The Importance of Improving Patient Safety In a Mental Health Setting

Josephine Cassar

A dissertation submitted to the University of Malta in partial fulfilment of the requirements for the degree of Masters of Health Science in Health Service Management

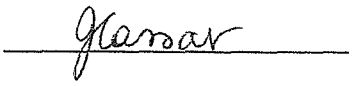
June 2011

To my loving husband Joseph, and my wonderful children

Robert, Suzanne, Matthew and Carl

Declaration

I, the undersigned, hereby declare that this dissertation is the result of my own effort and research conducted under the constant supervision of Dr. Natasha Azzopardi Muscat. I declare that the information contained herein is true, correct and accurate to the best of my Knowledge and belief.



Josephine Cassar

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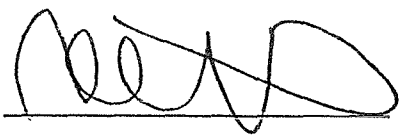

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I hereby declare that I am the legitimate author of this Long Essay/Dissertation/Thesis and that it is my original work.

No portion of this work has been submitted in support of an application for another degree or qualification of this or any other university or institution of learning.

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Executive Summary

Patient safety is an emerging issue in mental health that has only recently received attention. Whilst patient safety has moved to the forefront of the health care agenda nationally and internationally there is to date a shortage of research to guide patient safety systems, practices, policies and care delivery in mental health.

The aim of the study was to explore the prevailing knowledge and attitudes of staff in a mental health setting with regards to patient safety. To achieve this aim, the following objectives were set: to identify the knowledge, practices and attitudes of different categories of workers employed within the mental health hospital; to identify prevalent risks to health and safety; to identify existing policies, protocols or documents within the hospital and obtain feedback from staff regarding their utility in upholding patient safety.

The literature review focused on six patient safety incidents in mental health setting. These included: patient victimization; aggression and self-harm; seclusion and restraint; slips and falls; absconding and missing patients and adverse medication events.

An exploratory design making use of qualitative methods was used. Data was collected through a focus group discussion and through personal interviews with experienced personnel working in a mental health setting in Malta. Semi-structured interviews were audio-recorded. A topic guide guided the questions in the interviews and focus group followed by specific topics that were raised by the participants.

Thematic analysis which involved the search for themes was considered appropriate for this study. It involved the systematic qualitative analysis of transcripts of semi-structured interviews conducted with participants and a focus group.

Several findings emerged from the research pertaining to planning, policies, guidelines, practices and research. The findings suggested that for patient safety in mental health to improve, a safety culture needs to be embedded within all levels of an organization. It requires leadership, effective communication, service integration and inter-professional collaboration. Further, it requires ongoing training and education programs to all health care workers, better reporting of incidents, better documentation and handover system. Moreover, the impact of stigma against mental illness was also revealed.

Finally, this research study identified several potential important future directions for improving patient safety in mental health setting. A link between patient safety and service availability, quality of care and mental illness stigma was found. The main recommendations that have emerged from the findings are suggestions for management, for education and for future research. Therefore, promoting a culture of patient safety, involving various multidisciplinary workers and professionals in the organisation will improve patient safety in mental health setting.

Contents

Chapter 3: Methodology

Chapter 4: Findings and Discussion

Chapter 5: Conclusion and Recommendations

List of Figures

List of Tables

Chapter 4: Findings

List of Appendices

Chapter 1

INTRODUCTION

1.1 Introduction

Patient safety is defined as a discipline in the health care professions that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. It is an attribute of health care systems that minimizes the incidence and impact of adverse events and maximizes recovery from such events (Emanuel, 2008). It is increasingly clear that patient safety has become a discipline, complete with an integrated body of knowledge and expertise, well suited to the need for dealing with events that might be either familiar or entirely unpredictable (Reason, 2000).

Patient safety is fundamental to nursing care and health care across all settings and sectors. It is not merely a mandate; it is a moral and ethical imperative in caring for others. In recent years patient safety has moved to the forefront of the health care agenda nationally and internationally (Lucille, 2004).

1.2 Patient safety in mental health

Everyday a large number of patients are treated and cared for without incidents by health care practitioners worldwide. Like other high risk industries, safety incidents occur during the course of medical care, placing patients at risk for injury or harm. Although, many of the patient safety risk factors that exist in medical settings also apply to mental health settings there are unique patient safety incidents in mental health that are different to those in medical care. These include: patient victimization; aggression and self-harm; seclusion and restraint; slips and falls; absconding and missing patients and adverse medication events (Brickell, Nicholles; Procyshyn, Mclean, Dempster, Lavoie, Sahlstrom, Tomita & Wang, 2009).

Further, in order to determine the root causes of error within the health care system and improve patient safety, the health care system must develop, maintain and nurture a culture of safety (Lucille, 2004).

Although literature offers many different definitions of patient's safety, no single definition has been adopted universally and hence the field suffers from this lack of a common nomenclature (Chang, Schye, Criteau, O'leary & Leob, 2005). Patient safety was defined by the Institute of Medicine (2003) as the prevention of harm to patients. Emphasis is placed on the system of care delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) built on a culture of safety that involves health care professionals, organizations and patients (Aspden, Corrigan & Wolcott, (2004).

Moreover, health organizations globally have been galvanized to develop and establish best practices in patient safety, giving rise to the development of incident reporting systems, policies and procedures among service providers (Kohn, Corrigan & Donaldson, 1999). However, Bowers (2000) recommends that the method for calculating patient safety incidents in mental health is to be determined by the research question.

1.2.1 Contributing factors

Mental health service users are harmed everyday as a consequence of their care and treatment, despite the best efforts of staff working to support them. Like safety incidents in other systems, patient safety incidents in all health settings occur as a result of a complex set of contributing and interacting factors, rather than a single failure on the part of an individual or a system (Kohn et al., 1999; Nath & Marcus, 2006).

Factors contributing to patient safety incidents can be categorized in numerous ways. In fact, one common division is between the individual factors contributing to patient safety incidents

(i.e., human error) and systems factors (i.e., physical environment, unit design, staffing levels, heterogeneity of patients, and availability of structured activities, policies and procedures). In the past, there has been a tendency to blame individuals for patient safety incidents, be it the patients themselves for engaging in risky behaviours, or health care providers for making errors.

Although, a particular action or omission by an individual might be the immediate cause of an incident, a broader system analysis usually reveals a series of events and departures from safe practice that are caused by environmental/organizational factors (Vincent, Taylor, Adams & Stanhope, 1999).

Furthermore, recognizing that no single factor or group of factors accounts for a patient safety incident, other factors may contribute to adverse events in mental health. However, attention has turned to understand how system level factors contribute to patient safety incidents (Jayaram, 2006).

As such, when a patient safety incident occurs, the focus is not on identifying who committed the active failure, but on how and why the system failed and allowed the failure to occur (Department of Health, London, 2000).

1.2.2 Patient Factors

Patient safety incidents in mental health are co-dependent such that patients that are at risk for one type of disruptive behaviour (e.g., absconding) tend to be at increased risk for other disruptive behaviours (e.g., aggression). In particular, the behaviour of absconding, self-harm, suicide and aggression are likely to co-occur in the same patients. Research findings underscore the importance of fully involving patients in safety initiatives (Bowers, 2000).

1.2.3 Provider Factors

Research has demonstrated that mental health care providers have a considerable impact on the rate of patient safety incidents on inpatient units. The extent to which staff positively valued patients and were able to regulate their fear and anger towards patients and their behaviour, impacted rates of aggression, self-harm, and absconding (Bowers, Simpson & Alexander, 2005). Moreover, within mental health settings, the related factors of large caseloads and limited time to see patients have been linked to patient safety incidents (Department of Health, 2002b; Nath & Marcus, 2006).

Furthermore, poor communication between health care providers and between health care providers and patients has been linked to patient safety incidents (Health Canada, 2007; Lang & Edwards, 2006). In addition, communication may be affected by high staff turn-over, inexperienced staff, fatigue and interpersonal conflict. In general, improvements in communication are associated with improvements in patient safety. In fact, systems that provide high levels of feedback and staff coordination have fewer patient safety errors (Australian Resource Centre for Hospital Innovations, 2003).

1.2.4 Organizational factors

Non-clinical systems such as human resources, recruitment and retention, training programmes, and admission and discharge processes are all relevant to patient safety, and yet are beyond the control of the individuals providing care to patients with mental illness. Various organizational factors influence not only the frequency of patient safety incidents but also the likelihood that incidents and close calls are reported. This is influenced by the organizational policies and procedures in place for reporting, and also by the organizational culture that emphasizes or minimizes the importance of patient safety and the need to learn from incidents. In particular, information sharing, lack of community resources, bed

shortages and staffing shortages in the mental health system contribute to patient safety incidents.

1.2.5 Physical Environment

In general, poor physical design, including the layout and features of the physical environment, contribute to patient safety incidents and the feeling of lack of safety on the unit (College of Registered Psychiatric Nurses of British Columbia, 2006). Several papers provide guidance on the ideal physical design for inpatient units (Bolton, 2006; Department of Health, 2002a) and include information and recommendation. Examples of safe physical design include providing adequate washing facilities, toilets, sleeping space and common rooms, natural light, quiet areas, outdoors green spaces, to allow for space and to minimize aggressive and impulsive behaviour; installing unbreakable windows with limited opening and avoiding fittings that could be used by patients to hang themselves e.g. curtain rails, exposed pipes and others (Mental Health Commission, UK, 2008; Royal College of Psychiatrists, 1998).

1.2.6 Relationship between Patient Safety and Employee Safety

Patient safety and employee safety interact in important and complex ways (Kohn et al., 1999; Lang & Edwards, 2006). Incidents such as violence and aggression, sexual assault, and sexual harassment present safety risks for health care workers as much as for patients. Moreover, working conditions for staff can impact their ability to prevent, detect and respond to patient safety incidents. Not surprisingly, factors such as poor working conditions, workload, staffing levels and lack of autonomy in the workplace have been found to have a deleterious effect not only on staff safety but also on patient safety (Banerjee, Daly, Armstrong, Lafrance & Szebehely, 2008). Furthermore, employees involved in patient safety incidents are often troubled by feelings of guilt and fear of blame by their colleagues and

organization that may affect their work performance. In addition, the concept of a safety culture, with equal emphasis on patients and staff, could serve as a unifying concept for these two important issues.

1.3 Patient Safety in Malta

Patient Safety has always been a priority for all those involved in the provision of health care services since time immemorial. The need to ensure patient safety at the top of the policy agenda in the health sector and the pressure to place patient safety at the heart of our mission has partly resulted from increasing evidence that several patients are harmed as a result of failures within health care systems.

All professional groups have jointly contributed to raise awareness about the need to establish and maintain health care systems with the necessary safeguards and precautions to protect patients.

Research on patient safety in Malta is lacking and introduces an innovative concept. An undergraduate study of "Nurses' perceptions of medication errors" carried out by Petrova (2005) has shed some light on barriers to report errors. Other studies that are related to patient safety in Malta include: "Surgical Site Infection: An Exploration of Infection Control Practices among Health Care Professionals" by Tartari (2009) and "Patient Safety Culture in an Acute Care Hospital" by Baldacchino (2009).

Indeed, it is hoped that the present study on patient safety in mental health setting, presented in this dissertation, would generate new knowledge to help narrow the local research gap on the topic, as well as serve as a tool for improving patient safety.

1.4 The Research Question

In this dissertation, the researcher chose to focus on the research question, "What are the prevalent staff perceptions regarding patient safety in a local mental health setting?"

1.5 Outline of the study

This study uses a qualitative research design. The major types of qualitative research methods are: in-depth interviewing to individual participants, focus group and participant observation where data is gathered in a natural environment which engages natural behaviour.

1.6 Service/ management implications

Management has a key role in health and safety efforts within the organization and a high level integration into broader management systems. Particular findings from the study could prove useful to assist management by:

- Understanding the issue of health and safety within the mental health setting, pointing to particular areas that require attention and/or action to be taken.
- Identify resources that are required to set up health and safety system within the hospital.
- Giving an idea of management, operational facilities and structures that need to be modified and geared towards achieving a desired level of health and safety performance.

1.7 Justification of the study

In order for patient safety in mental health settings to improve, a culture of safety needs is to be embedded within all levels of an organization. Reporting of unsafe acts and adverse events

is promoted as an important organizational responsibility. Moreover, the concept of using close calls and adverse events as unique opportunities to learn is vital to implement change to improve the safety and quality of care of the patients.

Furthermore, it is critical to address the impact of discrimination and stigma against people with mental illness. Indeed, to reduce the risk of adverse event occurrences in mental health settings, effective communication, service integration, and inter-professional collaboration are required. Moreover, professional practice guidelines and standardized training and further education for health care workers are also suggestions as a way of ensuring comparable standards of care both within and between provinces as well as between care settings. In addition, the need for further research to ensure practices and tools are evidenced based was also acknowledged.

1.8 Conclusion

This study will attempt to explore the current level of knowledge and perceptions of staff regarding patient safety and the priorities and changes that are required within the hospital. The brief introduction to the study is followed by the literature review which confers the general themes of the study. Subsequently, the researcher will discuss the methodology and explains the aim and objectives, the research design and settings, instrumentation, methods of data collection, data analysis and ethical issues. In the findings and analysis section the researcher will give a general profile of the research participants, report the findings, analyse and discuss the findings in the light of the reviewed literature.

After that, the researcher will conclude with a general view of the findings and results, the strengths and limitations and measures to improve patient safety in mental health setting will be proposed.

Finally, a number of recommendations that have emerged from the findings of the study will be discussed and these include suggestions for management, for education and for future research.

Chapter 2

LITERATURE REVIEW

2.1 Introduction

Patient Safety has been defined as "the state of continually working towards the avoidance, management and treatment of unsafe acts within the health care system" (NSCPS, 2002, p. 37). It has been a relatively recent consideration in healthcare but has rapidly become a mainstay of the clinical governance structure of NHS organizations (Heighton, 2010).

Patient safety is a moral and ethical imperative in caring for others. Moreover, it has moved to the forefront of the health care agenda nationally and internationally (CNA, 2009). However, there is lack of awareness of the issues as well as a shortage of research and readily available information to guide patient safety systems, practices, policies and care delivery in mental health (Brikell, Nicholls, Procyshyn, Dempters, Lavole, Sahistrom, Tomita & Wang, 2009).

The literature review will focus on six patient safety incidents in mental health setting that were chosen by Brickell, Nicholles, Procyshyn et al., (2009):

1. Patient victimization

2. Aggression and self-harm

3. Seclusion and restraint

4. Falls and other patient accidents

5. Absconding and missing patients

6. Adverse medication events

WHO (2007) created a Conceptual Framework for the International Classification for Patient Safety, which is currently in field-testing. It represents a consensus of international experts and up-to-date information on patient safety within the healthcare context across the world, including mental health settings and patient. Patient safety encompasses harm to patients, incidents that may give rise to harm, the antecedents or processes that increase the likelihood of incidents, and the attributes of organizations that help guard against harm and enable rapid recovery when risk escalates (WHO, 2007).

Patient safety is a powerful motivation for governments and regulatory bodies to insist on improved inter professional team working. More generally, if we want health care to be responsive to the needs of patients, there needs to be an effective team approach in which information and responsibility are shared appropriately to allow the best decisions to be made (Spry, 2006). Moreover, patient safety is fundamental to nursing care and concerns everyone in healthcare, whether one works in a clinical or non-clinical role. Indeed, it is a critical component of health care quality.

Furthermore, tackling patient safety in healthcare collectively and in a systematic way by ensuring the provision of safe, compassionate, competent and ethical care to patients can have a positive impact on the quality of care and efficiency of healthcare organizations (Woodward, 2005)

2.2 A comprehensive review of the literature

The purpose of this chapter is to review the literature and research, exploring the prevalent perceptions of staff regarding patient safety and the changes that are required to improve patient safety in a mental health setting. In the review of the literature, the reference

databases Google Scholar, Pubmed and Medline were searched for journal articles published up to December, 2010. In addition, national and international government and other organization websites were searched for relevant articles, influential reports, guidelines and recommendations using the Google search engine. Literature was also searched from psychiatric nursing library books.

Keywords and phrases used included "*patient safety, mental health, patient safety incidents, patient safety culture, organizational culture, management culture, inter-professional communication and collaboration, empowerment, decision making, contributing factors, risk management and leadership strategies*". This chapter begins with the definition of patient safety and the importance of improving patient safety and quality care within healthcare. Details of the methodology used in the literature review including the search terms for patient safety in mental health setting are to be identified.

2.3 Defining patient safety

Although several definitions on patient safety exist from the literature, the Canadian Patient Safety definition has been chosen for the purpose of the study. Here patient safety is defined as "the reduction and mitigation of unsafe acts within the health care system, through the use of best practices shown to lead to optimal patient outcomes" (Davies, Hebert & Hoffman, 2003, p. 27). This definition has been chosen since it brings together a dual focus on avoiding risks and promoting quality care.

2.4 Patient safety in Malta

The delivery of high quality care is one of the core principles of the Maltese healthcare system. The quality of care is built upon the three pillars of clinical effectiveness, patient experience and patient safety. Monitoring of the services delivered allows for the

development of guidelines for improvements and planning of these services for the best of our patients (Busuttil, 2010).

According to the speech addressed at the official opening of the conference "Patient Safety, 2007, Developing Strategic Approaches" his Excellency President of Malta, stated in his speech that: "Improving patient safety will bring benefits in driving up standards and quality by helping build a safer health system; it will also help to improve the confidence of patients in the healthcare system" (Department of Information, 2007, p.1). Moreover, collaboration leads to shared expertise and the most effective use of the available resources, thus will benefit from best practices to raise standards. This conference considers patient safety to be rapidly evolving priority area. It recognizes that there is a need to provide accessible care of high quality, which is financially sustainable, but which is also designed to decrease any risk of harm coming to patients (DOI, 2007).

Patient safety is of paramount priority as there cannot be quality of care without patient safety and this principle will be foremost in view when planning all the department's activities. Furthermore, the pursuance of higher degrees of patient safety is an important task and remains high on the agenda of the Maltese Government (Pre Budget Document, 2008).

Research on patient safety in Malta is lacking and introduces an innovative concept. An undergraduate study of 'Nurses' perceptions of Medication Errors' carried out by Petrova (2005) has shed some light on barriers to report errors. Other studies that are related to patient safety in Malta include: "Surgical Site Infection: An Exploration of Infection Control Practices among Health Care Professionals" by Tartari (2009) and "Patient Safety Culture in an Acute Care Hospital" by Baldacchino (2009). It is hoped that this study, presented in this dissertation, would generate new knowledge to serve as a tool for improving patient safety in the mental health setting.

2.5 Professionals knowledge and attitudes about Patient Safety

Patient safety is a main determinant of the quality of healthcare services. It is a responsibility shared by all health-care professionals, health-care organizations and government and requires the involvement of the public (CNA, 2009). Canadian Nurses Association believes that providing for patient safety involves a wide range of actions at all levels to support research on best nursing practices (CNA, 2001). Moreover, the literature shows that the occurrence of medical errors is quite important in countries where it has been measured. In fact, various actions like legislative measures, financial, or educational measures may help, however, they are not always effective in controlling the level of avoidable errors. That happens because patient safety is strongly related to the culture specific to healthcare organizations (Hindle, Haraga, Radu, & Yazbeck, 2008).

A study was aimed at getting some perspectives on the organizational culture in Romanian hospitals in regard to patient safety (Hindle, Haraga et al., 2008). The main objectives were: to identify the views of healthcare professionals about patient safety in Romanian hospitals and compare those with other countries, and find out if there are differences in perceptions of professional categories about their own work and that of the clinical team. Meanwhile, a survey was conducted based on a questionnaire. This aimed at realizing a screening of the problem, to get some specific views of respondents from their work experience, and eventually to get suggestions on how to improve patient safety. In spite of, the same questionnaire was applied in four other countries: Australia, Singapore, Sweden and Norway. Overall views of hospital professionals from Romania were compared to those from the other countries. Moreover, views per professional categories - clinical vs. non-clinical staff, doctors vs. nurses and senior vs. junior staff were compared (Hindle, Haraga et al., 2008). Indeed, the aim of 'Improving patient safety in mental health' programme is to support four

organizations across the UK to improve the reliability of care in order to reduce harm and therefore, raise safety awareness throughout their organizations.

Answers from hundred respondents from Romania indicate that patient safety is a major concern of hospital professionals and a concern of health policy in other countries. In fact, they are facing many barriers such as inadequate leadership, lack of communication between professional categories, between senior and junior staff and most of all between the patients. This is a problem of organizational culture, which requires complex, multi-level strategies, and targeting a long-term change. Basically, they show as much interest and willingness to improve as observed in the other countries. In addition, this indicates that no major differences in the organizational culture exist in regard to patient safety. However, differences among professional categories have been noticed; for example, nurses are more aware than doctors on the need to take action for improving patient safety (Hindle, Haraga et al., 2008).

