

## **EXTERNAL PEER REVIEW**

### ***Approaches & Supports to Staff & Client Safety in the Mental Health In-Patient & Psychiatric Emergency Services***

St. Joseph's Healthcare Hamilton

April 20 – 23, 2016

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## **Final Report**

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## EXECUTIVE SUMMARY

To augment a comprehensive internal review of patient incidents of aggression in its Mental Health and Addictions Program, Dr. Ian J.R. Preyra, the Deputy Chief of Staff of St. Joseph's Healthcare Hamilton commissioned an external peer review. Three peers were asked to "review the team's current approach to patients with a history of violence and the impact on staff and client safety in relation to all Mental Health & Addictions in-patient units." The purpose of the review was to answer the following questions:

1. Are the appropriate policies and practices in place to manage patients with a history of violence as safely as possible?
2. Are there any organizational and/or professional cultural issues that need to be considered in the prevention and management of aggression/violence?
3. Are St. Joseph's Healthcare Hamilton's models of care appropriate in regards to patients with a history of violence?
4. Is there anything that should/could be done better or differently to align with best practices?
5. Are there any recommendations in regards to frequency and type of ongoing safety training related to the mental health patient population?

The peer reviewers commend St. Joe's Hamilton senior management team for their comprehensive efforts to promote staff and patient safety. The review clearly demonstrated that numerous mechanisms to promote safety were in place and that SJHH responded to the recent cluster of incidents swiftly and effectively.

This report answers the questions covered by the review and makes recommendations in 6 broad areas to further strengthen and evolve the approaches and structures to maximize staff and patient safety.

Grouping our suggestions into the following clusters provides for greater clarity and will allow for enhanced accountability for execution and implementation at the local level:

### **A. Enhancing workforce capacity for prevention and management of violence**

1. Enhance training in the Crisis Prevention and Intervention program regarding the circumstances in which staff members can "put hands on patients" to minimize injury to self and/or patient. **(Cluster A)**
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. **(Cluster A)**
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. **(Cluster A)**
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. **(Cluster A)**
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. **(Cluster A)**

## **B. Standards of care, therapeutic environment and team effectiveness**

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. **(Cluster B)**
2. Identify physician attendance at safety huddles as a priority. **(Cluster B)**
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, etc. **(Cluster B)**
4. Expand Safewards implementation to Psychiatric Emergency Services as well as all in-patient units. **(Cluster B)**
5. Expand the number and availability of activities and programs for patients on days, evenings and weekends. **(Cluster B)**
6. Develop and implement a standardized process and template to elicit and record each patient's personal story (see Appendix D). **(Cluster B)**
7. Consideration of dynamic risk factors for aggression be considered in the selection of violence risk assessment tool for implementation across MHAP. **(Cluster B)**
8. Adopt a utilization management tool. **(Cluster F)**
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. **(Cluster B)**

## **C. Standards for post aggression response (includes organizational learning)**

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. **(Cluster C)**
2. Collate, analyze and share data from the completed peer-led, post restraint/seclusion patient debrief tools to inform ongoing efforts to enhance safety. **(Cluster C)**
3. Develop a structured post-Code White debrief tool and process. **(Cluster C)**
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. **(Cluster C)**
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. **(Cluster C)**
6. Consider offering injured staff members contact by a Senior Team Member as part of Occupational Health follow-up (see Appendix D) **(Cluster C)**

#### **D. Corporate oversight for Safety/Quality**

1. Clarify and document the committee structure for the organization and consider adding a standing agenda item on safety to key committees. **(Cluster D)**
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 (see Appendix E). **(Cluster D)**

#### **E. Other – Staff protection**

1. Identify strategies to harmonize the approach of Security services at Charlton and W. 5th campuses. **(Cluster E)**
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. **(Cluster E)**
3. Ensure the distribution of personal alarms to all staff, physicians, volunteers and students in high risk areas. **(Cluster E)**

#### **F. Other**

1. Adopt a utilization management tool. **(Cluster F)**



## INTRODUCTION

To augment a comprehensive internal review of patient incidents of aggression in its Mental Health and Addictions Program, Dr. Ian J.R. Preyra, the Deputy Chief of Staff of St. Joseph's Healthcare Hamilton commissioned an external peer review. The reviewers were asked to "review the team's current approach to patients with a history of violence and the impact on staff and client safety in relation to all Mental Health & Addictions in-patient units." To inform that review, key documentation was provided and reviewed including policies and procedures and meetings were held with relevant stakeholders for discussion. As an outcome of the review the reviewers were asked to answer the questions below and make recommendations regarding best practices.

