Patient Safety Annual Report

2019-2020

CASA

Child, Adolescent and Family Mental Health

Summary

The 2019-2020 Annual Patient Safety Report is prepared by the Patient Safety Committee and includes:

- A summary of the reported patient safety incident data from the 2019-20 fiscal year;
- A summary of the organization's actions to improve patient safety over the course of the past year;
- Recommendations for future action related to patient safety at CASA, and;
- An organizational Patient Safety Plan for the 2020-2021 fiscal year.

Coronavirus (COVID-19) Pandemic

On March 11, 2020 the World Health Organization officially declared the Coronavirus (COVID-19) outbreak a pandemic. CASA immediately convened a COVID-19 Emergency Response Team (ERT), which has been responsible for CASA's initial and ongoing pandemic response. Several members of the Patient Safety Committee also sit on the ERT and patient safety has and continues to be a key priority in CASA's ongoing response.

Patient Safety Committee Chair Transition

In September 2019, Jacqueline Dagneau assumed the role of Patient Safety Chair, following several months of shadowing predecessor, Jean Anderson. Jean remained a crucial advisor to the Chair and committee until Spring 2020.

Patient Safety Improvement Activities

CASA continued to address gaps in its safety infrastructure through many different projects this year as part of the organization's commitment to continuous improvement. The main activities undertaken are outlined below.

The CASA Patient Safety Plan

In 2013, CASA's Senior Leadership Council (SLC) adopted a three-year Patient Safety Plan as recommended by the Safety and Risk Management Committee. In 2016, the Patient Safety Committee renewed the Patient Safety Plan until 2018, updating it regularly to reflect progress made. The Patient Safety Plan was renewed a second time for the 2019-20 fiscal year. The plan proposes strategies and actions to address three dimensions of patient safety: prevention, risk management, and quality improvement.

In March 2020, the Patient Safety Committee took part in a planning workshop in order to review the organization's current and future priorities with respect to patient safety. A new operational plan for 2020-2021 was created and is included in this report (Appendix A).

Canadian Patient Safety Culture Survey

In January 2020, CASA administered the Canadian Patient Safety Culture Survey. CASA staff successfully met the required completion threshold in late February. The results of the survey were considered in the creation of the 2020-2021 Patient Safety Operational Plan.

Canadian Patient Safety Officer Course Enrollment

Two CASA staff members involved in leading organizational patient safety enrolled in the Canadian Patient Safety Officer (CPSO) this winter. The course, created by the Canadian Patient Safety Institute (CPSI), is expected to provide these staff members and the Patient Safety Committee, with invaluable knowledge regarding current Patient Safety standards as well as additional training in post-incident analyses. The knowledge gained from participation in this course is also expected to assist Patient Safety Committee to improve and streamline the current reporting system.

Discontinuation of Off-Site Medication Error Reporting

On November 20, 2019, at the recommendation of the Patient Safety Committee, the Senior Leadership Committee (SLC) confirmed the discontinuation of off-site medication error reporting. Reporting these errors was deemed unnecessary and is not aligned with current best practice.

New Staff Orientation

To ensure that all staff understand CASA's commitment to patient safety and its associated processes and procedures, the Patient Safety Chair along with the Quality and Risk Lead, began to regularly attend and present at New Staff Orientation in Fall 2019. This activity has led to increased engagement and understanding among new staff and will be continued through the 2020-21 fiscal year.

Therapeutic Crisis Intervention (TCI) Update

As an organization, CASA continues to use the Therapeutic Crisis Intervention (TCI) Program which promotes a trauma-informed approach to managing challenging behaviour. TCI training continues on a regular basis. The TCI Working Group also continues to work diligently to optimize TCI use within CASA's programs and address any concerns that arise.

Overview of Reported Patient Safety Data

This section provides a summary of reportable patient safety data for the period of April 1, 2019 through March 31, 2020.

Terminology

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

Per 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 2019-2020.

A total of **99 Patient Safety Incident Reports** were submitted between April 1, 2019 and March 31, 2020. The reports included **126 safety events** and involved **57 unique children/adolescents**. The total number of reports submitted this year is lower than in previous years (99 (2019-20) vs. 153 (2018-2019) vs. 150 (2017-2018)).

