# UPDATED STATUS REPORT ON RECOMMENDATIONS, STRATEGIES AND ACTIONS ON EXTERNAL PEER REVIEW

St. Joseph's Healthcare Hamilton
**Updated November 2017**

**This is an update to the original report recommendations and actions released in September 2016. Updated actions/strategies are in bold type.**

**Background:** St. Joseph's Healthcare Hamilton (SJHH) requested an external peer review in the spring of 2016 after a series of incidents of aggression and violence against staff in its mental health program and psychiatric emergency services. We recognized that we needed an objective outside perspective to supplement the work we were continuing internally.

The reviewers were asked to look at policies and practices, training and education, models of care and best practices to care for patients with a history of violence, and the impact that has on staff and client safety. The three reviewers are all respected specialists in mental health, and understand the complex needs of this patient population. (Their bios are at the end of this document.)

The reviewers reported that St. Joseph's "has taken strong and effective action to enhance safety for staff and patients" and "responded to the recent cluster of incidents swiftly and effectively." However, we regard this report and our current initiatives as a foundation and we recognize that ongoing continuous improvement will be required in our efforts to enhance safety for our staff and patients. We will be considering further initiatives to supplement the work currently underway in consultation with our management, staff and union leadership.

Their report has six categories of recommendations, which deal with policies and practices, organizational issues, models of care, best practices, safety training and management systems. St. Joseph's accepts all of these recommendations and has already implemented many of them, and is well underway in planning or implementing others. This is an ambitious plan, and an important one for the safety of everyone.

Although the findings and events reviewed were in the mental health program, we also consider the recommendations to have hospital-wide impact as we care for patients with serious issues across our sites and out-patient programs.

Violence is never acceptable and St. Joseph's is working with our staff and physicians to become a leader in workplace safety.

This document provides details of actions and plans to proceed with recommendations outlined in the report. The full report can be found on StJoes.ca

| | External Peer Review Recommendation* | Status | Strategies in place and/or underway for Mental Health and Addiction Program<br>Green: Complete<br>Yellow: Underway<br>Green/Yellow: considerable work has been completed and more work is underway. |
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| **Rec. 1** | **Enhancing workforce capacity for prevention and management of violence (Updated status of initiatives in bold)** | | |
| 1.1 | Enhance training in the Crisis Prevention and Intervention (CPI) program regarding the circumstances in which staff members can "put hands on patients" to minimize injury to self and/or patient. | **Fully implemented** | SJHH has been providing CPI training to staff since 1988. The program is regularly updated and in 2014 updated curriculum for CPI Trainers included techniques to safely "put hands on patients" to minimize injury to self and/or patient. The intervention is taught in initial training and annual recertification training.<br>• **Hands on intervention incorporated in twice monthly mock code drills. Regular training and drills continue** |
| 1.2 | Evolve hiring practices to include standardized interview tools and processes that facilitate assessment of a candidate's competencies and aptitude for mental health practice and job performance. | | Only qualified staff is hired for positions across the hospital. CNA (Canadian Nurses Association) certification in psychiatric and mental health nursing (within first 5 years of hire) is required for nurses new to MHAP.<br>To enhance assessments for new hires, standard questions have been developed to help support consistent quality of hire, including validation of CAN certification.<br>**A nursing onboarding tool has been developed and is currently being piloted in one of the mental health programs. This tool supports a consistent, structured approach to validating current skill and knowledge sets as well as proactively identifying and supporting areas for development.** |
| 1.3 | Broaden tuition and learning support for national certification in mental health nursing to all mental health RNs and for mental health certificate programs to mental health RNs and RPNs. | **Complete** | Support for Canadian Nurses Association certification preparation workshops; two SJHH Foundation scholarships, clinical orientation highlights learning opportunities; TD Grants in Medical Excellence Education fund aids RNs, RPNs & other regulated healthcare practitioners with financial assistance for continuing education in many areas (to date over 200 staff have benefitted from over $220,000 in grants); Foundation grants support education (more than $1 million since 1994) |
| 1.4 | Expand staff training and education processes by incorporating videos of staff harm incidents into training and education processes and providing hands-on refreshers in how to apply mechanical restraints. | **Fully Implemented** | All staff who would be using mechanical restraints have been trained. Review of mechanical restraints is incorporated in the CPI classes effective September 2016 to ensure all new and recertifying staff receives the training. Video incorporated into training with plans to expand interactive learning exercises under way.<br>• **Continued expansion of library and creation of video scenarios as teaching aids in CPI training.**<br>• **100% compliance on mechanical restraints application achieved** |