1. Are the appropriate policies and practices in place to manage patients with a history of violence as safely as possible?
2. Are there any organizational and/or professional cultural issues that need to be considered in the prevention and management of aggression/violence?
3. Are St. Joseph's Healthcare Hamilton's models of care appropriate in regards to patients with a history of violence?
4. Is there anything that should/could be done better or differently to align with best practices?
5. Are there any recommendations in regards to frequency and type of ongoing safety training related to the mental health patient population?

## Method

In conducting their review, the peer reviewers considered interactions between and among patient-specific factors, staff approach and environment of care. Four key activities were undertaken:

1. Reviewed relevant documents and policies, (see Appendix A)
2. Viewed and discussed video recordings of 6 incidents that resulted in staff injuries (Appendix B)
3. Met with designated management leaders and staff (Appendix C)
4. Toured the MHAP inpatient units (West 5<sup>th</sup> Campus), including inspection of the physical locations where the incidents took place as well as the Psychiatric Emergency Service site (Charlton Campus) where one of the incidents took place

## Overview

The peer reviewers commend St. Joe's Hamilton senior management team for their comprehensive efforts to promote staff and patient safety. Proactive mechanisms include the design of the in-patient units (e.g. separate corridors for staff; individual patient rooms); an array

of policies, procedures and processes designed to address and optimize staff and patient safety (e.g. safety huddles; security services, Crisis Prevention and Response training, Safewards) as well as focused and swift responses to the recent series of incidents in which staff members were harmed by patients (e.g. extensive internal review and commissioning of external review). SJHH has further demonstrated strong commitment to promoting safety by taking steps to initiate a Corporate Committee titled “Management of Aggression and Responsive Behaviours (MARB)” which will further strengthen both proactive strategies to enhance staff and patient safety and continuous improvement in MARB through establishing a corporate approach to education and training for staff and by regularly monitoring Code White statistics and identifying measures to address related trends and needs.

It is noteworthy that incidents in which staff members are injured in mental health facilities have been reported in all mental health facilities in Ontario. In part because of those occurrences, the Ministry of Labour and the Ministry of Health and Long Term Care have partnered to sponsor the current provincial violence prevention in health care initiative in which key stakeholders including the Ontario Hospital Association and the Public Services Health & Safety Association are developing mechanisms by which to prevent violence in health care settings. During our three days at St. Joe’s Hamilton, all those whom we spoke or met with willingly shared their experiences, perspectives and suggestions related to staff and patient safety. We hope that our review findings and recommendations will further support and enable the efforts being taken to optimize safety for staff and patients.

## **FINDINGS**

### **1.1 Are the appropriate policies and practices in place to manage patients with a history of violence as safely as possible?**

The policies reviewed contain relevant and current information and are generally comparable in content and direction to those with which the reviewers are familiar. SJHH has a comprehensive prevention of violence in the workplace policy that includes several appendices addressing key areas, for example, it contains information and suggestions on preparing for a meeting with a potentially violent client, guidelines on verbal communication, ways to deal with criminal harassment or stalking and information on dealing with threats and personal safety measures for victims of domestic violence.

Through the activities of the review it was evident that SJHH has taken strong and effective action to enhance safety for staff and patients through several key strategies. These include:

- Developing and introducing mock Code White exercises occurring twice monthly
- Implementing Safewards on two of the forensic units.
- Enhancing the Crisis Violence Intervention Training program
- Changing the personal alarm transmitter testing requirement from monthly to daily.
- Implement the safety cross process on patient care units

Each and all of these activities have contributed to further preparing and enabling staff members to maximize safety.

## 1.1 Code White Policy

During the review, some participants shared that there is confusion about a perceived “no hands policy” which they believe prevents them from putting hands on a patient even when that patient is actively harming another individual (staff member or co-patient). The reviewers studied the existing Code White policy (dated May 22/14) and the Revised Code White policy (final draft, April 22<sup>nd</sup>/16). It is noted that the May 22/14 policy version includes the statement that “*At any time, staff not to endanger their own person but focus primarily on the containment of the individual involved and on the safety of all those in the immediate areas until additional assistance can be obtained.*” (p. 10 of 12). However, in the revised policy that statement is absent. To address this confusion consideration could be given to re-inserting the above paragraph into the revised policy with slight revision as follows: “At any time, staff ought not to endanger their own person, but focus primarily on the containment of the individual involved *so as to minimize harm to self or other* and on the safety of all those in the immediate areas until additional assistance can be obtained.” Additionally, it is recommended to *Enhance training in the Crisis Prevention and Intervention program regarding the circumstances in which staff members can “put hands on patients” to minimize injury to self and/or patient.*

Review participants identified uncertainty about when to call for police intervention during a code white or whether or not to charge the patient criminally for an assault. *Accordingly it is recommended that a fact sheet/protocol be developed for staff members that informs their decision-making regarding reporting patients to the police for the purpose of criminally charging patients for any assaults.*

## 1.2 Clinical Monitoring Rounding Policy

The Clinical Monitoring Rounding policy reflects best practices in that it describes a dynamic and interactive process grounded in person-centred, therapeutic, engagement and care. This type of monitoring of the patient’s mental and physical state, behaviour and environment promotes early identification of, and professional intervention for, safety issues including escalation of agitation and supportive interventions. Staff members are well-equipped to document clinical monitoring using a portable software device – Toughbook. The reviewers encountered staff while using Toughbook who reported ease of documentation with the device. Proactive auditing and review of clinical monitoring practices, specifically with the focus on therapeutic engagement around patient’s needs for behavioural support is encouraged.

