



The Patient Safety
Education Program™
CANADA

Module 13: Mental Health Care:
An Introduction to Patient Safety Issues

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Module 13 Mental Health Care: An Introduction to Patient Safety Issues

PSEP-Canada Objective	Related CPSI Safety Competencies
<p>The knowledge requirements include to understand</p> <ul style="list-style-type: none"> • the gaps in patient safety in mental health from a systems perspective; • how systemic cultural issues, such as stigma can affect patient safety; • different models of care delivery that can promote patient safety; and • how to integrate a mental health quality improvement framework for supporting patient safety. 	<p>Domain: Contribute to a Culture of Patient Safety</p> <p><i>1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:</i></p> <ul style="list-style-type: none"> 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care <p><i>2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:</i></p> <ul style="list-style-type: none"> 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices 2.2. The characteristics and capacities of organizations with respect to patient safety, namely: <ul style="list-style-type: none"> 2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels 2.2.2. The establishment and maintenance of a just culture 2.2.3. The implementation of patient safety best practices 2.2.4. The conduct of adverse event and incident (e.g., close call) analysis 2.2.5. The involvement of patients and their families as key players in patient safety 2.2.6. The provision of an environment of support and safety for health care professionals 2.3. The use of evaluative strategies to promote safety 2.5. Principles, practices and processes that have been demonstrated to promote patient safety 2.6. The nature of systems and latent failures in the trajectory of adverse events 2.10. The concept that health care is a complex adaptive system with many vulnerabilities, (e.g.,

space or workplace design, staffing, technology)

3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:

3.3. Analyze a patient safety event and give examples on how future events can be avoided

4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:

4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods

4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns

4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care

4.4. Demonstrate openness to change

Domain: Work in Teams for Patient Safety

1. Health care professionals who participate effectively and appropriately in an interprofessional health care team to optimize patient safety are able to:

1.2. Describe individual and team roles and responsibilities in the context of practice and in the health care system

1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice

2. Health care professionals who meaningfully engage patients as the central participants in their health

care teams:

2.1. Ensure that patients are at the centre of care

2.2. Engage patients in decision-making and the management of their own health

2.5. Respond to individual patient needs and respect cultural and personal health beliefs and practices

3. Health care professionals who appropriately share authority, leadership, and decision-making for safer care:

3.6. Demonstrate leadership techniques appropriate to clinical situations

Domain: Communicate Effectively for Patient Safety

1. Health care professionals who demonstrate effective verbal and non-verbal communication abilities to prevent adverse events:

1.1. Show respect and empathy in communication

1.5. Communicate in a manner that is sensitive to health literacy needs

1.6. Employ active listening techniques to understand the needs of others

1.7. Communicate in a manner that is respectful of cultural diversity

2. Health care professionals who communicate effectively in special high-risk situations to ensure the safety of patients:

2.1. Engage patients or substitute decision-makers in a discussion of risks and benefits of investigations and treatments to obtain informed consent

Domain: Manage Safety Risks

2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:

2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention

2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned

2.6. Adjust policies and procedures to reflect established guidelines, if applicable

3. Health care professionals who anticipate, identify and manage high-risk situations:

3.1. Recognize health care settings that may lead to high-risk situations

Domain: Optimize Human and Environmental Factors

1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:

1.2. The role of attitude and professional culture in clinical practice

1.5. How to evaluate the impact of organizational resource allocation, policies and procedures and culture

2. Health care professionals who apply techniques in critical thinking to make decisions safely are able to:

2.1. Describe the common types of cognitive biases

Domain: Recognize, Respond to and Disclose Adverse Events

1. Health care professionals who recognize the occurrence of an adverse event or close call are able to:

1.1. Define the terms harm, adverse event, close call, and the response that is appropriate to each

Abstract

A number of unique patient safety issues routinely face persons dealing with mental illness as part of receiving care across the health care system. However, there still remains a lack of awareness coupled with a lack of available evidence surrounding these patient safety issues within the mental health sector.

Persons receiving care in the medical setting are at risk of a variety of patient safety incidents (for example, falls, medication errors, infections); some are unique to the mental health population, and these are the focus of this cluster module. People with mental health needs may be at risk for: suicide and self harm; violence and aggressive behavior; restraint use and seclusion and absconding. All of these directly impact the safe delivery of care. It is important therefore, to understand the factors which may originate in the system or the interaction of the person with the system that lead to these types of events.