Nurses are involved in the provision of health care in every area of the health care system. This "presence" of nurses and their sound knowledge base enables them to play a critical role in patient safety (NSCPS, 2002). Through their vigilance, nurses act to keep patients safe, identify areas of risk and recognize situations in need of improvement. Nurses perceive multiple and complex work environment factors that influence nurse and patient outcomes, including the quality of leadership and management, staffing resources, workload, job stress and anxiety, teamwork, and effective communication (Milisen, Abraham, Siebens et.al., 2006). This study was taken from a cross-sectional questionnaire survey of hospital nurses in Belgium where all eligible nurses in a selection of 22 hospitals received the Belimage questionnaire. It identified several areas of tension in the nursing profession.

Moreover, for nurses, patient safety is not just part of what they do; nurses are committed through their code of ethics to provide safe, competent and ethical care (Canadian Nurses Association, 2009). Patient safety is of prime importance to nurses in all areas of practice, be it clinical practice, education, research or management/ leadership positions (NSCPS, 2002).

A recent survey asked Canadian nurses about patient safety in hospitals (Nicklin & McVeety, 2002). Nurses responded that most harm caused to patients can be attributed to problems in the health care system itself. In fact, among safety issues that nurses identified were those connected with workload, human resources, restructuring and bed closures, the increasingly complex needs of patients, the physical environment and technology

In addition, factors such as interruptions in the delivery of care, loss of information, outdated equipment, poor staffing, poor drug labeling, inadequate warnings about drug allergies or incompatibilities and environmental hazards all have the potential to lead to errors (Bates, 2003). Systems that provide high levels of feedback and staff coordination have fewer patient safety errors (Australian Resource Centre for Hospital Innovations, 2003). Similarly, poor communication between health care providers and between health care providers and patients has been linked to patient safety incidents (Health Canada, 2007; Lang & Edwards, 2006; NPSA, 2005). Moreover, to address patient safety issues, it is necessary to develop ways to ensure that both the individual health care provider and the health care system can contribute to the safe delivery of care (Brickell, Nicholls, Procyshyn et al., 2009).

2.6 A Patient Safety Culture

Patient safety is a critical component of health care quality. In healthcare organizations there is a growing recognition of the importance of establishing a culture of safety which requires an understanding of the values, beliefs and norms about what is important in an organization

and what attitudes and behaviours related to patient safety are expected and appropriate (Sorra & Nieva, 2004).

A safety culture is defined as "the product of the individual and group values, perceptions, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organization's health and safety programmes" (HSC, 1993a, p.23). Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures (ACSNI, 1993).

Moreover, safety culture can be generally defined as the way people think and behave in relation to safety (Cooper, 2002). The ultimate goal of developing a culture of safety has tremendous potential to benefit our patients and the health care team. Several factors have been identified as important in the development of a patient safety culture within healthcare including: supervisor/manager expectations, actions and support; organizational learning and continuous improvement; teamwork, both within and between units; communication openness; medical error, event reporting and response to reporting of errors; staffing and handovers and transitions within and between units (Sorra & Nieva, 2004).

A just culture accepts that discrimination of people with mental illness undermine access to care, quality and safety of care and health outcomes and seeks to eliminate the stigma against people with mental illness (Brickell, Nicholles, Procyshyn, et al., 2009).

2.7 Issues in Patient Safety in Mental Health

Although there have been significant developments in addressing patient safety issues, it is important to understand how safety problems arise. This stimulates discussion among nurses, other health care providers, employers, the public and policy-makers. These issues included:

- Patient safety incidents in mental health settings
- Contributing factors
- The concept of risk management
- Develop leadership strategies
- The relationship between patient safety and employee safety
- The seven steps in mental health
- Current trends and gaps

Patients receiving mental health treatment are at risk of patient safety incidents that are uniquely or strongly associated with mental health setting (Brikell, Nicholls, Procyshyn et al., 2009).

2.7.1 Patient safety incidents in mental health setting

A patient safety incident is defined as "an event or circumstance which could have resulted or did result, in unnecessary harm to a patient, has a more constrained meaning than the term incident which, when used in a general context, has a wider meaning as an event or circumstance which could have resulted, or did result, in harm to any person and/or complaint, loss or damage" (WHO, 2007, p.7). An adverse event is "an incident which results in harm to a patient" (WHO, 2007, p.7). The language and definitions used are therefore in alignment with the WHO's framework.

A seminal report by the United Kingdom's National Patient Safety Agency (NPSA) in 2006 on patient safety in mental health provided the first comprehensive survey of patient safety

incidents affecting mental health patients. Incidents are classified into a number of different types (Runciman, Hibbert, Thomson et al., 2009).

An incident is an adverse event which results in harm to a patient. Harm is considered an outcome that negatively affects a patient's health and/or quality of life, including illness, injury, suffering, disability and death and may thus be physical, social or psychological (WHO, 2007). In addition, errors, violations, patient abuse and deliberately unsafe acts occur in healthcare and are unnecessary incidents. Incidents arise from either unintended or intended acts (Reason, 1990). An error is a failure to carry out a planned action as intended or application of an incorrect plan. Errors may manifest by doing the wrong thing (commission) or by failing to do the right thing (omission), at either the planning or execution phase (Runciman, Merry & Tito (2003). Violation is a deliberate deviation from an operating procedure, standard or rule. Both errors and violations increase risk, even if an incident does not actually occur. Risk is the probability that an incident will occur (Reason, 1990; Runciman, Merry & Tito, 2003).

In consultation with OHA, CPSI, and the Advisory Committee, six patient safety incidents in mental health setting were chosen by Brickell, Nicholles, Procyshyn et al., (2009):

1. Patient victimization

2. Aggression and self-harm

3. Seclusion and restraint

4. Falls and other patient accidents

5. Absconding and missing patients

6. Adverse medication events

2.7.1.1 Patient Victimization

Research in victimization and mental health appears to be very much in the early stages and overall studies demonstrate that victimization rates remain a pressing concern. Unfortunately, many mental health patients report they do not feel safe while in care (Mind, n.d.). Of concern is the rate at which people with mental illness experience victimization by others. Although it is recognized that persons with mental illness are at a risk of perpetrating violence and aggression, they also are at considerable risk of being victimized by others. In fact, quite contrary to the widely held notion that mental illness is predictive of crime and violence, these persons are more likely to be victims of violence than they are to present a risk of violence to others. Victimization is broadly defined to include verbal, psychological, physical, sexual and financial abuse of the patient by others (Galpin & Parker, 2007).

Recent studies show that trauma victimization is highly prevalent among persons with severe mental illness who are served within public-sector mental health clinics (Mueser, Goodman, Trumbetta, Rosenberg, Osher, Vidafer, Auciello & Foy, 1998). In this study the subjects were men and women adults between the ages of 19 and 73, who had been hospitalised in the South Carolina public mental health system an average of 4 times. Exclusion criteria included active psychosis, intoxication, or cognitive impairments that would interfere with the participation in the assessment (Karen, Cusack, Frueh, Hiers, Suffoletta & Bennett, 2003).

Demographic information was collected for each subject. The Psychiatric Experiences Questionnaire used as an assessment instrument for the study based on focus groups with Consumers Affairs Coordinators throughout the state mental health system, whose purpose was to generate a list of experiences that clients found to be harmful in the patient setting (Karen, Cusack, Frueh et al., 2003). Data were grouped according to the type of event and categorised as: institutional events and procedures; sexual or physical assaults; coercive

measures; witnessing traumatic events and verbal intimidation/abuse. The results of this study indicate that mental health patients have experienced a number of traumatic, humiliating, or distressing events during their hospitalization. In fact, patients are affected by these experiences (Karen, Cusack, Frueh et al., 2003).

Furthermore, most mentally ill people are not dangerous to themselves or others. Studies show that the vast majority of people with serious mental illness are not inherently violent (Stuart & Laraia, 2005). Research does suggest, however, that a subgroup of people with mental illness may be dangerous. In effect, patients in this subgroup have a history of one or more of the following: violent behaviour, psychosis, noncompliance with medications, current substance abuse and antisocial personal disorder. These characteristics can serve as predictors of potential violence (McConnell & Catalano, 2001).

In addition, the Mental Health Act Commission (1998), cited in Copperman & Kowles, (2006) concluded that violence and harassment are common in inpatient settings and pointed to the lack of written policies and procedures in place as an important deficit.

Furthermore, the British Journal of Psychiatry, 2010, recommended that awareness in reporting safety incidents needs to be promoted. Moreover, health care organizations need to sharpen their systems for safeguarding vulnerable adults from abuse and continue to reduce the levels of violence in mental health settings. Similarly, mental health setting should contribute to feelings of safety and security, care and support, and essential characteristics of a therapeutic environment intended to foster recovery (Stuart & Laraia, 2005).

2.7.1.2 Aggression and Self-harm

Aggression

Aggression in mental health settings is a complex issue with a variety of antecedents, behaviours and consequences. Human aggression refers to any behaviour directed towards

another individual that is carried out with the proximate intent to cause harm (Anderson & Bushman, 2002). Mental health patients are a group particularly vulnerable to the harms associated with aggression, as perpetrators, witnesses and victims (NPSA, 2006). Aggression can be physical, verbal, active or passive and be directly or indirectly focused at the victim – with or without the use of a weapon, and possible incorporating psychological or emotional tactics (Rippon, 2000).

The literature review suggests that aggressive assaults are one of the most common types of events leading to patients safety incidents reports (NPSA, 2006). A survey from the British National Audit (2003) stated that violence and aggression accounted for 40% of reported health and safety incidents amongst healthcare workers (Oostrom & Mierlo, 2008). Furthermore, research was conducted to identify and evaluate approaches used to manage patient aggression and violence on three acute mental health wards. Data were gathered using an incident form, a questionnaire and interviews. The views of patients (n= 80), nurses (n = 72) and medical staff (n=10) were explored. Findings revealed a clear distinction between the way staff and patients view both the problem and the response. Patients view present staff approaches as 'controlling' and believe that environmental and poor communication factors underpin aggressive behaviour. Staff, conversely, attribute aggressive behaviour to internal patient and external factors, which may explain the reason for approaches used. A strong correlation was found between type of patient aggression and response ($r = 0.36$, $P < 0.000$) and a high percentage of incidents reported were of an aggressive, as opposed to violent and nature. For example 70% of incidents involved verbal abuse or threat (Rippon, 2000).

Key issues were further analysed using an internal, external and situational model, each of which endeavour to explain reasons for patient aggression from different perspectives. As a

result, approaches to deal with this problem could be more meaningful and subsequently effective. Research also demonstrates that those individuals who engage in challenging behaviour such as aggression are at greater risk for involvement in a variety of challenging behaviours in the future such as violence, absconding, self-harm, suicide and substance misuse (Bowers, Simpson & Alexander, 2003).

Additionally, when dealing with aggression in the workplace, training and education have been proposed as the primary strategy for resolution (Beech & Leather, 2006). There are a number or personal factors that can help reduce aggression which includes improved interpersonal skills and awareness of patient aggression and knowledge regarding dealing with emotional patients (Oostrom & Mierlo, 2008). Furthermore, a three-dimensional foundation by which to deal with aggression in the workplace involves 'researching the problem and assessing the risk, reducing the risk and checking what has been done' (Beech &Leather, 2006).

Self-Harm

Self-harm is defined as deliberate self-inflicted bodily injury undertaken in the absence of expressed intent to die (O'Donovan, 2007). People who harm themselves are usually finding life difficult and see self harm as a way to cope. It is often a way of coping with painful and difficult feelings and distress. In fact, it is usually a very private issue and motivation and methods will differ from one person to another. Further, some form of self-harm carry a serious risk and can take many different forms. Cutting is the most common form of self-injury, but others can include: burning; scalding; stabbing; banging heads and other body parts against walls; hair pulling; biting; breaking bones; jumping from heights or in front of vehicles and swallowing or inserting objects.

Self-poisoning is the term used for overdosing with a medicine or swallowing a poisonous substance. It may also be that someone self-harms by inhaling/sniffing harmful substances. Others may overdose on medication that may be prescribed by their doctor, such as antidepressants. Additionally, a small number of people will take a large amount of an illegal drug or poison themselves with another substance (Pearlman, 2009).

The Australian National Mental Health Working Group (2005) set the reduction of suicide and deliberately self-harm as a priority area for improving patient safety in Australia. They describe suicide as 'catastrophic system failures' that undermine confidence in the mental health care system.

2.7.1.3 Seclusion and Restraint

Seclusion and restrain are two very different emergency protective measures. The use of seclusion and restraint as an intervention to manage acutely disruptive and violent behaviour among patients in the psychiatric context is a highly contentious issue perceived by some as an infringement of basic human rights and dignity, and by others as unavoidable in order to maintain safety and control to protect patients from harm (Fisher, 1994).

Seclusion is the involuntary confinement of the patient alone in a room or an area where the patient is physically prevented from leaving (Stokowski, 2007). It has been defined as the temporary placement of a patient, alone, in a specially designed, unfurnished and securely locked room (Sailas & Fenton, 2008). In effect, seclusion can only be used for the management of violent behaviour that jeopardizes the immediate physical safety of the patient, a staff member, or others. It should not be used for punishment, coercion, or threat.

Furthermore, seclusion is used in circumstances when patient is temporarily unable to control impulses or surges of emotion leading to behaviour that might harm someone else. However, it is not safe for patients who might harm themselves. A locked seclusion room should also be avoided if the patient has medical problems because of the difficulty observing subtle signs of cardiac and respiratory compromise. The weight gain associated with some psychiatric medications, along with the increasing prevalence of co morbid medical conditions, exacerbates these risks (Stokowski, 2007).

Restraints can be classified into three main categories:

1. Environmental Restraint is the restriction of a person's mobility through physically confining the patient to a defined area.

2. Physical/Mechanical Restraint. The uses of any technique or device to manually prevent restrict or subdue the free physical movement of a person; or of a portion of the body.

3. Chemical Restraint. The use of pharmaceuticals specifically administered for the sole purpose of temporary behaviour management or control. Drugs commonly used as chemical restraints include benzodiazepines and antipsychotics (Macpherson, Dix, & Morgan, 2005).

Mortality and physical injury can occur when a patient is being placed in seclusion or restraint. In fact, the risk of harm tends to increase when physical restraint is applied in combination with other precipitating situational factors, such as rapid sedation (National Institute for Clinical Excellence, 2005). Moreover, a rare outcome, death, can occur during seclusion and restraint use. Causes of death include: asphyxia (the most common cause of restraint-based death, including strangulation, choking, smothering), aspiration, blunt trauma, Catecholamine Rush, rhabdomyolosis, thrombosis, other cardiac-related difficulties,

pharmacological interactions and overdoses, fire/smoke inhalation and dehydration (Mohr, Petti, & Mohr, 2003; Weiss, Altamira, Blind, & Megan, 1998).

The use of restraints to prevent injury from falls, such as bedside rail entrapment and trunk restraint (commonly used among elderly psychiatric patients), contributes to muscle weakness, physical reconditioning, balance and coordination impairment, which in term increases the patients' risk of falling and sustaining related injuries. Moreover, it has been associated with increased psychological distress and aggression (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Mohr, Mahon, & Noon, 1998; Mohr et al., 2003; National Mental Health Working Group, 2005).

What alternative approaches can nurses use to avoid the use of seclusion and restraint?

Early identification of the problem and appropriate assessment of the situation are essential because different situations must be dealt with differently. Anger, fear and frustration can all lead to violent behaviour, and each call for specific approach- to match the approach to the patient's emotional state and to what has triggered that state (Stokowski, 2007). Delaney, Pitula & Perraud, (2007) developed the four S Model as a way of reducing seclusion and restraint. The 4 S's are safety, support, structure and symptom management.

Staff members need training, resources and support to develop and implement strategies to replace restraint and seclusion while maintaining safety in the workplace (Stokowski, 2007). The use of seclusion and restraint is traumatizing to patients and staff, interrupts the therapeutic process, and is not conductive to recovery. Therefore, promoting highly visible, consistent, and effective organizational leadership appears to be the most significant and critical component in any successful seclusion and reduction initiative (Huckshom, 2004).

2.7.1.4 Falls and other patient accidents

The issue of accidents includes a range of incidents. Commonly reported examples in mental health settings include: slips and falls; burns from cooking, hazardous spills, fires from smoking; injury while participating in recreational activities; vehicular accidents; cuts (from knives during food preparation or from therapeutic programming - woodworking, arts and crafts); collisions and environmental factors (e.g. sunburn or drowning). However, accidental falls are far the most common patient accidents and account for over 90% of reported accidents during hospitilisation (Goodwin & Westbrook, 1993; NPSA, 2006).

Falls are common among the elderly patients in the psycho-geriatric wards and yet they have been understudied. A fall is a multi-factorial syndrome involving the patient and the environment. Psycho-geriatric patients who fall may suffer serious physical injuries that result in morbidity, further institutionalisation or even mortality and psychological consequences (Steinweg, 1997).

This study aims to examine the demography, the contributing factors to falls, morbidity and consequences outcome of falls among institutionalised psycho-geriatric patients so that preventive strategies can be refined. However, it is important to acknowledge that fully extinguishing the incidents of falling may be impossible (McMurdo & Harper, 2004). Data of patients who fell over a year's period in four psycho-geriatric wards in Woodbridge Hospital (Singapore) which were of similar structural design and patient characteristics were collected retrospectively by a standard questionnaire, analysed and compared with those who had not fallen within the same period. All patients admitted to the wards had to be reviewed by the psycho-geriatrician to ascertain the diagnosis and management issues (Lim, KD., Ng, KC., Ng., SK., & LL. 2001).

A total number of three hundred and eighty-four patients were studied. Subjects included were above 65 years old and with psychiatric morbidity. A comparison group of hundred and two patients was obtained by excluding patients who fell with patients who did not fall throughout the study period. The patients who fell were further subdivided into two groups consisting of those with one fall and those with recurrent falls respectively. The significance of the differences in age, sex, races, types of medications, medical and psychiatric illnesses were also determined (Lim, KD., Ng et al., 2001).

Moreover, while many factors are attributable to the common effects of aging and physical illnesses; psychotropic medications, change in mental state and specific environmental factors also play significant contributory roles to falls in this group of patients. In addition, the results show that there were no significant differences in the number of falls amongst the four wards. However, results could provide useful information for further formulation of fall-prevention strategies among the psycho-geriatric patients in the institution (Lim, KD., Ng et al., 2001).

Similarly, according to NPSA, 2006 research focus on falls among patients diagnosed with dementia and cognitive disorders who reside in long-term care. However, strong research focus on intrinsic risk factors for falling (e.g. unsteady gait) as well as equipment failures (e.g. restraints, bed rails), with investigations of extrinsic antecedents (e.g. poor staff observation or environmental hazards) being less studied.

In conclusion, the total fall prevention is considering the irreversibility of many risk factors (e.g. advanced age), and the desirability of an institutional culture which foster safe independent mobility. Indeed, a delicate balance must be struck between encouraging autonomous ambulation and restricting patient's mobility to protect them from harm (Brickell, Nicholls, Procyshyn et al., 2009)

2.7.1.5 Absconding and missing patients

Patients will abscond whether on a locked unit, from an open ward, or while on escorted leave. The issue of patients who go missing either from acute or long-term mental health settings is recognised as a significant patient safety concern, since these individuals can pose a danger to themselves or to others. Four risk factors have to be associated with absconding: 1) self-harm and suicide; 2) violence and aggression; 3) vulnerability for self-neglect or death; 4) loss of confidence in the management and treament provided by the hospital or organisation (Bowers, Jarret, & Clark,1998). In defining absconding, the NPSA (2006) states that 'absconding applies to a patient...who leaves the ward without permission or breaches terms of leave...and are to be considered to be safety incidents because of the patient's vulnerabbility and the risk to themselves or others'.

A type of absconding behaviour often studied seperately is wandering. Wandering itself is frequently defined as locomotion by individuals who are cognitively impaired (affecting memory, judgement and spitial disorientation) and whose behaviour may or may not be purposeful (Lai & Arthur, 2003). However, when wandering behaviour takes place within a confined setting (i.e. pacing hallways) without intent to leave or engaging in an unauthorized leave, it may not necessary be a harmful behaviour and may even promote well-being through physical activity.

In addition, recently, a subtype of wandering called exit-seeking wandering was recognized as category separate from other types of wandering (Lai & Arthur, 2003; Lucero, 2002). Exit-seeking wandering involves wilful intent to leave a secure ward or unit without permission (Aud, 2004; Lucero, 2002). These people are highly-motivated and goal directed and have the ability to plan and carry out an intention to leave the unit. Exit-seeking wandering poses the

same danger to the patient and community as absconding e.g self-harm, suicide, violence aggression and self-neglect (Lucero, 2002).

