Appendix 3:

Patient Safety and Quality in Mental Health Services Project Report Recommendations

Enduring Solutions (2003) ***Patient Safety and Quality in Mental Health Services: Project Report.*** Prepared for the AHMAC National Mental Health Working Group's Safety and Quality Partnership Group, September 2003 (in press).

Below is an extract from the recommendations of the Enduring Solutions report.

D. Recommendations

One thing that became clear when the project commenced was that our research efforts would have to be somewhat selective if we were ever to complete the task. The quantity of material on quality and safety in health care has grown exponentially over the past decade. What we instead have sought to do was to identify the main methodologies that might be useful. In virtually all cases, these could be used in the mental health area with little or no adaptation – they tend to be generic and non-specific ways of organising change. To this extent then, the Catalogues in the Appendix are not comprehensive, even though we have tried to include both project example summaries and summaries which explain generic methodologies and tools. It should provide a useful catalogue that can be canvassed when particular issues are chosen for action, either under the *National Mental Health Plan 2003-2008* or if our recommendation for a Mental Health Quality and Safety Action Plan were to be developed.

We do not see the need for a Plan to precede any quality and safety implementation – there are many places to start immediately given the two-pronged approach suggested. Once endorsed by the Partnership Group, the development of the Plan and many of the recommendations can proceed concurrently.

These recommendations are intended to be comprehensive across all mental health services and settings. For example, it covers public and private mental health services (including the non-Government sector), across the broad spectrum of service settings, including primary care, acute care and rehabilitation, whatever the clinical professions involved, and wherever services are provided eg in offices, institutions or in the community.

While the main focus of this project is not on the occupational health and safety of staff in mental health services, there is also a need to recognise that there are often complex interrelationships between quality care for consumers and staff safety eg de-escalation techniques for calming agitated consumers can often avoid injuries to staff as well as being less traumatic for consumers. Similarly, fear in staff can impact on the quality of care provided, both in mental health services and in general health services when they are accessed by people with a mental illness.

The recommendations are also intended to cover all consumers and carers, so implementation of the recommendations need to be mindful of the particular needs of some consumers and carers, such as those from culturally and linguistically diverse backgrounds, indigenous consumers and carers, forensic patients, people who are young or old, or consumers with additional complex needs eg drug and alcohol problems, intellectual disabilities etc. There is also a need to recognise the important role and potential burdens on carers when designing quality and safety initiatives.

Recommendation 1: It is recommended that the Safety and Quality Partnership Group work closely with the Australian Council for Quality and Safety in Health Care, the National Institute of Clinical Studies, and other National and State and Territory bodies engaged in safety and quality, to ensure that the mental health sector is adopting nationally consistent approaches to safety and quality, and clinical practice improvement.

Recommendation 2: In particular, discussions should be held to ensure the inclusion of mental health components in the National Medication Safety Breakthrough Collaborative of the Australian Council for Safety and Quality in Health Care – both in relation to specific drugs related to mental illness (such as anti-psychotic medications) and also in relation to the interactions of these medications with other medications used to treat other health issues in people with mental illness.

Recommendation 3: Given the recent completion of the Emergency Department Collaborative organised by the National Institute of Clinical Studies and the need to trial better processes for the reception and evaluation of people presenting at the Emergency Department with a mental illness, the Group should discuss the possibility of an extension of that work into this area.

Recommendation 4: Given that the implementation and continued compliance with *National Standards for Mental Health Services* and the *National Practice Standards for the Mental Health Workforce* are key ways of achieving a safe, high quality mental health system, the State and Territory and Australian Governments and all services, should be seeking to achieve these Standards as soon as possible and then to monitor their ongoing compliance. The Standards should be seen as evolving documents that set a minimum standard for services to measure themselves against.

Recommendation 5: The Safety and Quality Partnership Group should work with the Royal Australian and New Zealand College of Psychiatrists, other professional bodies and stakeholders, to develop a process for ensuring the ongoing development and appropriate use of clinical practice guidelines that have already been developed across all practice settings, as a tool to guide practice.

Recommendation 6: It is further recommended that, where these relationships do not already exist, the State and Territory members of the National Mental Health Working Group make contact with the State Quality Officials Forum member for their jurisdiction to ensure mental health quality projects are built into the State and Territory based agendas.

Recommendation 7: State and Territory mental health services and local mental health service should ensure that mental health data is being collected and identified in any incident or adverse event monitoring processes, and seek data from any of these existing sources and to use these, their own complaints data, reports from external scrutiny bodies (such as ACHS **clinical indicator** data, accreditation reports or official/community visitor), and any other data to start to determine their own local priorities for action.

Recommendation 8: The Safety and Quality Partnership Group should conduct a workshop, as occurred with the Mental Health Information Development Plan (MHIDP), to develop a Framework for Quality and Safety in Mental Health Services. This would underpin the focus on quality and safety in the *National Mental Health Plan 2003-2008*, in the same manner that the MHIDP underpinned the information needs part of the National Mental Health Plan 1998-2002.

Recommendation 9: To inform this workshop, the Safety and Quality Partnership Group should obtain as much incident monitoring data, coronial data, ACHS clinical indicator data and any other existing sources of adverse events data that relates to mental health, and look at what this shows about the areas of highest concern, either from severity of consequences or frequency of events. This can be used, among other things, to determine some useful 'low hanging fruit' in the mental health area which can be addressed early on, just has been done in the general health care system.

Recommendation 10: The workshop should look at this information and the proposed actions under the Safety and Quality component of the *National Mental Health Plan 2003-2008* and then consider the range of quality and safety improvements tools and methodologies presented in the attached Catalogues as ways of addressing the priority areas.

Recommendation 11: The Safety and Quality Partnership Group should consider recognising a number of 'Beacon' services, which are seen as demonstration sites for 'best practice' in quality and safety in mental health, as well as documenting case-studies where there has been evidence of positive changes in safety and quality for consumers.

Recommendation 12: A cultural change strategy is required to ensure that support is provided to encourage staff and consumers to identify unsafe systems or processes and to report them. Consumer and carer feedback processes need to be improved and consumers and carers encouraged to provide feedback – both negative and positive. A culture needs to be encouraged where every complaint is seen as an opportunity for service improvement.

Recommendation 13: Consumers and carers must be involved in all quality and safety work at all levels – within services, at the State or Territory level and nationally. The Evaluation of the National Mental Health Plan 1998-2002 reports that over 70% of services have a consumer/carer advisory group. This provides a ready-made organisational structure to engage service users with clinical service providers in strategies such as data analysis and review, local collaborative for change, and provision of peer reporting and feedback on quality and safety issues across both residential and non-residential service settings. In particular, consumers and carers should be involved on all quality improvement, critical incident and accreditation preparation committees.

Recommendation 14: Consumers, carers and staff all need to have access to training on quality improvement methodologies and tools.

Recommendations 15: A national agreed clinical governance framework for mental health services should be developed, to improve public reporting of progress, and enhance the development of tools, in improving quality and safety in the National Mental Health Report.

Recommendation 16: In recognition of the key role of data in identifying quality and safety concerns and monitoring the impact of interventions to improve quality and safety, the Safety and Quality Partnership Group should invite formal membership of a nominee from the Information Strategy Committee of the National Mental Health Working Group.

Recommendation 17: Ongoing links and information exchange should be established with mental health quality and safety initiatives occurring in overseas jurisdictions.