Frequency & Type

The three most commonly reported event types were Medication Errors (31), Aggression without

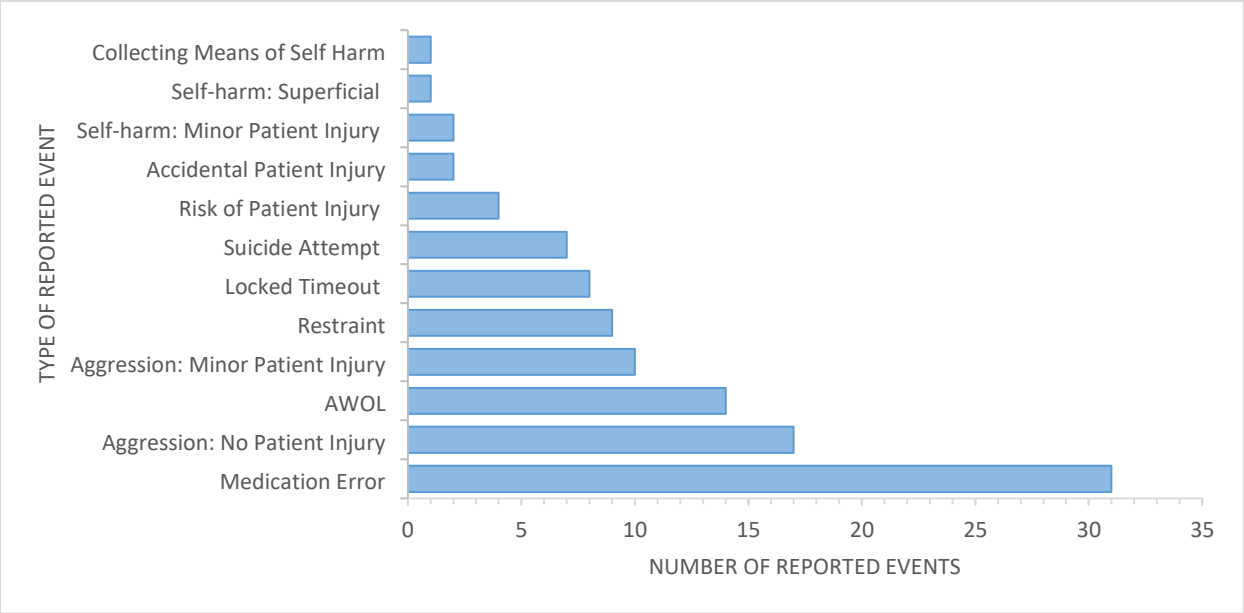

Figure 1. Frequency of Patient Safety Event by Type

Patient Injury (17), and AWOL (14). The remaining event types and their frequencies are shown in Figure 1. The event types shown are prepopulated in the Patient Safety Event Report Form which staff fill out to report an incident. However, staff are also able to "write in" events that are not

displayed on the reporting form. Table 1 describes the types of events classified as "other" and their frequency.

Table 1. Frequency of "Other" Patient Safety Events

"Other" Event Type	**n**
Property Destruction	5
Attempted AWOL	1
Patient to patient allegation	1
Unsupervised contact with peer	2
Weapon Possession	1
Minor Staff Injury	4
Duty to Warn	1
Biting	1
Overdose	1
Medication Error: Partial administration	1
Aggression toward others	2
Total	**20**

Medication Errors are classified into four categories including Wrong Dose (1), Wrong Time (4), Wrong Medication (1), and Missed Medication (24). Of the 31 reported Medication Errors, 19 occurred off-site. As mentioned in the Terminology sub-section, reporting of off-site Medication Errors was discontinued on November 20, 2019.

Table 2 shows the five most frequently reported events over a 3 year period as a proportion of the total number of events which occurred in the respective year.

Table 2. Most Frequently Reported Patient Safety Events over 3 year period by proportion of total events

Event Type	**2019-20 (n=126)**	**2018-19 (n=153)**	**2017-18 (n=150)**
Medication Error (All)	31 (24.6%)	67 (43.8%)	28 (18.6%)
AWOL	14 (11.1%)	26 (17.0%)	36 (24%)
Aggression with no patient injury	17 (13.5%)	13 (8.5%)	-
Aggression with minor patient injury	10 (7.9%)	10 (6.5%)	-
Restraint	9 (7.1%)	27 (17.6%)	-
Risk of Patient Injury	-	-	23 (15.3%)
Suicide attempt	-	-	15 (10.0%)

Program

Incidents were reported in eight CASA programs this year. The majority of incidents occurred at CASA House (48%) and in CDP (33%). A summary of the number of incidents by program can be found in Table 3 below.