Consequently, long-term units need effective intervention strategies to assist patients who, out of confusion, frustration or anger, seek to exit the unit, which can result in their becoming lost or injured. Moreover, educating the staff to intervene during these episodes, enabling them to deal with the exit-seeker in a calm, compassionate and dignified manner is highly beneficial (Lucero, 2002).

2.7.1.6 Adverse Medication Events

Concerns about safety in patient care have called attention to the need for governmental agencies and private sector accrediting bodies to work together with health care organizations to coordinate the monitoring, reporting, and analysis of medical errors, adverse drug reaction and adverse drug events.

The 2003 Institute of Medicine report, *Patient Safety: Achieving a New Standard of Care* (Institute of Medicine, 2003) recommends that standardization and better management of information on patient safety, including, near misses and adverse events, are needed to inform the development of strategies that reduce the risk of preventable medical incidents. Moreover, there is consensus that standardization of patient safety data would facilitate improvements in incident reporting, tracking, and analysis (Kaplan, Battles, Schaaf, Shea & Mercer, 1998).

Adverse medication events attributed to psychotropic medications are those which actually caused harm or had the potential to cause harm involving an error in the process of

prescribing, dispensing, preparing, administering, monitoring or providing medicines advice (Bates, 2003). Over 90% of incident reported to the NRLS are associated with no harm or low harm (NPSA, 2007). However, serious adverse psychotropic medications events do occur. The most frequently reported types of medication incidents involve: wrong dose, omitted or delayed medicines and wrong medicine (Bhalla, Duggan & Dhilon, 2003).

According to PA-PSRS, (2006) transcribing the wrong medication frequency also caused the majority of extra dose errors. About one-fourth of these reports involved failure to discontinue a medication. Recopying medication kardexes also resulted in such errors. In some cases, medications were administered after the physician discontinued the order. In others, patients received a medication while out on a pass and received an extra dose upon returning to the ward. Moreover, wrong drug errors involved several look- alike/sound-alike drugs.

Unlike medications used to treat medical/physical illnesses, the effectiveness of psychotropic medications requires that they enter into the central nervous system. Although their pimary pharmacological targets are receptors located within the brain, psychotropic medications will also act upon peripheral receptors and tissues. As a consequence of this lack of specificity for their intended targets, adverse events with psychotropic medications are associated with a wider range of adverse effects than most other medications (Brikell, Nicholls, Procyshyn et al., 2009).

Furthermore, The National Patient Safety Agency, (2008) provides regular feedback on patieent safety incidents. Indeed, patient safety incident reports are an invaluable source of learning for organisations. This is also in concordance with studies made by Hutchinson,

Young et al., (2009) whereby research has shown that higher reporting rates correlate with a better safety culture and risk management ratings.

In addition, research about medication error in mental healthcare is limited. Evidence is available from other sources that a sustained number of adverse drug events are caused by psychotropic drugs. Indeed, priorities for future research are suggested (Maidment, Lelliott & Paton, 2006).

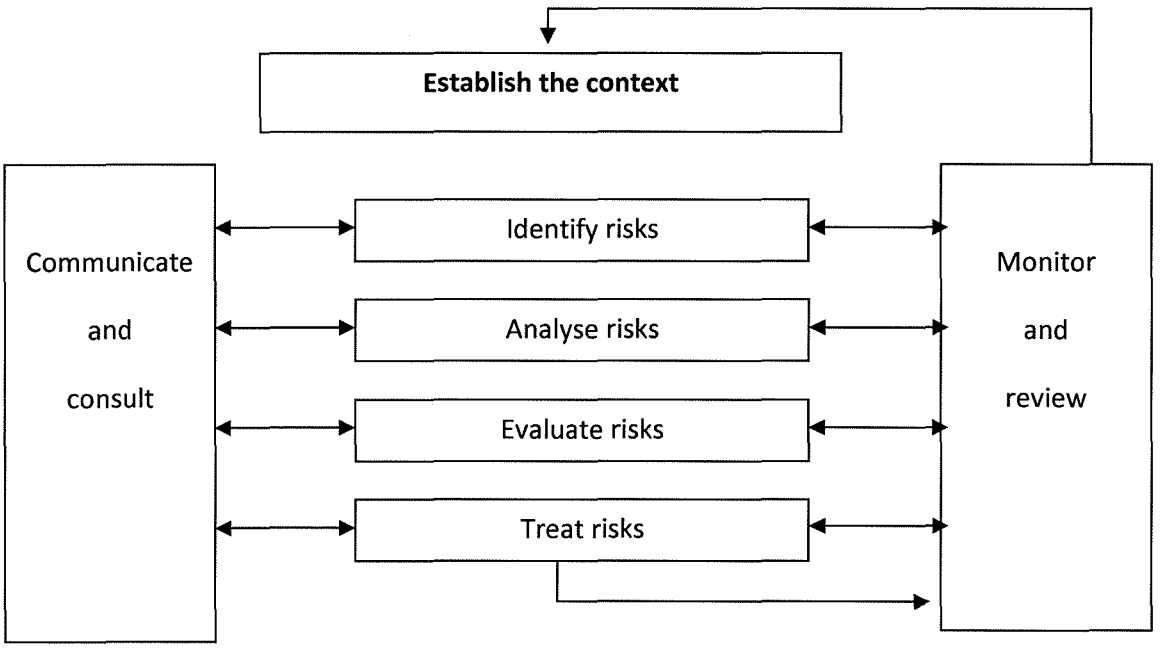
2.8 Contributing factors

A contributing factor is a circumstance, action or influence that is thought to have played a part in the origin or development, or to increase the risk, of an incident. Contributing factors may be external (not under the control of a facility or organization), organizational (e.g. unavailability of accepted protocols), related to a staff factor (e.g. an individual cognitive or behavioural defect, poor team work or inadequate communication) or patient-related (e.g. non-adherence). It may be a necessary precursor of an incident and may or may not be sufficient to cause the incident (Runciman, Hibbert, Thomas et al., 2009).

Safety incidents typically involve "a complex interaction between a varied set of elements, including human behaviour, technological aspects of the system, sociocultural factors and a range of organizational and procedural weaknesses" (Department of Health, 2000, p.19).

2.9 The concept of risk management

Fig. 1 The risk management process



In this process, risks of all kinds should be systematically identified, evaluated, assessed and managed in order of priority (Australian New Zealand Risk Management, 4360:2004).

Safety is central to the provision of quality mental health services. However, adverse events do occur, sometimes with tragic personal consequences. Protecting patients from harm is a key priority and risk management is an essential component of providing such protection (National mental health policy, 2006). "A safe, quality mental health service will flourish where a culture of quality improvement is encouraged by using quality and safety methods which adopts a whole-system approach" (Mental Health Commission, 2007, p.15).

Indeed, part of the work in mental health professionals, is to manage risk. In fact, risk is often perceived as a wholly negative process. Whilst it can be linked with the concepts of harm or

danger, risk also can be a chance to gain benefits in a situation where harm is possible (Gilmore, 2004).

Furthermore, risk assessment is the process that helps organizations understands the range of risks they face, the level of ability to control those risks, their likelihood of occurrence and their potential impacts. Indeed, it is used to describe some methods of identifying, understanding and controlling risks resulting in instituting additional controls where required. Furthermore, if risks are properly assessed and managed, these can help set all priorities for the organizations, teams and individuals and improve decision-making to reach a balance of risk, benefit and cost (NRLS, 2007).

Moreover, risk assessment and management involves a professional duty of care on the part of those working in mental health services towards the individual patient. Managing risk should not just focus on eliminating risk; in fact, it is about providing a process for ensuring the potential benefits identified are increased and the likelihood of harms occurring as a result of taking risks are reduced (Titterton, 2005). Additionally, effective risk assessment and management which actively involves the patient in the process can and should be empowering and health facilitating (Mental Health Commission, 2007).

2.10 Develop leadership strategies

The importance of good leadership is becoming increasingly apparent within health care. It has effects, not only on financial management, but on the quality of care provided. Some theories of leadership are discussed, primarily in terms of how different types of leaders might affect quality in different ways, including the effects that they might have on the stress or wellbeing of their staff which, in turn, is related to the quality of care produced. The conflicts shown in terms of leadership within the context of health care, leads to the

conclusion that development programmes must be specially tailored to address the complexities of this arena (Firth-Cozens, 2001).

It is often written that leaders are key contributors to a patient- safe environment. However, some books on this topic contain more platitudes than tangible action steps. *Taking the Lead in Patient Safety* is full of practical and proven recommendations for safety leaders (Spath, 2009). Estimates suggest that one in ten patients admitted to hospital, experience an incident which puts their safety at risk. Moreover, these incidents may result in harm and in some circumstances death.

In addition, a stark reality is the fact that about half of these events could have been avoided. Indeed, it is evident that patient safety needs to be placed high on the leadership agenda (Kirshaw & Bartley, 2008).

In 2005, in a response to this growing international problem, the Health Foundation launched the 'Safer Patient Initiative' (SPI), a UK-wide program designed to bring about radical improvements in patient safety through the implementation of a range of specific interventions using improvement methodology. The pilot involved four UK National Health Service Hospital Trusts that runs over a four-year period (Kirshaw & Bartley, 2008).

Meanwhile, the study looked for organizational level changes and suggests more support for middle managers, engaging clinical leaders at an earlier stage and encouraging reducing the numbers of areas to be tackled. As part of this complex programme the IHI led selected staff in four learning sessions. Here, teams of fifteen to twenty people from each hospital had time away from their normal duties to learn the principles and methods of safety science (Kirshaw & Bartly, 2008).

Furthermore, powerful leadership skills are needed by all health-care professionals - those providing direct care to those in top management positions. Anyone who is looked to as an authority (e.g., a nurse taking care of a patient) or who is responsible for giving assistance to others is considered a leader (Mahoney, 2001).

It is stated that a clinical nursing leader is one who is involved in direct patient care and who continuously improves care by influencing others. Leadership is not merely a series of skills or tasks; rather, it is an attitude that informs behaviour (Cook, 2001). In addition, leadership is consistent superior performance with long term benefit to all involved.

Moreover leaders are not merely those who control others, but they act as visionaries who help employees to plan, lead, control, and organize their activities (Jooste, 2004). In addition, leadership is a process, usually occurs in a group setting, and involves influence and the attainment of a goal (Faugier & Woolnough, 2002).

After years of research in many organizations, BST has identified eight best practices for excellence in health safety leadership that continuously improves safety performance (Spat, 2009): vision, credibility, action orientation, collaboration, communication, recognition and feedback, accountability and safety-critical leadership behaviours.

Indeed, patient safety is not a program; it is a way of life. Creating this way of life in an organization requires a conscious and sustained leadership effort. Leadership is a shared responsibility. Moreover, to support excellence in professional practice, humanism must be restored to the work environment to help health-care workers feel safe, respected and valued (Canadian Nurses Association, 2009).

2.11 The relationship between patient safety and employee safety

Patient safety and employee safety interact in important and complex ways. Incidents such as violence and aggression, unwanted sexual contact, sexual assaults and sexual harassment present safety risks for health care workers as much as, and in some cases more than, for patients (Kohn et al., 1999; Lang & Edwards, 2006). In addition working conditions for staff can impact their ability to prevent, detect and respond to patient safety incidents.

Safety challenges for staff impact on the quality of care they provide to patients, and therefore to the risks posed for patient safety incidents (Brichell, Nicholles, Procyshyn et al., 2009). Not surprisingly then, factors such as poor working conditions, workload, staffing levels and lack of autonomy in the workplace have been found to have a deleterious effect not only on staff safety but also on patient safety (Banerjee, Daly, Armstrong et al., 2008). Moreover, employees involved in patient safety incidents are often troubled by feelings of guilt and fear of blame by their colleagues and organization that may affect their work performance (Brichelle, Nicholles, Procyshyn et al., 2009).

In effect, Bowers et al., (2002) found two distinct approaches to security in psychiatric inpatient units in the National Health Service of the United Kingdom. The first, characterized by door security, restrictions and banning of items, emphasized patient safety while the second, characterized by guards, alarms and searches emphasized staff safety. These differing approaches suggest that, despite the links between patient and staff safety, managers and policy makers may view them as distinct and perhaps competing concepts. In spite of, his competition can be seen in the opposing views of Yassi & Hancock (2005) who argue that patient safety can only be improved by attending to employee safety, and that staff safety can be improved by attending to patient safety.

Therefore, the concept of a safety culture, with equal emphasis on patients and staff, could serve as a unifying concept for these two important issues (Kohn et al., 1999).

2.12 Seven steps to patient safety in mental health

The Seven Steps are core to patient safety in healthcare organizations. Each guide in the series provides a checklist to help staff to plan their activities and measure patient safety performance. Mental and behavioral disorders are common. More than 25% of all people are affected at some point during their lives and every year one million service users in England and Wales receive specialist mental healthcare, therefore, patient safety is an important concept (Woodward, 2005). Over 100,000 patient safety incidents are reported to the NRLS from mental health every year; therefore, good practice in this area is readily identifiable in mental health organizations (NPSA, 2008). Further, it is vital that health care staff can progress towards delivering this safety agenda (Woodward, 2005).

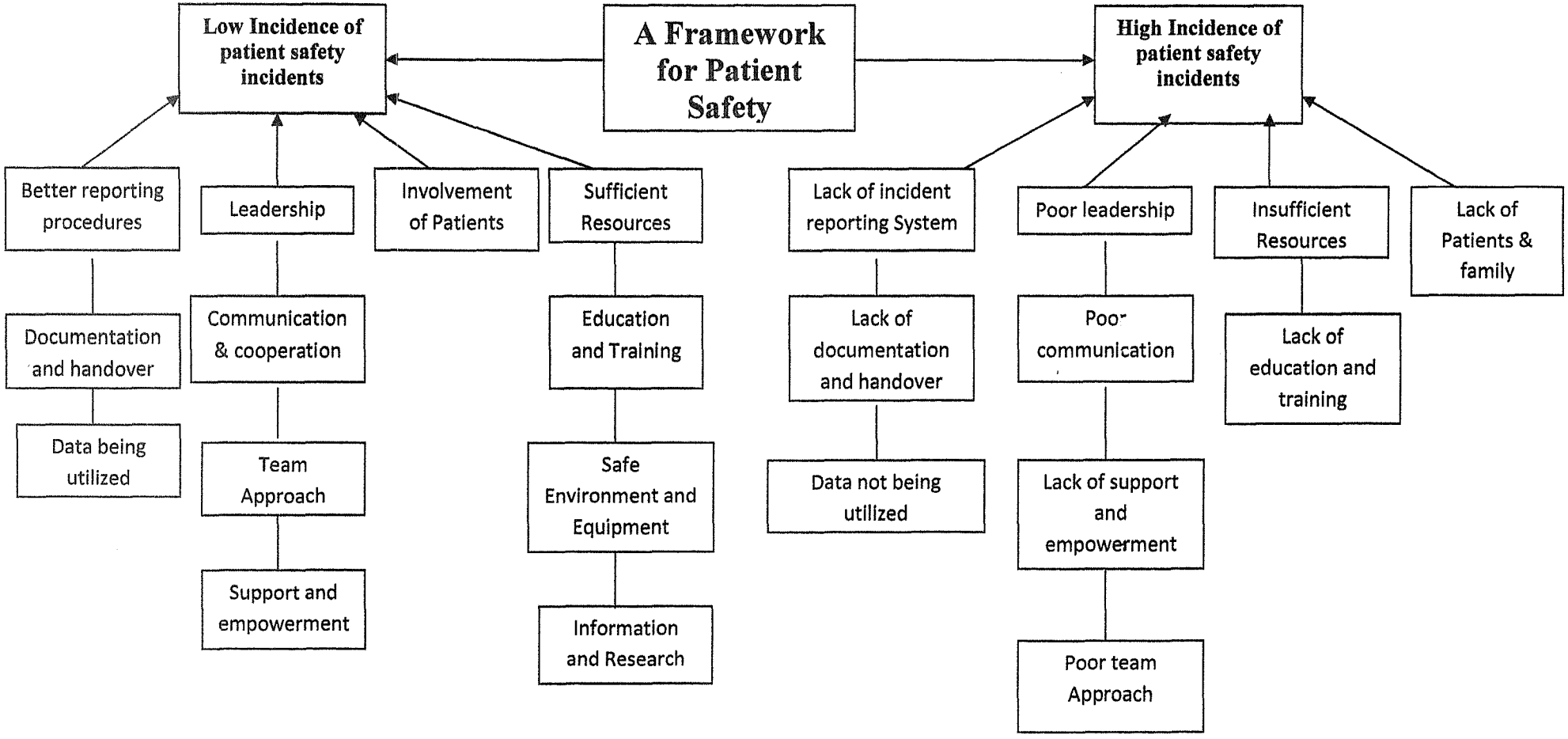
Furthermore, the effects of harming a patient are widespread. There can be devastating emotional and physical consequences for patients and their families. It is apparent from the literature that for the staff involved too, incidents can be distressing, while members of their clinical teams can become demoralized and disaffected. Moreover, safety incidents also incur costs through litigation and extra treatment (Woodward, 2005). The NSPA'S (2008b) guidance suggests clear strategies that mental health organizations, staff and teams should adopt locally to improve patient safety and meet clinical governance targets. Indeed, the steps are part of a continuing process on how patient safety can be improved. These include:

1. Build a safety culture
2. Lead and support your staff

3. Integrate risk-management activities
4. Promote better incidents reporting
5. Involve and communicate with patients, relatives and the public
6. Learn and share safety lessons
7. Implement solutions to prevent harm

Following the Seven Steps will help ensure that the care provided is as safe as possible, and that when things do go wrong the right action is taken. Furthermore, they will also help healthcare organizations to meet clinical governance, risk management and control assurance targets (NPSA, 2009).

Fig.2 Theoretical Framework: Patient safety in mental health



In this framework for patient safety, one can see that there are several factors that may enhance or hinder patient safety. Notably, these factors are linked in a chain of events that may eventually influence the occurrence of incidents. This framework was formed from the literature reviewed and the findings of the study.

2.13 Current trends and gaps

The review of the literature revealed that there were several common gaps in the literature across the patients safety incidents reviewed. Furthermore, many studies fail to report important variables (e.g. gender, age, substance abuse) and effect sizes.

In understudied populations, the search strategy employed in the present research yielded very few empirical or conceptual papers that looked at older adults (with the exception of the literature on accidental falls), adolescents or children using mental health services, with the focus of the literature largely on adults. Given the value of primary interventions to prevent adverse events and manage the risk of increasing severity over the life-course, it seems particularly important to address patient safety among young people with mental illness. At the other end of the spectrum, developing a knowledge base to inform practice with elderly patients should be a priority given to the aging population. Understanding issues of cultural, ethnic and religious diversity and institutional racism is an area for future research consideration.

Regarding patient's perspective, most of the research reviewed was from the perspective of the staff with a lack of research reflecting the patient's or their families and caregiver's perspective on safety incidents. Understanding patient safety from the perspective of the patient, their family and their caregivers could provide valuable insight into understanding the causes of patient safety incidents, risk assessment, and patient care management.

Harm associated with patient safety generally is regarded as physical harm, with minimal attention having been paid to investigate emotional and psychological experiences among patients following adverse events (e.g. witnessing or being the direct victim of violence, feelings of powerlessness or lack of safety following an aggressive event).

The literature review suggests that there is a lack of empirically validated risk assessment tools, training programs and interventions for preventing and reducing patient safety incidents specific to mental health. Little research has focused on establishing risk assessment tools to assist clinicians to identify "high risk" patients (i.e. patients at risk for suicide, violence, absconding etc...). Further, there is virtually a complete absence of high quality research focused on evaluating the efficacy of patient's safety training programs and interventions.

Gaps currently exist in relation to knowledge on the extent and nature of the role of nurses and other professionals in patient safety improvement. Considerable work is required before comprehensive solutions can be further developed. Therefore, the need for investment into well designed research studies to address these gaps is obvious, required and timely.

2.14 Conclusion

The review of the literature reveals several areas for future research to focus on. A limited number of studies of variable quality were found in this literature review that focused on patient safety. This limited evidence may be because of the fact that general research on quality and safety in health care is not yet fully developed, resulting in a paucity of research in this field (Grol, Berwick & Wensing, 2008). A further notable feature was that most of the studies in the review were from developed countries, which raises an important issue about the likelihood of even more limited or non-existent patient safety studies in developing and transitional countries.

Moreover, it is recognized that improvement in mental health reform, including efforts to establish integrated mental health services, to target anti-stigma and reduction of discrimination, to increase funding in mental health research and to facilitate education and knowledge exchange strategies, may indirectly impact patient safety in mental health services

as a positive unanticipated outcome. Nurses and other healthcare professionals will be trained to assess and document patient outcomes at the point of care using a standardized methodology (Brickell, Nicholles, Procyshyn et al., 2009).

