighted blanket ☐ a comfortable place to lie down if a patient wishes ☐ a floor with soft cleanable material like the seclusion room or with mats that can be brought out for yoga and stretching ☐ ability to adjust lighting in the room to patient preferences (dimmable warm light or natural light is better than fluorescent or cool whites) ☐ furniture and setting should be able to be used by all age groups admitted ☐ disposable earphones (in the ear type without wiring)	☐	☐

	☐ a way of suppressing noise out and into the room ☐ safe art supplies that are provided for patients who can use these without risks to self or others ☐ calming nature scenes and/or plants		
	3.14.7 The unit does not have a sensory room but has a sensory cart that can be wheeled into different rooms that has calming materials or a sensory space with a comfortable seat/location (VR calming equipment can be an adjunct) away from noise that has calming materials (not video games).	☐	☐
3.15	**Patients and staff have access to natural light, greenspaces, and the outdoors.**	☐	☐
	3.15.1 The unit has access to a safe outdoor greenspace.	☐	☐
	3.15.2 The unit has sufficient staffing to supervise and share outdoor greenspaces with youth.	☐	☐
	3.15.3 The unit has access to a garden that allows patients and staff to plant, weed, and care for vegetables or flowers.	☐	☐
	3.15.4 The unit has large windows that allow children, adolescents, and staff to have ample exposure to the outdoors.	☐	☐
	3.15.5 The unit has plants (that are safe to have) on the unit.	☐	☐
3.16	**The unit has exercise areas and equipment that patients (who are cleared for exercise) and staff can use.**	☐	☐
	3.16.1 There unit has sufficient space to accommodate the individual and group exercise needs.	☐	☐
	3.16.2 There are spaces available to allow patients and staff to exercise together.	☐	☐
	3.16.3 Patients and staff have access to a gym.	☐	☐
	3.16.4 Patients and staff have access a pool.	☐	☐
	3.16.5 Patients and staff have access to a courtyard, outdoor area, or in-hospital area for brisk walks.	☐	☐
	3.16.6 Patients and staff have access to safe and supervised stationary exercise equipment (e.g., bicycle, treadmill, stepper etc.).	☐	☐
	3.16.7 All exercise equipment is well maintained, locked when not in use, and supervised while in use.	☐	☐
3.17	**The unit has space, equipment, and supplies that encourage individual and group recreation and play.**	☐	☐
	3.17.1 There is a lounge, or a space for youth to socialize.	☐	☐
	3.17.2 There is a play area with toys and activities for younger children.	☐	☐
	3.17.3 Supervised internet use to maintain social connectivity is available	☐	☐
	3.17.4 The unit has developmentally appropriate mindfulness and therapy toys, games, and apps.	☐	☐
	3.17.5 The unit limits amount of screen time (e.g., TV, electronic games, social media).	☐	☐
3.18	**The unit has sufficient storage space.**	☐	☐
	3.18.1 There is sufficient storage space for belongings of staff.	☐	☐
	3.18.2 There is sufficient storage space for belongings of children and adolescents.	☐	☐
	3.18.3 Storage spaces of potential hazardous materials are locked and accessed only under the supervision of staff.	☐	☐
3.19	**The unit has space and resources that allow children and adolescents to privately visit with family and visitors.**	☐	☐

3.19.1	The unit environment has spaces that protect and protect opportunities for engagement and continued positive mental health attachments with parents/caregivers and other social supports.	☐	☐
3.19.2	The unit has space and equipment that allows children and adolescents to visit by way of video calls or videoconferencing when parents/caregivers and families cannot visit in person.	☐	☐
3.19.3	On units that admit younger children, the unit provides space for extended visits and overnight stay for parents when this is likely to improve outcomes.	☐	☐
3.20	**The unit has resources and separate spaces for staff including a staff (nursing) station and a staff room.**	☐	☐
3.20.1	The staff have access to a staff room in the hospital or unit for lunch and breaks.	☐	☐
3.20.2	The staff (nursing) station provides the right balance of observation and interaction with patients.	☐	☐
3.20.3	The staff rooms (including safe rooms) and nursing station should have doors that prevent patients from barricading and trapping staff inside.	☐	☐
3.21	**The unit has access to a designated, safe, seclusion room.**	☐	☐
3.21.1	The seclusion room is purposed and used specifically for seclusion.	☐	☐
3.21.2	The seclusion room has no ligature or other hazards that can be used to harm self or others (e.g., no opportunity to access electrical wiring or receptacles, no furniture or objects that can be thrown).	☐	☐
3.21.3	The seclusion room has no fall or accident hazards (e.g., no sharp corners or edges; floor is not slippery, there is no protruding hardware, nails, nuts, bolts, or protruding electrical plugs, or screw heads, there is no furniture, toilet or sink that patients can injure themselves on although there should be access to nearby toileting and washing if, and when, needed).	☐	☐
3.21.4	The floor covering is seamless.	☐	☐
3.21.5	There is a protective blanket or a protective cushioning material covering walls and floor to protect against self-injurious behaviors and falls.	☐	☐
3.21.6	The floor and wall covering are resistant to damage.	☐	☐
3.21.7	The seclusion door can be locked from the outside.	☐	☐
3.21.8	Doors cannot be barricaded or blocked by patients from inside the room (e.g., swing out rather than in).	☐	☐
3.21.9	The room is not located by elevators, stairs, exits, bedrooms, and shared activity areas.	☐	☐
3.21.10	The room provides sufficient lighting and large enough observation windows to allow uninterrupted observation while at the same time protecting privacy (e.g., the windows should not be visible to co-patients).	☐	☐
3.21.11	The seclusion room has a lock type that facilitates rapid, safe, entry and exit.	☐	☐
3.21.12	The room allows for uninterrupted communication among secluded patient and staff.	☐	☐
3.21.13	The patient can access toileting and washing facilities when needed.	☐	☐
3.21.14	The seclusion room allows beds to be moved in and out if necessary.	☐	☐
3.21.15	There is a clock that is visible to patients and staff (to encourage the briefest needed length of stays).	☐	☐