Table 3. Frequency of Reported Incidents by Program in 2019-20

Program	n
CASA House	48
CDP	33
SAS	4
CAMP	3
ADP	3
Family Therapy	3
PKP	4
Trauma Clinic	1
Total	**99**

Figure 2 depicts the number of incidents reported per program over the past three fiscal years. The number of incidents reported at CASA House in 2019-2020 (n=48) decreased from 2018-2019 (n=105), and 2017-2018 (n=88). This decrease is likely, at least partially, accounted for by the discontinuation of off-site reporting of medication errors in the third quarter of this fiscal year. Likewise, SAS and ADP have seen steady decline in their reported incidents over the past three years. In contrast, CDP reported more incidents in 2019-2020 (n=33) than in 2018-2019 (n=26).

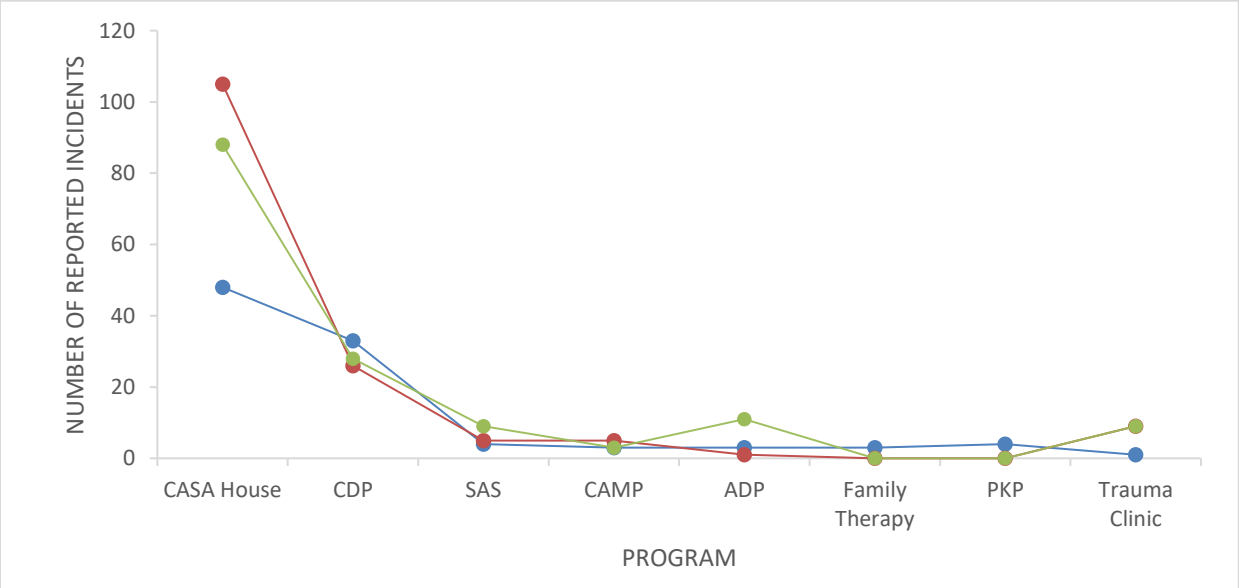

Figure 2. Number of Reported Events in each program by fiscal year: 2017-2018 (green), 2018-2019 (red), 2019-2020 (blue)

Month of Fiscal Year

The largest number of incidents occurred in September (n=17) and May (n=16) as shown in Figure 3 below. From an operational perspective it should be noted that CASA is closed for one full week in December. Additionally, CDP, ADP, and PKP follow the school calendar and are not operational in July and August. Also noted that the low number of events reported in March 2020, is likely due to the emergence of the COVID-19 pandemic and subsequent repercussions.