The reviewers commend SJHH for the debrief offered to patients by peer specialists after any incident of restraint/seclusion. This process is in keeping with best practices and reflects

recovery principles; however there is an opportunity to further maximize the benefits of this process by implementing the following recommendation. ***It is recommended that data from the completed debrief tools are collated, analyzed and shared with key stakeholders to inform ongoing efforts to enhance safety.***

### **1.3 Post-Incident/Code Activities and Actions**

Dialogue related to one of the incidents in which injuries occurred to staff during a code white situation identified that staff may need support not only in the immediate aftermath of the event but also over the days and weeks after the incident. Staff shared their perception that they were not permitted to talk about the incident and therefore were reluctant to share with their peers how they were doing after the incident. While there is a “Debriefing Tool & Guide for Post-Seclusion/Restraint” the reviewers did not see a debriefing tool and guide for post Code Whites. While a Code White may lead to the need to utilize seclusion or restraint, many Code Whites do not result in the use of those interventions and thus there is no debrief activity. ***Accordingly it is recommended that a post-Code White debrief tool and process be developed and that it include content to clarify what staff are able to say about the incident and to whom.***

#### **2.1 Are there any organizational and/or professional cultural issues that need to be considered in the prevention and management of aggression/violence?**

Organizational, professional and cultural factors, including models of care and service delivery that promote high quality effective care and treatment are also factors that promote the prevention and management of violence and aggression. Person-centred approaches to care, such as recovery oriented and trauma-informed care can be effective in reducing risk of violence or aggressive behavior. These approaches promote hope, supportive relationships, coping skills and social inclusion. Therefore, the approach that guides care must be explicitly stated and incorporated in decision making and activities. The expectations for the approach must be embedded within the accountability structure and processes – recruitment, staff competence and development, and performance reviews. The reviews have identified the need to strengthen the structure, processes and supports and recommend that MHAP:

***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.***

***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.***

***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.***

## **2.2 Change and Communication**

MHAP has had significant change over the past 3 years, including expansion of the program and relocating to a newly build site. While there have been integration efforts there is an opportunity to enhance integration within divisions of the program, between the program and the hospital, and between the sites. While there are many long-service employees there are also significant numbers of new employees. The organization and committee structure, including the quality structure was not clear to all staff, therefore it is recommended to ***consider adding a standing agenda item on safety to key committees.***

## **2.3 Patient and Staff Safety**

The reviewers heard some tensions between staff and patient safety often associated with various interpretations, and/or polarized or miscommunication. Such tension is not uncommon in mental health care where healthcare professionals understand the nature of mental illness and associated behavioral issues in acute phases of the illness. They often view these behaviours as reasons why persons are in care. They further understand that publicizing violence, particularly without the provision of context, negatively impacts recovery, including employment and housing, and stigmatizes an already stigmatized group.

While it is recognized that incidents of violence and repeated exposure to violence and aggression are an employment hazard, it is important that violence is not accepted as “normal.” It is equally important that behavioural changes, agitation, and aggression are understood as features of the illness and/or features of the illness in interaction with the environment. Accordingly, the past and ongoing efforts of SJHH in identifying, implementing and evaluating tools and processes to optimize safety and to send clear, consistent, and frequent messages that both patient and staff safety are priorities are imperative. To further augment the important work already achieved by SJHH management, the following recommendations are offered:

***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.***

In order to optimize safety through interprofessional collaboration and planning, ***it is recommended that physician attendance at safety huddles be identified as a priority.*** Additionally, as physicians may spend less time on site at the hospital than do staff members, they may find it harder to access or benefit from the post-incident support. ***Accordingly it is recommended that consideration be given to 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.***

***Consider offering injured staff members contact by a Senior Team Member as part of Occupational Health follow-up***

## **2.4 Security**

The reviewers had the opportunity to meet and engage with security at both Charlton and W.5<sup>th</sup> campuses and observed a distinct difference in the appearance and approach of the two security services. Security personnel at Charlton campus are dressed in black, and carry more equipment than do security personnel at West 5<sup>th</sup> who are dressed in yellow. While it is recognized that Security personnel at West 5<sup>th</sup> are contracted whereas those at Charlton are unionized employees, harmonizing the appearance of Security personnel may be an issue worth exploring during the collective bargaining process. Security personnel at West 5<sup>th</sup> articulated a clear understanding of their role in relationship to the role of clinical team members during a Code White. ***it is recommended that SJHH Identify strategies to harmonize the approach of Security services at Charlton and W. 5<sup>th</sup> campuses***