This module and the ones that follow will present information in all of these areas. Within these care settings, a variety of terms for the individual seeking treatment are used including client, consumer, patient and resident. Therefore, for purposes of these modules, the more inclusive and global term of “person/person in care” will be used to describe that individual.

Keywords

System perspectives, prevention, stigma, recovery oriented care, trauma-informed care, therapeutic relationship, communication, teamwork, cultural responsiveness, quality improvement, alignment of policy and practice.

Teaching methods

Didactic presentation

Objectives

The learning objectives of this module are to understand systems thinking and system engineering approaches to safety.

Knowledge requirements

The knowledge elements include an understanding of:

- the gaps in patient safety in mental health from a systems perspective;
- how systemic cultural issues, such as stigma can affect patient safety;
- different models of care delivery that can promote patient safety; and
- how to integrate a mental health quality improvement framework for supporting patient safety.

Definitions

<i>Patient safety</i>	“the reduction and mitigation of unsafe acts within the healthcare system” and “the use of best practices shown to lead to optimal patient outcomes”
<i>Patient safety incident</i>	An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient (WHO Conceptual framework for the international classification for patient safety, 2007)
<i>Adverse events</i>	Instances where an unintended injury, complication, or harm occurs as a result of healthcare delivery or management. These events can include reduced quality of life, injury, illness, or even death. An incident which results in harm to a patient
<i>Harm</i>	An outcome that negatively affects a patient’s health and/or quality of life, including illness, injury, suffering, disability, and death, and may thus be physical, social or psychological.
<i>Near miss</i>	An incident or event that has the potential to be an adverse event but does not as a result of timely intervention or chance.

Introduction

The prevalence of certain types of patient safety incidents is greater in persons within the mental health system than it is for persons receiving care in other care settings. These unique incidents that will be explored in subsequent modules are:

- suicide and self-harming behaviour;
- violence and aggressive behaviour;
- seclusion and restraint use; and
- absconding.

To understand the complexity of these patient safety incidents for person's receiving mental health care, it is important to distinguish between individual factors that contribute to an incident and system based factors. This distinction is now a basic premise of patient safety theory and practice that needs to be well understood in order to make significant improvements in the quality and safety of the care delivered.

In the past, patient safety incidents such as those listed above, were linked primarily to individual factors and consequently, improvement strategies were primarily aimed at changes for individual practitioners. However, we now see that individual factors alone do not cause adverse events, but instead are also the result of a number of system failures. The systems approach acknowledges that it is the interaction among the system components (people, tasks, tools and technologies, physical environment, cultural and organizational conditions), not the individual components (healthcare providers, patients, and family) that matters most for improving safety. The systems approach also recognizes that errors, violations and safety problems are not "caused by people", but rather are the result of the interaction among processes and workflows, technology designs, teamwork, staff, patients, family, financial resources, training and education. With an understanding of these systemic factors, organizations can create the appropriate policies, procedures and systems that support patient safety of persons in mental health care.

(See **Module 1 – Systems Thinking: Moving Beyond Blame to Safety** for a more detailed exploration of this topic)

Systemic factors contributing to patient safety incidents

System fragmentation

Patient safety in mental health settings may be further compromised by systemic factors beyond the individual healthcare organization. In many jurisdictions, the organization, delivery and funding of health services for persons with mental illness are fragmented. These kinds of fragmentation mean that within and across the mental health care continuum there is variation in practice and processes and gaps in care delivery, with concomitant potential for adverse events. Some of the kinds of fragmentation are described in more detail below.

Fragmented delivery of care

The organization and delivery of health services for persons with mental illness are often fragmented which contributes to patient safety incidents. For example, there may be lags or gaps in information sharing, lack of community resources, bed shortages and staffing shortages leading to comprised delivery of care.

Inconsistent governance and funding of health services

Within the mental health sector, there is no single overseeing body or funding source for mental health services. Furthermore, in Canada, the percentage of spending on mental health and

addictions is small in proportion of all health spending and is lower than spending in other similarly developed countries. Within Ontario, hospital funding for mental health services may come from a number of different Ministries contributing to inconsistency within the sector.

Variations in the types of care settings where services are provided

Mental health services can be provided in a variety of care settings. For example, general hospitals, specialized/free standing hospitals, community sector – each of which may deliver care in a different way contributing to inconsistency in the way care is delivered.

