

Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Summary of Recommendations of the
Ontario Expert Panel

February 2009

Introduction

Purpose

Many of the children entrusted to provincially licensed residential settings in Ontario have experienced chronic stress, abuse or other trauma, may be medically fragile or are coping with physical, cognitive or mental challenges. Some are taking prescription psychotropic medications (medications prescribed to affect mood, mental status or behaviour) before they enter care. Others may be diagnosed and prescribed medications while living in a provincially licensed residential facility.

In 2007, the Ministry of Children and Youth Services (MCYS) convened an Expert Panel to address the issue of the administration of psychotropic medications to children and youth in provincially licensed residential settings. The Expert Panel consisted of professionals who work with children and youth in the child welfare, youth justice and child and youth mental health systems. Although the Expert Panel recognizes that care must be taken with all forms of medications, its mandate was focused specifically upon the administration and monitoring of psychotropic medication. Over the past several years, the use of these medications among children and youth has increased. It is thought that many children and youth in provincially licensed residential settings may be taking such medications.

Through a process of consultation and deliberation, the Expert Panel developed a number of proposed recommendations that it believes will help to create a system that is safer and more responsive to the needs of children and youth in provincially licensed residential settings. These recommendations form the

proposed Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings. Some of the proposed standards describe practices that are already in place in some licensed residential settings; others reflect the Expert Panel's research into "best practices" or "promising practices" from other sectors or jurisdictions. Expert Panel members hope that over time, all provincially licensed residential settings will integrate the proposed standards into their policies and procedures.

Scope

The proposed standards developed by the Expert Panel are intended for all provincially licensed residential facilities. Panel members believe the proposed standards should be followed by all adults who work closely with and have responsibility for children and youth in these facilities, such as:

- Child protection workers,
- Staff in youth justice settings;
- Those working in group care settings or residential treatment centres; and
- Foster parents.

Because the proposed standards are designed to improve the safety and effectiveness of psychotropic medication administration and monitoring, they are also relevant to many other medications. People who may want to refer to the proposed standards include:

- Parents or other caregivers who may administer or monitor psychotropic medications to children and youth during home visits;

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- Teachers and those who may administer psychotropic medications to children and youth at schools;
- Health care providers, such as physicians, nurses and pharmacists; and
- Mental health specialists who work with children and youth in licensed residential settings.
- There should be continuity of care across transitions between settings or facilities; and
- Reporting policies and procedures should support continuous quality improvement in the administration and monitoring of psychotropic medications in all licensed residential settings.

The Expert Panel recognizes that many of the practices and policies described in the proposed standards may be relevant to the administration, storage, transfer and monitoring of other types of medications taken by children and youth in provincially licensed residential settings.

Key Principles

In developing the proposed standards, the Expert Panel was guided by a number of key principles. The Panel believes that:

- All children and youth in licensed residential settings should have fair and equitable access to high-quality, child and youth-centered, culturally-appropriate collaborative or interdisciplinary care;
- All children and youth should have appropriate opportunities to voice their preferences, needs and beliefs concerning psychotropic medications;
- All provincially licensed residential settings should have procedures in place to ensure that a process of informed decision-making is followed whenever there is assessment, treatment and communication of medical information;
- Medication systems in provincially licensed residential settings should promote safe medication administration, storage, transfer and disposal;
- The Expert Panel also believes that psychotropic medications should never be administered in licensed residential facilities:
 - If it is not in the best interest of the child or youth;
 - In quantities that lead to a loss of functioning;
 - When there is no clear diagnosis or reasonable expectation that the medication will treat a diagnosed condition or target symptom; or
 - As a substitute for appropriate and available psychosocial services (e.g., rehabilitative services, counselling, behavioural therapy, substance abuse counselling, psychosocial skills training, individual, group or family counselling or support programs).

Recommended Standards

Standard 1: Intake

When a child or youth enters into a licensed residential setting, a reasonable attempt should be made to document as much information as possible about all current and past medications. In addition, there should be effective communication of this information to all responsible for the child or youth’s care.

Many children and youth who enter provincially licensed residential settings have pre-existing prescriptions for psychotropic medications. To protect the health and well-being of the child or youth, there must be a systematic, coordinated and immediate effort to learn as much as possible about these medications. Furthermore, this information must be communicated to those responsible for planning care for the child or youth in an effective and timely manner.

To meet this proposed standard, panel members recommend that:

- **A full medication history is obtained (Standard 1.1)**

A complete medication history should be obtained for all children and youth entering a licensed residential setting. Standardized processes should be used to collect and update information on:

- All medications the child or youth is currently taking (prescription, over-the-counter, supplements and herbal remedies);
- The name, dose, frequency, prescribing physician and target symptoms or clinical indication for each medication;

- Previous psychotropic medications including doses, their efficacy and any adverse effects experienced;
- Allergies;
- Height and weight of the child or youth as these can affect the medication dose;
- The child or youth’s personal health care provider, if existing; and
- When possible, a family medication history of psychotropic drugs.

If the child or youth comes with existing prescription medications, an inventory should be conducted. The following documents should be created:

- Cumulative Medical History;
- Medication passport (e.g., the Med Ed passport developed by Dalhousie University and the Ontario Center of Excellence for Child and Youth Mental Health) for the child or youth; and
- Medication Administration Record (MAR), or equivalent, that shows when the medication should be administered.

Unless the medications are dispensed in the licensed residential setting by a health care professional, they should be in their original prescription vials that list the drug name, prescribed dose and directions for administration. These containers should accompany the child when the admission medical examination is conducted.