## **3.0 Are St. Joseph's Healthcare Hamilton's models of care appropriate in regards to patients with a history of violence?**

A common observation with several of the incidents reviewed was that of a prior interchange or communication between the staff and involved patient, whereby staff delivered bad news or redirected the patient, without attunement to the needs of the patient. One incident involved the staff approaching and redirecting the patient after he had gone to a TV room, following his receipt of bad news when he slammed the door upon exiting the interview room. Another aggressive incident occurred after the staff apparently asked the patient to leave the kitchenette and sit in the dining area. This patient was sitting on the kitchenette floor in a corner with his meal tray likely because the chair he brought to the kitchenette was removed by staff behind his back. The reviewers heard that upon review of the incident the staff would engage in the same actions, suggesting that the patient was not visible in the corner and the aggressive behavior was unpredictable. However, there are often signals, as was the case in many of the incidents, to the possibility of agitation and aggression. Social and psychological situations arising out of features of the social and physical location that signal or precede imminent conflict behaviours are referred to as ***flashpoints***. For example, communicating loss of privileges to a patient and restriction to a room for the purpose of managing the spread of conjunctivitis. For such flashpoints, there are actions that individual staff and teams can take in initiating and responding to interactions with patients that can decrease the frequency of conflict. Skilled clinician practice in mental health is required to recognize and prevent such flashpoints accordingly the recommendations (#6 &7) made under section 2.0 are applicable here.

***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, etc.***

Communication with persons dually diagnosed with mental illness and developmental delay and with those cognitively impaired is an area for enhanced support and development of staff competence, with emphasis on the need for staff to adjust their communication to meet the

cognitive ability and needs of patients. There seems to be an over reliance on the use of

redirection. Reminders to staff of when to effectively use redirection versus when such redirection escalates aggression would be beneficial. Additionally, the availability of sufficient and meaningful activities and programs for patients during weekdays, weekends and evenings can contribute to reducing the incidence of aggression. Accordingly, it is recommended that:

***That Safewards implementation be expanded to Psychiatric Emergency Services as well as all in-patient units; and***

***That the content of the videos of staff harm incidents be incorporated into staff training and education activities including scenario-based interprofessional team teaching and learning.***

***That the number and availability of activities and programs for patients be expanded on days, evenings and weekends.***

#### **4.0 Is there anything that should/could be done better or differently to align with best practices?**

Knowing the patient's life story and lived experience is foundational to effective care. A structured approach to capturing and documenting that story is essential. The reviews heard of plans to create comfort plans and endorse systematic implementation of these plans for all inpatients. Further, they recommend the ***development and implementation of a standardized template to elicit and record each patient's personal story*** (Appendix D provides a sample).

A recommendation from one of the internal reviews is the use of formal tools for risk assessment and management across the MHAP for each patient to identify the risk of self-harm, harm to others, aggression and known triggers of aggression. The external reviewers endorse this recommendation and further suggest that the violence risk assessment process be based on a combination of quantitative and q risk assessment and clinical observation of a patient's status. ***It is recommended that consideration of dynamic risk factors for aggression be considered in the selection of a violence risk assessment tool for implementation across MHAP.*** For example, the Dynamic Appraisal of Situational Aggression (DASA) tool could be used by psychiatric care unit staff to assist in early detection of imminent aggressive behavior. The structured measure addresses seven items: negative attitudes, impulsiveness, irritability, verbal threats, sensitivity to perceived provocation, tendency to get angered when request are denied, and unwillingness to follow instructions. Acute or situational dynamic risk factors as opposed to static risk factors for violence are more modifiable by targeted interventions and therefore identification of such dynamic factors is more effective in ongoing day to day management of risk in acute psychiatric inpatient settings.

Because the environment may also present risk factors, and in light of comments shared by staff members during the review it is recommended to ***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.***

SJHH is encouraged to consider the potential for violence in all patient populations. While there is a clear expectation for MHAP staff training in crisis prevention and intervention, the expectations for staff in other programs across of the hospital is not clear. If not already done, it is suggested that the hospital establish minimum training requirements for non-MHAP staff in prevention and management of aggression. It is also recommended that the hospital ***ensure the distribution of personal alarms to all staff, physicians, volunteers and students in high risk areas.***

To further augment efforts to assess the effectiveness of the many strategies SJHH has implemented to maximize safety it is recommended that consideration be given to 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 (Appendix E.)

