PATIENT SAFETY IN MENTAL HEALTH

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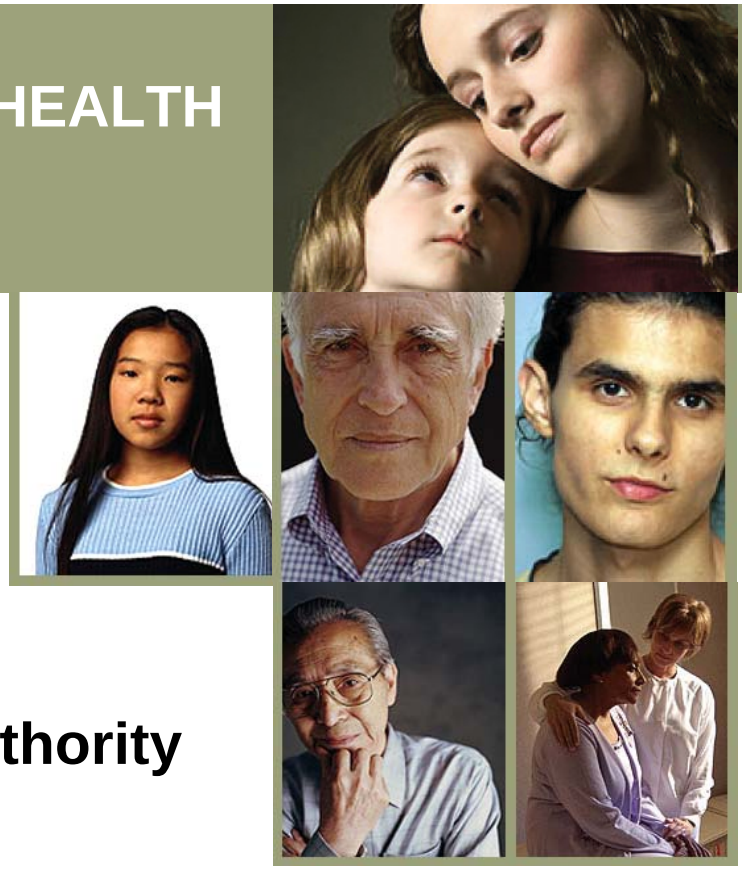
PAPER PREPARED BY:

BC Mental Health & Addiction Services

BRITISH COLUMBIA MENTAL HEALTH AND ADDICTION SERVICES



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PROVINCIAL HEALTH SERVICES AUTHORITY (PHSA)
PROVINCIAL AGENCIES

BC Children's Hospital
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Sunny Hill Health Centre for Children
A program of BC Children's Hospital

Women's
BC Women's Hospital & Health Centre
An agency of the Provincial Health Services Authority

BC Cancer Agency
Care + Research
An agency of the Provincial Health Services Authority

BC Mental Health & Addiction Services
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BC Centre for Disease Control
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BC Transplant
An agency of the Provincial Health Services Authority

BC Renal Agency
An agency of the Provincial Health Services Authority

Cardiac Services BC
A program of the Provincial Health Services Authority

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BRITISH COLUMBIA MENTAL HEALTH AND ADDICTION SERVICES (BCMHAS)

- Tertiary-level mental health services to people across BC.
- Recognizes that people with mental health challenges may also have co-occurring issues with substance misuse.

BCMHAS Specializes in:

- Adult Psychiatry and Geriatric Psychiatry.
- Forensic Psychiatric Services.
- Child and Adolescent Mental Health Services.
- Eating Disorders.
- Mental Health and Addictions Research, Knowledge Exchange, and Health Promotion.

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PATIENT SAFETY IN MENTAL HEALTH RESEARCH

- The majority of our understanding of patient safety has come from acute health care settings.
- While there is some overlap with mental health, there are also unique patient safety issues in mental health that are different to those in acute care.

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OHA ONTARIO HOSPITAL ASSOCIATION

- CPSI and OHA jointly commissioned a research team from BCMHAS, through a competition process, to develop a background paper on patient safety in mental health.
- Pan-Canadian Patient Safety in Mental Health Advisory Committee was formed to guide the research process.