Stigma

Stigma is another systems issue that is broader than any one healthcare organization. Stigma can manifest itself in many ways but can be generally understood as an attitude which devalues an identified group of people based on common stereotypes or beliefs and actions that proceed from those beliefs. This stigma can directly influence a person's ability to access care and the quality of care they receive. In other words, stigma can influence the interactions of the other components of a health care delivery system in such a way as to lead to patient safety incidents.

Stigma can lead others to avoid talking to or listening to someone with a mental illness. These experiences are dangerous for persons with mental illness because they perpetuate distress and hopelessness.

Within an organization, stigma can manifest through its staff and their belief that mental health conditions are less important than physical conditions. Consequently, health care providers may not deliver services to people with mental health conditions in a timely manner or at all. This kind of stigma is felt by the person wanting / needing care. Persons with mental illness often report that they are made to feel that something is *wrong* with them; that they are to blame; that they have some sense of control over how they feel and they are exaggerating their feelings of distress; and that their views or opinions are not valid. More broadly, stigma in the mental health context may manifest as a lack of investment in needed programs and services to this particular population.

Approaches to care

The systems approach allows that factors beyond those within the person's control impact the safe delivery of care. Within this framework, it is important to understand how different approaches to mental health care delivery, tailored to the needs of the person within the system, can support safety. A person centered care approach considers persons as equal partners in the care process and involves collaborative decision making between the person and the care team in the planning and implementation of care (programs, services, and interventions that the person will receive). Since persons vary in their needs, interactions, and ability to engage in their own decision making regarding their care, tailoring the decision-making and delivery of care to the person's individual needs is crucial.

The therapeutic relationship

All the approaches to care that are discussed subsequently are predicated on a strong therapeutic relationship. The therapeutic relationship is one of the central principles of patient safety in mental health care because:

- it underpins the connection between the person and the care providers; and
- care providers are better prepared to recognize a person's needs and reactions to certain situations because they understand the person's perspective and preferences.

Where there is a strong therapeutic relationship the person feels safe and more easily trusts his/her care provider. In turn, this will make him/her more receptive to interventions suggested by care providers when in a crisis or in an agitated state.

Several simple strategies can help develop a strong therapeutic rapport with the person such as:

- asking the person how he/she wants to be addressed;
- explaining the health care providers role which will minimize feelings of uncertainty and anxiety;
- listening empathetically;
- taking the time to consider the person's story;
- highlighting the person's strengths; and
- meeting the person in a comfortable and private environment.

Recovery oriented care

Recovery oriented care avoids the tendency to understand mental health care as “pathologies” based on symptoms and common experiences which can lead to a view that all persons with mental health needs are the same or cannot recover. Instead, recovery oriented care is a collaborative care model, where the person is valued as being unique in perspective and lived experience. As an approach, it leverages the person's voice, involvement, and choice in care planning through the recovery process and in so doing, promotes patient safety in two ways. Firstly, the person in care is a partner in their own care. Secondly, the person is given the appropriate opportunities to make choices during their care thereby minimizing the development of negative power relationships between the person and provider.

Negative power relationships can be characterized by a view that the care provided is punitive and the role of the care provider is to control the person and limit his/her choice in how the care progresses. Such perceptions can lead to adverse outcomes such as increased risk of violence or aggressive behaviour, absconding from care, and diminished self-esteem and dignity. Recovery oriented care mitigates these perceptions by demonstrating an approach to sharing power and control with the person – helping to guide the person rather than force the person to accept certain care paths.

That is not to say that this approach is incompatible with situations where the immediate necessity of keeping someone safe requires unwanted (from the person’s perspective) restrictions on his/her liberty and right to make choices for him/herself. At those times, it might not be appropriate to honour the person’s preferences. What is important to keep in mind in these instances is that any measure(s) implemented should strive to achieve a balance between maintaining the safety of the person and others and the obligation to respect the person’s autonomy and choice.

One practice within the recovery oriented care framework is *peer support* which can play an important role in promoting patient safety. The peer support principles of respect, shared responsibility, trust and empathy help persons feel like part of a community, cope with conflict, and prevent isolation in the care process – thus decreasing the likelihood of a patient safety incident.