In Ontario, the LOCUS tool (Level of Care Utilization System) has been successfully implemented at Trillium Health Partners in Mississauga, The Centre for Addiction and Mental Health in Toronto and Ontario Shores Centre for Mental Health Sciences in Whitby. The Royal in Ottawa, Lakeridge Health in Oshawa and Waypoint Centre for Mental Health Care in Penetanguishine are similarly just beginning to use LOCUS to appropriately manage patient flow. LOCUS was developed by the American Association of Community Psychiatrists to establish consistency in the management of scarce health care resources (i.e. inpatient beds) and increase the ability to use all levels of care more efficiently, combating problems of overutilization of resources and idiosyncratic treatment decisions by multiple healthcare personnel. It has been tested for reliability and validity and as a tool it is quantifiable, facilitates communication, is interactive, and supports the ability to track changes across a patient’s care continuum.<sup>1</sup> It combines assessment (clinical needs) with levels of care (resource management). Below is an outline of LOCUS recommended levels of care, examples of corresponding services and the assigned LOCUS score.

The aim of implementing LOCUS is to adopt a standardized approach for assessing placement to manage patient flow that will improve overall utilization of the scarce resources of an inpatient bed while ensuring appropriate patient placement by decreasing current length of stay. Utilizing the LOCUS tool to create a flow process that can address clients who are occupying a bed while having the required levels of support in place and stabilization in symptoms to facilitate discharge can lead to quick wins for creating capacity to move patients sooner to the ward beds from the emergency department or Consult Liaison service. Furthermore, through our stakeholder interviews it was clear that there was no standard practice of length of stay decisions resulting in variability between the physicians of various units for patients of similar needs. Conceptually

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<sup>1</sup> Sowers, W., George, C., & Thompson, K., (1999). Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS): A Preliminary Assessment of Reliability and Validity. *Community Mental Health Journal*, Vol. 35, No. 6. 545-561.

LOCUS could also provide a numerical framework that would support the sickest clients occupying the right type of beds and illustrate the least acute clients occupying a ward bed whom should be mobilized for the necessary supports then discharged based on the level of care recommendation to the community.

**Table 1**

Level of Care	Suggested Examples	LOCUS Composite Rating
Basic Services	Primary Care; Family Doctor, Family Health Team	<10
Recovery Maintenance and Health Management	Psychiatrist Care (Community Based)	10-13
Low-Intensity Community Based	LHSC MH Outpatient; CCAC Case Management; supportive housing with a case worker.	14-16
High Intensity Community Based	ACT team; high support housing through community or strong family supports.	17-19
Medically Monitored Non-Residential	Partial Hospitalization/attend groups during day on ward; Crisis Centre beds in Community; Short Stay Beds in ED	20-22
Medically Monitored Residential	IP General Ward Bed (7B)	23-27
Medically Managed Residential	Intensive Care Bed (PICU)	28+

Research has established that UM has led to a reduction in psychiatric hospital admissions, a decrease in length of stay (LOS) and has improved discharge planning and aftercare.<sup>2</sup> The cost reductions per case are significantly decreased, and also increase the capacity for potential number of unique clients who are able to be served in an inpatient bed annually by reducing and eventually eliminating unnecessary prolonged length of stay. A suggested achievable aim of such an initiative is to reduce current average length of stay by 20% for all clients who are admitted within six months of establishing a utilization management tool such as LOCUS.

<sup>2</sup> Wickizer, T. M., & Lessler, D. (1998). Do treatment restrictions imposed by utilization management increase the likelihood of readmission for psychiatric patients? *Medical Care*, 36(6), 844–850

Given the broader system success to date with LOCUS, we recommend that consider a pilot of the LOCUS tool to bring standardization and a clear understanding to ensure that the sickest clients are occupying the most acute beds. From a broader systems improvement lens, this would also provide an opportunity to compare metrics and system success in a standardized language.

The role and contributions made by the physicians and psychiatrists at SJHH were identified by review participants as valued and pivotal to patient care and team effectiveness. There was significant variability expressed regarding the number of hours physicians are expected to spend on the patient care units on a daily/weekly basis and there was a lack of consistency regarding the number of patients each psychiatrist was expected to carry on their caseload. ***Accordingly, it is recommended that 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.***

### **5.1 Are there any recommendations in regards to frequency and type of ongoing safety training related to the mental health patient population?**

Some staff directly involved in the incidents suggested to the reviewers the need for increased training in the use of physical techniques for responding to code whites. Hold techniques when such are needed for managing violence are already included in the CPI training that is mandatory for all staff. The reviewers observed the use of effective physical intervention in the videos of the incidents and overall good code white responses. However, it is suggested that the CPI training place some emphasis on how to safely release a hold and remind of the dangers associated with holding a person in the prone position. Additionally, in a couple of incidents, the victim while in the presence of the team had their backs slightly turned toward the aggressor. It is suggested that the CPI training emphasize that vulnerable body positions are to be avoided even within the context of a team. The teams would benefit from learning and practicing together prevention strategies and approaches to respond to changes in patient presentation as a team. The CPI training could be enhanced by integrating principles of Safewards and/or Trauma Informed Care if this has not already been done. MHAP is encouraged to review the physical techniques taught and determine their appropriateness for the geriatric mental health population as well as how well the principles of the Gentle Persuasive Approach is embedded in the training. The recent addition of the twice yearly mock code exercises is an excellent strategy. It was not clear if security personnel were included in those mock codes.