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PAN-CANADIAN PATIENT SAFETY IN MENTAL HEALTH ADVISORY COMMITTEE

- 13 individuals with knowledge and experience in the field of mental health and/or patient safety.
- Researchers, academics, clinicians, decision makers, and OHA/CPSI representatives.
- The members were identified by OHA and CPSI through a call for membership and a competitive selection process.
- Selected the research team, provided guidance during the development of the research methods, assisted in the facilitation of the Roundtable Event, reviewed and critiqued the paper.

UNDERSTANDING PATIENT SAFETY IN MENTAL HEALTH

- Mental health patients are at risk of patient safety incidents unique to mental health (i.e., suicide, self harm, seclusion, restraint) as well as incidents in general medical settings (i.e., adverse medication events, misdiagnosis).
- Commonly reported incidents: Accidents, elopement, aggression, self-harm, patient abuse, diagnosis, medication, medical equipment.
- Policies and procedures need to balance the tension between safety measures and patient autonomy (i.e., locking units, security monitoring).
- Patient safety measures can contribute to safety incidents (i.e., restraint and seclusion).
- Patient safety and employee safety interact with each other and efforts to improve one must take into account the other.

PATIENT SAFETY IN MENTAL HEALTH RESEARCH

Three Research Methods

1. In-depth review of the white and grey literature.
2. Qualitative analysis of telephone interview data with 19 national and international key informants.
3. Qualitative Analysis of small groups discussion data from an invitational Roundtable Event with 72 participants.

Ethics Approval

- University of British Columbia's Ethics Review Board.

Research Lead

- Dr. Tracey A. Brickell

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PATIENT SAFETY IN MENTAL HEALTH RESEARCH

Nine Research Team Members

Tracey A. Brickell, D.Psych.

Tonia L. Nicholls, Ph.D.

Ric M. Procyshyn, Pharm.D., Ph.D.

Carla McLean, M.A. (Ph.D. Student)

Rebecca J. Dempster, Ph.D.

Jennifer A. A. Lavoie, M.A. (Ph.D. Student)

Kimberly J. Sahlstrom, M.A.

Todd M. Tomita, M.D., FRCPC

Eugene Wang, M.D., FRCPC

LITERATURE REVIEW METHOD

Inclusion Criteria

1. Eight patient safety incidents: Violence and aggression, patient victimization, suicide and self-harm, seclusion and restraint, falls and other patient accidents, absconding and missing patients, adverse medication events, and adverse diagnostic events.
2. Mental health diagnoses in the DSM-IV-TR.
3. Mental health services across primary, secondary, and tertiary care levels.
4. Mental health services across hospital, private sector, and other community-based settings.
5. Mental health across the lifespan including child and youth, adult, and older adult populations.
6. Limited to documents published between 1999-2008.

LITERATURE REVIEW METHOD

Exclusion Criteria

1. Patient safety incidents in people with mental health issues outside the mental health sector.
2. Privacy violations.
3. Documented adverse effects of specific medications.
4. Medical equipment failure not specific to mental health settings.
5. Infectious disease.

- A literature search on infection prevention and control, and fire prevention and precautions, did not reveal results unique or relevant to mental health, and were therefore not included in the search strategy.

LITERATURE REVIEW METHOD

White Literature Search Method

- Conducted by ***Orvie Dingwall*** (CPSI librarian).
- Searches were conducted in four electronic databases.
  1. Medline.
  2. Cumulative Index to Nursing & Allied Health Literature (CINAHL).
  3. Embase.
  4. PsycINFO.
- RAs searched through approximately 5,600 papers.
- 974 documents were retrieved for review.