- **Mechanisms are in place for asking questions or voicing concerns about psychotropic medications (Standard 1.2)**

Everyone – direct care workers, foster parents, caregivers, parents, families, and children and youth themselves – should know who they can contact and what resources are available if they have urgent or non-urgent questions or concerns about psychotropic medications. Immediate medical attention should be sought if the child or youth taking psychotropic medication exhibits stiffness, muscle weakness, unusual or repetitive motor movement, lethargy, disorientation or confusion, bizarre behaviour, severe agitation, suicidal thought or behaviour.

- **Information gathered or created as part of the intake process is effectively communicated to all members of the collaborative care team, including foster parents (Standard 1.3)**

Licensed residential settings should have processes for communicating information from the Cumulative Medical History, MAR, medication passport and other information relevant to psychotropic medications to all members of the child or youth's collaborative care team. Effective communication is particularly important when children or youth move between different facilities or sectors. At the same time, these processes must also respect the privacy of the child or youth and conform to the principles of informed consent as described in Standard 2.

Standard 2: Informed Decision-Making

Assessment and treatment with psychotropic medication requires informed consent of the child or youth.

The Expert Panel strongly believes that a standardized informed consent process should be used to ensure that all provincially licensed residential settings conform to the requirements of the *Health Care Consent Act*. To make this happen, panel members recommend:

- **A standardized informed consent process that conforms to the *Health Care Consent Act* (Standard 2.1)**

All health care providers and provincially licensed residential settings should follow an informed decision-making process so children and youth are aware they can either consent to or refuse diagnostic assessment and treatment with psychotropic medications. As part of the consent process, the health care provider should explain the risks and benefits of accepting or refusing treatment in language the child or youth can understand.

Under the *Health Care Consent Act* and the *Substitute Decisions Act* of 1996, capacity to make treatment decisions is not determined by age but is presumed. If the health care provider determines the child or youth is incapable of making a decision with respect to a specific treatment, the reasons must be recorded and the child or youth informed that he or she can appeal the decision.

Consent for assessment and treatment can be given verbally by the child or youth to a physician. If acceptable to the child or youth, a direct care worker should be present to take notes and document the consent process. These notes can be initialed by the physician and the child or youth. When psychotropic medications are being prescribed, the consent should include information on when the prescription will be reviewed and reassessed.

In the child or youth's plan of care, the date informed consent was given for a medication should be documented. The consent process should be repeated whenever new medications are prescribed or when the most recent consent is more than 12 months old.

Standard 3: Diagnostic Assessment

All licensed residential settings should have procedures and protocols for obtaining mental health assessments in a timely manner.

It is essential that the right psychotropic medication be given in the right dose to the right child or youth. To ensure that psychotropic medications are used correctly and for the benefit of a child or youth, a diagnostic assessment by a qualified health care provider is required before medication is prescribed. In some cases, a diagnostic assessment may also be required for children or youth with existing prescriptions.

To meet this standard, panel members recommend:

- **A diagnostic assessment by a qualified health care professional (Standard 3.1)**

Before a psychotropic medication is prescribed, a physician, preferably one who is experienced in children and youth mental health, should conduct a diagnostic assessment. As described in Standard 2, unless deemed to lack capacity, the child or youth must give informed consent for such an assessment. It is important that the assessment identify what specific target symptoms the medication is intended to treat. If the assessment is conducted by a mental health professional who cannot prescribe psychotropic medications, such as a psychologist, the results of the assessment should be made available to the prescribing physician.

If a child or youth has an existing prescription for a psychotropic medication and there is no record of an assessment within the previous 12 months confirming the medication is still required, an assessment should be scheduled. This assessment may be linked to the annual medical examination required for all children and youth in provincially licensed residential settings.

- **A responsible adult attend and document appointments (Standard 3.2)**

If consent is given by the child or youth, and in consultation with the health care professional conducting the assessment, a representative of the provincially licensed residential care team should attend the diagnostic appointments. This representative may be the child or youth's direct care worker (preferably, the responsible case worker), foster parent, parent, caregiver or guardian. The representative should fully understand the results of the

diagnostic assessment, so that it and its recommendations can be documented and explained in the child or youth's plan of care.

Standard 4: Collaborative Care and Plans of Care

Each child or youth living in a provincially licensed residential setting should have a child-centered plan of care developed by a collaborative care team. For children and youth prescribed psychotropic medication, the plan of care should include (a) a record of the results of all diagnostic assessments, (b) a method for monitoring ongoing medication effectiveness and side effects and (c) a schedule for regular review of all psychotropic medications.

One of the basic principles of the Expert Panel was that psychotropic medications should be given as part of a coordinated, comprehensive plan of care for a child and youth. Coordinated, comprehensive care is best delivered by a collaborative care team (also sometimes referred to as an interdisciplinary or inter-professional team). A collaborative care team is a group of professionals from different fields or disciplines who work with the child or youth in a planned, interdependent manner. The composition of the collaborative team will vary according to the needs of the child or youth and local resources. Part of the responsibility of the collaborative team is to ensure that psychotropic medication is only one aspect of an overall plan for care for the child or youth.

To ensure children and youth in provincially licensed residential settings receive collaborative care, panel members propose:

- **Each child and youth have a personalized plan of care (Standard 4.1)**

Each child or youth should have a plan of care that is individualized to his or her own specific needs (i.e., is child- or youth-centered) as determined by the diagnostic assessment, is culturally appropriate and respects the child or youth's preferences and beliefs. The development and delivery of the plan of care is the responsibility of the collaborative care team. Foster parents and caregivers should be included in the process of developing and delivering the plan of care.