***Accordingly it is recommended to further enhance CPI training by integrating principles of Safewards and/or Trauma Informed Care and include Security Personnel in semi-annual mock code exercises.***

## **CONCLUSION**

Promoting safety for staff and patients in mental health settings is a complex, dynamic and multi-faceted endeavor. SJHH has successfully advanced safety through a comprehensive set of policies, processes and programs. Through these efforts, a strong foundation for growth and the ability to adapt approaches to safety to meet the challenges of constant change in clinical, social and health system needs and evaluation of effectiveness has been established. It is hoped that the recommendations in this report assist SJHH in its dedicated efforts.

## RESOURCES

Stewart D, Bowers L, Ross J. Managing risk and conflict behaviours in acute psychiatry: the dual role of constant special observation. *Journal of Advanced Nursing*. 2012; 68:1340-1348.

Bowers L, Stewart D, Papadopoulos C, Iennaco JD. Correlation Between Levels of Conflict and Containment on Acute Psychiatric Wards: The City-128 Study. *Psychiatric Services*. 2013;64:423-430.

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Ogloff, J. R. P. and Daffern, M. (2006), The dynamic appraisal of situational aggression: an instrument to assess risk for imminent aggression in psychiatric inpatients. *Behav. Sci. Law*, 24: 799–813. doi: 10.1002/bsl.741

## Appendix A: Materials Provided and Read to Inform Review

### **Policies, Protocols, Guidelines:**

- Seclusion/Restraint
- Seclusion/restraint Debriefing Tool & Guide
- Post Seclusion/Restraint Process Flow
- Clinical Monitoring
- Personal Alarm System
- Safety Incident Reporting and Management Policy – Patient and Visitor
- Code White Policy – Violent Situation (April 22<sup>nd</sup>, 2016 Final Draft)
- Code White Policy dated May 22, 2014
- Management of Aggression and Responsive Behaviours (MARB), Terms of Reference dated April 11, 2016

### **Education/Training Materials**

- Crisis Prevention and Intervention Training Overview

### **Clinical Services/Programs**

- Therapeutic Recreation Program – Overview
- Recreation Schedule for March, 2016

### **Data**

- Incidents by Fiscal Quarter for Mental Health & Addictions Overall Program 2013 Q 4 to 2015 Q 4
- Assaults by Type (Physical & Verbal Q 4 2013/14 to 2016 Jan-Feb YTD), West 5<sup>th</sup> Campus
- Total Assaults by Outcome (Lost Time, Health Care or First Aid), West 5<sup>th</sup> Campus
- Incidents (Physical & Verbal) resulting in Lost Time, West 5<sup>th</sup> Campus
- Assaults (Physical and Verbal) Requiring Health Care, West 5<sup>th</sup> Campus
- Assaults Requiring First Aid (Physical & Verbal), West 5<sup>th</sup> Campus
- Assaults Requiring First Aid, Health Care or Lost Time, West 5<sup>th</sup> Campus

### **Reports**

- St. Joseph's Healthcare Hamilton Confidential Mental Health Internal Review
- Priorities for the ECFAA Quality Improvement Plan (QIP) 2016/17 for St. Joseph's of Hamilton Organizations

### **Other**

- MHAP Quality & Access Committee Reporting Structure
- St. Joseph's Healthcare Hamilton Organizational Chart 2013
- Organizational Chart Mental Health and Addictions Program
- Quality & Patient Safety Steering Committee Terms of Reference
- Baseline Staffing Grids for General Psychiatry, Schizophrenia & Forensic Service
- Schedules & Assignments for Forensic Units, Schizophrenia Units & General Psychiatry Unit

## Appendix B: Incidents Reviewed on Video & Key Points from Reviewers' Discussion (Removed for patient and staff privacy)

### Appendix C - Reviewers Biographical Information

**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. Working in collaboration with Trillium's senior leadership team, as well as its medical and allied health professionals, he is focused on advancing the quality of care and fostering leading interprofessional practices in mental health care. He was recently appointed as Chair of the Ontario Hospital Association's Suicide Prevention Standards Task Force, a diverse panel of researchers, academics, clinicians and lived experience experts with a mandate from the Minister of Health and Long Term Care to focus on establishing best practice, evidence based standards to guide the care for at-risk people in all of Ontario's 151 hospitals.