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LITERATURE REVIEW METHOD

Grey Literature Search Method

- Supervised by ***Brook Ballantyne-Scott*** (BCMHAS librarian).
- 66 Canadian/international patient safety, mental health, government health care, and library websites were searched (e.g., World Health Organization; National Libraries of UK, Canada, Australia, and USA; Canadian Psychiatric Research Foundation; National Patient Safety Agency).
- The list was created in collaboration with the CPSI and BCMHAS librarians and based on our knowledge of key mental health and patient safety websites.

LITERATURE REVIEW METHOD

Grey Literature Search Method

- Enter one of seven key mental health search terms into the main search box (e.g., mental, psychiatry, psychotic).
  - ~ < 20 hits – Results were examined individually for inclusion.
  - ~ > 20 hits – Mental health patient safety search term was combined with one of 32 keywords (e.g., safety, error, suicide, restraint, elopement, assault, misdiagnosis, and fall).
- When websites were not easily searchable (i.e., no search box), the *publication* or *research* link was used and visually scanned.
- After four RAs searched through thousands of documents over two months, 403 documents were retrieved for review.

LITERATURE REVIEW METHOD

Reviewers

Understanding Patient Safety in Mental Health - *Rebecca J. Dempster, Ph.D.*

Violence and Aggression - *Tonia L. Nicholls, Ph.D.*

Patient Victimization - *Tonia L. Nicholls, Ph.D.*

Suicide and Self-Harm - *Rebecca J. Dempster, Ph.D.*

Seclusion and Restraint - *Jennifer A. A. Lavoie, M.A.*

Falls and Other Patient Accidents - *Jennifer A. A. Lavoie, M.A.*

Absconding and Missing Patients - *Kimberly J. Sahlstrom, M.A.*

Adverse Medication Events - *Ric M. Procyshyn, Pharm.D., Ph.D.*

Adverse Diagnostic Events - *Todd M. Tomita, M.D., FRCPC & Eugene Wang, M.D., FRCPC*

PATIENT SAFETY INCIDENTS REVIEWED

Violence and Aggression

- *Aggression*: Any behaviour in which the patient places their hands on another with the intention of causing harm.

- *Violence*: Threats with a weapon in hand, sexual assaults, and assaults resulting in injury.

Patient Victimization

- *Victimization*: Any verbal, psychological, physical, sexual, and financial abuse by others.

PATIENT SAFETY INCIDENTS REVIEWED

Suicide and Self-Harm

- *Suicide*: Deliberate self-inflicted bodily injury causing death.
- *Attempted suicide* - Deliberate self-inflicted bodily injury committed with intent to die, but does not result in death.
- *Self-harm*: Deliberate self-inflicted bodily injury without expressed intent to die.

Falls and Other Patient Accidents

- *Patient accident*: An unanticipated occurrence during which a patient sustains an injury or potential injury.
- *Fall*: A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object; excluded falls resulting from violent blows or other purposeful actions.

Seclusion and Restraint

- *Restraint*: Involuntary immobilization or restriction of a person's movement.

- Three main categories:

1. *Environmental Restraint (Seclusion)*: Physically confining a patient to an area.

2. *Physical/Mechanical Restraint*: Using a technique or device to prevent movement.

3. *Chemical Restraint*: Using pharmaceuticals to control behaviour.

PATIENT SAFETY INCIDENTS REVIEWED

Absconding and Missing Patients

- *Absconding*: A patient who wilfully leaves a ward or facility without permission or breaches terms of leave.
- *Wandering*: Locomotion by patients who are cognitively impaired but express no wilful intent to leave a ward or facility.
- *Exit-seeking wandering*: Locomotion by patients who are cognitively impaired but have wilful intention to leave a ward or facility without permission.
- *No shows*: Patients who go missing from the private sector or other community based services; the patient safety implications of no shows is an understudied area.

PATIENT SAFETY INCIDENTS REVIEWED

Adverse Medication Events

- *Adverse medication event*: 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.

Adverse Diagnostic Events

- *Adverse Diagnostic Event*: Delay in formulating appropriate diagnoses, a failure to use appropriate techniques for making diagnoses, and a failure to act on the results of diagnostic tools.
- *Misdiagnosis*: Assigning the wrong psychiatric diagnosis.
- *Underdiagnosis*: In assigning a psychiatric diagnosis, failing detect a coexisting psychiatric or medical condition.
- *Missed diagnosis*: Total failure to detect a coexisting psychiatric condition.