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| 1.5 | Further enhance CPI training by integrating principles of Safewards and/or Trauma Informed Care, including Security Personnel in the mock code exercises and providing hands-on refreshers in applying mechanical restraints. | **Fully Implemented** | Principles of Trauma Informed Care (TIC) are already integrated in the CPI training.<br>Monthly mock code drills incorporate scenarios to allow additional opportunities to practice crisis prevention and management skills, care planning considerations, team interventions and debrief.<br>Enhancements to monthly drills to incorporate Code White exercises are under development and will include participation by clinical staff and Security Personnel.<br>GPA Gentle Persuasive Approach training is offered to staff on specific units<br>• **Code White drills fully implemented and sustained at West 5th campus**<br>• **Code White drills fully implemented on 9 Tower, 10 Tower and PES**<br>Mechanical restraints – see 1.4<br>Safewards – see 2.4 |
| **Rec. 2** | **Standards of care, therapeutic environment and team effectiveness (Updated status of initiatives in bold)** | | |
| 2.1 | Implement a clinical practice optimization program to build capacity for quality mental health clinical practice including (but not limited to) mechanisms such as formal reflective practice opportunities, and completion of practice self-assessment tools and individualized learning plans supported by Clinical Educators or Clinical Nurse Specialists. | **Fully Implemented** | Several opportunities to build capacity for quality mental health clinical practice, continuous learning and formal reflection are in place and they include but are not limited to:<br>• Debriefing with staff, patient and family is completed as soon as possible after a significant event. Purpose of debriefing is to enable reflection, enhance learning, identify areas for improvement, review plan of care and celebrate achievements.<br>• Each unit in mental health conducts daily safety briefings and huddles. These forums provide opportunities for brief and focused daily team conversations to share safety concerns, develop plans to reduce risks and celebrate success when team goals have been met. The goal of the safety briefings is to mitigate risks through team work and problem solving by all team members.<br>• Weekly formal debriefing with service leadership helps identify any patterns or recommendations that have broader implications for the program.<br>• Critical and non-critical incident 24-hour reviews are conducted as soon as possible after the incident for the purpose of addressing any immediate safety concerns, reflecting on immediate actions taken and identifying whether a Quality of Care review shall take place or whether a focused incident review process |

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| | | | shall suffice. The purpose of quality of care reviews is to provide opportunities for conducting a root cause analysis, and identify potential recommendations for enhancing quality of care.<br>• Chart audits completed by clinical managers are shared with staff individually for the purpose of enhancing clinicians' professional practice and promoting self-reflection. |
| 2.2 | Identify physician attendance at safety huddles as a priority. | **Fully Implemented** | Heads of Services are ensuring full implementation by Nov. 1, 2016.<br>• **Heads of Service in discussion with physicians re expectations to participate in daily safety huddles**<br>• **Physicians engage in safety discussion in form of team meetings/ TOA / Safety Huddles** |
| 2.3 | Evaluate the appropriateness and effectiveness of the staff mix model for the Mental Health and Addictions Program services with a view to adding or expanding providers such as Behavioural Therapists, Recreational Therapists, | **Complete** | Mental Health and Addiction Program leadership team regularly reviews the staff mix to ensure optimal care for our patients, and this will continue. |
| 2.4 | Expand Safewards implementation to Psychiatric Emergency Services as well as all in- patient units. | | Implementation underway, with full implantation planned for April 2018 (full implantation after Dovetale completion)<br>• **A Project lead has been appointed with over 50 unit leads trained across the Mental Health and Addiction program**<br>• **Currently the project has 14 Inpatient Mental Health units participating, as well as Psychiatric Emergency Services and Peer Support**<br>• **Training will be provided to all Mental Health and Addiction Program inpatient staff by spring of 2018 on resolving conflict, respectful limit settings, as well as the importance of knowing a patient outside of their illness** |
| 2.5 | Expand the number and availability of activities and programs for patients on days, evenings and weekends. | **Fully implemented** | • Recreation Therapists have scheduled programming at Unit level and centrally on days, evenings and weekends.<br>• Centralized programming offered on weekends/holidays at W5th |