To optimize the collaborative team, provincially licensed residential settings are encouraged to develop working relationships with a variety of mental health services in their region. Mental health services can be delivered by a number of providers, such as child and youth mental health agencies, school-based services, community physicians, hospital-based services, telepsychiatry, and other community services.

- **Ongoing monitoring of the effects and side effects of psychotropic medication (Standard 4.2)**

The plan of care for a child or youth should include a process for monitoring the effects of the psychotropic medication on a regular and systematic basis. This monitoring should look at the effects of the medication on behaviour, as well as any adverse effects (side effects) or problems that occur. The child or youth, foster parents, caregivers and direct care workers should be encouraged to give verbal or written feedback, and this information

recorded in the plan of care so it is available to the collaborative care team.

Foster parents are a particularly important source of information, as they can monitor behaviours, emotions, thoughts and possible effects and side effects of the medication on an ongoing basis. Height and weight should also be monitored in the plan of care, as they can affect medication dosage.

- **A schedule for reviewing psychotropic medications (Standard 4.3)**

The plan of care should document the name and contact information of the physician responsible for reviewing the child or youth's psychotropic medications, a schedule for medication review, and when informed consent was given for the medication. The effects, side effects and dose of all psychotropic medications should be reviewed periodically by the child or youth's responsible physician. When a child or youth's condition is stable, a review of psychotropic medication is required every three to six months. When dose adjustments are required or there is emotional, behavioural or cognitive instability, reviews should be conducted more frequently, as determined by the responsible physician. For those taking three or more prescription medications for chronic conditions, the plan of care should include a schedule for an annual medication review by a pharmacist under the MedsCheck program of the Ontario Ministry of Health and Long-term Care.

- **A plan for filling and refilling prescriptions in a timely fashion (Standard 4.4)**

Provincially licensed residential settings should have a plan to ensure prescriptions are filled and refilled in a timely fashion.

- **Non-pharmacologic or alternative interventions for the child or youth (Standard 4.5)**

It is important that psychotropic medications not be used as a substitute for other forms of care but as part of a comprehensive plan of care that includes a range of non-pharmacologic interventions such as counselling, behavioural therapy, rehabilitative services, etc. The plan of care should document which other interventions have been implemented or considered, as well as the rationale for interventions used, rejected or stopped. Regularly, or as the need arises, the collaborative care team should discuss what non-pharmacologic interventions could be helpful. As a member of the collaborative care team, the prescribing physician should have access to this information.

- **Effective communications with children or youth taking psychotropic medication (Standard 4.6)**

Many children and youth who take psychotropic medication lack information about what to expect when taking it, their rights to consent to or refuse treatment, and their treatment options. It is important that the plan of care include opportunities for children and youth to discuss their psychotropic

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medication(s) and to have their concerns, cultural beliefs and preferences documented and addressed. Foster parents may be able to play an important role in talking with children or youth about their experiences and facilitating communications with the collaborative care team.

Provincially licensed residential settings should also have mechanisms in place so they can respond to the concerns of foster parents, caregivers, families or other adults about the effects of a psychotropic medication on a child or youth.

If a child or youth refuses to take his or medication as prescribed, direct care workers should discuss the situation and document his or her reasons. If several consecutive doses have been missed, the prescribing physician should be contacted, informed of the refusal and an appointment scheduled for the child or youth.

Standard 5: Preparation and Administration of Psychotropic Medications

Direct care workers, foster parents and caregivers should ensure there is a safe, secure system for preparing and administering psychotropic medications within all provincially licensed residential settings.

Like all prescription medications, psychotropic medications must be prepared for administration in a manner that is safe and minimizes the chance of errors. To make this happen, we need:

- **All medication containers to be appropriately labeled (Standard 5.1)**

Whenever possible, psychotropic medications should be kept in their original containers, labeled with the medication name, strength, frequency, dose, child or youth's name and the date it is to be dispensed. In ideal circumstances, medications should not be "pre-poured" but prepared individually for each child or youth just prior to administration.

- **There is a safe environment for preparing medication for administration (Standard 5.2)**

To reduce errors, medications should be prepared in a location where there is adequate space and lighting and few distractions, clutter or noise. Each child or youth should be observed during administration to ensure that the medication has been taken correctly.

- **Infection control practices (Standard 5.3)**

Prior to preparing, administering or taking a medication, the hands should be washed.

- **All doses are recorded on the Medication Administration Record (MAR) (Standard 5.4)**

The MAR should be referred to at the time of medication administration. Immediately after each dose is administered, it should be documented on the MAR.

- **Consistent scheduling of medication administration (Standard 5.5)**

Standard times should be established for the administration of medications.

- **Safe processes for when medication is administered outside of the provincially licensed residential setting (Standard 5.5)**

Sometimes, medications must be provided to another facility or adult for administration (e.g., at school or during home visits). When this occurs, the medications should be provided in labeled containers that show the medication name, strength, frequency, dose, child or youth's name and date of dispensing. The proper administration and storage of the medication should be explained to the person responsible for giving the child or youth the medication. All medication provided in this fashion should be documented on a MAR or MAR-like record.

- **There is no sharing of medication (Standard 5.6)**

Medication should only be used for the child or youth to whom it has been prescribed. Medication for one child or youth should never be given to another, even if it is the same drug or dose.