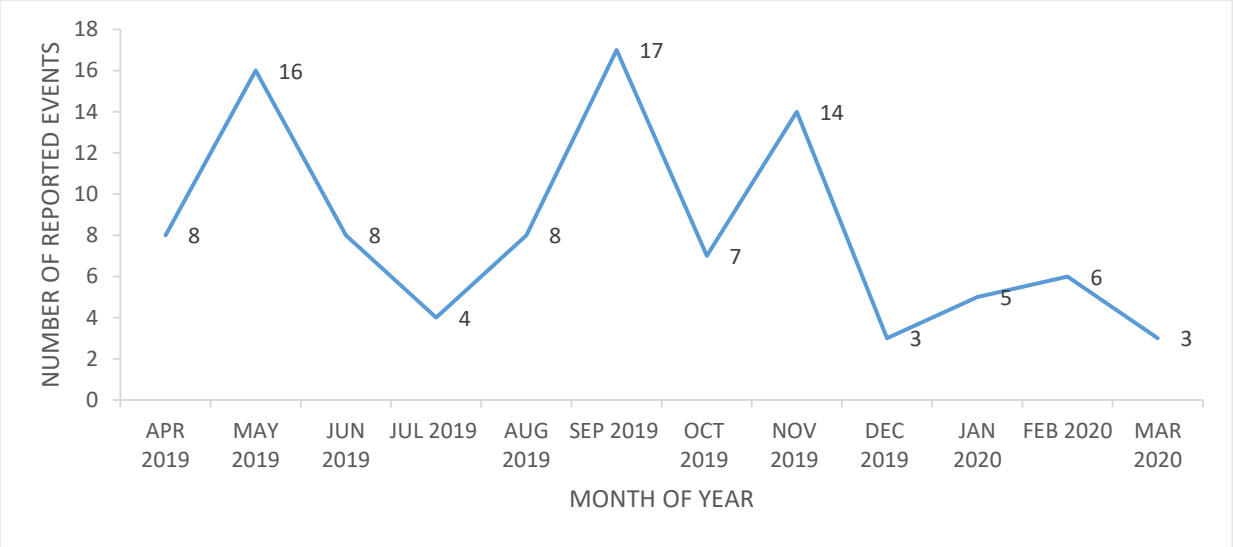

Figure 3. Frequency of Reported Events by Month

Day of Week

The highest number of incidents occurred on Mondays (n=25) and Tuesdays (n=24) as shown in Figure 4. Off-site events are eligible for reporting in some scenarios, which is why there are some incidents which occur on the weekend. Some of these incidents also occurred at CASA House, as it was operational on the weekends until the beginning of March 2019.

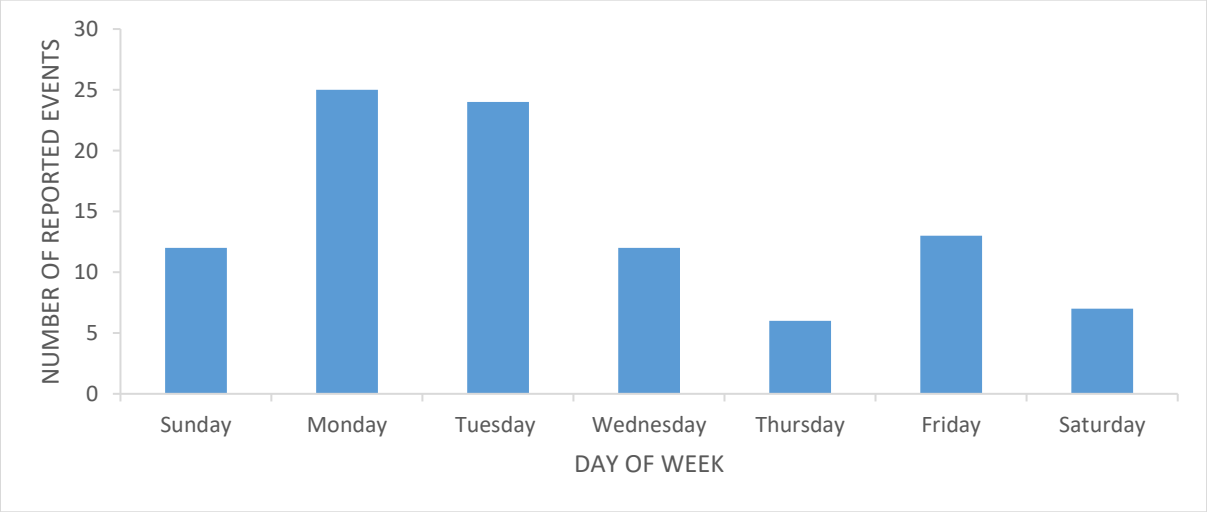

Figure 4. Frequency of Reported Events by Day of Week

Summary of Demographics of Children & Adolescents involved in Reported Patient Safety Events

Gender

During the 2019-2020 fiscal year, males (n=57, 58%) were more commonly involved in reported events than were females (n=38, 38%). Gender was not reported on 4 reports (4%). This is consistent with our historical data, which shows that males are more commonly involved in reported incidents.

Age

The **mean age** of the 57 children and adolescents involved in incidents this year was **12.9**. Note that age was not reported for two individuals. For reference, the mean age reported in 2018-2019 was 13.4 years. The ages of patients involved in this year's events ranged from 3 to 17 years. Most events involved patients ages 13 to 17 (n=38, 69%), followed by those ages 8 to 12 (n=14, 25%). Children ages 3 to 7 were least commonly involved (n=3, 6%).