Furthermore, ensuring responsibility, accountability, authority, effective communication, inter-professional collaboration, setting up employee training and having established and maintained system documentation are key issues in the organization of a safety and health management system (ILO-OSH, 2001).

In addition, patient safety is dependent upon all levels of health care, starting from individual patients and their practitioner, moving to the clinic or ward setting, to organizational and system levels (Sorra & Nieva, 2004). Therefore, to improve care within mental health care institution, all healthcare workers must be engaged and participate in the selection and development of measures and must receive feedback regarding their performance. Measures must be important to the organization, be valid, reliable, and feasible, be usable for people expected to employ the data to improve safety and must have universal applicability within the entire institution (Pronovost, Holzmueller, Needham, Sexton, Miller, Berenholtz, Albert, Pearl, Davis, Baker, Winner & Morlock, 2006).

Finally, empirically-validated risk assessment tools, training and education programs to develop and implement evidence-based patient safety interventions for preventing and reducing patient safety incidents in mental health is recommended for future research, thus, safeguard mental health service users (Mental Health Forum, 2004).

Therefore, by an integrated approach involving various multidisciplinary workers and professionals in the organisation, it is hoped that the study outcomes can serve as a means towards improving patient safety in the mental health institution.

Chapter 3

METHODOLOGY

3.1 Introduction

The methodology used to conduct this study is outlined in this chapter. It provides a description of the research process of this study and how the research study was planned and conducted with an explanation of the underlying rationale for decisions made in the design of the study.

The methodology also describes the aim and objectives and gives an account of the study population and setting, the tool used and the research design adopted. Further, issues related to reliability and validity, data collection, analysis and ethical considerations are discussed. Furthermore, the researcher chose to focus on the research question, "What are the prevalent staff perceptions regarding patient safety in a local mental health setting?"

3. 2 Aim and objectives of the study

Despite International and European recognition of the importance of patient safety in healthcare, research in Malta about this subject is still lacking. The aim of the study is to explore the prevalent knowledge and perceptions of staff in a mental health setting regarding patient safety. The following objectives were set:

1. To identify knowledge, practices and attitudes of different categories of workers employed within the mental health hospital.
2. To identify prevalent risks to health and safety.
3. To identify any existing policies, protocols or documents regarding health and patient safety within the hospital and obtain feedback from staff regarding their utility in upholding patient safety.

Understanding the broad range of errors that occur in inpatient psychiatry is a critical step toward improving systems of care for a vulnerable patient population. An explorative qualitative analysis of key informant interviews and focus group discussion identified a preliminary typology of errors and the contextual factors that precipitate them in inpatient psychiatry (Cullen, Nath & Marcus, 2010).

3.3 The research design

Research design refers to the overall structure or plan of the study. Qualitative methods play an important role in health and safety planning and intervention evaluations. The qualitative assessment methods that are most often utilized to study work practices include in-depth interviews, semi-structured interviews, focus group interviews, field studies or observations.

Qualitative research is a broad umbrella term for research methodologies that describe and explain person's experiences, beliefs, attitudes, behaviours, interactions and social contexts without the use of statistical procedures of quantification. However, qualitative research entails a high complexity of data analysis, which may threaten reliability and validity of the findings (Strauss & Corbin, 1990).

Additionally, using a qualitative research design had various benefits including that of being interpretative in form, flowing in a naturalistic paradigm, allowing for multiple perspectives, and focusing on process (Carter & Henderson, 2005). Qualitative data is holistic and strives for a whole understanding (Polit, Beck & Hungler, 2001).

Furthermore, the major strengths of qualitative approach were that they privilege the research subjects' social realities (Flick, 1998).

3.4 The research setting

The study was conducted in a public mental health hospital in Malta. It offers both in and out-patient service and focuses on the well being of patients. The inpatient care includes: Acute care; Rehabilitation and long stay; Old age and Medical care, Children and Adolescents; Learning disability and Forensic/ prison ward.

This hospital aims to promote mental health with the Maltese Society by:

- Assisting persons with mental health problems who require specialist treatment and care as well as support for their social network.
- Providing, through specialist multi-disciplinary teams, a comprehensive and integrated range of community and hospital mental health service.

The mental health hospital in Malta serves nearly 18,000 patients each year. These patients suffer from different types of mental health disorders. These include: schizophrenia, personality disorders, depression, bipolar disorder, anxiety, dementia- Alzheimer's, chemical dependency, trauma and post traumatic stress disorder and obsessive - compulsive disorder. Diagnosis is not always exact, and some of these disorders overlap.

3.5 Target population and sampling techniques

This study sought a sample that will provide appropriate and adequate insight into people's experience of the world, using people who offer depth and richness to explanations and who can 'represent' a breath of human experiences (Nicholles, 2009).

In order to do so the qualitative sampling technique used within the study was that of purposive sampling which is the most widely used methods for directly identifying potential study participants (Nicholls, 2009). This is a non-random method of sampling, which aims to

sample a group of people with particular characteristics that target in depth information which can be very valuable, especially if the cases are information rich (Quinn Patton, 2002). Such participants for individual interviews included: three consultant psychiatrists; two senior resident specialists; two nursing managers; one pharmacist; four nurses with administrative responsibility and one nurse with educational responsibility.

The focus group consisted of fifteen employees selected from different categories from the mental health hospital who were experienced in mental health and patient safety. These included: two departmental nursing managers; one nursing officer; one staff nurse; two enrolled nurses; one nursing aide; one cleaner; one pharmacist; two occupational therapist, two physiotherapists; one care worker and one maintenance worker. Focus groups have the advantage of making use of group dynamics to stimulate discussion, gain insight and generate ideas in order to pursue a topic in greater depth.

Moreover, the group processes can help people to explore their views and generate questions in ways that they would find more difficult in face-to-face interviews (Kitzinger, 1996). These persons with experiences in mental health and patient safety are a source of information on current practices, upcoming initiatives and other issues. Confidentiality was assured throughout the process.

Before the interviews were conducted, meetings with the chief executive officer, with the director of psychiatry and with the manager nursing services were held to get the permission to conduct this qualitative study.

3.6 Research Methods

Interviews and focus group were chosen to collect data from the target population. Before starting data collection, a pilot study of the proposed interview schedule was conducted. This

was followed by the first phase of data collection in which interviews with selected personnel were held. The final phase of the data collection was the focus group discussion with different categories of employees working in a mental health hospital in Malta. More details regarding each phase are to be given in the following sections.

3.6.1 The pilot study

The first stage of data collection was a small scale pilot study of the interview programme as a trial of the research method so as to ensure that the design was feasible (Van Teijlingen & Hundley, 2001). The pilot study was held in the same mental health hospital in Malta. Two elite interviews were conducted with selected participants. This helped in assessing the adequacy, feasibility and functions of the data collection instrument, and identified any need to modify it (Polit, Beck & Hungler, 2001). Moreover, such a pilot study allowed the researcher to practice face to face interaction in order to develop interview skills (Schreiber, 2008).

In addition, two group members selected from different categories were asked to proof read the focus group discussion questions to assess their feasibility.

Following the completion of the interviews, these individuals were asked to give their feedback on the method used for data collection, the structure of the interview and clarity of the questions used. The suggestions obtained were that there was no need to carry out any alterations to the interview schedule.

3.6.2 Interviews

The first phase of data collection consisted of semi-structured interviews conducted with different levels of management using a schedule comprised of fourteen open ended key informant questions in Maltese and English (refer to appendix 4–documents 5a & 5b). The

schedule was prepared after an extensive literature research was carried out by the researcher. The questions were designed in such a way to meet the aim and objectives of the study.

The researcher prepared a set of questions. This schedule was then reviewed by an experienced researcher, who made some alterations in the wording and sequence of the interview questions.

Participants were contacted through a letter of informed consent to the participants in Maltese and English version (refer to appendix 6 - documents 7a & 7b) where all the information was given and on acceptance of participation, a meeting was set to conduct the interview.

The researcher made sure that the rooms where the interviews were conducted were comfortable, quiet and with utmost privacy. The researcher was attentive, listened with all the attention and interested in what the interviewee had to say. The information was audio-taped. This was vital to increase the natural conversational nature of the interview and understanding of the subject.

An interview topic guide based on the issues that emerged from the literature review was included in the appendices. In this way, the researcher could adjust the progression and the wording of the questions to each particular interview and to each individual. Interviews were approximately an hour each, during which the interview schedule was followed (refer to appendix 4 – documents 5a & 5b).

This interview style had the advantage of allowing the researcher the flexibility to probe initial participant's responses. In fact, great importance was given to listen carefully to what participants said, engage with them and use probes to encourage them to elaborate their answers (Mack, Woodsong, MacQueen, Guest & Namey, 2005). This facilitated the

gathering of richer more textured data from the participant than could be obtained through formally structured scheduled questions (Ryan, Coughlan & Cronin, 2009).

The interviews consisted of an initial introduction to the study and verification of consent. This was then followed by the essential interview questions, with topics discussed including: patient safety, mental health, patient safety incidents, patient safety culture, inter-professional, communication and collaboration, empowerment, decision making, contributing factors, risk management, leadership strategies training.

Additionally, all interviews were conducted face-to-face at participants' place of work. This offered the opportunity to interpret non-verbal cues through observation of body language, facial expression and eye contact. Moreover, the Maltese version of the interview schedule was mostly used (refer to appendix 4 – document 5a). All interviews were audio-taped.

3.6.3 Focus Group

The final phase of data collection consists of the focus group. Focus groups are an effective way of exploring the views of persons with a common background as they allow interaction and discussion between participants (Morgan, 1996). The focus group was composed of fifteen employees selected from different sections and categories within the hospital experienced in mental health.

In addition, four questions were designed as an interview guide for the focus group (refer to appendix 5 – documents 6a & 6b). These were also reviewed by an experienced researcher, who made some alterations.

The focus group was carried out with participants around a circular seating arrangement, thus allowing each person to maintain eye contact with all other participants (Plummer-D'Amato, 2008). They were audio taped and the discussion lasted round one and a half hours.

The focus group schedule used targeted information on themes, issues and actions and about practices and programmes being utilized to optimize patient safety in mental health hospital. The Maltese version of the interview guide was used (refer to appendix 5 – document 6a).

Within this focus group schedule a triangular structure for questioning was used, with questions moving from a very broad opening to an extremely focused end point. This in turn led to key questions, during which participants were encouraged to speak spontaneously. Additionally, importance was given to seek any additional thoughts or comments before closing the discussion.

3.7 The research instrument

For this study the researcher opted to collect qualitative data by means of face-to-face semi-structured interviews to individuals and through focus group discussion using the interview guide respectively (refer to appendices 4 & 5 - documents 5a, 5b, 6a, 6b). The researcher builds a complex picture, analyse words, reports detailed views and conducts the study in a natural setting.

Furthermore, Polit et al., (2001) and Burnard & Morrison (1994) stated that, semi-structured interviews are amongst the commonly used methods of gathering data in qualitative research and well suited for the exploration of perceptions and opinions of respondents.

Apart from this, the interviewer is able to note the interviewee's non-verbal communication. However, the interviewer needs to keep in mind the risk of influencing the interviewee with non-verbal cues if the interviewer does not pay attention to his interview technique. This is usually referred to as interviewer bias (Polit & Hungler, 1996). Furthermore, Robson (1993) explained that face-to-face contact with the researcher encourages participation and involvement.

Moreover, interviews allow collection of data from subjects unable or unlikely to complete questionnaires, which might be the case with target population involved in the study.

In the focus group a topic guide list (refer to Appendix 5 – documents 6a & 6b) developed from the literature review was used to stimulate and guide the discussion. In addition, a comfortable environment was provided with refreshments.

3.8 Validity & reliability

Issues related to validity and reliability in qualitative research is more appropriately assessed by the criteria of truth value, applicability, consistency and neutrality (Lincoln & Cuba, 1985). Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researcher set out to measure.

The research tool used in this study was assessed for its face validity as this need to be established (Bowling, 2002). Face validity refers to whether a measure superficially appears to measure the concept it is intended to measure (Black, 2003). The research supervisor gave positive comments about the research tool.

3.9 Data collection

Permission to conduct this study was sought and obtained from the chief executive officer, the director of psychiatry and from the manager nursing services. Data was collected by means of semi-structured interviews and focus group discussion with the use of guide questions (refer appendices 4 & 5 – documents 5a, 5b, 6a, 6b respectively). The aim of these was to capture as much as possible information about what the subjects think about the particular topic.

First of all, the researcher had to explain the rationale of the dissertation with full detail to all health care workers involved in the study. The questions that were used were open-ended as these were necessary to acquire detailed data that permitted an interpretive analysis (Hutchinson & Wilson, 1992). Moreover, the participants were asked in which language they preferred the interviews and focus group discussion to be conducted. They preferred the Maltese version.

In addition, recording data in focus group needed to be collected not only on what is said, but also on the interaction between the group members (Plummer- D'Amato, 2008b). Furthermore, hand written field notes were also taken which consequently aimed to include the seating arrangements, the order of speakers to aid in voice recognition during transcription, non-verbal behaviour, major themes and ideas and as much of the conversation as possible (Plummer – D'Amato, 2008b). These aided the interpretation of the recorded verbal interchange.

Due to the fact that the interviews and discussion were audio-tape recorded the researcher managed to get the exact identical replication of the contents, thus facilitating the analysis (Koch & Harrigton, 1998; Hogston, 1995; Bariball & White, 1994). Themes and trends developed which were grouped under headings and compared with the literature.

3.10 Data analysis

Thematic analysis is considered appropriate for this study as it involves the systematic qualitative analysis transcripts of semi-structured interviews and a focus group to be conducted with participants involving a 2-step process (1) coding each interview, and (2) identifying larger themes. Identified themes from participants' interviews and group discussion will be pieced together to form a comprehensive picture of their collective experience.

Thematic analysis which is a process that involves the search for themes was used. This did not only discover the commonalities across subjects but also the natural variation of data. In order to gain insight, understand the importance of improving patient safety and search for thematic explanation, all the data were carefully read through. The researcher attempted not to corrupt or modify the respondents' opinions and comments. For the sake of clarity the responses were quoted directly and both the positive and the negative findings were reported.

Data analysis was conducted by means of content analysis, which is the process of categorizing qualitative data into clusters of similar entitle so as to identify consistent patterns and relationships between variables or themes (Heidi, 2008). Such an analysis followed a number of principles, with the first stage involved organising and ordering the data collected.

Then, after re-reading the interviews and discussion, ideas with similar traits were grouped into categories. This was repeated for each transcript which was then arranged into smaller groups of similar meaning.

Finally, relationships between categories were uncovered which were then reduced to themes (Holloway & Fulbrook, 2001). Such themes reflected a shared understanding among participants of the phenomenon under investigations. The researcher analysed data by looking especially to similarities and dissimilarities and by counterchecking the observations with the expert literature. The researcher was continuously alert to differences.

3.11 Rigour in research study

The concept of rigour is relevant in relation to the reliability and validity of the data and the reduction of bias. Rigour refers to several essential features of the research process. Rigour is imperative if the findings of a qualitative study are to be believed. In fact, a variety of

strategies exist within qualitative research to protect against bias and enhance the reliability of findings (Mays & Pope, 1995).

Moreover, within this study a number of strategies have been employed to exercise and demonstrate a rigorous approach. These have included targeting the establishment of audit ability, applicability and truth value, which are approaches for attaining rigour in qualitative research (Nicholles & Will, 2009)

Importance has also been given to the establishment of truth value within the study. It has been put forward by Sandelowski (1986) that the search for truth is much more elusive in qualitative research, whereby truth value is subject oriented rather than defined by the researcher.

In addition, attention has been given within the study to anticipate and reduce sources of errors in the production of verbatim transcription composed from the data collected. In order to accomplish this, a number of strategies where used to maximize the transcription quality as offered by Poland (2008). These include: ensuring the highest possible audio-recorder, using field's notes to aid transcriptions and compiling transcriptions within a short time span from when recordings were made. These transcriptions offered a highly reliable record of recordings on which to base the data analysis (Seale & Silverman, 1997).

3.12 Ethical considerations

Ethical considerations are values that the researcher has to consider while planning the study. Prior to starting the study, ethical approval was submitted and attained from both the Faculty Research Ethics Committee and University Research Ethics Committee. These can be viewed in Appendix 1.

Authorisation was also attained from the chief executive officer, the director of psychiatry and from the manager nursing services of the Mental Health Hospital in Malta to conduct the study within the hospital (refer to appendix 2 – documents 2, 3, and 4 respectively).

In addition, informed consent of participants is fundamental in research involving human beings (Bowling, 2002). It is a way of ensuring that participants understand what it means to participate in a particular research study so that they can decide in a conscious, deliberate way whether they want to participate or not. Informed consent is one of the most important tools for ensuring respect for persons during research (Mack, Woodsong, MacQueen, Guest & Namey, 2005).

Therefore, all participants were given in writing information regarding the aim and objectives of the research to be conducted, about confidentiality and anonymity and what the study involves in relation to the participant. Following this, written consent of all participants was obtained, giving their informed consent to participate in the study (refer to appendices 6 & 7 – documents 7a, 7b, 8a, 8b respectively).

Moreover, beside the written consent, verbal consent was also attained prior to interviews and the focus group, during which, importance was given verbally stating the study objectives and assuring participants that what they said would be kept in confidence. This is significant so as to earn participants trust and thus elicit good data (Mack, Woodsong, MacQueen et al., 2005).

Furthermore, participants were informed that they had the right to decide whether to participate or not and to withdraw at any point in time (refer to appendices 6 & 7– documents 7a, 7b, 8a, 8b respectively).

3.13 Conclusion

This chapter discussed the methodology for this present study. In the next chapter, findings and results of the data analysis are presented. Themes are highlighted and important quotes from the participants are cited.

Chapter 4

FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents and discusses the findings derived from the data collected through semi-structured individual interviews and a focus group discussion. These research findings are to be analysed and discussed in the light of the literature reviewed. The discussion will consist of a comparison of the data collected with the literature reviewed so as to identify any similarities or dissimilarities.

Patient safety is not an issue that can be considered on its own. It is dependent on other concerns involved in the treatment of mental health. According to most of the interview participants and others from the focus group discussion, patient safety concerns need to be balanced with patient rights and autonomy. Furthermore, patient safety in mental health is context dependent and issues around patient safety in mental health vary by the service setting.

This chapter is divided into sections. The first section addresses the participants and the coding system, used to ensure participants' anonymity. This is then followed by other sections which emerged from the thematic analysis. Identified themes from participants' interviews and group discussion will be pieced together to form a comprehensive picture of their collective experience.

4.2 Participants and coding System

Thirteen individuals selected from three levels of management in the psychiatric hospital participated in the interviews. A coding system of P1- P13 was used to assure that the identity of the participants (P) remains hidden. The sequence of the code numbers have been given randomly and not according to rank within the management hierarchy.

Similarly, a coding system was also used for the participants of the focus group. This group, consisted of fifteen employees (F) selected from different categories from the mental health hospital, included a departmental nursing manager, nursing officer, staff nurse, two enrolled nurses, nursing aide, two care workers, cleaner, two physiotherapists, pharmacist, two occupational therapists and an employee from maintenance section. These participants were of different ages and genders and their work experience in mental health varies. They have been coded F1 – F15 and again these codes were randomly assigned to the participants.

In addition, two individual interviews were carried out as pilot study. The main aim of this was to expose potential problems with the whole research process and environment. Pilot studies help in assessing the adequacy, feasibility and functions of the data collection instrument, and identifies any need to modify it (Polit et al., 2001; Rubin & Babbie, 1997; Barribal &White, 1994; Robson, 1993). However, as these preceded well and no amendment were required, the researcher deemed that these two interviews could be included in the study so as not to lose the richness of the data yielded.