**Barbara Mildon** is currently the Chief Nursing Executive and Vice President at the Ontario Shores Centre for Mental Health Sciences in Whitby, Ontario. A registered nurse for over three decades, she has extensive experience in nursing clinical practice, regulation, research and administration. Barb earned her undergraduate (BScN) and graduate degrees (MN, PhD) from the University of Toronto, Lawrence S. Bloomberg Faculty of Nursing. She has a strong record of contributions to provincial and national nursing associations and is a past president of the Canadian Nurses Association. She champions nursing practice excellence and a cohesive, engaged nursing workforce that achieves its full potential in optimizing health for those we serve and an effective, accessible health care system.

**Ann Pottinger** is a Registered Nurse with a Master's in Nursing from the University of Toronto. Her areas of expertise are in geriatrics, mental health, addiction, health equity and cultural competence. She has worked across the continuum of care- community, acute mental health care, and psychiatric emergency. Ann is an educator who has lectured at Ryerson and York Universities, and has an appointment as Adjunct Lecturer at the Bloomberg Faculty of Nursing, University of Toronto. Ann is a Master Facilitator with the Canadian Patient Safety Education Program. She served as a member for the Pan Canadian Advisory Group for Suicide Prevention and was a steering committee member for the Ontario Hospital Association / Canada Patient Safety Institute-Patient Safety Education Program (PSEP) Mental Health Modules partnership. Ann has worked in various roles at CAMH for over 18 years. She is currently the Director of Quality, Patient Safety and Risk at CAMH.

# Appendix D – Sample Materials

## Patient Story – Ontario Shores Centre for Mental Health Sciences – Meditech EHR

		Thu May 5 00:01 by EA
Interventions		
Patient Story		✓
Assessments		
<b>Plan of Care Patient Story</b>		✓
About the patient		
What are your views towards hospitalization and treatment?		
Where have you lived in the past?		
Have you ever worked or volunteered? If so, doing what?		
What are your interest? do you have hobbies?		
What are you proud of?		
Would you like to share your cultural or religious practice?		
Would you like to share any struggles or challenges?		
What are your hopes for the future?		
What do you see as your purpose in life?		
Tell me a little about your family, friends and community.		
Do you view intimacy and/or sexuality important to you at this time?	<input type="radio"/> Yes <input type="radio"/> No	
Have you been sexually active in the last 12 months?	<input type="radio"/> Yes <input type="radio"/> No Comment:	

Script Used by Occupational Health Nurse to Offer Follow-Up by a Senior Team Member to Injured Staff

*Ontario Shores Centre for Mental Health Sciences*

*“I noted the incident you have entered into Meditech and wanted to follow up with you at this time to see if you are okay. Please respond to this email or give me a call if you wish to discuss. I also will need to know if you have lost any time from work or have required to see your doctor as a result of this incident.*

*Senior Management is also genuinely concerned that you were hurt while doing your job and have relayed to occupational health their desire to follow up with you if you so desire.*

*Please let me know if you would like one of the members of Senior Management to call or email you and either Barb Mildon or Sheila Neuburger will be in touch.”*