3.21.16	The room is free of games, apps, and other potential reinforcers that can make the seclusion room a desired destination.	☐	☐
3.22	**The unit has designated, safe, infection control spaces, and equipment.**	☐	☐
3.22.1	The unit has sufficient and appropriate space and partitions to allow for separation of infectious and potentially infectious patients from each other and from staff.	☐	☐
3.22.2	The unit airflow that does not present a significant infection transmission risk for patients, visitors, and staff.	☐	☐
3.22.3	All non-disposable equipment, materials used, and the unit itself do not present significant risk for the spread of infectious micro-organisms and can be cleaned ("If you can't clean it or dispose of it after one use don't have it on the unit").	☐	☐
3.22.4	The environment is cleaned regularly so that it is free of moulds, moisture build-ups, and other dirt and other causes of infection.	☐	☐
3.22.5	The unit has sufficient access to the most effective disinfection equipment (e.g., disinfectant wipes, cleaning cloths, liquids) for use on all surfaces.	☐	☐
3.22.6	The unit has sufficient stock of personal protective equipment including masks and gloves appropriate for both patients and staff.	☐	☐
3.22.7	Personal protective equipment includes a range of sizes, textures, and shapes appropriate for the varying patient groups that can best assure safety on the unit and willingness of patients to wear.	☐	☐
3.22.8	Laundry is safely stored and cleaned in ways that minimize infection risk.	☐	☐
3.22.9	The unit can access an isolation room for patients who need to be quarantined from other patients.	☐	☐
3.22.10	The unit can access a negative airflow room for airborne infections.	☐	☐
3.22.11	The unit can be locked down and patients quarantined when there are outbreaks that pose risks to other hospital units and the public.	☐	☐
3.23	**The unit has the space and equipment required for teleconferencing, learning, social contact, and communication.**	☐	☐
3.23.1	Subject to safety, capacity, and confidentiality, all patients have the means (e.g., sufficient phones, tablets, and computers) to access to maintain communications and attachments with their social supports, community care providers, and family.	☐	☐
3.23.2	The unit has a space and equipment for teleconferencing with parents/caregivers, partner professionals in the community, and other hospitals.	☐	☐
3.23.3	The unit has and utilizes a screen or wall display that allows staff, parents/caregivers, patients, and community partners to review and edit information together.	☐	☐
3.23.4	Care providers have prompt electronic access to patient information, unit performance, and the latest research and best practices.	☐	☐
3.23.5	Care providers have portable/mobile laptops and tablets.	☐	☐
3.23.6	The unit has the software, internet access, and equipment that allows patients to learn about their conditions, to connect with self-help and health care supports, and to engage in guided positive health practices like relaxation, calming music, meditation, and yoga.	☐	☐