4.3 Discussion of findings

A thematic analysis was performed. The analysis involved identifying common themes from each individual interview and focus group discussion. Six major themes were identified as most descriptive of the phenomenological experience of these participants. These themes were related to the objectives of the study where the knowledge and perceptions of the staff in mental health setting regarding patient safety were explored. Moreover, contemporary risks to health and safety, practices and attitudes of different categories of workers employed within the hospital were identified. Furthermore, any existing policies, protocols and documents regarding patient safety within the hospital were also identified and feedback from

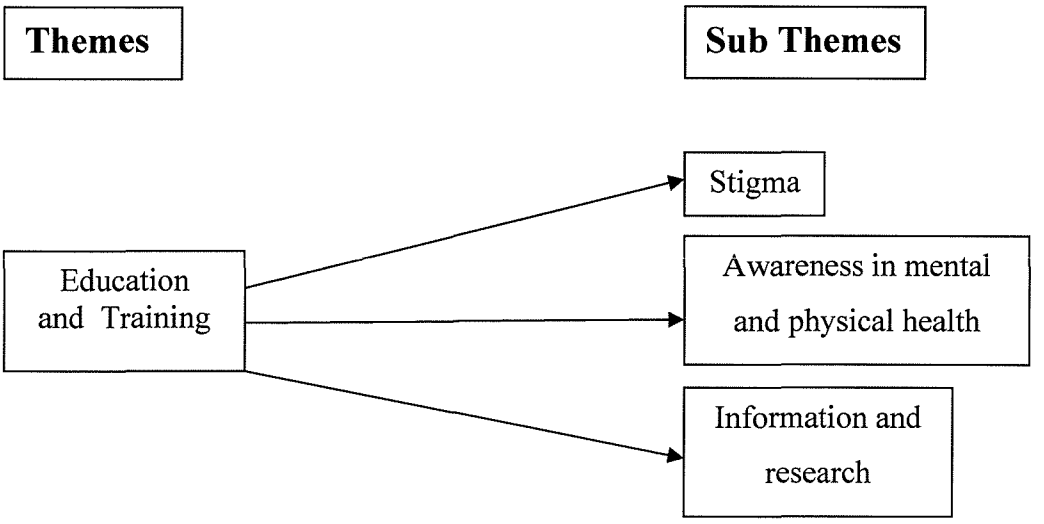
staff regarding the utility in upholding patient safety was obtained. Finally, changes to improve patient safety in this particular mental health setting were recommended.

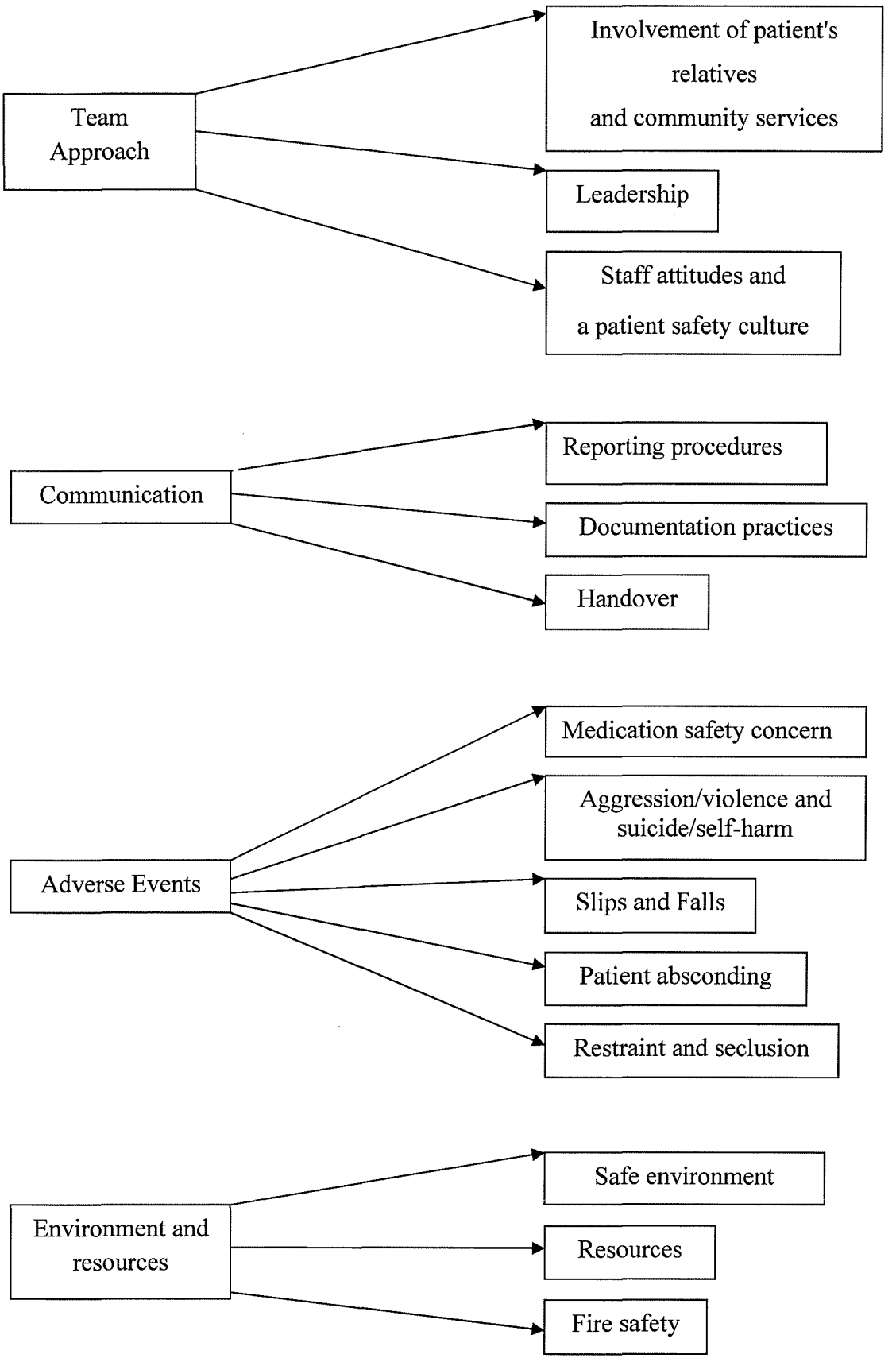
In addition, it is important to note that, although themes are discussed separately, these were intertwined in the narratives, as is often the case when one is orally relating. The main themes that emerged from the analysis were:

- Education and Training
- Team approach
- Communication
- Adverse events
- Environment and Resources

Along with these themes, other sub themes were identified. These themes and sub themes were reported in the following paragraphs using participant's words wherever possible.

Figure 3 Themes and Sub themes




Team Approach
Involvement of patient's relatives and community services
Leadership
Staff attitudes and a patient safety culture
Communication
Reporting procedures
Documentation practices
Handover
Adverse Events
Medication safety concern
Aggression/violence and suicide/self-harm
Slips and Falls
Patient absconding
Restraint and seclusion
Environment and resources
Safe environment
Resources
Fire safety

4.4 Theme 1 Education and Training

Education and training were presented as important steps in promoting patient safety, achieving standardization of core-competencies and safe practices, and breaking down the stigma around mental illness. These were mentioned by most of the participants.

The Mental Health Policy Implementation Guide (DOH, 2002) stated that mental health service providers must ensure their training staff, attend appropriate training programmes in order to:

- Promote service user and staff safety
- Emphasise the recognition, prevention and de-escalation of aggression and violence strategies
- Recognises race and culture diversity
- Recognises issues of age and gender
- Use physical interventions as a last resort
- Promotes service user engagement and reconciliation based within an ethical and legal framework
- Demonstrate regular review and evaluation

Furthermore, all staff must have extensive knowledge and understanding of the challenges and implications for clinical practice in mental health service provision. This should be demonstrated via a portfolio or evidence or a relevant professional qualification (health, social care/ teaching).

In addition, education and training programmes should be delivered in a supportive manner and within a safe environment, which is responsive to the diverse needs and capabilities of staff. These should be developed in consultation with multidisciplinary teams, services users, staff and managers (DOH, 2002).

Table 4.1 Theme 1: Education and Training

Concepts	Excerpts	No. of times was cited
Education	"We started with basic training courses such as, Emergency Response Team, courses on diabetes, infection control, tissue viability, nutrition and on mental health nursing." (P11) "Educational courses about mental health patients and their disorders should be continuous and obligatory...if need be we should get experts from abroad to inform us." (F2)	7
Training	"Training is important, there should be training courses on health and safety of patients in mental health setting, how to handle suicide, self-harm, aggression and violence," (P12) "Ongoing training is important for health and safety of patients...to improve our knowledge and approach."(P4)	6
Sharing of knowledge	"It is something good to learn...understanding and sharing of knowledge...we need to improve our standards" (P1)	2
Protocols / guidelines	"Protocols and guidelines are important to know how to deal with such situations if they arise," (P6)	3
Sources of education	"Feedback, good examples to students, leaflets, interviews and questionnaires are all sources of good education for the benefits of the patients." (P9)	1
Patients characteristics	"For staff working in acute wards there should be training about how to handle patients during aggressive outburst events...handling victims in patient victimization, in medication errors, in absconding and in seclusion and restraint...balance safety with risks." (P10)	2
All levels of health	"Everybody needs education and training about these	3

care workers, even ancillary workers	conditions...all levels, doctor, nurses and even ancillary workers." (P4) "Education and training are also important to the cleaners, to wash their hands before handling food; not to leave detergents around as these may be swallowed by patients and not to let water on the floor to prevent slips and falls." (P8)	
Multidisciplinary Team	"All members of the multidisciplinary team including doctors, nurses, social workers, occupational therapists, psychologists and physiotherapists should update their knowledge by continuous training to improve patient safety and quality of care."(P3) "Each member of the team has specific training, knowledge and experience...to address mental health patient's needs." (P5)	3
Geriatric patients	"Education and training regarding safety issues especially in geriatric wards...elderly are more susceptible to fractures, leading to complications...we need to know how to handle patients, lifting etc...special knowledge and attention to keep all doors closed as patients suffering from dementia may abscond with all the consequences" (F11) "Training/education in geriatric wards are needed, to prevent complications that may cause more hospitalisation, more cost...with more attention and respect we can avoid these complications."(F13)	2
Incident prevention and safe care practices	"Education programs on policies and procedures should always be encouraged for incident prevention and safe care practices." (P13)	4

After analysing the participants' responses in table 4.1, staff were described to have adequate training to carry out their tasks, however, in certain special occasions like aggressiveness and violent episodes staff needed to be more educated and trained. Here, the knowledge of different categories of workers and any policies and protocols were identified. Thus, it is significant that the organization should promote education both within the working environment as well as continuously throughout employment. This is one of the recommendations to improve patient safety.

As such, this is in line with the literature by the Department of Health (2002) where it stated that mental health service providers must ensure that information and education is available to service users and staff in respect of their personal safety and actions to take if they are exposed to aggression, violence, harassment or abuse whilst being cared for or working in mental health setting (e.g. information book / advice, leaflets provided as part of admission packs, regular seminars/workshops for service user group etc…).

Moreover, it is essential that education and training are developed in a safe and therapeutic management and delivered by trainers who have expertise and practice credibility. This is based upon an organizational risk assessment of work. Furthermore, current policies and procedures related to education and training should be reviewed and evaluated to support mental health service providers (Pearson, 2011).

The rationale here is that it is essential that all health care professionals are educated and trained using best available knowledge, skills and attitudes. Delivering safe and effective care should be our priority for good quality care in healthcare provision. Furthermore, the hospital should be responsible for the patients and should empower them to ask, learn and report their experiences. Moreover, empowering and encouraging health care professionals and the continuous need for strong and committed nursing leadership at all levels of the hospital would be beneficial to improve patient safety.

It was evident in this study, that keeping patients in safe environments that are clean, hygienic and protected from any harm will ensure that patient safety remains the highest priority. Oddly enough, two participants did emphasised special training on safety issues in geriatric wards such as lifting, handling and prevent slips and falls as the elderly are more susceptible to fractures which may lead to complications and more hospitalisation which in turn lead to more cost. In addition, the elderly especially those that suffer from dementia may

abscond and get lost or injure themselves. Therefore, all doors should be kept closed at all times. Indeed, absconding was another serious issue in acute wards as well as was seclusion and restraint. Furthermore, special training should be carried out to know how to handle aggressiveness and patient victimization, but most of all education regarding medication administration is of upmost important to prevent errors, adverse events and other incidents.

Additionally, educating the workforce, by attending regular refresher/ updated education and training programmes, promoting effective learning and increasing involvement of patients and their families will improve patient safety and quality of care in mental health setting. This was stated by most of the participants who emphasised the importance of ongoing training and continuous education to all the staff and ancillary workers. Moreover, educating new health care providers involved in mental health care was presented as a key area for improving patient safety.

4.4.1 Sub theme: Stigma associated with mental health

Stigma associated with mental illness is considered as one of the barriers to create a safe environment and it directly influences an individual's ability to access care and the quality of care he/she receives. Further education and training are critical to break down the stigma around mental illness and to achieve standardization of safe practices (Brickell, Nicholles, Procyshyn et al., 2009).

Unfortunately, this is a common experience for people who have a mental health condition. Stigma may be obvious and direct, such as when someone make a negative remark about your mental illness, or your treatment. Or it may be subtle, such as someone assuming you could be unstable, violent or dangerous because you have a mental health condition, also, spouses may be reluctant to define their partners as mentally ill, while families may delay

seeking help for their child because of their fears and shame (Canadian Mental Health Association, 2002). The stigma attached to mental illness is so pervasive that people who suspect that they might be mentally ill are unwilling to seek help for fear of what others may think (Canadian Mental Health Association, 2002).

Oddly enough, when analysing, as can be viewed below in table 4.2, it was stated that mental health care professionals are trying to eliminate the word stigma and talk positively and with respect about mental health. Moreover, due to stigma, the typical reaction encountered by someone with a mental illness (and his or her family members) is fear and rejection and many people have found that they lose their self-esteem and have difficulty making friends.

Table 4.2 Sub theme: Stigma associated with mental health

Concepts	Excerpts	No. of times was cited
Strategy	"Strategies for overcoming the stigma of mental illness are integral to improve patient safety." (P2)	2
Education about stigma in mental health	"Providing education to health care workers to increase awareness that stigma influences health care practices to mental health...aware of how important these issues are...aware of mental and physical health.." (P1)	3
Health-care professionals in other hospitals	"Stigma is an area of concern; it creates a series of negative effects...it is sometimes our own fault...also among health care professionals in other hospitals and still is with us." (F1)	3
Quality of life	"The stigma and discrimination associated with mental illness can affect the quality of care patients receive." (F3)	4
Short of funding and resources	"Mental health services are short of funding and resources... education and information about mental health patients is important to eliminate some of the stigma present." (F10)	6
Eliminate stigma	"We can start talking about honour, value and respect not about stigma...Mental health crisis is being underestimated and patient concerns and complains are being disregarded...we	2

	should eliminate the word stigma and talk positively about mental health." (F13)	

This is in line with the literature where according to Brickell, Nicholles, Procyshyn et al., (2009) mental health services are often considered less worthy of resources then other areas of medicine or are considered a low priority. Stigma and discrimination against mental illness has also created the situation where mental health services are underfunded and undervalued. As such, among safety issues attributed to problems in health care system itself were those connected with funding and resource allocation, workload, restructuring, outdated equipment, poor staffing and bed closure (Nicklin & McVeety, 2002).

Stigma is a very real problem for people who have a mental illness. Based on stereotypes, stigma is a negative judgement based on a personal trait- in this case, having a mental health condition. Progress is being made to remove the stigma of mental illness and mental health disorders. One can take positive steps to combat stigma by improving knowledge and attitudes (Brickell, Nicholles, Procyshyn et al., (2009).

What was evident in the study was that stigma has its impact on the lives of people with mental illness. These people choose not to attend mental health services because they do not want to be labelled a "mental patient" nor do they wish to suffer the prejudice and discrimination this label entails. However, this study shows that health beliefs are not the only possible barriers to treatment participation or access to care but financial problems and availability of services are also factors. Moreover, stigma is not the only social element effecting health beliefs, knowledge about illness; treatments are factors that also affect them.

Meanwhile, one can argue that patients should not let the fear of being 'labelled' prevent them from seeking diagnosis and treatment. These can relieve a great deal of stress and tension by identifying what is wrong in specific terms and reduce symptoms. Stigma can lead to social isolation, therefore, making it extremely important to stay in touch with family and friends who understand and support patients with mental health illness.

Furthermore, many health care professionals do not know the basic facts about mental illness; they may have some misconception that need to be corrected. Also, stigma can be reduced through knowledge especially about helpful interventions and information. Moreover, people will benefit from learning about the causes of mental illness and the kinds of treatments that are available.

In addition, anti-stigma programmes emphasizing social acceptance of mentally ill patients and education regarding the causes, course and treatment outcome, with additional measures for consideration services provided should be carried out to help these patients integrate once again in the community.

4.4.2 Sub theme: Awareness in mental and physical health

Awareness of mental health issues has definitely improved in recent decades. Mental illnesses are a major public health concern. They adversely affect functioning, economic productivity, the capacity for healthy relationships and families, physical health and the overall quality of life. It can contribute to a host of physical ailments including digestive disorders, sleep disturbances and lack of energy.

However, there is lack of awareness of these issues to guide patient safety systems, practices, and policies and care delivery in mental health. The challenge is to treat the mental issue

while also caring for the related physical ailments (Brickell, Nicholles, Procyshyn et al., 2009).

Furthermore, according to World Mental Health Day, (2010) there is no health without mental health. Physical and mental health is intertwined. Mental Health refers to "A state of complete physical, mental and social well-being and not merely the absence of disease". Moreover, World Health Day (2010) raises public awareness about mental health issues.

Table 4.3 Sub theme: Awareness in mental and physical health

Concepts	Excerpts	No. of times was cited
Awareness of physical health	"Apart from treating mental illness there should be awareness of physical health concerns. Mental health patients should be treated holistically." (P1) "Aware of issues that concern mental and physical health." (P2)	4
Under-treated because of psychiatric illness	"Physical health concerns of mental health patients are often under-treated because they may be assumed to be a symptom of the patient's psychiatric illness." (P4)	3
Stigma influence access to care	"Stigma can also influence access to care and quality of care…these people are being stigmatized and abandoned as if they don't exist." (F1)	3
Prevent harm to patients	"We should all develop a good, clear conscience to prevent harm to patients." (P2)	2
Evaluation on patient outcome	"We should learn how to reflect when there are issues concerning patient safety…evaluate what went wrong, why and what should be done." (P2)	3

This is all in line with the literature by Brickell, Psych & McLean (2009) where it stated that some practitioners refuse to treat persons with mental health concerns or patients may be denied mental health treatment because of other ailments such as active addictions and

alcoholism. What was emphasised in the study was that mental health concerns are at greater risk than most medical diseases because the signs and symptoms of mental disorders are almost always behavioural and self-reported in nature. In fact, awareness is about prevention and early detection. Moreover, according to most of the participants in the focus group discussion, in emergency department, mental health concerns are often assigned a low priority, which can result in patients leaving without treatment or not receiving the type of treatment they need. Here stigma can lead to the situation where patients are reluctant to disclose a psychiatric diagnosis and treatment, which can result in insufficient psychiatric care or care for other medical conditions.

Furthermore, there is real need to deal with mental health problems of people with chronic physical illnesses and physical care of mental health patients through a continued and integrated care. Other participants insisted that all health care workers should have a clear conscience and treat patients with mental health illness holistically and without discrimination.

We can challenge people's misconception of mental illness, by gently pointing out the facts that mental illness is quite common, that recovery and management are possible and that people are not to blame for their illness (Bag, Yimaz & Kirpinar, 2006). In addition, according to Berry (2011) a successful initiative should include the elements of awareness promotion, intervention methods and preventive measures.

4.4.3 Sub theme: Information and research

The majority of participants suggested that further research and information would help develop our understanding of patient concerns in terms of promoting safe practice or creating safe care setting.

Research can be defined as the search for knowledge to solve new or existing problems, prove new ideas, or develop new theories, usually using a scientific method. Oddly enough, the primary purpose for research is discovering, interpreting and the development of methods and systems for the advancement of human knowledge. Moreover, there is lack of awareness of the issues and a shortage of available information regarding patient safety.

Table 4.4 Sub theme: Information and research

Concepts	Excerpts	No. of times was cited
Improve safety and condition of patient	"Research is always important to improve safety and the condition of the patient...you will know about what is going on around you...take what is good from other institutions...various courses are being organized, we are getting on somewhere...the main thing is that what is beneficial for the patient will be implemented." (P9) "Research is important...it is the centre of all...some statistics can be taken through research...there should be awareness of what is going on around us... always to improve patient safety in the hospital." (F14)	7
Update knowledge	"Research will update your knowledge regarding patient safety in mental health setting...the changes should be well evaluated and implemented." (P5)	4
Data not utilized	"There are a lot of data on the shelves, not being utilized... incident reports are ideal to see what happened and what caused it...we have to use it and do something about it to avoid other incidents." (P10) "A lot of energy is being used to undergo diploma and degree courses by our nurses...dissertations and theses are done... always to improve...but nothing is being done about them." (P6) "It is important to use research information to prevent physical harm and injuries and give good quality care to the patients." (F14)	3
Changes implemented	"Research is something you read about, learn,	5

	adjust and the changes done should be implemented...without it we cannot improve and keep on going forward." (P11)	
Involvement of patient's relatives	"Patient's relatives should be involved in the care of the patient...nurses are to work hand in hand with the relatives of patients so that there will be continuity of care when patient is discharged home." (P5)	3

Research and development is a routine and necessary part of the mental health services that can lead to better treatments and services for mental health problems. Improving the health and wealth of the nation through research is a very positive development. The Department of Health and Human Services (HHS) plays a critical role in promoting safer health care and in improving the collection of patient safety data. HHS agencies support a wide range of initiatives designed to reduce preventable medical errors and to improve the quality care provided to Americans of all ages. These efforts include: collecting and analyzing data to measure quality and target improvement efforts; identifying and promoting best practices to avoid systemic medical errors; and educating consumers and providers about ways to prevent errors (HHS, 2011).