# Appendix E – Mental Health & Addictions Quality Improvement Scorecard

Mental Health and Addictions Quality Initiative Peer Scorecard (2015-2016)																								
REPORTING PERIOD: Q3: October 1 - December 31, 2015																								
Domain	Indicator	Definition	Frequency	Dat	2014-2015	2015-2016				2014-2015	2015-2016				2014-2015	2015-2016				2014-2015	2015-2016			
					YE	Q1	Q2	Q3	Q4	YE	Q1	Q2	Q3	Q4	YE	Q1	Q2	Q3	Q4	YE	Q1	Q2	Q3	Q4
Client Complexity	# of Reasons for Admission	% of clients admitted with more than one reason for admission	Quarterly	CIHI RAI-MH	83%	69.8%	69.7%	70.1%		43.0%	46.7%	45.2%	40.7%		88.0%	89.1%	90.0%	89.9%		55.0%	57.6%	57.3%	51.2%	
	# of Psychiatric Diagnoses	% of clients with more than one psychiatric diagnosis at discharge	Quarterly	CIHI RAI-MH	56%	61.5%	65.4%	63.4%		57.0%	53.0%	54.8%	56.3%		51.0%	54.7%	56.1%	62.3%		51.0%	50.9%	51.9%	57.6%	
	# of Medical Diagnose	% of clients with more than one medical diagnosis at discharge	Quarterly	CIHI RAI-MH	24%	30.3%	30.5%	29.7%		42.0%	43.0%	41.7%	36.2%		19.0%	50.0%	50.3%	57.6%		25.0%	27.7%	28.7%	23.9%	
Client Outcomes	Global Assessment of Functioning Scores ≥ 10 points	% of clients with positive difference of at least 10 points between admission & discharge GAF scores	Quarterly	CIHI RAI-MH	62%	61.5%	63.7%	62.9%		80.0%	78.4%	77.9%	76.2%		47.0%	54.2%	53.8%	54.9%		67.0%	57.2%	61.9%	64.9%	
	Self Care Index	% of clients with an improvement in the self care index score from admission to discharge	Quarterly	CIHI RAI-MH	58%	60.7%	54.5%	59.1%		63.0%	74.9%	59.2%	63.5%		43.0%	42.9%	36.5%	44.5%		61.0%	57.0%	61.1%	65.8%	
	Overall Change in Care Needs	% of clients with reported improvement or marked improvement at discharge	Quarterly	CIHI RAI-MH	New Indicator	83.4%	85.8%	84.7%		New Indicator	79.4%	83.2%	84.9%		New Indicator	70.2%	67.8%	63.2%		New Indicator	66.4%	64.2%	73.8%	
	Readmission Rate	% of clients re-admitted to any facility within 30 days of discharge (reported one quarter behind)	Quarterly	CIHI RAI-MH	New Indicator	21.4%	18.2%	20.6%		New Indicator	11.0%	10.4%	9.2%		New Indicator	16.7%	14.3%	13.2%		New Indicator	17.4%	18.8%	17.4%	
		% of clients re-admitted to the same facility within 30 days of discharge	Quarterly	Internal Database		14.2%	12.0%	14.6%	12.6%		5.6%	5.5%	5.9%	7.3%		9.4%	7.3%	9.3%	5.6%		11.1%	9.7%	6.8%	6.8%
	Client Satisfaction Inpt Survey	% of positive responses to the question, "Overall, how would you rate the care you are receiving?"	Annual	Internal Database	69%	Annual Reporting				71%	Annual Reporting				68%	Annual Reporting				69%	Annual Reporting			
Client Satisfaction Outpt Survey	% of positive responses to the question, "Overall, how would you rate the care you are receiving?"	Annual	Internal Database	92%	Annual Reporting				89%	Annual Reporting				92%	Annual Reporting				93%	Annual Reporting				
Client Safety	No Use of Control Interventions	Prevalence of non-use of control interventions – percentage of patients whose admission assessment submitted during the quarter indicated no use of any control	Quarterly	CIHI RAI-MH	New Indicator	74.8%	73.3%	78.9%		New Indicator	84.9%	85.8%	88.3%		New Indicator	77.9%	68.9%	73.0%		New Indicator	82.4%	84.3%	81.0%	
	Unauthorized Leave of Absence Days (ULOAs)	% of Unauthorized Leaves of Absences in the period	Quarterly	Internal Database	Not Available	1.05%**	2.16%**	1.37%**		0.06%	0.12%	0.21%	0.06%		0.06%	0.06%	0.06%	0.04%		0.02%	0.02%	0.03%	0.02%	
	Inpatient Medication Reconciliation on Admission	% of In-patient Medication Reconciliations completed on Admission	Quarterly	Internal Database	79%	90%	91%	88%		100%	100%	100%	100%		99%	99%	100%	99%		92%	93%	98%	91%	

Client Access	Alternative Level of Care Days	% of Alternative Level of Care days reported during period	Quarterly	Internal Database	19.9%	18.3%	18.2%	19.0%		5.5%	4.6%	6.9%	7.4%		12.5%	16.4%	17.1%	17.3%		4.8%	6.3%	7.7%	6.7%	
	Staff Safety	Lost Time Injury Index Frequency	Lost time injury frequency based on # of WSIB lost time claims started in the reporting period	Quarterly	Internal Database	1.62	0.42	0.55	0.38		1.23	0.09	0.28	0.11		4.15	2.16	1.06	1.06		2.04	0.10	0.20	1.39
HR Indicator	Absenteeism Rate	% of paid sick hours for employees	Quarterly	Internal Database	2.16%	2.04%	1.98%	2.01%		3.66%	3.14%	2.42%	3.84%		5.60%	5.05%	5.51%	6.43%		5.25%	5.50%	5.60%	5.75%	
	Staff Engagement	% positive score on the Employee Engagement Survey "Engagement" subscale.	Bi-annual	NCR Picker	Bi-Annual Reporting				Bi-Annual Reporting				Bi-Annual Reporting				Bi-Annual Reporting							
Financial	Balanced Budget	% of balanced budgets in last 5 years	Annual	Internal Database	100%	Annual Reporting				100%	Annual Reporting				100%	Annual Reporting				80%	Annual Reporting			

\*WSIB transition to a new electronic claim record results are higher than in previous years due to known data quality challenges that are currently being addressed.