- **Appropriate use of PRN medications (Standard 5.7)**

Direct care workers or those responsible for a child or youth in provincially licensed residential setting should ask that the prescription for a PRN medication (*pro re nata*, "as needed," or "as the situation arises") should ask that the prescription clearly describe or define the specific target symptom it is intended to treat. The order should state how frequently the dose can be given (e.g., every 4 hours) and the maximum daily dose that cannot be exceeded. PRN prescriptions should

be reviewed regularly by the direct care worker and the prescribing or responsible physician.

- **Procedures for children and youth allowed to self-administer their medication (Standard 5.8)**

In some cases, a physician or registered nurse in the extended class may determine that a child or youth is capable of administering his or her own medication. In these cases, every effort should be made to work in cooperation with the health care provider to develop a written self-medication plan. A copy of the plan should be kept in the resident's record. Medications must still be stored and dispensed in a safe and secure manner (see Standard 6) to prevent unauthorized access and risk to others. In the case of a disagreement about a child or youth's ability to self-administer a medication, a meeting should be held among all those involved to review the situation and develop a new plan. Self-administration is considered a privilege and can be discontinued if medications are shared with others or not taken as authorized.

Standard 6: Psychotropic Medication Storage, Transfer and Disposal

All provincially licensed residential settings should have safe and secure methods to store, transfer and destroy psychotropic medications.

As well as safe practices for the administration of psychotropic medications, provincially licensed residential settings must have safe practices for storing, transferring and disposing them. This involves:

- **Safe practices and locations for storing medications (Standard 6.1)**

All provincially licensed residential settings should have policies and procedures in place to ensure psychotropic medication are stored in a secure manner. This means assuring that containers are locked when not in use and that they are inaccessible to children and youth in the facility. When appropriate, these containers should be child-proof. Medications should be kept away from direct sources of heat, moisture and sunlight. If the medication requires refrigeration, it should be stored in a locked container within the refrigerator, separate from food products. The container or space used to store medication should be large enough so that the medications can be kept in an organized manner.

Discontinued or expired medication should be kept in a secure area separate from the medications in active use until they can be disposed of safely (see Standard 6.3).

- **Procedures for safely transferring medications and information between settings or facilities (Standard 6.2)**

When a child or youth moves between residential settings or facilities, medications and information about the medications (e.g., MAR, Cumulative Medication Record, medication passport) must be safely and securely transferred between the adults responsible for the child or youth (e.g., between direct care workers, foster parents or caregivers). All medication containers should be labeled with the child's or youth's name and the medication

name, dose, strength and frequency of administration.

- **Safe practices for psychotropic medication disposal (Standard 6.3)**

All provincially licensed residential settings should have a process for the timely, secure and safe destruction of medications that are discontinued or expired. In most cases, this should involve returning the medication to a community pharmacy for destruction.

Standard 7: Medication Information

All parties – children, youth, direct care workers, foster parents, caregivers and health care providers – should have accurate information about a child's psychotropic medications and access to resource information about these medications, including information on PRN ("as needed") or emergency medications

In its consultations with children and youth and direct care workers, the Expert Panel was concerned to learn that many children and youth in provincially licensed residential settings who take psychotropic medication feel they lack adequate information about why they have been prescribed the drug or what effects and/or side effects to expect. To ensure that children and youth, as well as those who care for them, have adequate knowledge about psychotropic medications, the Expert Panel recommends:

- **Medication passports for children and youth (Standard 7.1)**

All children and youth prescribed psychotropic medications should be given a "Medication Passport" (e.g., Med Ed) as part of the intake process

(see Standard 1.3). This passport should clearly state:

- The name of the medication;
- Why it has been prescribed;
- How it should be administered;
- Dose and date of any dose change;
- Who should be contacted in case of emergency; and
- Anticipated medication effects and side effects.

With the child or youth's consent, the provincially licensed residential setting should maintain a duplicate copy of the Medication Passport. When the child or youth is moved between settings, with the consent of the child or youth, the duplicate copy of the Medication Passport, like the medications themselves, should be transferred in a safe and secure manner between the direct care workers responsible for him or her (see Standard 6.2).

Standard 8: Training

Educational curriculum and resources should be available to ensure that everyone who cares for children and youth in provincially licensed residential settings receive orientation and ongoing training on the proposed standards and issues relevant to psychotropic medications.

To fully implement the proposed standards will require training and education of the people who work in provincially licensed residential settings. In this standard, the Expert Panel describes the key elements of the sort of training, education and resources that it believes are essential.

- **Identify who requires education and training (Standard 8.1)**

To be effective, training and education must be tailored to the needs of different residential settings, as well as different professions within each setting. Thus, a first step in developing an effective education and training approach is to identify target audiences, their training needs and methods for addressing those needs. A primary target will be direct care workers in the different sectors (e.g., child welfare and protection workers, youth justice workers and those working in residential mental health facilities).

There is also a need for training of others who work closely with children and youth in provincially licensed residential settings and who may therefore face issues raised by the administration or monitoring of psychotropic medications. These audiences include foster parents, parents, health care providers, and community mental health specialists.

- **Establish minimum expectations for those who work with children and youth in provincially licensed residential settings (Standard 8.2)**

At a minimum, everyone involved in the provincially licensed residential system should receive training in effectively implementing the proposed standards and understanding the broader issues of child and youth mental health and psychotropic medications. This training should begin during formal college or university education, be an essential part of workplace orientation, and be reinforced by ongoing training and resources.

Whenever possible, training and education should build upon existing or proven programs and approaches, such as the MCYS regional training system, or resources offered by expert or professional bodies. In some cases, implementation may require coordination and collaboration with other bodies, such as community colleges and universities.