Furthermore, in 2000, the Task Force sponsored a national summit on medical errors and patient safety research that included health care providers, administrators, purchasers, policymakers, oversight groups and consumers to address future research needs to reduce medical errors (National Health Information Infrastructure, 2000).

According to the literature by Brickell, Nicholles, Procyshyn et al., (2009) harm associated with patient safety is generally regarded as physical harm. What is evident in the study is that most research was conducted on adult populations and in the hospital settings, with little research in older adults and child/ adolescent populations; different cultural, ethnic and

religious groups; patients from private sector, rural settings and community mental health care services. Also, research was lacking in investigating the emotional or psychological experiences following patient safety incident, with most research focusing on physical harm and injuries. In addition, there was a complete absence of research focusing on evaluating the efficacy of patient safety training programs and interventions.

Furthermore, in order to attract high quality research, funding for patient safety in mental health settings needs to be a priority. Moreover, the need for further research to ensure practices and tools are evidenced based was acknowledged. Indeed, research is information which could then be used to help determine what the next steps would be in promoting patient safety.

In addition, as shown in the above Table 4.4, it has been stated that research is important to improve patient safety in mental health setting, and this is required through various courses organized to gain information and update the knowledge. Nevertheless, it was also viewed that when something is adjusted or changed for the benefit of the patients, these should be evaluated and implemented so as to keep on improving.

Further, the salient point here is that all health care workers should use all the information related to practice changes, new practice guidelines and regulations to fulfil their mandate of providing safe, competent and ethical care to improve patient safety in mental health setting.

4.5 Theme 2 Team Approach

The majority of the participants in the current study emphasised the importance of an effective team approach to tackle patient safety. Developing an approach to meet the high demands of mentally ill patients and the best utilize resources became necessary. The result is the use of a multidisciplinary team approach which involves a diverse group of healthcare

professionals, such as physicians, nurses, psychologists, pharmacists, physiotherapists, dieticians, occupational therapists, health educators, social workers and mental health providers. By this approach all the needs of the patient will be met. The most important member of this team is the patient; he or she is the centre of the team. This approach is holistic healthcare (Perkins & Ripper, 1998).

In addition, multidisciplinary team involvement is important within mental health nursing as people with mental health problems have multiple needs, so a variety of expertise is required to meet the needs of these people (Webster & Harrison, 2004). Moreover, Perkins & Repper (1998) demonstrated the benefits and importance of communication within a team and how all contributors within meetings should be valued. This is extremely interesting to see a MDT in action and witnesses the teamwork between different disciplines.

Table 4.5 Theme 2: Team Approach

Concepts	Excerpts	No. of times was cited
Teamwork	"Teamwork is very important and this should be horizontally and vertically." (P2) "Teamwork should be between the staff in the ward, between all other wards, between the management and other institutions." (P11)	8
Involvement of multidisciplinary team	"We want to give the best to our patients... to cure them and send them back to the community where they belong...we need to work as a team...the involvement of MDT." (P5) "We should learn how to reflect...this reflection will discuss the importance of the MDT and how they work with the patient in a trustful way to promote independence." (P1)	7
Effectiveness of services	"Everything has to work within a team...the organization will benefit by improving effectiveness of services and better quality in patient care...to be a member of a team makes a	5

	big difference to patient service." (P3)	
Good quality care	"There should be the involvement of all the teams of different professions…everybody is included…important to discuss together issues concerning mental health patients and their safety…to obtain a good quality care." (P7)	5
Improve teamwork	"Teamwork is not present in my ward…everyone on his own, which is not fair for the patients…if there would be a team that together discuss the patients, take handover, solve problems together and see what should be done to improve patient safety…this would be much better." (F6)	6
Information	"The importance and advantage of teamwork especially multidisciplinary team working…all professionals work together by bringing information together and obtain a complete view of problems of each individual patient." (P13)	3
Support	"We should give our patients all the support they need as they are human beings with all the dignity they deserve." (F13) "The most important is that you are part of the team…sense of belonging…and as you belong to a team, whenever one has a problem, they help each other…achieving staff satisfaction and support." (F11)	4
Communication and cooperation	"The importance of teamwork, greater communication and cooperation between different categories of employees…improving standards of care which will ultimately improve patient safety and quality of care." (P12)	6
Safe environment	"Teamwork is increasingly encouraged in healthcare services…work together so that no one gets hurt, not the patient not even the staff, safe environment based on trust… problems will affect the whole system." (P8)	5
Cooperation between all staff	"In nursing, teamwork is important…we are at work to work and all the staff should be in the same level path…patient safety is at top priority, we should cooperate more with each other for the benefit of the patients." (F2)	4
Disadvantage in a team	"The disadvantage in a team approach is how to harmonise a team…there may be some conflict between members…it involves a lot of time and energies as everybody wants to be better than the other one…there will always be problems	3

	with harmonisation to get the message across." (F4)	

This is in line with the literature by Spry (2006) where it is stated that if we want health care to be responsive to the needs of patients, there should be effective team approach in which information and responsibility are shared appropriately to allow the best decisions to be made. The team must individualize its services to the needs of each patient. Factors to be considered are the patient's mental disorder and its phase and the patient personal values, cultural norms and long term goals. According to Suddick & Souza (2007) an organization must fully understand the rewards and benefits that can be obtained from teamwork.

However, one of the major disadvantages of the MDT is that sometimes they work individually; therefore, there can be lack of direction, unclear goals and poor leadership if effective communication between the team is not achieved (Webster & Harrison, 2004). In addition, in line with the literature by Schofield & Amodea (1999) it is stated that the interdisciplinary team provides a comprehensive assessment through their individual expertise and in consultation with one another. It is one of the most widely accepted innovations in the delivery of mental health care.

Furthermore, from the findings obtained, it can be stated that within mental health hospital the importance of teamwork is being emphasised and focused upon. However, it was highly cited that teamwork needs to be improved and that even though it was being mentioned as being important it was not being implemented. Additionally, one can understand the numerous rewards and benefits that can be obtained from teamwork. Moreover, advantages of teamwork were recognised; however, possible disadvantages were also expressed. It was also stated that to improve patient safety, the team should discuss the patients, take handover and solve problems together. Additionally, the importance of teamwork, greater

communication and cooperation between different categories of employees was also cited by most of the participants which ultimately will improve standards of care and patient safety. In addition, creating a safe environment based on trust for patients and staff was highly emphasised by the participants.

4.5.1 Sub theme: Involvement of patient's relatives and community services

The involvement of patient's relatives can play a vital role in the recovery process. Patients who have family supports tend to have a better outcome than those who do not. In addition, patients who receive psychosocial treatments are likely to respond better to these treatments when they are living with a family member (Perreault, Paquin, Kennedy, Desmarais, & Tardif, 1999).

Table 4.6 Sub theme: Involvement of patient's relatives and community services

Concepts	Excerpts	No. of times was cited
Involvement of patient's family	"We need to involve the patient's family in the provision of patient's care and in decision-making...to see what is bothering them...to support and empowering them...to talk if something is doing them harm...better outcome...continuity of care...patients return back to the community where family is responsible for them." (P2) "We should work hand in hand with the patient's relatives; because at the end of the day when one member in the family is suffering from a mental health illness, other members in the family are affected too...we should support everyone." (P5) "The involvement of the family is important because there may be the risk of relapse...continuity of care...relatives are prepared to deal with the patient and his/her illness thus prevent readmission...this is under the health and safety of the patient." (F14)	4
Community services	"It is important to involve all the staff of the ward, patients, relatives of patients and the community service...work as a team together for the benefit of the patient...patient gets better and return back to the community where he/she belongs." (P9)	2

Allowing patients and their family to play a more active role in decision making, patient care and risk assessment could play a large role in improving safety for mental health patients. The majority of patients preferred that their relatives be involved in many aspects of their treatment. Moreover, with the growing interest in the patient's perspective regarding mental health services, relatives are invited to play an increasing role in the community (Perreault, Paquin, Kennedy, et al., 1999).

According to table 4.6, family involvement is a critical aspect for improving the lives of patients suffering from mental health illness. It is important to involve the family in the treatment and care of the patients and helping patients deal with their mental health issues. Indeed, mental health care workers demonstrate knowledge and education to patient's relatives to improve the standards of care and to continue at home when patient is discharge.

Moreover, as stated by some of the participants families are more likely to participate in the treatment process if they feel that they are included in the decision- making process. In addition, family engagement, support and empowerment play a key role in initiating and sustaining use of services and thus improving patient outcome. These services are provided via multi-disciplinary teams which include psychiatrists, nurses, psychologists, occupational therapists, social workers and others.

Furthermore, as mentioned by some participants, patient will benefit by community mental health services which are accessible to people with mental health illness; the program aims to support patients and their families, strengthen and improve family functioning. Ongoing assessment and treatment, education and support services will maximize patient empowerment.

4.5.2 Sub theme: Leadership

Leadership is about creating a way for people to contribute, to make something extraordinary happen. It is the process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task. Further, effective leadership is the ability to successfully integrate and maximize available resources within the internal and external environment for the attainment of organizational or societal goals. Indeed, leadership remains one of the most relevant aspects of the organizational context. However, defining leadership has been challenging and definitions can vary depending on the situation. It is often written that leaders are key contributors to a patient- safe environment (Spath, 2009).

Furthermore, nursing requires strong, consistent and knowledgeable leaders, who are visible, inspire others and support professional nursing practice. Leadership plays a pivotal role in the lives of nurses. It is an essential element for quality professional practice environments where nurses can provide quality nursing care. Key attributes of a nurse leader include being: an advocate for quality care, a collaborator, a communicator, a mentor, a risk taker, a role model and a visionary (Canadian Nurses Association, 2009).

Table 4.7 Sub theme: Leadership

Concepts	Excerpts	No. of times was cited
Sharing of knowledge	"We need to have a lot of leadership…leadership need attitudes not of discipline and control but based on understanding and sharing of knowledge and principles to help the person grow... leadership and attitude of understanding and …same vision and mission."." (P2) "It is a shared responsibility…if the leader is not able to grow…his place does not belong there."(F 14)	2

Safe working environment	"A safe working environment where all people concerned are supported...sharing same vision and mission...through leadership...we need to have a strong conscious of patient safety."(P8) "When such issues arise we need to have good leadership...learn to reflect and do an evaluation of what went wrong, what to do to avoid it not to happen again."(P1)	3

This is in line with the literature by Canadian Nurses Association, (2009) where it says that creating a way of life in an organization requires a conscious and sustained leadership effort. Leadership is a shared responsibility. With the collective energy of shared leadership nurses forms strong networks and relationships that ultimately result in excellence in nursing practice. To support excellence in professional practice, humanism must be restored to the work environment to help health-care workers feel safe, respected and valued (Canadian Nurses Association, 2009).

What we can see in Table 4.7 is that nurses have the obligation to their patients to work and practice in an environment well supported for safe and ethical nursing care. Leaders should identify areas that need to improve to ensure that safety actions are properly conducted and that measures are taken to prevent incidents from happening and harming the patients. According to some participants, although leaders convey safety-critical leadership behaviour they should reflect on issues of concern and use their conscious to avoid errors as much as possible. Moreover, leadership should be shared to improve workforce development that would result in better quality care for the patients.

4.5.3 Sub theme: Staff attitudes and promoting a patient safety culture

Staff attitudes have an important role to play in patient safety because it is unlikely that policies will be translated into practice if staff does not actively support the principals behind the policies. A patient safety culture can be defined as the way people think and behave in

relation to safety (Cooper, 2002). There should be increased awareness and changes in staff attitudes toward patient safety. However, these were new developments and further change was needed, particularly with regards to attitude and ensuring that policies were fully implemented (Brickell, Nicholles, Procyshyn et al., 2009).

Table 4.8 Sub theme: Staff attitudes and promoting a patient safety culture

Concepts	Excerpts	No. of times was cited
Trustful environment	"To improve staff attitudes one of the things that we should develop is a trustful environment between the staff...because if there is no trust in the system the problems become hidden with upcoming consequences."(P2)	2
Staff communication	"All the staff should communicate well with each other and with the patients...knowledgeable about patient's mental health disorder...know how to deal with patient's behaviour especially during violent and aggressive behaviour...to prevent any harm and injuries to patient and staff." (P9) "The way staff communicate with each other effects the quality of care of our patients...all staff should behave well with the patients...I hated when I hear staff shouting with the patients in a vulgar language because these suffer from mental health illness...I never heard these things in a general hospital." (F11)	3
Remove stigma towards mental health	"If we want to remove the stigma towards mental health we all have to combat this issue by not shouting, talk in a descent way and behave well...staff with staff, patients...patients between themselves...this is a disgrace, because we are all humans beings...we do not find these things in a general hospital...we should get the same level." (F10)	4
Teamwork	"We should work hand in hand with other workers of the team...staff cooperate well with other staff of the MDT...attitudes of sharing....patients will benefit more."(F2) "Helping physiotherapist in the morning, doing physio to patients...friendly attitudes...we can do the same thing in the evening ...physically, patients will feel better...continuity of care"(F7)	2

This is in line with the literature by ACSNI (1993) where it states that organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. Indeed, patient safety issues pertaining to mental health settings are an urgent issue and require greater understanding.

Meanwhile, some participants emphasised the importance of how the staff should communicate together and with the patients. They indicated that mental health care providers require a cultural shift in understanding patient safety. Three participants in the focus group mentioned the importance of improving staff attitudes during the provision of care. Indeed, attitudes of hospital staff are important for admission, early diagnosis and treatment and the rehabilitation process of mentally ill patients. Therefore, for patient safety in mental health settings to improve, a culture of safety needs is to be embedded within all levels of an organization.

Furthermore, increased awareness and changes in staff attitudes towards patient safety is highly beneficial, however, ensuring that policies were fully implemented was also pointed out by most of the participants. Therefore, any existing policies or protocols were being identified. Additionally, the need to promote good standards of practice, leadership, ongoing training, information sharing, and additional research were also voiced by the participants.

4.6 Theme 3 Communication

Communication in organizations encompasses all the means, both formal and informal by which information is passed from up, down and across the network of managers and employees in an organization (Lang & Edwards, 2006). Its actions reflect skills which foster personal, academic and professional success.

Indeed, as stated in the literature, effective communication is very important for successful working of an organization and for a team to work in harmony. However, poor communication between health care providers and between health care providers and patients has a link to patient safety incidents (Lang & Edwards, 2006). Direct communication with mental health care professional is almost always preferred. This should be in a confidential and safe environment where issues are well understood and any recommendations made are carried out. Furthermore, communication between all health care professionals, patients and their families and between other organizations will identify and addresses pathways that produce inequality in healthcare (Epstein & Fiscella, 2010).

Table 4.9 Theme 3: Communication

Concepts	Excerpts	No. of times was cited
Focal point	"Communication is the focal point in health care and it is across and with everyone."(P5) "Effective communication is highly beneficial between all the staff and between the staff and the management… and between the staff and patients."(P2)	4
Communication between MDT	"I like to see more communication and cooperation between different disciplines…you have to include everyone…patient care should be holistically, for the benefit of the patients."(P7) "Communication should be horizontally, vertically and across…everyone should work hand in hand so that neither the patients nor the staff would get hurt."(P8)	4
Communication between staff and patients and systems	"Communication between the staff and between systems is important to keep the staff together working in a team……important to avoid conflict by more communication and teamwork...giving feedback for continuity of care will benefit the patient."(F7)	5

	"Over these past few years the communication between the nurse and patient and the level of care has changed to better outcomes due to the training we are giving to the staff...but we still has to improve more." (P6)	
Motivation of staff	"Motivation of staff will increase communication and collaboration...the main focus is always the patient."(F13)	5

Research has shown that the number one cause of unhappiness at work is a lack of communication from the top. Success depends on a happy, motivated workforce, so a manager has a key role in making sure that one follows basic principles of communication and communicate regularly and effectively. Attitudes of different categories of workers were identified.

In general, improvements in communication are associated with improvements in patient safety. Systems that provide high levels of feedback and staff coordination have fewer patient safety errors (Australian Resource Centre for Hospital Innovations, 2003). This is in line with the literature by Health Canada, (2007) where it states that communication is a process of transmitting information, ideas, thoughts, opinions and plans between various parts of an organization. It is not possible to have human relations without communication. Improvements in communication are associated with improvements in patient safety, effectiveness of prevention and health promotion.

As shown in Table 4.9 to improve communication in mental health setting there should be cooperation and collaboration between all health care professionals and between organizations. Moreover, better communication has led to improvements in prevention and motivation for behaviour change. Furthermore, these changes may result to greater equity in healthcare system.

Most of the participants during the interviews and in the focus group discussion mentioned the importance of communication between all health care professionals working in the mental health setting to improve patient safety.

In addition, as stated by most of the participants, communication is essential in mental health settings for all the patients to make their needs, wants and ideas known. In mental health illness, communication may be delayed with difficulties. All members of the MDT should work hand in hand with mental health patients to develop skills to work with the communication deficits and delays in an individual, thus improve the quality of their lives.

Moreover, it is to be emphasized that mental health patients are people in their own right and should be treated with respect and dignity. Under no circumstances should someone be labeled terms like 'mental', 'mad 'or 'insane', instead always use 'a person'.

Finally, for good communication, the key point is that if someone is mentally unwell, this is not the same as being mentally ill. However, it is misleading to say that people with mental health problems have mental health.

4.6.1 Sub theme: Reporting procedures

The majority of the participants in the current study mentioned the importance of better reporting procedures. Information about critical incidents to be reported, sorted, integrated, evaluated and acted upon in a highly coordinated and timely manner, whilst maintaining a system-based emphasis on seeking and understanding the lessons that can be learned from events analysis (Brickell & Psych, 2007).

Table 4.10 Sub theme: Reporting procedures

Concepts	Excerpts	No. of times was cited
Environment of no blame- critical incidence is reported	"If there is an attitude of no guilt or of guilt but of no fault or of no blame and there is a critical incident you can report the incident...for example, if a nurse gave the wrong medicine to the patient, if the nurse is going to be penalised and disciplinary actions taken against her everyone is going to cover for her...that, we cannot grow forward...however if there is an environment of no blame...critical incident is reported...the manager will evaluate the case and see what could be done to avoid it next time...supported environment...empowered by the management." (P2)	2
Evaluation of accidents /incidents report	"The management is responsible to know what is happening in the hospital...through the system of accident/incident reports...evaluate it and do something about it." (F2) "Unfortunately nothing is being done...reports should be evaluated through meetings with all the staff involved and the management and see what can be done to avoid it next time." (P3)	3
Incidents reported immediately	"Incidents should be reported immediately to the more senior officers and does whatever can be done...the most important thing is to be always aware of what could happen...better safe than sorry and be more attentive of any risks that could happen." (P9) "When we notice that there is something wrong we should report immediately...there is no need to do four reminders to take action." (F7) "If there is something which is not safe, action should be taken at once...not pointing the finger to one another." (F14)	3
To use all data	"We have a lot of data on the shelves from the incidents reports ... not being utilized...it is a shame to see what caused the patient's most injuries and nothing is being done... ideal to use it." (P10)	2

This is in line with the literature by the Department of Mental Health (2010) where it ensures the safety of the patients and staff. It is the policy of the Department to continuously and systematically monitor and evaluate all adverse incidents.

According to table 4.10 some participants suggested that systems were in place to report incidents, and provide feedback and that an adverse incident is any situation in which the health and safety of patients and staff has been affected. Indeed, all corrective actions should be promptly and completely carried out.

Moreover, understanding patient safety incidents that is identifying who committed the incident, what and why it happened in a fair environment, and how the system can prevent it from happening again is important. In addition, staff and patients should feel confident that the organization will support them in reporting incidents.

4.6.2 Sub theme: Documentation practices

Improved documentation may improve continuity of care and improve the accuracy of record information used for other quality measurement systems. Quality of care, in particular, can be difficult to monitor, especially in the management of chronic disorders. However, a team-based quality review process appears to have a positive impact on the quality of medical record documentation (Smith, Fischer & Nordquist, 1997). Documentation may prove to be one of the most influential strategies to improve the health care. It can improve the ability to conduct useful research and can also positively affect identification, assessment and follow-up. Documentation also strengthen our understanding of the impact on patient's health and safety (Baker, Shanfield & Schnee, 2000).