Peer support refers to a system of giving and receiving help from others who share a connection, typically between persons who feel a shared “likeness” with each other. In clinical terms, a peer support person can be someone who has been or is currently going through the care experience (e.g., a “person in care”) and makes himself or herself available to connect with others who are in similar situations.

Peer support is important right from the beginning of the care process.

- For inpatient settings, having a patient representative or peer support group available to meet with and introduce persons new to the care setting can help them feel welcomed.
- In outpatient settings, peer support groups and representatives can introduce the person to the care process and provide an ongoing network of support and community, vital processes for preventing patient safety issues such as suicide.

Trauma-informed care

Like recovery oriented care, trauma-informed care is an approach that recognizes that each person is unique in perspective and lived experience. Trauma-informed care further recognizes that for some, their lived experience may have been traumatic and that trauma shapes the way the person copes and functions. Moreover, this approach acknowledges that the delivery of care may unwittingly cause the person to relive the distress associated with that past trauma. Revisiting past trauma may be expressed as violence or aggressive behavior or suicidal ideation. Trauma-informed care is therefore an approach which can impact patient safety because it ensures that care is not having further adverse effects on the person and helps the person work through the recovery process. It is an approach that informs how care providers work with the person in the recovery process.

Some key components of trauma-informed care include:

- recognizing that a person’s belief system can affect their own interpretation of trauma and recovery process;
- recognizing that there are cultural variations in how persons perceive and respond to trauma;

- prioritizing the person’s needs for safety, choice, and control;
- focusing on personal strengths to instill hope (e.g., supportive friends or family);
- building trust with the person and the person’s family to reinforce a sense of safety;
- listening to the person and family about how they define trauma and distress then working with them based on this definition; and
- including the person in the planning and evaluation of services.

Culturally responsive care

Like trauma-informed care, culturally responsive care recognizes every person’s lived experience is unique and tries to understand how his/her cultural experience could impact their receiving care. Culturally responsive care is facilitated by integrating those with cultural expertise as core members of the care team. For instance, providing culturally responsive care to Aboriginal people of Canada (First Nations, Inuit and Metis), whose traditions approach health holistically – focusing on the body, mind, heart and spirit – would mean developing paths to recovery that would marry both western and traditional approaches to health and wellness.

Some concrete steps that could be taken to develop and provide culturally responsive care include:

- when developing policies consult or involve key stakeholders including persons, families, communities, and affiliated service providers;
- having staff resources that represent a diversity of cultures and/or are fluent in languages that can be available in the care planning process;
- training staff to be culturally competent i.e. to have the knowledge, skills and attitudes necessary to provide adequate and appropriate health care services to all people in a way that respects and honors their particular culturally based understandings and approaches to health and illness;
- being flexible in the development of treatment approaches to accommodate specific cultural beliefs and traditions;
- advocating for or adopting legislative supports, such as the *North West Territories Mental Health Act* requires that in certain circumstances, a psychiatrist conducting an involuntary psychiatric assessment must consult an *elder* from the person’s community to assist with the assessment to determine the person’s mental health needs and risk within the context of the person’s culture; and
- utilizing available community supports, such as for Aboriginal patients, Health Canada has established seven Mental Wellness Teams that work with communities across Canada to integrate Aboriginal tradition and culture with western clinical perspectives; these multi-disciplinary teams may be helpful when working with Aboriginal patients to ensure that their care is connected to their community and culture.

More information about cultural competence can be found in **Module 3: Communication: Building Understanding with Patients and Care Givers.**

The mental health team

The mental health team plays a crucial role in the assessment, prevention and management of patient safety issues. In practice, and for all the modules that follow, the mental health team consists of persons involved in the immediate care environment as well as other, auxiliary persons or groups.

Immediate team members

Immediate team members include the care providers directly involved with the care of the person (psychiatrist, nurses, a psychologist, social worker, occupational therapist, recreation therapist, or other allied health professionals).

- This group takes direct responsibility over the person's care and safety.
- Patient safety responsibilities include the health and safety assessment of the person, interventions to mitigate or prevent risk, and ongoing monitoring.

The person who may be at risk (i.e., the patient) is also a part of the immediate team.

- The person at risk should be a central member of the team
- The person is involved throughout the assessment, care planning, prevention, and intervention processes so that both his or her patient safety risks and coping strategies are understood.

Auxiliary team members

The auxiliary team includes the person's family or other informal supports.