Information on the proposed standards and on psychotropic medications should also be incorporated into the training of foster parents.

- **Provide ongoing training and support (Standard 8.3)**

Resources and opportunities should be available so people can continually upgrade their knowledge about the proposed standards and the issues surrounding the administration and monitoring of psychotropic medications. Ongoing opportunities for training and education are particularly important given the high turnover rate in some settings and the reliance on relief staff.

Resources should be easily accessible (e.g., Internet or telephone-based), easy to understand and use, practical, comprehensive and tailored to the different provincially licensed residential settings. The MCYS may want to collaborate with other bodies to help in the development of tools and resources.

- **Define training curriculum (Standard 8.4)**

The exact curriculum or content of training materials will vary according to the provincially licensed residential

setting and the varied responsibilities of different direct care workers. Moreover, the content of training programs will probably evolve over time as knowledge increases and changes. Some of the initial issues that should be addressed in training programs include:

- How facilities and workers at all levels, especially direct care workers, can implement and follow the proposed standards;
- The effects and side effects of psychotropic medications;
- What tools and resources are available and how to access and use them;
- How to work in interdisciplinary teams in a collaborative manner;
- How to communicate effectively with children and youth about psychotropic medications; and
- Issues relevant to child and youth mental health, including the effects of trauma, stress and relocation on behaviour.

Standard 9: Quality Improvement

To reduce the risk of preventable harm from medication use and to promote continuous quality improvement, all residential, provincially licensed settings where psychotropic medications are administered to children and youth should have a system to report and analyze medication incidents and errors.

Medication incidents are situations in which an error occurred or may have occurred in the administration of a medication. Medication incidents include both errors (e.g., the child or youth received the wrong medication or wrong dose) and those that were detected and corrected before there was any harm.

Developing a system of medication incident reporting makes it possible to learn from mistakes and potential mistakes.

In Ontario, hospitals and long-term care homes report medication incidents. The Expert Panel believes that a medication incident reporting system for provincially licensed residential settings could make it possible to identify problems and make the sort of system changes that support safer medication practices. To make this happen, we need:

- **A clear definition of what is meant by a medication incident (Standard 9.1)**

The first step in developing a medication incident reporting system for provincially licensed residential settings is developing and communicating what is meant by a medication incident. It is important for those working in provincially licensed residential settings to understand that the objective of a medication incident reporting system is not to assign blame to individuals. Rather, it is to identify problems and potential problems so system changes can be made to prevent future errors.

- **A process for submitting and reviewing medication incident reports (Standard 9.2)**

A medication incident reporting system for provincially licensed residential settings will make it possible for all facilities to learn from one another. Establishing such a system may be as simple as adding a medication incident box to the current incident reporting form. The key is to develop a process whereby facilities can immediately and easily

report incidents and receive feedback and guidance.

- **Honest disclosure of errors (Standard 9.3)**

Provincially licensed residential facilities should have processes to ensure that all medication incidents, regardless of the level of harm that result, are honestly disclosed to the child, youth and/or guardian.

- **Incident analysis (Standard 9.4)**

The value of a medication incident reporting system lies in the potential to analyze reports and identify high-risk situations and how they can be addressed. Provincially licensed residential facilities should conduct quarterly analysis of all cases so they can develop system enhancements that reduce the potential for recurrence of similar errors.

- **Learning for quality improvement (Standard 9.5)**

As well as provincially licensed residential settings, those who work with children and youth in care (direct care workers, foster parents and caregivers) should receive ongoing information about medication errors and strategies to prevent them.

Membership of the Ontario Expert Panel

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Glossary of Terms

Note: This glossary is provided to help readers understand more about the complex issues of provincially licensed residential care and psychotropic medications; however, it is a not complete compilation. What people mean by a term may vary by context, setting and perspective. These definitions should not be read as representing the policy or legal position of the MCYS.

Adverse Reaction¹ According to the World Health Organization, an adverse reaction is any response to a drug which is noxious and unintended, and which occurs at doses normally used in humans for the prevention, diagnosis or treatment of disease or for the modification of physiologic functioning.

“Best Possible” Medication List A list developed when a child or youth enters a provincially licensed residential setting that documents all current medications, target symptoms or clinical indications, and prescribed dose and frequency. The term “best possible” recognizes that the list is created with the information available at that point in time from the resources available. The list forms the basis for future reference and is updated when additional information emerges or new information becomes available.

Capacity² Everyone, regardless of age, is entitled to make their own treatment decision if they are capable of doing so. Under the *Health Care Consent Act*

(HCCA), a person is considered to have capacity if they are capable of understanding and appreciating the relevant information and what could happen as a result of making or not making a decision. If a child or youth is found to lack capacity to make treatment decisions, the HCCA stipulates that the substitute decision maker has the authority to do so.

Caregiver An adult who cares for a child or youth in a provincially licensed residential setting, such as a parent, guardian or relative providing kinship care.

Child and Adolescent Psychiatrist Child and adolescent psychiatrists (CAPs) are physicians who specialize in disturbed cognition, emotions, and behavior that impact on the social, emotional, psychological, and spiritual development of children and youth in the context of their environments (i.e., home, school and community). CAPs investigate, evaluate, diagnose, treat and rehabilitate children and youth with mental health disorders, play an important role in defining and supporting interventions by mental health professionals and other physicians and have direct care responsibilities for the most severely affected, acutely ill or at-risk children and youth.³ They may provide consultation to the child/youth’s primary care provider, other members of the care team, community mental health agencies, social services, schools and correctional services.