Table 4.11 Sub theme: Documentation Practices

Concepts	Excerpts	No. of times was cited
Raised standards of nursing profession	"Documentation is important to increase efficiency and raise the standards of the nursing profession…for continuity of care…saved data regarding outcomes."(P11)	2

Misunderstood documentation	"A patient was send home on leave after ward round...on the nursing report it was written that patient was no longer experiencing suicidal ideas, was stable and compliant to medication and was send on leave by Dr so and so for some days with her relatives...after two days she committed suicide at her home...after debriefing and evaluating the case it was found that on her history file the doctor wrote that he told her that when she is stable, not experiencing suicidal ideas and compliant to medication she would be send home for leave...this was misunderstood and written wrongly...fearful and alarming."(P6)	3
Actions to be taken after documentation	"I should have been actively involved in this decision, before any actions have been carried out...removing patient's clothes is not a solution...she was aggressive not suicidal...just put her in a safe place until I give orders what to do...after reviewed and a written note done on patient's file." (P4)	1
Safety for patients and staff	"This week we had a case of Herpes Zoster in our ward...nobody said anything...but during handover as it was documented on the nursing report all the staff were told and precautions taken to prevent cross infection." (F4) "It is important that whatever happens in the ward should be documented for the safety and security of the patients and of the staff." (F2)	2

As it was found in the literature that better record keeping may provide more accurate data required for measuring outcomes. Issues affecting the quality of care of patient should be reported and documented for any requiring actions and for references (Baker, Shanfield & Schnee, 2000).

As it was mentioned about a case in an acute ward where a patient became aggressive towards the staff and other patients. Patient had to be secluded in the single room. The doctor had neither examined her nor written a note on patient's file. The nurse phoned the doctor telling him that they had put the patient in the S/R as she became aggressive and to come and write a note on her file. When he went to review patient he found her naked in the S/R and started complaining with the staff. This was not appropriate, actions should have been carried

out when ordered by the doctor and documented on patient's file; the nurse in charge took full responsibility, and it was not worth the trouble if something happened to the patient. Furthermore, the other case where the documentation was misunderstood with a bad outcome for the patient, disciplinary actions had to be carried out. These are delicate issues and one should be very careful when dealing with such issues that may threaten patient's life.

Nevertheless, it was also viewed that when proper documentation is carried out the standards of nursing care are raised because there will be continuity of care. Moreover, ensuring responsibility, accountability, authority, setting up employee training and having established and maintained system documentation are key issues in the organization of a safety and health management system (ILO-OSH, 2001). Indeed, this would ultimately, improve the safety and security of patients and staff.

4.6.3 Sub theme: Handover

Handover is the transfer of information from one shift of staff to another. It is related to the patient's health care, but could include: exchanging clinical information; outstanding tasks; operational issues affecting the care of the patient; untoward occurrences; activities i.e. social events and risk assessments. The handover is of particular importance if a staff member has been absent from duty for a specific reason, or a new member. Moreover, handover is to be at the commencement of shift and all the staff to receive handover at the earliest suitable time (Davies & Priestly, 2006).

Moreover, handover is a tradition in mental health settings and can occupy a significant amount of time each day, yet the topic has commanded limited attention in the psychiatric literature. Increasing staff changes and the growing reliance on casual staff has heightened the need for the effective and efficient transfer of essential information, as staff will often

find themselves in setting with unfamiliar patients. In this context, effective and timely handovers are crucial (McCloughen, O'Brien, Gillies & McSherry, 2008).

Table 4.12 Sub theme: Handover

Concepts	Excerpts	No. of times was cited
Continuity of care	"Handover of the main things that happened during the day regarding patient or other issues concerning patient's care should be given to the other shift for continuity of care...patient will benefit." (P9) "All staff belong to the same team...handover to one another about the patients should be for continuity of care...I am sure that we will work better for the benefit of the patients."(F6)	3
Lack of handover may cause consequences	"We work twenty-four hours a day...handover between the staff is very important...it is unfair when one staff does something and the other one does not know anything about it...consequences may arise."(F2) "Once, in the middle of a session...a staff approached me and told me that the patient is a biohazard...he was an HIV positive...handover should have been given from the start before the session had started." (F10) "Once we were taking a group of patients for an outing...nobody gave us any over about a particular patient...who was involved in a court case and was under level one supervision...anything could have happened...nobody from the staff gave an extra care." (F14)	4

Systems that provide high levels of feedback and staff coordination have fewer patient safety errors (Australian Resource Centre for Hospital innovations, 2003). As seen in table 4.12 above, the nurse in charge is responsible to ensure that handover is given completely to all the staff present to continue with good quality care, thus improving standard of care.

The need to appraise nursing handover in unique contexts was also revealed. Handover may be used optimally to enhance service delivery. To reduce information loss and increase accuracy, verbal handover could be supplemented with computer patient data. Further

research is necessary to evaluate such a handover system (Cleary, Walter & Hosfall, 2009). Oddly enough, participants stated that handover is very important every time the shift is changed for continuity of patient care. Moreover, some participants emphasised the fact that when handover is not given accurately, something may go wrong which may threaten the safety of the patients and staff.

4.7 Theme4 Adverse events

As mentioned earlier, setting priorities is necessary for shaping an effective response to safety concerns in mental health. Adverse events that were commonly mentioned during interview participants and focus group discussion that were experienced in their organization include: medication safety concerns, aggression/violence, self-harm/suicide, restrain and seclusion, slip and falls and patient absconding.

4.7.1 Sub theme: Medication safety concern

Table 4.13 Sub theme: Medication safety concern

Concepts	Excerpts	No. of times was cited
Medication safety concern	"The most important thing for us is that the patient takes the right treatment with fewer side effects...our objective is to prevent medication errors...in Europe every year there are 197 thousands deaths from medication errors and is also a high common cause of hospital deaths." (F12) "There was an incident where two patients in the ward with the same name by mistake were given the wrong treatment... unfortunately this mistake was repeated again after two weeks...may be due to lack of staff, not enough attention when administering treatment, lack of communication between staff and the management...something should have been done...maybe there may have been more severe consequences...all against the principle of patient safety." (P3)	10

	"When the doctor is prescribing medicine, to check if it is the right medicine and the right dose... nurses should be qualified enough to notice any side effects...double checking before administering the treatment is important...this all affect patient safety." (P5) "Always treat patients well...the pharmacist dispense medicine that was ordered by the doctor...one should know the interactions between the tablets so that certain mistakes could be avoided...always double check...report incident and see what went wrong...we can deal with it." (P7) "When we administer the treatment we always double check...the environment should be as quiet as possible...one should be sure that it is the right treatment to the right patient...that the patient had swallowed them all." (P8 and P9) "It is an acute ward...medication is double in dispensing...nurses had to prepare tablets and check them again...to prevent medication errors." (P10) "Medicine should be prepared by the same nurse who is going to administer it...double checked...if an error occurred, it should be reported immediately...nurse should not be penalised...we can learn from mistakes." (P11) "Once, there was a prescription that could not be read well and a wrong dose was given...with consequences...we hope that one day all prescriptions are done through computerised system to lessen these errors...the system would be a joint one with pharmacy, doctors and nurses...any queries on drugs can be solved through this system...more cost effective." (F12) "Treatment should be legible as much as possible...given at the right time and dose and to the right person to prevent errors." (F2)	

According to one participant, it is important that all checking procedures should be carried out with utmost attention, that is for expired dates, prescription dose, and if any problems are present to check with the doctor who prescribed the medicine. Moreover, according to table 4.13, most of the participants mentioned the importance of reporting incidents of medical

error at once so that actions are carried out immediately to save the patient. Indeed, illegible handwriting when transcribing medication should be avoided at all times to prevent giving the wrong dose was also commented.

Furthermore, communication between the staff when administering medication and between staff and the management when incidents happen was emphasised by most of the participants. This in line with the literature by Bates (2003) where it states that adverse medication events attributed to psychotropic medications are those which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice.

In fact, the most frequently reported types of medication incidents involve: wrong dose, omitted or delayed medicines and wrong medicine. Therefore, it is important to identify any contemporary risks regarding medication errors to prevent medication incidents from happening.

4.7.2 Sub theme: Aggression/violence and suicide/self-harm

According to the literature by Rippon (2000), aggression can be physical, verbal, active or passive and be directly or indirectly focused at the victim, with or without the use of a weapon, and possible incorporating psychological or emotional tactics.

Additionally, patient suicide and self-harm are among the most concerning patient safety incidents in the mental health setting. This concern arises from both the frequency and severity of the behaviour (NPSA, 2006).

Furthermore, the relationship between self-harm and suicide is complex. Most self-harm and suicide are distinct and separate acts, some have suggested that self-harm should be established as an independent clinical syndrome (Muehlenkamp, 2005).

Table 4.14 Sub theme: Aggression/violence and suicide/self-harm

Concepts	Excerpts	No. of times was cited
Aggression/violence and suicide /self-harm	"In acute wards patients are in an unstable and vulnerable position and at times they are violent... ideally these should not be mixed with patients of all types and categories for example; old people especially those with dementia should not be admitted there... they may suffer from some form of aggression and violence from others...this is bad management...patients should be streamed in wards according to their needs...staff should be trained how to deal with aggressive and violent episodes." (P3) "My ward caters for patients with learning disability... and they are at times aggressive and violent...but we have also old people over eighty years of age...these people cannot protect themselves from these frequent episodes of aggressiveness and impulsiveness." (P8) "All cases are different...you have to act accordingly...the health and safety of the patient involved and of the others cannot be threatened." (P4) "It is important to have a team trained to deal with self-harm and attempted suicide... sometimes these maybe due to mis-management from our side or negligence...also the cleaners should know not to let any disinfectant around as these can be swallowed by the patients as self-harm." (P5 and P6)	7

As stated in table 4.14, according to one participant, the Mental Health Act is used when persons need to be admitted to the hospital against their will, if there is threatening of self-harm or harm to others, according to its gravity. Oddly enough, this was also mentioned by

other participants in this study who stated that issues may be due to the mixture of patients with different mental health problems in the wards. Other participants commented that patients should be streamed according to their illness and needs, that for example patients with dementia should not be placed with patients that are susceptible to aggressiveness like the ones with learning disability.

Moreover, the majority of the participants perceived that communication between patients and staff before patients become acutely disturbed will de-escalate the aggressive behaviour. In addition, staff should be trained to know how to deal with aggressive and violent episodes.

4.7.3 Sub theme: Slips and falls

Table 4.15 Sub theme: Slips and falls

Slips and falls can greatly threaten patient's health and independence. They are major causes of serious injury and death; however they could be prevented (Eustice, 2006).

Concepts	Excerpts	No. of times was cited
Slips and falls	"The elderly should have a descent environment that do not get hurt…cleaners are not well trained…they should take extra precautions to remove any danger that may harm the patients…slippery floors that can cause patient to slip…boards indicating wet floors are used."(P3) "It is the responsibility of everyone to do a proper job… the management is responsible that he has good cleaners that are well trained to do their work well…the cleaner should never leave excess of water on the floor and dry it well…." ((P2) "We dry the floors well...we use boards indicating wet floors...patients would not slip and get hurt...this would be our fault with consequences." (F9) " It is of no use applying boards indicating wet floors in geriatric wards as the majority of patients suffer from dementia...you have to be there for them to protect	5

	them...even the bedsides should always be in place after attending the patient, to prevent them from falling from their beds." (F2)	

According to the participants, everyone is responsible to keep the patients safe and prevent them from falls especially elderly patients as these may suffer from serious physical injuries, further institutionalisation and in turn increased in cost. In addition, inadequate training was reported among the cleaners and that the management should select cleaners that are well traineed to work with these patients. Meanwhile, a participants insisted that we have to be there for the patients to protect them from any harm and create a safe environment that prevent them from injuring themselves.

This is in line with the literature by Brickell, Nicholls, Procyshyn et al., (2009) where it said that the total prevention is challenging considering the irreversibility of many risk factors (e.g. advanced age), and the desirability of an institutional culture which fosters safe independent mobility.

4.7.4 Sub theme: Patient absconding

Table 4.16 Sub theme: Patient absconding

Concepts	Excerpts	No. of times was cited
Patient absconding	"When a patient tries to abscond, the doctor puts him/her under level 1 supervision...a long time ago the nurse doing L1 stays with the patient watching him and follow him everywhere...nowadays there is more communication between the nurse and the patient...talking, listening, helping in decision making and empower the patient...different approach for the best." (P6) "We have to be careful not to let any doors opened... dementia patients may go out of the ward unintentially, wander about and get lost...with consequences." (P8)	6

	"In geriatric wards where patients with dementia are present...the doors should be kept closed at all times...the keys kept in a safe place...not to be taken by patients as they may leave the ward...find themselves in the traffic...with consequences." (F4) "When I go to throw the garbage out of the ward I always pay attention that the door is closed...as patients may abscond and get hurt." (F9) "We had some patients that abscond from the ward...with consequences...the main gate of the hospital has an operating mechanism system which costs a lot of money and yet not operational because there is no staff to operate it...it is a shame because one of the patients that abscond, just got through the gate...no measures to stop anybody...she committed suicide." (P10)	

Patient absconding applies to a patient that leaves the ward without permission and is considered to be safety incident because of the patient being vulnerable and risk to harm herself/himself or others.

According to table 4.16, when patients who are mentally ill are admitted to hospital, and they leave without the agreement of the staff, or go missing, is a serious concern, because many patients are brought into hospital in the first place because they are at risk of harming themselves or others. All participants agreed that it is important that all precautions are taken, that is: the doors are kept closed at all times, the keys kept in a safe place and any incident should be reported immediately. Furthermore, participants mentioned that communication between patient and staff has improved and patients will benefit from this approach. It is known that about a third of those inpatients that complete suicide do so following absconding from the hospital (Bowers, Jarrett &Clark, 1998).

This is in line with the literature by Bowers, Jarret, & Clark, (1998) where it states that the issue of patients who go missing either from acute or long-term mental health settings is recognised as a significant patient safety concern, since these individuals can pose a danger to

themselves or to others. We are aware that patients still manage to abscond from locked wards, and we believe that the principles underpinning the intervention to reduce absconding are widely applicable.

4.7.5 Sub theme: Restraint and seclusion

Table 4.17Sub theme: Restraint and seclusion

Concepts	Excerpts	No. of times was cited
Restraint and Seclusion	"Patient is put in a seclusion area when he/she is aggressive to prevent self-harm and harm to others...doctor has to be informed and the seclusion book signed before patient is put in." (P4) "Although we did a lot of good work for our patients in seclusion area and other areas, we still need to do more...we fixed cameras to observe the patient more especially when we are short of staff...we fixed the heat detectors when patient wants to smoke in S/R...wall thermometers and air conditioners in dormitories...our behaviour changed to a more communicative way, we sit and discuss issues that are upsetting the patient and calm him/her down...these are all part of health and safety for the patient." (P5) "Nothing is done in advance...there has to be some bad consequences before something is done...hospital management manage patient safety after the incident/accident happens...like the case when a patient was in her S/R, became acutely disturbed and when the nurses went to get her out, the lock brake and the patient remained locked for over one and a half hours, held only through the window by her hands...maintenance section called but took more than an hour to pull off the door...if patient was suicidal or managed to pull off her hands, she could have been death...the locks are now changed" (P10) "There is a whole protocol on restraint...the doctor has to write a note and sign on patient's file to be able to restrain the patient...health and safety became a continuous procedure."(F2)	5

Seclusion and restrain are interventions used in the treatment and management of disruptive and violent behaviours in psychiatry. These should not be used for punishment, coercion or threat.

According to the table above, despite the fact that good things have been done in the hospital to improve patient safety regarding seclusion and restrain, there are other important things to be done. Furthermore, some participants stated that nurses' behaviour regarding communicative skills towards the patient has improved through further education and training. However, in contrast, amongst the participants there was one participant who argued negatively that the hospital management does something after the accident/ incident happens and not in advance to prevent incidents from happening and keep patient safe at all times.

In addition, some participants mentioned the importance to stick to the protocol; most of all, the doctor should examined the patient before seclusion or restraint performed and the seclusion book signed. These protocols or documents should be identified and implemented to safeguard the patients.

This is in line with the literature by Delaney, Pitula & Perraud (2007) where it states that support involves listening and talking in a supportive way, offering comfort measures or whatever is needed according to the individual, and using verbal de-escalation. The effectiveness of restraint and seclusion interventions in the nursing management of disturbed and aggressive patients remains questionable, however, considerable debate continues regarding the use of these treatment options in psychiatric hospitals (Sailas & Fenton, 2000).

4.8 Theme 5 Environment and Resources

Psychiatric treatment hospitals have a duty to keep patients safe and provide treatment and accommodation in a safe hospital environment centre, on mental health care workers' awareness, attending, caring and ensure a safe living environment (Delaney & Johnson, 2007).

4.8.1 Sub theme: Safe environment

Table 4.18 Sub theme: Safe environment

Concepts	Excerpts	No. of times was cited
Supportive work environment	"First of all we have to develop an environment of trust between the staff...a supportive work environment where doctors and nurses are happy to work in...no pressures...lessens errors...safety for patient and staff...quiet and calm atmosphere...more co-operation and communication...teamwork (P2)	2
Right environment according to the needs of patients	"Safe environment by refurbishment of dormitories, with new furniture, new mattresses, well secured doors...wall thermometers and air conditioners...heat detectors and cameras...right environment according to the needs of the patients...done and kept by the management" (P4) "Safe environment by always keeping an eye on the patients...watch them as they are always up to something...see that the doors are kept closed...no water or something slippery on the floor...single rooms with a window and good ventilation." (P5) "We have patients with dementia...see that all doors are closed...patients with Huntington chorea, due to their involuntary movements...some form of cushioning around them to prevent injury." (F4)	4
Classification of Patients in wards	"Safe environment by giving healthy diet...enough staff...administering good treatment...communication and teamwork... classification of patients in wards." (P8) "More attention...everything can cause harm and be of any danger...observe patient's behaviour...they do not have anything to do and nurses are busy with their work...training and sessions how to deal with aggressive	3

	patients…handling and lifting." (P9)	
Safe equipment	"Safe equipment is important to avoid injuries to the patient…the state of the wheelchairs; they are not safe at all…we need them to accompany patients to O.T. and to Physiotherapy Department….some are without pedals, rubber, handles, footrest and others…we should keep the patients safe and avoid risks to the staff…maintenance section informed about them but takes long to be repaired…no co-operation on the side of maintenance section." (F2)	3

To promote a safe environment to patients suffering from mental health illness, all the members of the multidisciplinary team should work together to develop a comprehensive and therapeutic treatment plans to help the patients recover mentally and physically. As some participants mentioned, the organization should provide a safe and supportive environment in which patients can feel safe and recover quickly from his/her illness.

Oddly enough, everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well being including adequate water supply, sanitation and protection from all forms of environmental danger. It is not acceptable to feel unsafe in the hospital.

Furthermore, one of the participants emphasised the importance of developing an environment of trust between the staff where all staff cooperate with each other to keep patients safe and happy. Indeed, despite all this, with leadership, communication and working in teamwork by sharing our knowledge will definitely reach the goal of protecting patient safety and promoting good quality care. However, as suggested by some of the participants, due to broken equipment and lack of resources patients cannot be attended well and safely, also there is the risk of harming the staff.

4.8.2 Sub theme: Resources

In addition to adverse events, interview and focus group participants identified lack of resources as issues of concern. Concern about mental health services being offered or not offered has a number of different manifestations in the context of patient safety. Moreover, there is a general concern that the demand for services outstrips the supply of available services.

In addition, insufficient resources were also mentioned as hindering an organization's ability to respond to safety concerns. This is another quality care concerns, centred on staff attitudes and assessment skills (Brickell, Nicholles, Procyshyn et al., 2009).

Table 4.19 Sub theme: Resources

Concepts	Excerpts	No. of times was cited
Service availability	"The issue of patient safety is not being tackled well in the hospital due to short of staff...more awareness of mental health, so that our patients will have a positive and holistic care." (P1)	1
Lack of human resource	"It is a good idea that the pharmacist starts attending ward rounds with other multidisciplinary team...but we are always short of staff...all we have time to do is only dispensing."(F12)	2

Insufficient resources	"We need more funds, this huge problem...the lay administration does not know the needs of our patients...we need to improve patient safety." (P9) "We are very short of human resources and funds...we cannot start new procedures to improve our system...basic services are needed first...then we can start new things when resources are available." (P7) "We need a lot of resources...if there is lack of staff and other resources, one cannot reach the maximum care and the health and safety of the patient...all changes involves money and also has to do with the attitudes of the staff...it is hard but we can try." (P3) "Due to lack of staff we cannot reach our targets...more co-operation is needed to help each other improve the system."(F10) "This is due to short of staff...we have been complaining for a long time now with no success...sometimes we need to buy new parts for the broken item and are sometimes out of stock...no adequate funds...so everybody is in the same shoe...we try hard to fix everything that is reported... broken or out of order as soon as possible...we know it is for the benefit of the patients...to prevent injuries" (F15)	7

According to one participant, although there are lack of funds, the management still organize courses to train nurses and care workers to improve the quality care of patients, however, there needs to be done much more.