- Family involvement can provide information that can inform the assessment, prevention, intervention, and review processes.
- Family members should be educated about the person's level of risk as well as the plans to mitigate this risk, including plans for alerting the clinical team if a change occurs in the person's safety.

It also includes other staff in care settings. While not directly involved in the person's care, all staff needs to understand patient safety issues and contribute to the monitoring of the person and care environment. Examples include:

- environmental (e.g., maintenance), nutrition, and housekeeping services staff;
- security personnel;
- students or volunteers; and

- housekeeping. For instance, they may notice a person at risk of suicide hoarding plastic bags and report this to the clinical team.

Finally, the auxiliary team includes persons who have had interactions with the person or have knowledge of the person's background and with whom the care team can consult, such as:

- other care providers (e.g., general practitioners);
- cultural consultants;
- education professionals; and
- first responders (i.e., fire, ambulance, and police).

Inter-professional collaboration and communication

Module 3 – Communication: Building Understanding with Patients and Care Givers and **Module 4 – Teamwork** should be read in conjunction with the information given in this section.

As noted earlier in this module, the delivery of mental health care is fragmented. That fragmentation of care delivery can give rise to unintended adverse events. Inter-professional collaboration and communication are therefore key to supporting patient safety, creating as they do a team approach to care that reduces the risks of gaps in care delivery. Moreover, inter-professional collaboration and communication create a more inclusive care model within which various perspectives can be heard and respected. Inter-professional collaboration reduces the gaps in care delivery (and the potential for patient safety issues) by:

- reducing “silos” in health care;
- defining roles and expectations among care providers and team members;
- improving teamwork;
- fostering open, honest, and respectful communication between care providers, team members, patients, and families;
- developing collaborative and coordinated care plans within and between organizations; and
- promoting understanding of inter-professional perspectives.

In addition to communicating with and among care team members, effective communication is necessary for conveying information to persons in care (including families) in ways that enable them to be and feel fully involved, suitably empowered, and respected, and to make informed choices. How well caregivers are able to communicate with the person in care will often determine whether a trusting and successful relationship is established. Learning to be an effective communicator does not mean brutal honesty at all costs. Rather it entails communicating information in a manner that is aligned to clinical intentions. Open, honest, and respectful communication between care providers, team members, patients, and families will support patient safety.

Prevention

The concept of prevention should be considered as a system activity that rests on a diverse array of stakeholders, structures, and processes of care. Prevention is not the responsibility of any one person but rather of many people integrated within a system of interacting policies, procedures and safety culture with the organization and delivery of care. Recognizing that adverse events will occur within and outside of care environments, the goal for prevention should be continual improvement in the delivery of safe mental health services that focuses on the delivery and monitoring of factors that reduce the risk of patient safety incidents in care.

Incident management and review

Incident management refers to the activities of an organization to identify, analyze and correct hazards. (Refer to **Module 9 Methods for Improving Safety**). It can be thought of as a three step process that should include:

- a debrief,
- incident reporting, and
- a formal incident review process (e.g., root cause analysis) in instances where the incident was deemed inappropriate or led to harm of the person or others.

The debrief is an informal process that usually takes place between the team in the immediate aftermath of an incident. The next step, incident reporting, is the process whereby the details of the incident are recorded – either in database or in a paper format.

The last step, incident review, is a process used to discover the factual events and system issues that may have contributed to the event with a view to quality improvement. The review can use a variety of methods, including root cause analysis, to explore what happened, why it occurred, and what can be done to prevent it from happening again. The goal of these reviews is system improvement, not identifying or placing blame at any one person. The incident review team may consult other clinical staff members, the person and when appropriate, the person's family. The output of the incident review should be a report outlining findings as well as recommendations for quality improvement. These recommendations can become the framework for working with relevant stakeholders within the system of care including the immediate care team, the family, as well as the organization providing the care.

Each organization should have an incident review team to review patient safety and other issues related to quality of care. A team:

- consists of interdisciplinary members who can also draw on the experiences of others in the event under review;
- involves experts in quality and risk management, clinicians, administrators, health information and information technology, and others with specific expertise (e.g., legal, ethical specialists)

- maintains a scheduled review process where standard quality and safety indicators are evaluated on an ongoing basis; and
- has an incident review team that oversees the evaluation of adverse events, such as suicide (near misses and deaths by suicide) and self-harm, to promote quality improvement and patient safety.