¹ World Health Organization. *Requirements for adverse reaction reporting*. Geneva, 1975.

² Consent and Capacity Board. Applying for a Review of Capacity to Make Decision with Respect to Treatment (Form A). <http://www.ccboard.on.ca/english/publications/documents/forma-treatment.pdf>

³ Parker Z, Steele M, June K W, Morin L, Davidson S, Fleisher W, MacLeod R, Sande T, White H, Yates T. *Child Psychiatry in Canada: Physician Resources*. Position Statement. Canadian Academy of Child Psychiatry, Physician Resource Committee, 2002.

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In some situations, the CAP may be involved in a child/youth's care for a period of time until the mental health problem is stabilized or resolved or medical care is taken over by a primary care provider; in different situations, they may be involved in the child/youth's care for an extended period of time. They may assist with following and adjusting psychotropic medications as needed, as well as various aspects of treatment such as psychotherapy (e.g., cognitive-behavioural therapy, family therapy), attendance at meetings (e.g., school meetings or plan of care meetings), or psychopharmacology.

Child and Family Services Act (CFSA) The purpose of the Act is to promote the best interests, protection and well being of children and to outline the manner in which children's services (including those delivered by Children's Aid Societies) should be provided.

Child Protection Worker An employee of a Children's Aid Society (CAS) who is mandated to protect children and youth and promote the health and well-being of children, youth and families.

Children's Aid Societies There are 53 Children's Aid Societies (CASs) in Ontario, including five Aboriginal child welfare agencies designated as CASs. Each CAS is responsible for providing child welfare services in its mandated geographical area. Children and youth can come into the care of a CAS in a number of ways.

- **Temporary Care Agreement** Allows for the voluntary temporary transfer of custody of a child or youth to a CAS with the agreement of the parent and consent of a child over 12 years of age who has capacity.
- **Supervision Order** Court direction for the child or youth to be placed, remain with, or returned to the

parent or a relative or other member of the child's or youth's community under the supervision of a CAS. The court may specify terms and conditions regarding the child's or youth's care.

- **Society Wardship Order** Court direction for the child or youth in need of protection; an order for the child or youth to be placed into the temporary care of the society.
- **Crown Wardship Order** Court direction for the child or youth to be made a permanent ward of the Crown.

CASs are provincially licensed to provide residential care and programs for children and youth. They can directly operate group homes, receiving homes and foster care homes, or may purchase services from provincially licensed independent private operators.⁴

Collaborative Care Team A collaborative care team (also known as an interdisciplinary or inter-professional team) consists of a group of professionals from different disciplines who work with the child or youth in a planned, interdependent manner to develop and implement the plan of care. The team may include: direct care workers, child protection workers, family physicians, specialist physicians (e.g., paediatricians, child and adolescent psychiatrists), nurses (registered nurses, nurse practitioners), pharmacists, psychologists and social workers.

⁴ Human Resources and Social Development Canada. Definitions adapted from *Child Welfare in Canada 2000. Ontario. Administration and Service Delivery*. <http://www.hrsdc.gc.ca/en/cs/sp/sdc/socpol/publications/reports/2000-000033/page09.shtml> 1/08/07.

Consent⁵ Under the *Health Care Consent Act (HCCA)*, consent must be related to the treatment in question, be informed, be voluntary and not be obtained through misrepresentation or fraud. “Informed” means the person received information about the nature of the treatment, expected benefits, material risk and side effects, as well as alternative courses of action and likely effects of not having the treatment.

Direct Care Workers In this document, “direct care worker” refers to any adult who works closely with, and has responsibility for, a child or youth in provincially licensed residential care. Different titles may be used in different settings (e.g., group homes, residential treatment centres, hospitals, institutions, and correctional facilities). Many of these workers have diverse skill sets that allow them to work in multiple roles and various contexts. They are capable of conducting a range of prevention, intervention, and treatment strategies in a number of different structured environments. These strategies may include crisis intervention, conflict management and problem-solving, counselling, activity program development and delivery, group work and psychotropic medication administration. They advocate for and guide children and youth through their daily lives, teach social and life skills, support efforts to manage behavior, and engage in counselling to facilitate better understanding of change.

Family Physician Family physicians are involved in many aspects of the health care of children and youth, including the early identification and/or diagnosis of mental health problems, initiation and

⁵ Government of Ontario. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch A. Available at: <http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html> 24/03/08.

monitoring of treatment, and/or referral to specialists (e.g., paediatricians and/or child and adolescent psychiatrists). Provided the child/youth has given informed consent, the family physician should be informed of any assessments which may have taken place, diagnoses and treatment recommendations, both non-pharmacological and pharmacological, and the names of the other members of the care team so they can work together and communicate when necessary.

Foster Parent^{6, 7} While the legal responsibility for a child or youth in the care of a CAS remains with the CAS, foster parents play an essential role by providing a home environment. Foster parents are individuals or couples who provide care for children and youth until they can be reunited with their families or long-term plans can be made. Foster parents work with CAS staff as part of a team to develop a plan for each child in care.

Guardian A guardian is someone appointed by the Court under the *Substitute Decision Act*.

Health Care Consent Act (HCCA)⁸ The legislation that applies to all regulated health professionals who treat patients in any setting. Under the *HCCA* there is no age cut-off for capacity; the health practitioner proposing the treatment determines the patient’s capacity according to guidelines available from the regulatory colleges. A person is presumed to be capable to make decisions about a

⁶ Foster Parents Society of Ontario. www.fosterparentsociety.org.