Events per Individual

The number of events that an individual child or adolescent was involved in ranged from 1 to 9 this year. The majority (65%) of individuals were only involved in one event over the course of the year. However, as see in Table 4 below, 20 individuals were involved in multiple events. Only one individual was involved in nine different events.

Table 4. Number of Reported Events per Individual

Number of Events per Individual	Number of Patients (n=57)
1	37 (65%)
2	10 (17.5%)
3	6 (10.5%)
≥4	4 (7%)

Recommendations for Further Action

1. The Patient Safety Committee recommends updating patient safety related terms and definitions to ensure that CASA is operating under current best practices.
2. Revision of the Patient Safety Event Report Form and process is also necessary to ensure collection of meaningful and usable data. Efficiency of use for staff should also be carefully considered.
3. The Patient Safety Committee continues to recommend benchmarking against past CASA data as well as other children and youth community mental health organizations in order to set a baseline for the incidence of events occurring each year and analysis of emergent trends both within the organization and outside of it.

Appendix A: Patient Safety Plan 2020-2021

OPERATIONAL PLAN 2020-2021

Patient Safety Committee

VISION STATEMENT

To establish a culture of patient safety throughout the entire organization.

GOALS

(1) Create Sustainable Patient Safety Training and Education all CASA staff.

(2) Revise the Patient Safety Event Management System to increase Impact.

GOAL: Create Sustainable Patient Safety Training and Education for all CASA staff					
	Objective	Action(s)	Accountability	Expected Timeline	Progress including outcome
1	J. Dagneau (Patient Safety Chair) and A. Ewasiuk (Quality and Risk Lead) to complete formal Patient Safety Training through the Canadian Patient Safety Institute.	a. J. Dagneau and A. Ewasiuk to complete the Canadian Patient Safety Officer course online.	J. Dagneau, A. Ewasiuk	August 2020	J. Dagneau has left the organization and this portfolio will fall under Ian Lang, who also oversees OHS&W, Patient Safety, and Facilities. A nurse has been hired to support Ian with OHS&W and Patient Safety.
2	To ensure that all CASA leadership is trained in patient safety best practices and procedures annually.	a. Develop leadership specific patient safety training.	Clinical Educator	January 2021	
3	To ensure all CASA staff are trained in patient safety procedures annually.	a. Develop front-line staff specific patient safety training.	Clinical Educator	February 2021	
4	To ensure all new staff members are trained in patient safety at new staff orientation.	a. Develop patient safety training materials for new staff.	I. Lang, A. Ewasiuk	Ongoing Every 1-2 months at HR New Staff Orientation	

5	To ensure patient safety best practices are embedded into daily clinical practice at CASA.	a. Regularly update Patient Safety page on CASA Connect. b. Mentor and support Clinical Leads in taking more active patient safety leadership role. c. Ensuring that patient safety is standing agenda item at team meetings and clinical case conferences.	I. Lang Program Managers Program Managers, Clinical Educator	Ongoing November 2020 Ongoing	

GOAL: Revise the Patient Safety Event Management System to increase Impact					
	Objective	**Action(s)**	**Accountability**	**Expected Timeline**	**Progress including outcome**
1	To ensure consistent patient safety terminology at CASA.	a. Appropriately define terms including patient safety, patient safety event, harm event, no harm event, post event analysis, cultural safety, using current standards and best practices. b. Revise the Patient Safety Event Report Form.	I. Lang, A. Ewasiuk I. Lang, A. Ewasiuk	September 2020 October 2020	
2	To ensure the Patient Safety Committee and the Patient Safety Chair have a clear understanding of their mandate, authority, and relationships to other committees and/or groups.	a. Review and update the Patient Safety Committee's Terms of Reference, including membership.	A. Ewasiuk	July 2020	

		b. Clarify the integration and relationship/alignment of Patient Safety and MIC.	A. Ewasiuk	September 2020	
3	To ensure that the Post-Event Analysis protocol/process is clearly defined and openly accessible.	a. Write or adapt a Post-Event Analysis (PEA) protocol which includes roles and responsibilities, when a PEA will be initiated, monitoring of PEA results, sharing the PEA results, resulting action plans and how they will be implemented. b. Create training module on PEA in the Leadership specific patient safety training as well as the staff patient safety training.	I. Lang, A. Ewasiuk Clinical Educator	November 2020 January 2020	
4	Thoroughly explore the implications of EMR use on Patient Safety at CASA.	a. Liaise with MIC, Clinical Council, Data Management Committee to better understand the how the EMR impacts patient care and safety. b. Start relationship with Data Management Committee and Patient Safety Committee to establish Patient Safety issues inherent with EMR use and vis a versa.	K. Merritt (CC), A. Ewasiuk (MIC), I. Lang (DMC) I. Lang	Ongoing June 2020	

