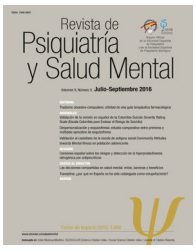
Revista de psiquiatría y salud mental (Barcelona) 15 (2022) 211–215

Revista de Psiquiatría y Salud Mental

www.elsevier.es/saludmental



SCIENTIFIC LETTER

Towards a classification framework for patient safety incidents and adverse events for a mental health community-based model of service provision

Hacia un marco de clasificación de los incidentes y efectos adversos para un modelo de atención comunitaria de la salud mental

Dear Editor,

The international classification for patient safety developed by WHO intended to be applicable across the full spectrum of healthcare from primary to specialised care areas.[1]

Since most incident types (i.e. clinical administration, medication, etc.) can be applicable; those related to clinical processes, behaviour and patient outcomes or contributing factors are to lesser extent specific for mental health.

Scarce attention has been addressed national and internationally to mental health patient safety, particularly for community-based models of care, and a conceptual framework is lacking. Instead, principles and methods from physical healthcare have been adopted, rather than focus as subject itself.

We sought to develop a specific framework for mental health patient safety, applicable to our community-based model of service provision.

Our project started in 2018 and has several stages. (1) Initially, professionals from each level of care of our mental health institution were required to conduct a risk analysis to identify key areas at risk for patient safety incidents and to develop protocols to prevent potential harms. Economic incentives, educational outreach visits, professional roles expansion, and specific patient safety teams were implementation strategies used.[2] Key areas initially identified are been validated through: (2) local multidisciplinary consensus group, (3) data extraction from the electronic cloud platform incident reporting system ''The Patient Safety Company'' (TPSC Cloud™), and a (4) prospective observational study, which will analyse a sample of patient contacts at each level of care.

Preliminary results are reported for stage 1, 2 and 3. Approximately 267 (78%) professionals (psychologists, psychiatrist, nurses and social workers), were exposed to educational outreach visits on patient safety. 39 protocols, applicable to hospital and community, day and long and recovery care for adults and young people, were developed yielding to a list of key relevant risk areas for mental health, validated by the multidisciplinary consensus group (see Table 1). Initial analysis of the TPSC Cloud™ has identified 18 patient safety incidents reported in 2020; 75% were of moderate risk. Falls and medical errors were more frequent at hospital-based services, and behavioural and structural safety incidents at the community level (see Table 2). Some of these areas have also been identified in the literature,[3] nonetheless no triangulation of methods were used. We found a low incidents rate reported, which can be explained by the lack of patient safety culture in mental health particularly at community level. Broadly, incidents

Table 1 Classification of key relevant risk areas identified for patient safety.

Clinical processes	*Clinical administration*
Restraint[a]	-Patients identification systems
Seclusion[a]	-Admissions
Diagnostic errors	-Communication systems among levels of care/handover
Involuntary patient admission[a]/treatment refusal	-Patient information consent
Patient elopements/absconding[a]	-Transitions of care
Mental competency/incapacity[a]	-Confidentiality[a]
	-Risk assessment, registry[a]
Patient behaviour	*Medication errors*
Agitation[a]	Reconciliation
Interpersonal aggression/problem behaviour	Preparation
Substance use related harm	Dispensing
Sexual harassment	Administration
Maltreatment[a] (elderly, child, youth, gender...)	Drop out
Suicide	Waste management
Self-injurious behaviour/self-arm	Storage
Recurrence[a]/relapse risk	Adverse effects
Patient compliance/adherence	
Social isolation[a]	
Falls	
Professionals' safety	
Structural safety	

[a] Additional areas not included in WHO framework.

Table 2 Data extraction from TPSC Cloud™ (2020).

Incidents	Community outpatient service	Day care-adults	Long stay	Acute and subacute service	Total
Falls		1	1	3	5
Patient behaviour	2				2
Documentation				1	1
Structural safety	1	1			2
Medication	1	1	1	4	7
Communication		1			1
Total	4	4	2	8	18

retrieved from national registries are infra-estimated due to under-report.[4] The additional difficulty of attributing a behaviour to the diagnosis or to a safety incident complicates the understanding of safety in mental health.[5] We expect that our ongoing observational study, which analyses the contributing, mitigation factors and impact on practice will elucidate on those doubtful risky behaviours, by bringing specific definitions and indicators for patient safety in each of the identified areas.

Transparency statement

The main author * Eva Frigola-Capell, affirms that this manuscript is an honest, precise and transparent account of the study that is presented, that no important aspect of the study has been omitted, and that the differences with the study that was initially planned are explained (and if relevant, recorded). * Guarantor of the manuscript.

Conflict of interest

No conflict of interest to disclosure.

References

1. World Alliance for Patient Safety. The conceptual framework for the International Classification for Patient Safety. WHO; 2009. https://www.who.int/patientsafety/implementation/taxonomy/ICPS-report/en/ [accessed 22.4.21].
2. Effective Practice and Organisation of Care (EPOC). EPOC Taxonomy; 2015. https://epoc.cochrane.org/epoc-taxonomy [accessed 15.4.21].
3. Mascherek AC, Schwappach DL. Patient safety priorities in mental healthcare in Switzerland: a modified Delphi study. BMJ Open. 2016;6:e011494.
4. Classen DC, Resar R, Griffin F, Federico F, Frankel T, Kimmel N, et al. Global trigger tool' shows that adverse events in hospitals may be ten times greater than previously measured. Health Aff (Millwood). 2011;30:581–924.
5. Brickell TA, Nicholls TL, Procyshyn RM, McLean C, Dempster RJ, Lavoie JAA, et al. Patient safety in mental health. Edmonton, Alberta: Canadian Patient Safety Institute and Ontario Hospital Association; 2009.

Eva Frigola-Capell[a,b,*], René Morgan[a], Albert Nogué[a], Ingrid Thelen[a], Jordi Font[a], Begoña Gonzalvo[a], Pilar Oliveras[a], Eva Bacardí[a], Maria Dolors Malla[a], Alex Gimeno[a], Anna Pla[a], Domènech Serrano[a], Eduard Palomer[a], Glòria Trafach[a], Jose Luís Ignacio Sagredo[a], Margarita De Castro[a], Montse Gibernau[a], Roser Serrallonga[a], Maite Roger[a], Jordi Cid[a,b]

[a] *Institut d'Assistència Sanitària (IAS), Girona, Spain*
[b] *Mental Health & Addiction Research Group, Institut d'Investigació Biomèdica de Girona (IDIBGI), Spain*

* Corresponding author.
E-mail addresses: eva.frigola@ias.cat, eva.frigola@gmail.com (E. Frigola-Capell).

https://doi.org/10.1016/j.rpsm.2021.11.007