⁷ Ontario Association of Children’s Aid Societies. *Becoming a foster parent*. <http://www.oacas.org/childwelfare/foster.htm>

⁸ Government of Ontario. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch A. Available at: <http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html> 24/03/08.

treatment (anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose) unless there are reasonable grounds to believe he or she is not.

Lowest Optimal Dose⁹ The dose of a medication that creates the greatest efficacy balanced against tolerable side effects.

Med Ed Resources created by the experts at Dalhousie University and the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario. The resources include a medication education guide for young people and those who care for them, as well as a Med Ed Passport that children and youth can use to track their questions, symptoms, activities, side effects, medications and appointments. As of early 2008, the Med Ed resources were in the latter stages of development and training in how practitioners should use Med Ed was being piloted.

MedsCheck¹⁰ A program provided by the Ontario Ministry of Health and Long-term Care which supports all Ontario residents who take three or more prescription medications for chronic conditions by funding an individual, 30-minute consultation once a year with their community pharmacist. During the

review, the pharmacist verifies any patient allergies or chronic medical conditions; collects personal, lifestyle and other health information; reviews the patient's medications to help them better understand drug names, strengths, side effects and usage instructions; ensures patients are taking their medications as directed and provides tips on how to get the best results for their medication; answers any patient questions or concerns; and develops an up-to-date medication list the patient can show to their doctor, pharmacist or when admitted to hospital. After the review, the pharmacist may follow up by telephone to talk about any concerns. With permission, the pharmacist may also forward a copy of the medication list to the prescribing physician.

Medication Administration Record (MAR)

A form for recording the administration of medications to children and youth in care by direct care workers.

Medication Incident¹¹ Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Medication incidents may include administration of the incorrect drug, an incorrect dose, administration at an incorrect time or to the wrong patient.

Medication Interaction A medication interaction can occur when different medications taken together interact with one another. Some times interactions are beneficial (e.g., using two different types of medications to lower blood pressure) but in some cases are unwanted and may be harmful (adverse interactions). Prescription medications can interact with

⁹ Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Child and Parent Resource Institute (CPRI) Committee Report, August 2002.

¹⁰ Ontario Ministry of Health and Long-term Care. MedsCheck Program Provides Better Care for Patients. Backgrounder. http://www.health.gov.on.ca/english/media/news_releases/archives/nr_07/jul/medscheck_factsheet_03_20070716.pdf

¹¹ Institute for Safe Medication Practices. <http://www.ismp.org/>

other prescription or non-prescription medications including herbal or nutritional supplements.

Medication Passport A resource or booklet for recording medication information for and by the child or youth. Please refer to “Med Ed” for more information.

Medication Reconciliation The process of verifying, clarifying and reconciling the patient’s most current list of medications against the physician orders. Medication reconciliation occurs at the time of admission, transfer for consultation and discharge.

Non-prescription Medication Drugs or products sold in pharmacies and stores that do not require a prescription from a health care professional. This category also includes herbal remedies and nutritional supplements. Non-prescription medication is also referred to as over-the-counter medication.

Over-the-counter Medication Drugs or products sold in pharmacies and stores that do not require a prescription from a provincially licensed health care professional. This category also includes herbal remedies and nutritional supplements. Over-the-counter medication is also referred to as non-prescription medication.

Paediatrician (Pediatrician) Paediatricians are medical doctors with specialized training in the care of children and youth. Many paediatricians are capable of diagnosing and initiating treatment of mental health disorders in children and youth. Paediatricians may act as primary care physicians for children or youth or as consulting physicians. With the appropriate consent, they can be active members of the collaborative care team (e.g., acting as the health case manager, communicating with schools and others to

implement both pharmaceutical and non-pharmaceutical treatment). Developmental paediatricians are paediatricians who have completed two additional years of training in child development, with specific training in the use of psychopharmacology.

Pharmacist The community pharmacist can be a valuable member of the child or youth’s collaborative care team and as such should be aware of the indications/diagnosis for which each drug is prescribed, so as to be better involved in the care. The pharmacist can be a source of information on prescribed medication (including education/information sheets for each newly prescribed drug). As some children and youth may have contact with several physicians (who may each prescribe medications), or may take over-the-counter drugs (e.g., vitamins, allergy preparations, herbal products), whenever possible medication records of each child or youth should be consolidated in one location. This will enable the pharmacist to monitor for drug-drug interactions for both prescribed and over-the-counter drugs. Should a child or youth move to another community, the pharmacist can also provide a medication history. A *MedsCheck* review can be done by the pharmacist, on an annual basis, for any child or youth prescribed three or more prescriptions for chronic conditions.

As part of the collaborative care team, the pharmacist can be involved in a number of activities, depending on needs, availability and financial considerations. These activities include regular medication reviews/evaluation of the child/youth with the team, acting as the contact person for questions that arise about medication effects and adverse effects, being involved in preparing assessment tools for monitoring effects of medication, conducting periodic

medication education of the direct care workers and/or of the child/youth and helping to organize and follow medication usage and adjustments.

Prescription Medication A medication that requires a prescription from a provincially licensed health care professional, such as a physician or nurse practitioner-extended care, and is typically dispensed by a licensed pharmacist. Key elements of a prescription are:

- Name: the medication may have both a generic and brand name;
- Strength: the amount of medication in each pill or dose;
- Dose: what amount of the medication should be taken (e.g., how many pills) each time;
- Frequency: how frequently the medication should be taken (e.g., once daily, twice or four times a day); and
- Administration: depending upon the medication, it can be administered by mouth (oral or sublingual tablets), rectally, by inhalation, by injection or as a topical application (e.g. cream, ointment, sprays or patches). The prescription should also indicate whether the medication should be taken with or without food and may have additional, specific warning labels (e.g., do not consume alcohol).