Once issues have been identified, the incident review teams should produce a report outlining findings and recommendations. These recommendations become the springboard for quality improvement activities as well as a framework for working with relevant stakeholders within the system of care for the person. These stakeholders can include individuals or groups close to the person, i.e., immediate care team of the person, auxiliary care providers not part of the immediate care team (e.g., primary care), family, as well as the organization providing care.

It is especially important that where the purpose of the incident review is quality improvement, incident review participants feel free to fully disclose and discuss all relevant information without fear of legal reprisal. To ensure full and frank discussions during incident reviews, many jurisdictions across Canada have put legislation in place to afford protection to such quality of care reviews. Under most legislation, information provided to hospital quality of care committees and other designated quality of care committees that deal with quality improvement is shielded from public disclosure. This promotes sharing of information and open discussion among health professionals, which can lead to improved patient care and safety. Any incident review committee that is designated as a quality of care review committees should be formed in accordance with the legislation of the jurisdiction or with the relevant organizational policies.

Quality Improvement

Quality mental healthcare assures services are available, safe, effective, and accountable. For those who receive services, quality of care, broadly speaking, means that the services are delivered in such a way as to promote positive outcomes without introducing risk. For clinicians, planners, and policy makers, quality means incorporating the use of current best practice and technology in the delivery of care while maintaining fiscal responsibility and clinical effectiveness. For the organization, quality means the delivery of care and services within a culture that promotes and supports patient safety.

One of the most crucial elements of instilling a culture of quality and patient safety is strong leadership. Only senior leaders can productively direct the efforts needed to foster the culture and commitment required for addressing the underlying causes of adverse events and harm to patients. For quality and patient safety in general, leadership activities include:

- making patient safety a strategic priority within the organization;
- designating a patient safety/quality committee at the Governance level;
- designating a patient safety lead and patient safety committee at the operational level;
- developing a model for continuous quality improvement;

- engaging key members to support safety, from patients and families to executives and the board;
- implementing a communication strategy to build awareness that includes briefings and indicator monitoring and reporting;
- supporting patients and families affected by patient safety incidents;
- ensuring staff have the skills, resources, and infrastructure to maintain their own safety; and
- consistent alignment of policies, procedures, and roles across the system of care.

Below is a suggested team structure and process for achieving quality improvement in organizations.

Composition:	Quality improvement is best achieved through the development of a quality improvement team. This team could be headed by a member of the quality review team who carry out incident reviews as well as members of a clinical program or programs, a person representative, and a family consultant. In essence, this team can then act as a champion for organization wide improvement.
Mandate:	The quality improvement team should review organizational policies and practices incorporating what is known about risk factors for suicide and self-harm specific to the organization and target several factors for initial improvement efforts. This may include knowledge of risk factors, risk assessment process, prevention strategies, interventions for person level or extrinsic risk factors, or other factors related to risk of suicide or self-harm. Pilot studies can then be developed targeting a reasonable number of outcomes for change, typically one or two, for each factor.
Process:	The quality improvement team should include staff involvement in the pilot study to build consensus around the improvement effort and to solicit ideas to improve care delivery. Various innovations can be tried in order to improve care with regard to the specific risk factors, with data collection documenting the impact on the intermediate measures (e.g., improved risk identification). Innovations leading to improvement in the outcome measure can then be “rolled out” to other units, with continued data collection. As success is achieved, other risk factors can be selected for modification.

Summary

Like other health care sectors, the patient safety issues in mental health care are more often the result of system issues rather than individual factors. However, unlike other sectors, there are unique systems issues in mental health that impact patient safety incidents such as system fragmentation, stigma, and variations in the approaches to care. Attention to these various issues are required to make improvements in the delivery of safe, quality mental health care.

Since patient safety is a dynamic issue, ongoing evaluation and quality improvement are needed to demonstrate improvement. Ultimately, supportive leadership willing to lead through example is key for implementing a patient safety culture across all levels of service delivery.

