

A Canadian Perspective of Patient Safety in Mental Health: A Qualitative Analysis of Small Group Discussions during an Invitational Roundtable Event

Tracey A. Brickell, D.Psych., & Carla McLean, M.A.

British Columbia Mental Health and Addiction Services

Introduction

Patient safety in mental health is an emerging issue that has only recently received attention. Much of the literature to date, and consequently our understanding of patient safety, has come from primary health care settings (e.g., acute care and emergency). Although many of the patient safety risk factors that exist in medical settings apply also to mental health settings, there are unique patient safety issues in mental health that are different from those in primary care, such as issues around seclusion and restraint use, self-harming behaviour and suicide, absconding, and reduced capacity for self-advocacy. It is only recently that patient safety in mental health was considered as a field in its own right and as such, there is a lack of readily available information to guide patient safety systems, practices, policies, and service delivery in mental health.

The present research builds on existing knowledge by soliciting the expertise and experiences of persons providing mental health services and working in the patient safety field or patient advocacy via discussions at an invitational roundtable event.

Method

Participants

The Roundtable Event participants were selected by a Pan-Canadian Patient Safety in Mental Health Advisory Committee. Participants were selected because of their knowledge and expertise in patient safety and/or mental health. Seventy-one experts from across Canada and one from the United Kingdom participated in the roundtable event. The participants were drawn from different regions across Canada and worked in a variety of settings. Signed consent was obtained from each participant.

Procedure

The Roundtable Event was coordinated by a professional facilitator. Each participant was provided in advance with a summary paper outlining the

findings from (a) a literature review on patient safety in mental health and (b) an analysis of interview data with 19 key informants in patient safety and/or mental health. On the day of the Roundtable Event, an overview of the summary paper was presented and the Roundtable participants had an opportunity to ask questions of the research team. Following the question and answer forum, the participants were divided into nine separate pre-determined breakout discussion groups and were asked to discuss and provide their perspectives on three topics: (1) What are the themes, priority issues, and actions for patient safety in mental health?; (2) What best practices, tools, programs and initiatives are currently being utilized to optimize patient safety for patients receiving mental health services?; and (3) What are the next steps/future directions for patient safety in mental health? The breakout groups were designed to consist of a mix of participants from various geographic regions across Canada and various professional roles. Each group was assigned a small group facilitator (Advisory Committee member) who guided the discussion, and a scribe (research team or Advisory Committee member) who took notes on flip charts. After each small group discussion, a rapporteur presented their group's main themes to the larger group. At the conclusion of the Roundtable Event, the scribe notes were collected and the data generated from the small group discussions were analyzed qualitatively.

Analysis

A thematic analysis was performed. The analysis involved identifying common themes from each discussion topic. Themes were identified by reading and re-reading the notes from each of the nine discussion groups. Once the themes were identified the information from each group was organized or categorized under each of these themes. This information was then used to provide a more detailed discussion of the theme.

Results

National action, leadership, and standardization

There was agreement among the roundtable participants that national action was required to promote patient safety in Canada. Paired with the idea of national action was the view that patient safety leadership is needed to champion the cause. It was suggested that definitions and nomenclature, practice, reporting mechanisms, and policy need to be created at the national level to ensure standardization across all mental health settings, health regions, and provinces/territories.

Quality of care and best practice

Issues around access to care and quality of care were identified as they directly impact patient safety. Issues raised include: Stigma and discrimination, geographic distance, exclusion or admission criteria, shortages in services and trained professionals, comorbidity and increased patient complexity, and service breakdown during transitions of care and handovers/handoffs. Also identified as important for improving patient care and safety was the need to consider safety issues from the perspective of patients and their caregivers/family when developing care plans and patient safety initiatives. Participants were able to identify many tools and best practices, but said that it was difficult to know what tools and best practices were available and the degree to which they were evidence-based. Similarly, there was concern that tools and best practices were not being implemented or interpreted correctly or applied in a consistent fashion, and due to time and resource constraints were often abandoned in favour of what is perceived to be 'more efficient methods'.

A safety culture

It was suggested that a necessary shift in understanding what constitutes a culture of patient safety within organizations is needed. Participants suggested that some organizations' policies and decisions contribute to a culture of complacency, blame, and a lack of accountability. Some roundtable participants were sceptical about how far the idea of a "blame free" culture could go and whether this could actually be achieved in practice; however, they provided a number of suggestions on how to promote a culture of safety in mental health settings, such as through continued efforts to raise awareness and ongoing education and training.

Ongoing training

Education and ongoing training were presented as important steps in promoting patient safety, achieving standardization of core-competencies and safe practices, and breaking down the stigma around mental illness.

Research

The need for ongoing patient safety research in mental health and the integration of clinical practice, research, knowledge transfer, and education was seen as integral to ensuring that best practice and change actually occurs. Populations, including children, youth, older adults, indigenous people and other cultural groups, as well as individuals residing in rural areas, were identified as being under-researched and facing increased barriers to service access. Participants acknowledged that funding for patient safety research and initiatives was critical to their success.

Conclusion

The findings from the Roundtable Event indicate that concerted effort is needed to include the voice and perspective of patients and their caregivers/family in patient safety initiatives. It is also necessary to assess what tools and best practices are currently available, and to develop a common patient safety language. Expanding existent knowledge of patient safety in community care settings and recognizing the unique safety concerns of special populations, such as children and youth, older adults, and indigenous people, is also an area requiring attention. The need for a common standardized approach to patient safety in mental health settings across Canada was strongly voiced by the participants at the roundtable event. Developing a national patient safety strategy and standardizing practices, core-competencies, and training will ensure comparable standards of care across Canada and promote patient safety. However, there are significant challenges unique to mental health that must be overcome. Stigma and access to care (or the lack of access) are two systemic issues that potentially negatively impact patient safety for persons with mental illness which need to be addressed through a comprehensive strategy.

This research is part of a larger project which includes a literature review and analysis of key informant interview data conducted to produce a background paper on patient safety in mental health. Direct correspondence to TRACEY A. BRICKELL, D. Psych., email: tbrickell@bccancer.bc.ca.