Appendix B: CASA Patient Safety Plan 2016-2018 (Extended into 2019-2020)

Strategic Priority: Prevention				
Strategy	**Action***	**Lead**	**Timeline**	**Progress/Status**
Staff Education	Orientate all staff to their responsibilities for patient safety at new employee orientation	Human Resources, Patient Safety Chair	Ongoing as part of staff orientation	Ongoing
	Survey staff annually about patient safety culture	Evaluation & Research Officer	Next survey: September 2018	Ongoing
	Maintain a CASA CONNECT Patient Safety page and forum which includes: • Patient safety quarterly and annual reports • Policy and procedure updates • Information about leading practices • Information about safety improvements and completed recommendations.	Assigned Patient Safety Committee Member, Webmaster	As Needed	Ongoing
Patient Education	Download information about child and youth safety to waiting room monitors	Clinical Educator	September 2018	Incomplete
	Consider distribution of information about safe practices to patients and guardians in writing and verbally at the time of admission. Include medication safety, waiting	Patient Safety Committee	October 2018	Ongoing

	room safety, playground safety			
Prospective risk analysis	Assess patient safety risks at admission and document in the health record	Intake team	Winter 2019	Ongoing
	Review admission practice of developing a written safety plan with the patient and family that addresses identified risks. This includes the proper use of the Caution Indicator form.	Program Managers, Clinical Leads	Fall 2018	Incomplete
Strategic Priority: Risk Management				
Strategy	**Action**	**Lead**	**Timeline**	**Progress/Status**
Staff Education	Train all staff in Therapeutic Crisis Intervention (TCI) philosophy; Train all clinical staff in philosophy and methods	Clinical Educator	Next Training Session: August 2018	Ongoing
	Train all staff in safety event reporting	Patient Safety Chair, Patient Safety Committee	Monthly	Ongoing
	Train all clinical and front-line staff in safety event disclosure to families	Clinical Educator, Patient Safety Chair	January 2019	Incomplete
	Train program managers and safety leaders in systemic methods of analyzing safety event factors	Patient Safety Chair, Patient Safety Committee	June 2018	Complete
Patient Education	Provide guardians written information and training in crisis de-escalation	Assigned Therapist	N/A	Ongoing
	Inform patients and guardians about CASA policies and	Program Manager, Treatment team	As Needed	Ongoing

	procedures related to managing safety events			
	Inform patients and guardians about CASA policies and procedures related to managing safety events through external version of Patient Safety Annual Report	Evaluation & Research Officer	Annually	Ongoing
Tracking and reporting	Report all patient safety events using the electronic reporting form	All staff, physicians and volunteers	As Needed	Ongoing
	Patient safety data is tracked and reported to leadership and on CASA CONNECT quarterly	Evaluation & Research Officer	Quarterly	Ongoing
Timely follow-up and communication	Patient guardians are informed of safety events and invited to participate in debriefings and analysis	Program Manager, Clinical Lead	As Needed	Ongoing
	Program Managers conduct post event debriefing with staff, patients and families involved in safety events	Program Manager	N/A	Incomplete
Strategic Priority: Quality Improvement				
Strategy	**Action**	**Lead**	**Timeline**	**Progress/Status**
Safety Investigation Training	Safety leaders, including Program Managers, are trained in systemic methods of analyzing the factors contributing to safety events. Investigation training is a strategic priority for 2017-2018.	Patient Safety Chair, Patient Safety Committee	N/A	To be revisited in 2019-20 as current staff is not meeting this strategy due to turnover

Data reporting and analysis	Identify quality improvements during the review of the safety event with the team and report to the Patient Safety Committee for follow-up and tracking	Program Manager and Respective Team		Implemented
	Document follow up recommendations and communicate to staff	Patient Safety Committee		Implemented
	Track progress and report annually	Accreditation Coordinator		Implemented
Communication	Post annual patient safety reports on the CASA website	Accreditation Coordinator		Implemented
	Open invitation to staff and patients to attend meetings of the Patient Safety Committee	Patient Safety Committee Chair		Incomplete

* Implementation plans and quarterly progress reports are required for each action