3.23.7	Patients and/or their substitute decision makers have electronic access to the patient's health care record when they need.	☐	☐
3.23.8	The unit collaborates with patients, and parents/caregivers to define and to inform users about what technology and communication equipment is to be restricted and the conditions for its access.	☐	☐
3.24	**The physical environment is appropriate for all inpatient age groups.**	☐	☐
3.24.1	The unit provides a physical and social environment that is age appropriate for all admissions and redirects admissions which are not age appropriate.	☐	☐
3.24.2	The unit's system of care has access to units specific for children, adolescents, transitional age youth, and adults.	☐	☐
3.24.3	The unit is an active partner with its system of care in advocating and supporting the development of age-appropriate units if it does not have access to these	☐	☐
3.24.4	The unit provides space for parents/caregivers of very young or attachment-vulnerable children to "room in".	☐	☐
Although it is inappropriate and not best practice for a unit to admit blended child and adolescent age groups, and adolescents to adult units, it is nevertheless essential for units who admit different age groups to take following compensatory steps until the system of care moves to separate units for children, adolescents, transitional age groups, and adults.			
3.24.5	Separate younger children at risk of exploitation, bullying, and assault from older adolescents, and older adolescents from adults.	☐	☐
3.24.6	Provide developmentally appropriate zones on the unit, or shared spaces with pediatric or nearby community settings that encourage opportunities for developmentally appropriate socialization, recreation, and healthy activities with same age groups.	☐	☐
3.24.7	Provide spaces for the activities of younger children and adolescents, or the capacity to flexibly change the look and materials in a room for different age groups.	☐	☐
3.24.8	Assure sinks, toilets, light switches, tables, chairs and other furniture or fixtures that can be reached by and are comfortable for younger children.	☐	☐
3.24.9	Signage and art are understandable and meaningful for the youngest patients who are admitted as well as older ones.	☐	☐
3.25	**The physical environment accommodates the needs of all its diverse patient groups in ways that protect and promote dignity, rights, and engagement for all.**	☐	☐
3.25.1	The physical environment is a friendly, welcoming, comfortable, warm setting that conveys it values dignity, diversity, and personal rights and freedoms.	☐	☐
3.25.2	The unit has spaces and equipment that protects confidential conversations and assures private conversations are not overheard.	☐	☐
3.25.3	Children and adolescents have access to spaces and materials they need for their spiritual, religious, and/or cultural practices.	☐	☐
3.25.4	The unit provides spaces that can reduce visibility and shield patients during embarrassing situations (e.g., transport by police especially when they are transported in mechanical restraints, or physical restraint).	☐	☐

3.25.5	Art, movies, brochures, reading, and entertainment reflect that the unit is inclusive and that the patients are diverse.	☐	☐
3.25.6	Signage on the unit can be understood across language groups (e.g., icons and pictographs) and there are accommodations for hearing and visually impaired youth.	☐	☐
3.25.7	Posters, signage, and decorations inform and welcome youth of different ages, with different levels of reading abilities, different cultural backgrounds, and differing interests.	☐	☐
3.25.8	Posters, signage, and decorations reflect inclusion and celebrate the cultural, linguistic, LGBT2SQ and other diverse groups on the unit.	☐	☐
3.26	**The unit size is large enough to support a social milieu, but not so large that individualized care is compromised.**	☐	☐
3.26.1	If the unit is in a larger urban area, the number of beds on the unit is in the range of 8 to 12 beds.	☐	☐

Benchmarks: Unit Size

Numbers of beds on the unit _____

(In Ontario, 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).

3.27	**The unit is in a location that best assures access, safety, and recovery.**	☐	☐
3.27.1	The unit is in a setting that is easily accessible to all those it serves, and if not, it partners with communities in addressing transportation and access problems for patients and families.	☐	☐
3.27.2	The unit shares spaces and resources with day and community programs.	☐	☐
3.28	**The unit annually audits the physical environment and its design with patients, families, and staff.**	☐	☐
3.28.1	All children and adolescents, and visitors, are encouraged to report any potential environmental risks and hazards that could contribute to harm to themselves or others.	☐	☐
3.28.2	Child and adolescent inpatients are routinely consulted about their views about the environment's provision of physical and psychological safety, and their recommendations are incorporated in unit re-design, food choices, and purchases of materials and equipment.	☐	☐
3.28.3	The unit routinely engages with patients and their families from minority and more vulnerable groups to better understand, identify, and address their concerns about the physical environment.	☐	☐
3.28.4	The unit gleans information about the environment from client satisfaction and feedback forms and uses these to make improvements.	☐	☐
3.28.5	The unit provides regular "physical and psychological safety tours" of the environment that engage patients, parents/caregivers, and staff.	☐	☐
3.28.6	The unit completes and reports at least one annual audit of the physical environment	☐	☐

3.28.7	The unit doors, equipment, ergonomics, electrical, and fire extinguishers and alarms are inspected according to schedules that follow hospital safety inspection guidelines and building and safety bylaws.	☐	☐
3.28.8	The unit engages in root cause analyses and similar assessment after close calls and incidents and implements all recommendations for making the environment physical and psychologically safer.	☐	☐
3.28.9	The unit encourages and facilitates collaborations with academic health care researchers on studies of the physical environment.	☐	☐
Comments:			