Resources

- **Patient Safety in Mental Health:** Brickell, T. A., Nicholls, T. L., Procyshyn, R. M., McLean, C., Dempster, R. J., Lavoie, J. A. A., Sahlstrom, K. J., Tomita, T. M., & Wang, E. (2009). *Patient safety in mental health*. Edmonton, Alberta: Canadian Patient Safety Institute and Ontario Hospital Association. www.patientsafetyinstitute.ca
www.oha.com/Services/PatientSafety/Pages/200809BackgroundPaperandRoundtableEvent.aspx
- **Conceptual Framework for the International Classification for Patient Safety** World Health Organization (2009). Conceptual Framework for the International Classification for Patient Safety Version 1.1, Final Technical Report. http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf

Recovery oriented Care

- **Recovery rediscovered: Implications for the Ontario mental health system:** Everett, B., Adams, B., Johnson, J., Kurzawa, G., Quigley, M., Wright, M. (2003). *Recovery rediscovered: Implications for the Ontario mental health system*. The Canadian Mental Health Association, Ontario Division
http://www.ontario.cmha.ca/admin_ver2/maps/recovery_rediscovered.pdf
- **Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada:** Mental Health Commission of Canada (2009). <http://www.mentalhealthcommission.ca/>

Trauma-informed care

- **SAMHSA National Centre for Trauma Informed Care**
<http://www.samhsa.gov/nctic/>
- **The Trauma-informed Toolkit:** Clinic Community Health Centre. The Trauma-Informed Toolkit: A tool kit designed to help service providers and organizations deliver services that are trauma informed. www.trauma-informed.ca

- **Healthcare Toolbox: Guide to Helping Children and Families Cope with Illness and Injury:** A website devoted to education and tools for promoting trauma-informed care with children. The website was developed by the Center for Pediatric Traumatic Stress at The Children's Hospital of Philadelphia. <http://www.healthcaretoolbox.org/>

Cultural responsiveness

- **Mentally Healthy Communities: Aboriginal Perspectives:** Canadian Institute for Health Information, ed., *Mentally Healthy Communities: Aboriginal Perspectives* (Ottawa, Ont.: CIHI, 2009).
- **Cultural Responsiveness Framework: A Guide for Victoria Health Services.** Developed by the Rural and Regional Health and Aged Care Services, Victorian Government, Department of Health, Melbourne, Victoria, Australia. <http://www.health.vic.gov.au/cald>
- **Performance measures of cultural competency in mental health organizations:** Siegel C, Davies-Chambers E, Gaugland G, Bank R, Aponte C, & McCombs H (2000). *Administration and Policy in Mental Health*, 28, 91-106.

Therapeutic Relationship

- **Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour:** Registered Nurses' Association of Ontario (2009) Toronto, Canada. Registered Nurses' Association of Ontario. Provides specific strategies for developing and sustaining a therapeutic relationship.

Interprofessional Collaboration

- **CHSRF Synthesis: Interprofessional Collaboration and Quality Primary Healthcare:** Barrett J, Curran V, Glynn L, & Godwin M. (2007). Ottawa, ON: Canadian Health Services Research Foundation. www.chrsf.ca
- **A National Interprofessional Competency Framework:** Canadian Interprofessional Health Collaborative (2010). Vancouver, Canada. College of Health Disciplines, University of British Columbia. http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf
- **Position Statement: Interprofessional Collaboration:** Canadian Nurses Association/ Association Des Infirmieres et Infirmiers du Canada. Ottawa, ON: Canadian Nurses Association. www.cna-aiic.ca
- **Improving patient safety with effective teamwork and communication: Literature review needs assessment, evaluation of training tools and expert consultations:** Teamwork and Communication Working Group. Edmonton (AB): Canadian Patient Safety Institute; 2011. www.patientsafetyinstitute.ca
- **Patient safety: a case study in team building and interdisciplinary collaboration:** Horak BJ, Pauig J, Keidan B, Kerns J. (2004). *Journal for Healthcare Quality*, 26:6-12.

Leadership

- **Strategies for Leadership: Hospital Executives and their Role in Patient Safety:**
Dana-Farber Cancer Institute, Boston, Massachusetts, USA
<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/StrategiesforLeadershipHospitalExecutivesandTheirRoleinPatientSafety.htm>

