Patient Safety Annual Report

2020-2021

CASA

Child, Adolescent and Family Mental Health

Overview of Reported Patient Safety Data

This section provides a summary of reportable patient safety data for the period of April 1, 2020 through March 31, 2021.

Terminology

For the purposes of this report, note the following definitions:

Per CASA Policy A.02 Managing Patient Safety Events, a ***Reportable Patient Safety Event*** is defined as "an event which has the potential to harm or does cause harm to a patient." Note that one incident may involve more than one event." For example, one Patient Safety Report may include an "AWOL" and "Risk of Patient Injury" as two events which took place as part of the same incident. Events are considered reportable if they occur on CASA property or off CASA property if requiring medical intervention. Note that in previous years, CASA House would also report medication errors occurring off CASA property. However, on November 20, 2019, offsite medication error reporting at CASA House was discontinued.

Medical Intervention is defined as "when a child was admitted to the Emergency Room/Hospital, was taken to the hospital but not admitted, interacted with a mental health crisis until."

To respect and celebrate the diverse patient identities at CASA, and to reflect that gender is an identity, the term ***male*** is defined as all patients who identify as male, and ***female*** is defined as all patients who identify as female. Our current data collection system does not allow us to know for certain that the gender recorded is the gender the patient identifies as because staff complete the patient event forms, so we have made the assumption that the gender that is reported accurately reflects that child's identity.

Summary of Patient Safety Events

The information presented in this document is based on data collected through Patient Safety Event Report Forms which are submitted by CASA staff to the Patient Safety Committee for review. As such this following data may underestimate the number of patient safety events which actually occurred in 2020-2021.

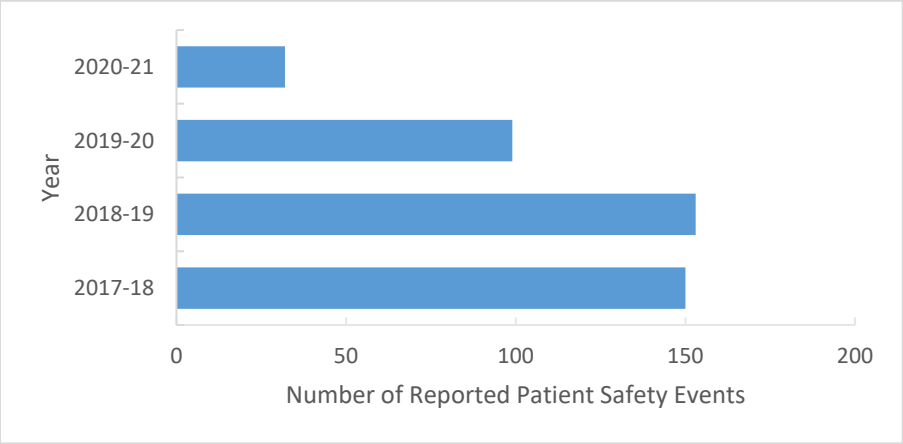


Figure 1. Number of reports submitted over the past four fiscal years

During the 2020-21 fiscal year, a total of **32 Patient Safety Incident Reports** were submitted to the Patient Safety Committee for review. These reports included **65 safety events** and involved 18 unique

children/adolescents. As seen in Figure 1, this is the fewest number of reports submitted in the past 4 years.

Frequency & Type

The most commonly reported event over the past 12 months was "aggression with no or minor patient injury," accounting for nearly one-third of all events. The proportion of reported AWOL events continues to trend downward year over year since 2017-18 (24%). The proportion of events involving a restraint was nearly identical between this year and last (7.3% vs. 7.1%). There was an increase in the number and proportion of staff injuries this year compared to last year (9 (16.4%) vs. 4 (4%)), which is concerning and warrants additional monitoring and analysis.

Table 1. Reported Patient Safety Event Frequency by Type

Type	Frequency
Risk of patient injury	3 (5.5%)
Aggression with no or minor patient injury	16 (29.1%)
Aggression with major patient injury	1 (1.8%)
Assault of patient	1 (1.8%)
AWOL	3 (5.5%)
Locked timeout	8 (14.5%)
Restraint	4 (7.3%)
Collecting means of self-harm	1 (1.8%)
Suicide attempt	2 (3.6%)
Aggression with staff injury	9 (16.4%)
Aggression towards staff	2 (3.6%)
Property damage	3 (5.5%)
PRN Administered	1 (1.8%)
Intermittent locked time away	1 (1.8%)
TOTAL	**55**

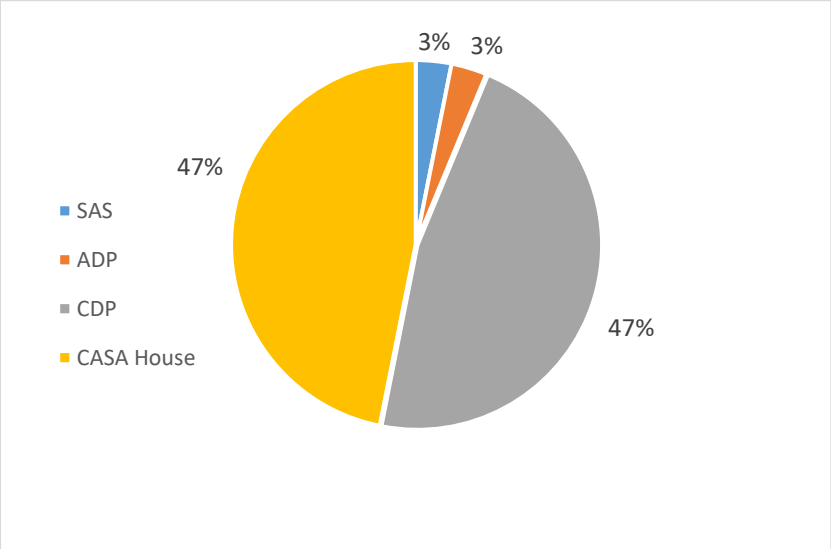
Table 2. Reported Medication Error Frequency by Type

Medication Error Type	Frequency
Wrong dose	2 (20%)
Wrong time	1 (10%)
Wrong medication	1 (10%)
Missed medication	6 (60%)
TOTAL	**10**

Program

Reports were submitted from five different programs this year, including Adolescent Day Program (1), SAS (1), Children's Day Program (15), and CASA House (15).