KEY INFORMANT INTERVIEW METHOD

Participants

- Qualitative semi-structured telephone interviews with 19 experts in patient safety and/or mental health.
  - ~ 15 Canada (BC, Alberta, Ontario, Quebec, Nova Scotia).
  - ~ 4 international (UK, USA, Australia).
- Key informants were selected by the Advisory Committee; selection was based on the key informant's knowledge, expertise, and prominence in patient safety and/or mental health.
- The selection process ensured the key informants were sampled from a variety of professional positions including management, administrative, academic, research, clinical, patient advocacy, consulting, patient safety, law, and risk assessment.

KEY INFORMANT INTERVIEW METHOD

Procedure

- Interview questions were compiled by the BCMHAS research team and reviewed by the Advisory Committee.
- Interview questions were designed to gather information on:
  - ~ Current initiatives and research.
  - ~ Strategies for improving patient safety.
  - ~ Emerging issues.
  - ~ Gaps in current knowledge and practice.
  - ~ Barriers to improving patient safety.
- Thematic qualitative analysis was performed - *Carla McLean, M.A.* Two-step process:
  1. Coding each interview on issues that were easily categorized and that could provide some basic quantitative data.
  2. Identifying larger themes emerging from the data.

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ROUNDTABLE EVENT METHOD

- September 18th, 2008 in Toronto, Ontario, Canada.

Participants

- 72 leaders in patient safety and/or mental health participated in the roundtable event.
  - ~ 71 from Canada (BC, Alberta, Ontario, Quebec, Nova Scotia, Manitoba).
  - ~ 1 from United Kingdom (invited guest speaker).
- Roundtable participants were selected by the Advisory Committee; selection was based on the participant's knowledge and experience in patient safety and/or mental health.
- The selection process ensured the participants were sampled from a variety of professional positions including academic, research, clinical, patient safety, patient advocacy, management, administration, and risk assessment.

ROUNDTABLE EVENT METHOD

Procedure

- The Roundtable Event was coordinated by a professional facilitator.
- Participants were provided with an overview of the findings from Literature Review and Key Informant methods.
- Participants divided into nine separate pre-determined discussion groups; ensured mix of professional and geographic representation.
- Discussed and provided 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?
    3. What are the next steps and future directions for patient safety in mental health?

ROUNDTABLE EVENT METHOD

Procedure *(continued)*

- 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.
- The scribe notes were collected at the end of the day and the notes formed the data for a qualitative analysis.
- As per the key informant interviews, a thematic qualitative analysis was performed - *Carla McLean, M.A.*
- Two-step process:
    1. Coding each interview.
    2. Identifying larger themes.

EMERGING THEMES

Planning and Policy

- Agency or agencies to provide leadership and advocacy for patient safety in Canadian mental health care.
- Standardized national patient safety framework specific to mental health settings including standardization of (1) patient care practices; (2) education and professional development; (3) patient safety language and terminology; (4) categorizing system (type, severity, setting, population).
- Consistent reporting and learning structure and central reporting place to facilitate the collection and analysis of data on patient safety incidents in mental health across Canada. Provide a database for research.
- Cultural shift in understanding patient safety incidents from a human level to a system level. More work is required to fully embed a safety culture within an organization: Encourage open reporting and communication; learn from incidents and implement change; provisions for patients and family/caregivers active roles; eliminate discrimination and stigma.

EMERGING THEMES

Practice

- Policy, planning, risk assessment, and training needs to adapt to increases in the complexity of patients and care required in acute, tertiary, and forensic mental health care.
- Improvement in communication and service integration during transitions of care.
- Identify and evaluate existing risk assessment tools and establish an effective means to disseminate information on psychometrically sound tests, and proper use and interpretation.
- Better education and training on patient safety procedures, risk assessment, and best-practices; ensure it is ongoing, evidence-based.
- Better provisions for patients, family, and caregivers to play a more active role in monitoring their safety and providing information on potential safety incidents.
- Greater effort and action is required to eliminate stigma and discrimination against people with mental illness.