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| | | | • Rehabilitation and nursing staff use a continuous process for evaluating and modifying the program schedules on the units according to patients' needs<br>• **Larger group spaces have been created or modified to support group sessions for patients with restricted access to the public area.**<br>• **There is a newly formed Patient Wellness Advisory Group – a group committed to review and enhance the Mental Health and Addiction Program's approach to support Patient Wellness. This group has patient and family representatives as well as front line clinicians** |
| 2.6 | Develop and implement a standardized process and template to elicit and record each patient's personal story | | • Exploring ways to utilize existing resources where this information is available e.g. Social Work Assessment, Comfort Plan<br>• **The Safewards "Know Each Other" intervention will be incorporated into the existing practice of comfort plans, as well as admission checklists.**<br>• **Training is to be provided to staff once changes to comfort plans are completed by April 2018.** |
| 2.7 | Consideration of dynamic risk factors for aggression be considered in the selection of violence risk assessment tool for implementation across MHAP. | **Fully Implemented** | Every patient receives a comprehensive risk assessment<br>All units complete the RAI (Resident Assessment Instrument) Risk Assessments<br>Safety risks are reviewed at daily safety huddles, and twice daily Transfer of Accountability (TOA) (shift handover)<br>Additional Risk Assessments for responsive behaviours and aggression is fully implemented in 10 inpatient units<br>Task group is ensuring that an evidence based violence risk assessment tool is being used consistently across services. Regular audits done to monitor consistent application. Considering harmonizing model.<br>• **Standardized risk assessment is in place across all designated inpatient areas.** |
| 2.8 | Adopt a utilization management tool.<br>*NOTE: The external review states this recommendation a second time in an independent category* | | Will be reviewed after implementation of electronic medical record system |

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| 2.9 | Request the Medical Advisory Committee convene a task group to study and make recommendations regarding expected on-unit time and caseload size for psychiatrists through such activities as consultation with peer hospitals/services to identify their approaches and expectations, and a review of related literature, psychiatrist to patient benchmarks and standardized practice guidelines/pathways. | **Fully Implemented** | • **Psychiatrist staffing has been reorganized, and consolidated to optimize care. All inpatient psychiatrists attend daily reports, safety huddles and weekly multi-disciplinary team meetings.** |
| **Rec. 3** | **Standards for post aggression response (includes organizational learning) (Updated status of initiatives in bold)** | | |
| 3.1 | Develop a fact sheet/protocol for staff members that informs their decision-making regarding reporting patients to the police for the purpose of criminally charging patients for any assaults. | **Fully Implemented** | • **Guidelines on when to call police created and posted on internal website along with video and educational material for staff.** |
| 3.2 | Collate, analyze and share data from the completed peer-led, post restraint/seclusion patient debrief tools to inform ongoing efforts to enhance safety. | **Fully implemented** | The data from the completed peer-led, post restraint/seclusion debrief tools is collated and reported through Formal Debriefing and Seclusion/Restraint Steering Committee.<br>Information from staff and patient peer debriefings informs changes in clinical care planning at individual and service level as applicable.<br>All patients are offered debriefing with a peer support worker following a restraint/seclusion event.<br>An extensive process is being developed to aggregate data from peer led patient debriefs at program<br>• **Data from peer debriefing collected and analyzed, findings & recommendations shared with Seclusion/Restraint Reduction Steering Committee.** |