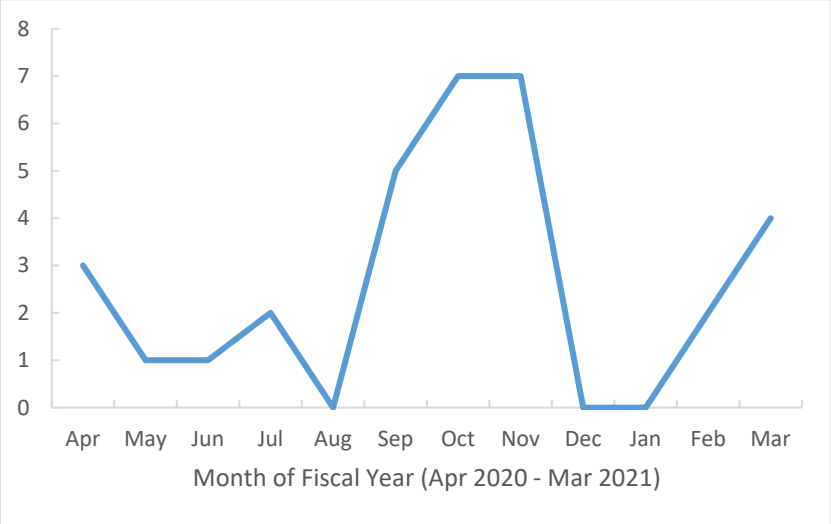
Figure 2. Number of Reports submitted by Program



Month of Fiscal Year

The highest number of reported events were in October and November (n=7). There were three months, August, December, and January, without any reported events.

Figure 3. Reported Events by Month of Year



Day of Week

Most events occurred on Tuesday (n=10), followed by Wednesdays (n=7), and Mondays (n=6).

Table 3. Reported Events by Day of Week

Day of Week	Number of Events
Monday	6

Tuesday	10
Wednesday	7
Thursday	3
Friday	5
Saturday	0
Sunday	1

Demographics

Gender

Males (n=10, 56%) were more commonly involved in reported events than females (n=6, 33%) and those who identified as non-binary (n=1, 6%). Gender was not provided on one report. The aforementioned statistics are consistent with our available historical organizational data.

Age

The mean age of the 18 children/adolescents involved in reported events was 12.4 years (9-17). None of the reported events involved preschool children. This can likely, at least in part, be attributed to the shift from in person to virtual care due to the ongoing pandemic. The mean age was lower this year than the past 2 years (12.9, 13.4).

Events per Individual

The majority of individuals were involved in a single event this year (n=14, 78%). Two children/adolescents were involved in 2 events (11%). There were also two individuals that were involved in 5 and 9 events, respectively.

COVID-19 Pandemic

This year, we continued to see a dramatic decrease in the number of reported Patient Safety Events compared to past years. For reference, in 2019-20, the Patient Safety Committee received 99 Patient Safety Event Reports. In 2020-21, a total of 32 reports were received. This marked decrease is likely, at least in part, due to our organizational transition to increased virtual service, including Day Programs and CASA House, for multiple, extended periods this year.

Prevention & Continuous Improvement

As an organization, when patient safety events occur, we use them as an opportunity to identify conditions and/or systems that may have contributed to the event and act to prevent similar incidents from recurring. Learnings from patient safety event reports have prompted the following improvement this year:

- Re-introduction of casual staff at CASA House, to assist regular staff cope with burnout and pandemic- related fatigue. Note that casual staff were not utilized earlier in the pandemic due to concerns regarding increased risk of viral transmission from introduction of additional staff, most of whom held other health care positions.
- Review and revision of the Strangulation policy and procedure.
- Scheduling of additional crisis event training via simulations to improve staff competence and comfortability in high stress, crisis situations.

Committee Transition and Recommended Action

In late April, the Senior Leadership Team approved a recommendation to amalgamate to Patient Safety Committee with the Medication and Infection Control Committee to improve efficiency and increase collaboration. The new group will be called the "Patient Safety & Quality Care Council" and will be co-chaired by the incoming Clinical and Medical Directors. This Council will have a diversified membership, which is expected to facilitate a more holistic, well-rounded view of patient safety at CASA. For the remainder of this fiscal year, this committee should consider addressing the following:

- Define Patient Safety at CASA based on current best practice to facilitate high quality care.
- Review and revise the organizational Patient Safety Event Management System, including re-defining what is considered a reportable event.
- Review and revise the current Patient Safety Event Report Form to improve user-friendliness and encourage reporting.
- Review and revise the patient safety policies and procedures, including outlining when additional review of an event is required (known as a Post-Event Analysis).
- Develop formal Patient Safety Training for all leadership teams and staff, to facilitate ongoing, education and a more active, organizational patient safety culture.