Primary Care Nurse Practitioner or Registered Nurse in the Extended Class (RN[EC]) Primary Care Nurse Practitioners (RN[EC]) practice autonomously and offer the full scope of primary health practice, including consultation with physicians or other health professionals. They offer comprehensive health services encompassing health promotion, prevention of disease and injury, cure, rehabilitation and support services. Their

scope of practice includes areas of assessment, diagnosis, prescription of drugs and treatment and health promotion. This includes controlled acts (College of Nurses of Ontario, 2005) such as: communicating a diagnosis made by the RN(EC) to a client or a client's representative; prescribing a drug from the approved drug list as per the regulations; prescribing psychotropic drugs with medical directives in an institutional setting; administering an approved drug by inhalation and injection that RN(EC)s are authorized to prescribe; and ordering the application of a form of energy as prescribed in the regulations (e.g., diagnostic ultrasound).

Provincially Licensed Residential Setting^{12, 13} The CFSA defines a "children's residence" and "residential care", and for purposes of licensing, separates the places where children live into two streams:

- "Children's residences" (commonly called group homes) can be operated by either staff or by live-in parents. In a staff model, the staff works in shifts to care for three or more children not of common parentage. In a parent-model, live-in parents provide care to five or more children not of common parentage. Children's residences are individually licensed.
- "Residential care" (commonly called foster care) is provided to four or fewer unrelated children. Foster care agencies are the licensed entity, rather than individual foster homes.

¹² Office of Child & Family Service Advocacy. Appendix 1: Types of Placement for Children's Residential Care. Quality of Care Review. June 2007.

¹³ Cooke D, Finlay J. Open Detention and Open Custody. Review. Office of Child and Family Service Advocacy. January 2007.

The majority of children and youth in foster care homes and group homes have been placed through Children's Aid Societies (CASs) but some may come through other means, such as from mental health agencies. Some residential services offer specialized treatments and therapeutic programs.

PRN PRN is the short form of *pro re nata* and means "as needed" or "as the situation arises." These are medications that are prescribed not to be taken regularly or routinely, but as required. Some medications may be prescribed as both a routine medication and on a PRN basis.

Psychologist Psychologists are part of a diagnostic and treatment team and bring expertise in performing and interpreting standardized and other diagnostic measures and interviews. Psychologists participate in formulating and communicating diagnoses, developing treatment plans, carrying out cognitive-behavioural and other child- and youth-centered treatment interventions. Psychologists participate in supervision of qualified staff in providing services to children and youth. Psychologists consult with staff and others, such as foster parents, group home staff, kinship settings in behaviour management and collaborate in program development.

Psychotropic Medication A psychotropic medication is any drug prescribed to stabilize or improve mood, mental status or behaviour.¹⁴

¹⁴ Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Child and Parent Resource Institute Committee Report, August 2002.

Self-Administration When a physician or extended care nurse has authorized a child or youth to consume or apply medication in the manner prescribed, without additional assistance or direction.

Side Effects¹⁵ Side effects are the known and frequently experienced secondary, non-intended reactions to a medication. They can vary by how frequently they occur and how serious they are.

Social Worker Social workers are employed in a variety of settings including child and family welfare agencies, mental health agencies, hospitals and correctional services institutions. Their primary responsibility is the protection and promotion of the welfare and well being of children and vulnerable youth. They offer a broad range of services from emotional support to referrals for community resources, based on psychosocial assessments of the individual child/youth's needs and the parent/caregivers capacity to respond appropriately to the child's identified needs. Social workers can provide case management (e.g., linking clients with agencies and programs that will meet their psychosocial needs) and are also skilled therapists (i.e., may provide individual, group or family therapy). Social workers can help guide professionals in their treatment, management, and interaction with a child/youth, identify and address obstacles to a successful intervention, and help children/youth and their families negotiate the social services, health and mental health systems.

Substitute Decision-Maker¹⁶ Under the *HCCA*, a substitute decision-maker can

¹⁵ Ibid.

¹⁶ Government of Ontario. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch A. Available at: <http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html> 24/03/08.

make treatment decisions for someone who is incapable of making an informed decision regarding a particular treatment. They are, in descending priority: a court appointed personal care guardian, an attorney for personal care, a representative appointed by the Consent and Capacity Board, a spouse or partner, a child, a parent with access, CAS or other lawful organization, parent with right of access, brother or sister, any other relative (through blood, marriage or adoption) or the Public Guardian and Trustee.

condition. A plan of treatment provides for the administration of treatments and may also provide for the withholding or withdrawal of treatment in light of the person's current health condition.

Substitute Decisions Act¹⁷ The Act passed by the Ontario Legislature in 1992, enacted in 1995 and amended in 1996, which governs what may happen when someone is not mentally capable of making certain decisions about their own property or personal care.

Treatment¹⁸ According to the *HCCA*, a treatment consists of anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or another health-related purpose. It can include:

- A course of treatment – a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; and
- A plan of treatment – deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems a person is likely to have in the future given their current health

¹⁷ Government of Ontario. A Guide to the *Substitute Decisions Act*. Available at: <http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/pgtsda.pdf>

¹⁸ Government of Ontario. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch A. Available at: <http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html> 24/03/08.

Notes