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| 3.3 | Develop a structured post-Code White debrief tool and process. | **Fully Implemented** | Our current informal Code White debriefing will be replaced by a standardized process. This will be implemented by the end of October, 2016. A Code White written record about Code White incidents has been created with implementation beginning in October.<br>• **Code White Record captures real-time data of the Code White incident including post incident debriefing.**<br>• **Corporate rollout complete** |
| 3.4 | Develop a communication strategy to disseminate information to the entire organization **as appropriate** when staff members have been injured or violence toward staff has been identified as a risk | **Fully implemented** | Incidents currently communicated as considered needed to entire organization.<br>Conducting focus groups to identify preference for communication.<br>• **Focus groups held, recommendations developed for strategy to use standardized and, where possible, existing communication mechanisms (such as safety huddles, TOA) to inform within units, across sites, and across organization as appropriate.** |
| 3.5 | Consider developing a specific outreach strategy for physicians who are involved in a Code White or who experience physical injury or trauma from a Code White incident. | **Fully Implemented** | Psychiatrist in Chief reaches out to involved physicians re: Employee Assistant Program and physician wellness support availability. |
| 3.6 | Consider offering injured staff members contact by a Senior Team Member as part of Occupational Health follow-up (example of script included in the report) | **Fully Implemented** | Managers routinely contact their staff when an incident occurs to ensure the person is fully supported and receives the appropriate care and ongoing support to address the incident.<br>Senior staff is always made aware of significant issues. A formal process has been developed in which senior leaders will offer support to staff when a significant incident occurs. |
| **Rec. 4** | **Corporate oversight for Safety/Quality** | **(Updated status of initiatives in bold)** | |
| 4.1 | Clarify and document the committee structure for the organization and consider adding a standing agenda item on safety to key committees. | **Fully Implemented** | An Executive Committee on Prevention of Violence in the Workplace, established in May, reports directly to the Board and Senior Leadership Team, and is pulling together the work of various groups within the organization. |

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| 4.2 | Regularly review data against established benchmarks and explore a potential association with the four stand-alone mental health hospitals in their "Mental Health and Addictions Quality Indicators" initiative. | **Complete** | St. Joseph's Mental Health and Addiction program has been a member of the MHAQI group since 2011 and reporting into the scorecard since Q1 2011-12. |
| **Rec.5** | **Staff protection (Updated status of initiatives in bold)** | | |
| 5.1 | Identify strategies to harmonize the approach of Security services at Charlton and W. 5th campuses. | | Preparation, training and education in terms of supporting clinical teams for incidents of violence is identical. Security have the same training.<br>The response to calls at all sites is comparable.<br>We are continuing to standardize the approaches |
| 5.2 | Consult with front line staff members and other key stakeholders to identify indications and feasibility to make any structural changes to the environment such as creating hatches in seclusion room doors to promote safety in meal delivery and assessing the structural soundness of toilets in the seclusion room. | **Complete** | Consultation underway: Review and implementation team was developed to consult with front line staff members and other key stakeholders to identify issues and feasible solutions<br>• **Data was collected regarding current practices when entering seclusion room**<br>• **Information from other hospitals was collected and reviewed.**<br>• **Focus Group that included representatives of all inpatient units at West 5th (front line staff, charge nurses, managers, security) occurred on December 15, 2016.**<br>• **It was the unanimous opinion of the Focus Group participants that creating hatches and adding toilets in the seclusion room should NOT be pursued for the following reasons:**<br>o **The practice is more congruent with a prison setting than a hospital setting and would not support the vision and mission of providing compassionate care.**<br>o **It would not support the development of a therapeutic relationship which is central in all cases.**<br>o **It would not preserve the dignity of the patient in seclusion**<br>o **Nurses would still need to enter the seclusion room to provide care so the contribution to improving safety is unclear**<br>• **Inpatient units have procedures for the very rare situations where entry of seclusion rooms is not** |

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| | | | **considered safe in the moment.**<br>• **This has been fully reviewed by front line staff and key stakeholders** |
| 5.3 | Ensure the distribution of personal alarms to all staff, physicians, volunteers and students in high risk areas. | **Complete** | All staff, physicians, volunteers and students at West 5th campus have access to personal alarms.<br>All staff on acute Mental Health units and Psychiatry Emergency Services at Charlton campus have personal alarms. Emergency Department staff have access to Personal Sounding devices (screamers) and panic buttons in all nursing stations. |

*** EXTERNAL PEER REVIEW:** ***Approaches & Supports to Staff & Client Safety in the Mental Health In-Patient & Psychiatric Emergency Services*** **St. Joseph's Healthcare Hamilton**

**Reviewers**

**Ian Dawe** is an Associate Professor of Psychiatry at the University of Toronto and the Program Chief and Medical Director of Mental Health at Trillium Health Partners in Mississauga, ON.
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