EMERGING THEMES

Research

- Higher quality research with fewer methodological limitations.
- Research conducted within Canadian mental health settings.
- Specific areas under-researched and require greater attention:
  a) Older adults and child/adolescent populations.
  b) Cultural, ethnic, religious groups, indigenous populations.
  c) Private sector, rural and geographically isolated settings, other community-based mental health care services.
  d) Patient's, their family, and caregiver's perspectives.
  e) Emotional and psychological outcomes.
- Funding for patient safety research in mental health needs to be a priority among Canadian funding bodies.

ACKNOWLEDGEMENTS

- Canadian Patient Safety Institute and Ontario Hospital Association for commissioning the project.
  - ~ Sandi Kossey and Orvie Dingwall (CPSI)
  - ~ Dominique Taylor, Michelle Caplan, Cyrelle Muskat and Deborah Cumming (OHA)
- Pan-Canadian Patient Safety in Mental Health Advisory Committee members.
- British Columbia Mental Health and Addiction Services administration and research support staff, senior leadership.

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DISSEMINATION AND KNOWLEDGE EXCHANGE

Conference Poster Presentations

2009 The Canadian Healthcare Safety Symposium 9

- Bond, L., Brickell, T. A., Nicholls, T., McLean, C., Procyshyn, R., Dempster, R., Lavoie, J., Sahlstrom, J., Tomita, T. M., & Wang, E. *Patient safety in mental health*.

2009 OHA Mental Health and Patient Safety Conference

- Brickell, T. A., & McLean, C. *A Canadian perspective of patient safety in mental health: A qualitative analysis of small group discussions during an invitational roundtable event*.
- Brickell, T. A., Nicholls, T., Procyshyn, R., et al. *Patient Safety in mental health: A systematic review of the literature*.

2008 OHA Mental Health and Patient Safety Conference

- Brickell, T. A., McLean, C., & Howard, K. E. *Emerging Issues and Challenges for Improving Patient Safety in Mental Health: A qualitative analysis of key informants' perspectives*.

DISSEMINATION AND KNOWLEDGE EXCHANGE

Peer-Reviewed Manuscripts

- Brickell, T. A., Nicholls, T., McLean, C., Procyshyn, R., Dempster, R., Lavoie, J., Sahlstrom, J., Tomita, T. M., & Wang, E., Kossey, S. N., Dingwall, O., Taylor, D. (under review). Broadening the patient safety agenda to include mental health care. *Quality and Safety in Health Care*.

- Brickell, T. A., & McLean, C. (under review). Emerging issues and challenges for improving patient safety in mental health: A qualitative analysis of expert opinions. *Journal of Patient Safety*.

- Procyshyn, R. M., Barr, A. M., Brickell, T. A., & Honer, W. G. (accepted pending minor revisions). Medication errors in psychiatry: A review. *CNS Drugs*.

DISSEMINATION AND KNOWLEDGE EXCHANGE

Paper Posted on Websites

- Canadian Patient Safety Institute (CPSI)

  www.patientsafetyinstitute.ca

- Ontario Hospital Association

  www.oha.com

- BC Mental Health and Addiction Services

  www.bcmhas.ca

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NEXT STEPS

- Exploration of opportunities for inter-provincial collaboration on key patient safety areas highlighted in the paper (e.g., stigma, suicide, seclusion and restraint).
  - Build upon work already underway in some provinces (e.g. classification and reporting systems for adverse events specific to mental health, risk assessment tools).
  - CPSI and OHA consulting with key stakeholders and partners.
- BCMHAS is leading the development of a provincial framework in B.C. for the assessment and management of suicide risk.
- Sharing of information, leading practices and tools.
  - CPSI has created an online Community of Practice for patient safety in mental health.

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