Quality Improvement

- **Best Practices by Topic: BC Mental Health and Addiction Services**
<http://www.bcmhas.ca/Library/ClinicalStaffResources/MedicalLinks/LibBest.htm>
- **A framework for carrying out root cause analysis in Canadian healthcare contexts:**
Canadian Patient Safety Institute partnered, Saskatchewan Health, and the Institute for Safe Medication Practices Canada (ISMP Canada).
www.patientsafetyinstitute.ca/English/toolsResources/rca/Pages/default.aspx
www.patientsafetyinstitute.ca/french/toolsresources/rca/pages/default.aspx
- **Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies; Volume 1: Series Overview and Methodology:** University of California, San Francisco-Stanford Evidence-based Practice Center (EPC) –Academic Institution Agency for Healthcare Research and Quality – Federal Government Agency [U.S.]
<http://www.ahrq.gov/downloads/pub/evidence/pdf/qualgap1/qualgap1.pdf>

References

- Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep.* 2003;118(4):293–302.
- Campinha-Bacote J. Cultural competence in psychiatric mental health nursing. A conceptual model. *Nurs Clin North Am.* 1994;29(1):1-8.
- Ginsburg LR, Chuang YT, Berta WB, et al. The relationship between organizational leadership for safety and learning from patient safety events. *Health Services Research.* 2010;45(3):607-32.
- Murphy T, Greco P. Leadership's role in patient/client safety: are we doing enough? An accreditation perspective. *Healthcare Management Forum.* 2004;17(4):34-5.
- Jacobs P, Yim R, Ohinmaa A, Eng K, Dewa CS, Bland R, Block R, Slomp M. Expenditures on mental health and addictions for Canadian provinces in 2003 and 2004. *Can J Psychiatry.* 2008;May;53(5):306-13.
- Johnstone MJ, Kanitsaki O. Culture, language, and patient safety: making the link. *International Journal for Quality in Health Care.* 2006; 18(5):383-8.
- Mead S, MacNeil C. Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation.* 2006;10(2):29-37.
- MacNeil C, Mead S. A narrative approach to developing standards for trauma informed peer support. *American Journal of Evaluation.* 2005;26(2):231-44.
- Reading CL, Wien G. *Health Inequalities and Social Determinants of Aboriginal People's Health.* Victoria, BC: National Collaborating Centre for Aboriginal Health, 2009.
- Soo S, Berta W, Baker GR. Role of champions in the implementation of patient safety practice change. *Healthcare Quarterly.* 2009;12(Spec No Patient):123-8.
- Shortell S, Singer S. Improving Patient Safety by Taking Systems Seriously. *JAMA.* 2008;299(4):445-7.

Principal message

The single most important message your audience should come away with is the awareness of the unique systems issues that impact patient safety in mental health including system fragmentation, stigma and variations in approaches to care.

Module overview

There are a number of unique patient safety issues that persons dealing with mental illness face every day when receiving care across the health care system. However, there still remains a lack of awareness coupled with a lack of available evidence surrounding these patient safety issues within the mental health sector.

While persons receiving care in the medical setting are at risk of a variety of patient safety incidents (for example, falls, medication errors, infections), there are a number of critical safety incidents that are unique to the mental health population. These incidents include: suicide and self harm; violence and aggressive behavior; restraint use and seclusion and absconding, all of which directly impact the safe delivery of care for mental health clients. It is important therefore, to understand the variety of factors that lead to these types of events.

This module and the ones that follow will present the most current information in all of these areas. Within these care settings, a variety of terms for the individual seeking treatment are used including client, consumer, patient and resident. Therefore, for purposes of these modules, the more inclusive and global term of “person/person in care” will be used to describe that individual.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
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Presentation	35 minutes
Debrief about teaching methods	5 minutes
Summary	2-3 minutes
<u>Post-test & Evaluation</u>	<u>5 minutes</u>
Total	49-51 minutes

3. Number of slides: 10

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP – Canada Front Cover Page;**
- **PSEP – Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise. To foster discussion, ask participants for examples from their institutions or experiences. Ideally, the examples could be linked to one of the major teaching points.

Alternative style: case-based teaching

Use a case you are familiar with to include some case-based teaching. To help participants feel involved and invested, you may invite them to give you a case from their

institution or experience. However, it is usually best to return to the case you know to draw out analytic points for teaching since you do not need to ‘think on your feet’ too much.

5. Key take-home points

1. It is important to understand the gaps in patient safety in mental health from a systems perspective.
2. Systemic issues, such as stigma, can affect patient safety.
3. Different models of care delivery, each with its own individual strengths, can be used to promote patient safety.
4. A mental health quality improvement framework should be integrated into your institution to help support patient safety.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session.