What is clearly demonstrated here is a link between patient safety and quality of care. Time and the work of dedicated health care workers can make patient safety a high priority and reduce the harms to patients in hospitals.

In addition, other participants emphasised that the lack of available services and resource shortages can result in patients not being monitored and care not being properly planned and given. Therefore, we need more co-operations and more collaboration between the staff and the management for better quality of care and thus improve patient safety.

4.8.3 Sub theme: Fire safety in hospital

Fire safety refers to precautions that are taken to prevent or reduce the likelihood of a fire that may result in death, injury or property damage; alert those in a structure to the presence of a fire in the event one occurs, better enable those threatened by a fire to survive, or to reduce the damage caused by a fire accident (Ranjith, 2010).

Table 4.20 Sub theme: Fire safety in hospital

Concepts	Excerpts	No. of times was cited
Fire drills and fire risk assessments	"With the help of the management we are organizing a team that will emphasize on fire drills and fire risk assessments...extinguishers are being updated and serviced however, there is no one trained enough to use them." (F6)	1
Lack of funds	"We started doing something, but still there are a lot to be done...the hospital is big and the budget for fire safety is minimal." (F6) "We fixed the heat detectors in single rooms and smoking areas, so that if something wrong happens, these detectors may be utilized...we even asked the civil fire protection to help us in anyway but they refused...the biggest obstacle is money as it involves a lot but we are trying to do something about it." (P5) "It is important to learn about fire drills and fire assistance but no funds are available... everyone is responsible for the prevention and for knowing how to handle a fire emergency." (P10)	4
Training	"Some form of training should be undertaken to know exactly what to do and where to go if a fire occurs." (P8) "Our aim is to train people and make patients aware that when they are smoking, they will make sure that the cigarette is well put out as cigarettes have high risk flame signals and so may be still on...about evacuation procedures, we are trying to get a group of people from private institutions in all the wards and train the ward staff...a team leader will be allocated to lead the way if emergency occurs to know how to evacuate people to safeguard patients and staff."(F6)	2

Fire accidents are becoming more prone and threat to hospitals because consumables used have more affinity to catch fire and lives are lost in fire accidents (Ranjith, 2010). Therefore, great consideration should be undertaken by the management to protect and safeguard all patients and staff involved. During the focus group discussion, the coordinator of the Fire Health and Safety in the hospital stated that the best defense against fire is to prevent the fire from starting. Furthermore, training on fire safety should be undertaken to safeguard our patients and all the staff involved. As shown in table 4.20, it is important that all the staff learn and train about fire drills so as to know how to handle a fire emergency and evacuate people in case it happens. However, despite all the efforts by the hospital coordinator to organize training by a group of people from private institution, there is the problem of funding as the budget for fire safety is minimal.

4.10 Conclusion

This chapter discussed the results of the current study carried out in a mental health hospital to assist in answering the study's research question. The study findings provided a measure of the knowledge and perception of staff in a mental health setting regarding patient safety.

It was highlighted that patient safety in mental health is an emerging concern in health care and as such, there is lack of awareness of the issues as well as a shortage of information. All the participants in the individual interviews and focus group discussion emphasised the importance of more guidelines, protocols and ongoing training.

Therefore, increasing our understanding of patient safety in mental health and improving tools and best practices through research and knowledge are important avenues for improving patient safety, as is promoting a culture of patient safety. Inter-professional collaboration, communication, teamwork, staffing, sufficient resources and handovers were among those

issues discussed. Preventing adverse events is necessary for achieving safe care and safe environment for mental health patients. Additionally, several recommendations on how improvements in patient safety may be achieved in this particular area will be discussed in the next and final chapter.

Chapter 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The aim of the study was to explore the prevalent knowledge and perceptions of staff regarding patient safety in mental health setting. The study used a qualitative approach to obtain the information needed. Data was collected from individual interviews with selected personnel and focus group with different categories of employees working in a mental health hospital.

This research study identified several potentially important future directions for improving patient safety in mental health setting. Identified themes from participants' interviews and group discussion were pieced together to form a comprehensive picture of their collective experience. Thus, a summary of the findings and objectives obtained are outlined in the following section, which is then to be followed by the strengths and limitations of the study as well as recommendations that emerged from the research findings.

5.2 Objectives and findings of the study

The following objectives were set:

- To identify knowledge, practices and attitudes of different categories of workers employed within the mental health hospital.
- To identify prevalent risks to health and safety.
- To identify any existing policies, protocols or documents regarding health and patient safety within the hospital and obtain feedback from staff regarding their utility in upholding patient safety.

As highlighted by the key interviewees and focus group participants, educating health care workers about patient safety and enabling them to use the tools and knowledge to build and maintain a safe system is regarded as a critical component of good quality care for mental

health patients. However, there is a general lack of training initiatives on health and safety issues within the hospital. Moreover, training should emphasise prevention, calming and negotiation skills as opposed to confrontation. Furthermore, guidelines, protocols and feedback are important for patient safety.

In addition, the stigma associated with mental illness and its effects for patient safety was also mentioned during the focus group. However, only two interviewees brought it forward as an issue of concern. They stated that as people with mental health illness are assumed to be unstable, violent and dangerous, stigma associated with mental illness is considered to be one of the barriers to create a safe environment. In addition, stigma also creates a flow of negative effects (e.g. fear and rejection) that pass through mental health care system.

Oddly enough, physical health concerns of mental health patients are often under-treated because they may be assumed to be symptoms of the patient's psychiatric illness. Stigma among staff and health care professionals is particularly important to patient safety because it directly influences an individual's ability to assess care and the quality of care they receive. Therefore, providing education is needed to increase awareness of mental illness.

On further analysis of findings, additional research would help develop our understanding of patient safety concerns and assess where we are at in terms of promoting safe practice or creating safe care settings. Furthermore, the need for further research is needed to determine priorities in patient safety and to ensure that practices and tools are evidenced based. It was also acknowledged, that research would help determine what the next steps would be in promoting patient safety.

In addition, the majority of the participants in the study emphasised the importance of an effective team approach to tackle patient safety. However, this multidisciplinary team which involves a diverse group of healthcare professionals to meet the needs of these people is still

lacking. Therefore, developing an approach to meet the high demands of mentally ill patients is necessary. Moreover, an organization must fully understand the rewards and benefits that can be obtained from teamwork.

Furthermore, most of the participants mentioned, that improving communication and cooperation between organizations and health care professionals would improve patient safety and quality of patient care. In fact, effective communication is very important for successful working of an organization. As one of the participants stated, "Communication is the focal point in health care and it is across, and with everyone." In general, systems that provide high levels of feedback and staff coordination have fewer patient safety errors. However, some comment were made that there are too many communication problems between different health care providers. Therefore, collaborative care plans were suggested as a specific tool to improve cooperation between care settings or organizations.

Meanwhile, it was stated by some of the participants that patients who have a supportive family tend to have a better outcome than those who do not, therefore, allowing patients and their family to play a more active role in decision making, patient care and risk assessment could play a large role in improving safety for mental health patients. Moreover, the majority of patients preferred that their relatives be involved in many aspects of their treatment.

In addition, some participants stated that leadership should be more apparent within healthcare as it is an essential element for health care workers to provide quality care to their patients. According to the participants leaders are key contributors to a patient-safe environment and best practices for excellence in health safety should be promoted. Moreover, patient safety in an organization requires a conscious and sustained leadership effort.

Furthermore, some participants indicated that mental health care workers require a change in understanding patient safety. Indeed, staff attitudes have an important role to play in this

because it is unlikely that policies will be translated into practice if staff does not actively support the principle behind the policy.

In addition, the majority of the participants in the current study mentioned also the importance of better reporting incident procedures. They stated that information about critical incidents should be reported, evaluated and acted upon because an adverse incident is any situation in which the health and safety of patients and staff has been adversely affected. On the other hand, staff and patients should feel confident that the organization will support them in reporting incidents. Thereafter, all corrective actions are promptly and completely carried out.

Furthermore, some of the participants mentioned that improved documentation may improve continuity of care. Moreover, improving standards of care during handovers will ultimately improve patient safety and quality of care. On the other hand, it is the responsibility of nurse in charge to ensure handover is completely, and all the staff receives it but oddly enough, it was argued by some of the participants, that handover of information is not always transferred from one shift of staff to another.

Other participants stated about specific adverse events such as medication errors, aggression/violence, self-harm/suicide, the misuse of restraint and seclusion, slips and falls and patient absconding. There was a call for more information on how to manage and prevent these issues more effectively. In addition to adverse events, participants also identified service availability and quality of care as issues. Moreover, there is a general concern that the demand for services outstrips the supply of available services. In fact, insufficient resources and funding were mentioned as hindering an organization's ability to respond to safety concerns. In addition, the lack of available services and resource shortages can result in patients not being monitored and care not being properly given.

On further analysis, it was mentioned that all health care workers have a duty to keep patients safe and provide treatment and accommodation in a safe hospital environment. To promote a safe environment to patients suffering from mental health illness, all the members of the multidisciplinary team should work together to develop comprehensive and therapeutic treatment plans to help our patients recover mentally and physically. According to participants, an environment of trust between staff and a supportive work environment are ideal for patient safety, however these may be hindered due to insufficient resources and funding.

5.3 Strengths and limitations of the study

The findings from the data collected following the individual interviews and focus group should be understood within the strength and limitations of the methodology adopted and are presented in the following sections.

5.3.1 Strengths of the study

At the initial phases of the research study, an extensive review of literature was conducted, as to provide a stable base for the research study. This reviewed literature guided the formation of selected objectives, methodology, and composition of the research tools used.

This research study was conducted using a qualitative methodology. Qualitative methods play an important role in health and safety planning and intervention evaluations. In fact, the major strengths of qualitative approach were that they privilege the research' social realities (Flick, 1998).

Furthermore, to ensure participant confidentiality, it was determined by the researcher that demographic information would not be collected, other than the occupation title and the number of work experience of the participant.

Within the methodology used to conduct the research study, rigour was given great significance. In fact a number of strategies were used to protect the study against bias and enhance the reliability of the findings. These included using multiple data sources and select participants from different levels of management. Additionally, transferability of the data gathered was increased by providing a full description of the context, participants and research design. The research methods used were appropriate for the study as during the interviews and focus group discussion, the researcher could probe for responses and ask more complicated and detailed questions. Thereby building a more complete picture.

Furthermore, the use of a focus group allowed interactions among participants. In fact, it made use of group dynamics to stimulate discussion, gain insight and generate ideas in order to follow the topic in greater depth. Moreover, the group process helped participants to develop and refine ideas, since focus groups participants not only questioned one another but also explain themselves to each other.

5.3.2 Limitations of the study

Although several measures were taken to make the study as rigorous as possible, some limitations still arose in this study. Since the data was collected by using face-to-face interviews, anonymity was not maintained. However, confidentiality procedures were implemented. Participants were reassured that all the names and information given would be kept in a safe and secure place.

Another weakness lies in the fact that since all interviews and focus group discussion were conducted in Maltese, they had to be translated into English. The limitation with translating the interviews was that some of the Maltese expressions could not be literally translated into English. Care was taken that the meaning of the translated interviews was not distorted.

The participants were informed about the purpose of the study; therefore, another possible limitation could be that this led to unconscious exclusion of material. In addition, the experiences may have been exaggerated in an attempt to present a particular picture to the researcher.

Some of the interviewees were at times interrupted during the session due to duty commitments possibly resulting in a loss of complete focus on the interview.

Although group participants have been selected from diverse backgrounds to provide as complete a representation as possible, this could have had a negative effect on the group dynamics. In addition, when conflicting issues arose between participants of the same grade or profession it was noticed that some hidden agendas were kept aside to reduce interpersonal conflict with colleagues.

5.4 Recommendations

A number of recommendations may be proposed from the findings of the study. These include suggestions for management, education and for future research.

5.4.1. Recommendations for Management

5.4.1.1 Promoting a culture of patient safety

Promoting a culture of patient safety should be encouraged by managers to make everyone in the institution aware that safety is part of his/her job as it is one of the core principles of good quality care. Openness and transparency in reporting and learning from adverse events should be instituted.

5.4.1.2 Further development of teamwork

The management should continue to explore ways that inspire teamwork as teamwork leads to improved quality of mental health, value-added patient outcomes, enhanced patient safety and satisfaction. Leadership should be apparent within healthcare for a safe environment and the best practices for excellence in health and safety of the patients and staff. The manager should support, motivate and empower the staff for quality improvement.

5.4.1.3 Communication

The management should be more engaged to improve communication and cooperation between and within hospital units, organizations and health care professionals thus improve patient safety and quality of patient care. Collaborative care plans are a specific tool that can serve to improve cooperation between care settings or organizations.

5.4.1.4 Establish an effective Incident Reporting System, Documentation and Handover

The hospital management needs to develop a policy to encourage and support staff to report patient safety incidents without facing disincentives like disciplinary actions when errors are reported. Incidents in healthcare systems are a serious problem which requires urgent attention.

Moreover, improving standards of care during documentation and handovers will ultimately improve continuity of care and strengthen the impact on patient's health and safety. Standard policies and procedures could be established and enforced to harmonize hospital handoffs and transitions throughout the organisation, thus reducing the risk for errors and improving the quality of care. Clear protocols and guidelines need to be addressed to guide practice and provide opportunity for remedial action when staff does not meet this standard.

5.4.1.5 Staffing

Adequate staffing is an important aspect of creating and maintaining a positive culture of patient safety. This refers to both staff complement as well as competence and skill mix.

5.4.2 Recommendations for Education

A call for more information on how to manage and prevent specific adverse events such as medication errors, aggression/violence, self-harm/suicide, the misuse of restraint and seclusion, slips and falls and patient absconding more effectively.

a. Management and supervisors are urged to provide staff training and education programs on procedures to improve patient safety. Educating health care workers about patient safety and enabling them to use the tools and knowledge to build and maintain a safe system is regarded as a critical component of good quality care for mental health patients.

b. Management needs to provide feedback about error and share knowledge from incident reporting system as an organisational learning and continuous improvement experience.

c. The development of evidenced-based guidelines for clinical handover is needed.

d. Resources need to be provided to support the learning needs of the organisation, in particularly staff identified as requiring knowledge and skill-up dates and training.

e. Organisations need to promote a learning environment and promote opportunity through learning from mistakes. This can be supported through the data collection of incidents and strategy building around preventing adverse events.

5.4.3 Recommendations for Further Research

a. Further research is needed to determine priorities in patient safety and mental health as well as evaluate existing tools and practices. This information could then be used to help determine what the next steps would be in promoting patient safety.

b. More research on specific population groups.

c. Issues of cultural, ethnic and religious diversity and institutional racism are an area for future research consideration.

d. Specific studies focussing on the particular patient safety needs of the elderly, children and adolescents

e. This study did not address the patient's, their family and caregiver's perspectives on mental health safety incidents. This is an important aspect to consider.

f. A focus on the emotional and psychological outcomes associated with patient safety events is also needed.

5.5 Conclusion

In this study, the researcher concluded that although efforts are being made to improve patient safety in this mental health setting, further progress is required to safeguard the patients. Moreover, despite the hospital expanding its services and offering an ever-increasing quality of specialised care to the respective patients, resources and funding are not being channelled towards patient health and safety initiatives.

However, there is a general agreement between the management and the employees that something needs to be done by all parties involved. Encouraging positive signs for possible future collaboration and involvement between the management and the staff have emerged from the study that could serve as an impetus for the management to start showing signs that the problem is going to be tackled and that everyone will give his/her contribution. Furthermore, the employees seem to have quite a fair understanding of what patient health and safety entails and what it is all about.

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Appendices

Appendix 1

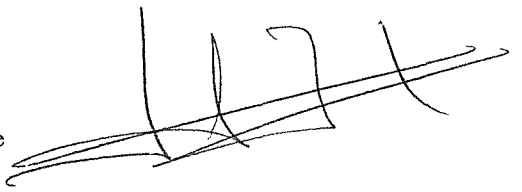
Ethics Committee Approval

To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance ✓ **Refusal** **Conditional acceptance**

For the following reason/s:

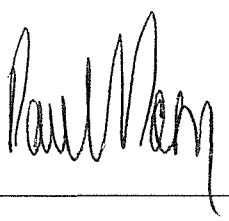
Signature  Date 02.06.10

To be completed by University Research Ethics Committee

We have examined the above proposal and grant

Acceptance **Refusal** **Conditional acceptance**

For the following reason/s:

Signature  Date 29/7/10

Appendix 2

Letters of informed consent to the

Chief Executive Officer

Director of Psychiatry

Manager Nursing Services

Document 2 Letter of informed Consent to the Chief Executive Officer

Josephine Cassar
32, 'Melahat',
Hal-Bordi Str.,
Lija.
LJA1622
21st April 2010

Mr Edward Borg
Chief Executive Officer
Mount Carmel Hospital
Attard

Dear Mr Borg
For the past twenty-one years I have been working as a Staff Nurse at Mount Carmel Hospital at various wards and for these past six months I have been working as A/DNO at female ward 2. I graduated in BSc (Hons.) in Mental Health Nursing in December 2008 and currently I am reading a Masters degree in Health Services Management at the Institute of Health Care - University of Malta.
As part of my studies I have to submit a dissertation in a year's time.

My study will be focusing on 'The importance of improving patient safety in a mental health setting'. The aim of the study is to establish the current level of knowledge and perception of the staff in the hospital regarding patient safety. This will achieve improvement in the quality of care.

I would like your permission to conduct this qualitative study by collecting data through focus group interview with different categories of employees and through ten personal interviews with selected personnel working in a mental health hospital in Malta. These persons with experience in mental health and patient safety are a source of information on current practices, upcoming initiatives and other issues. I shall be conducting an hour discussion with the focus group and an hour interview with each of the respondents in a one to one basis. I would like to ascertain you that I will follow the ethical considerations especially confidentiality and the interviewee's consent. I will give the respondents an oral explanation about my procedures, hopes and benefits. I will also read a declaration of principles to each and every respondent.

Whilst thanking you in advance

I remain

Yours truly,
J Cassar
Josephine Cassar Staff Nurse; BSc (Hons) in Mental Health Nursing
MSc in Health Services Management (student)

Approved 26/04/10

Document 3: Letter of Informed Consent to the Director of Psychiatry

Josephine Cassar,
32, 'Melahat',
Hal-Bordi Str.,
Lija.
LJA 1622
16th April 2010

Dr.J.R.Saliba
Director of Psychiatry
Mount Carmel Hospital
Attard.

Dear Dr Saliba,

For the past twenty-one years I have been working as a Staff Nurse at Mount Carmel Hospital at various wards and for these past six months I have been working as A/DNO at female ward 2. I graduated in BSc (Hons.) in Mental Health Nursing in December 2008 and currently I am reading a Masters degree in Health Services Management at the Institute of Health Care - University of Malta.
As part of my studies I have to submit a dissertation in a year's time.

My study will be focusing on 'The importance of improving patient safety in a mental health setting'. The aim of the study is to establish the current level of knowledge and perception of the staff in the hospital regarding patient safety. This will achieve improvement in the quality of care.

I would like your permission to conduct this qualitative study by collecting data through focus group interview with different categories of employees and through ten personal interviews with selected personnel working in a mental health hospital in Malta. These persons with experience in mental health and patient safety are a source of information on current practices, upcoming initiatives and other issues. I shall be conducting an hour discussion with the focus group and an hour interview with each of the respondents in a one to one basis. I would like to ascertain you that I will follow the ethical considerations especially confidentiality and the interviewee's consent. I will give the respondents an oral explanation about my procedures, hopes and benefits. I will also read a declaration of principles to each and every respondent.

Whilst thanking you in advance

I remain

Yours truly,
JCassar
Josephine Cassar Staff Nurse; BSc (Hons) in Mental Health Nursing
MSc in Health Services Management (student)

Approved subject to above and with introduction from IHC course organiser / Head of Dept.

Dr Joseph R. Sali
MD, FRCPsyc
Prof of Psych

Document 4: Letter of Informed Consent to the Manager Nursing Services

Josephine Cassar,
32, 'Melahat',
Hal-Bordi Str.,
Lija.
LJA 1622
16th April 2010

approved
21.4.10

Mr. Mario Hili
Manager Nursing Services
Mount Carmel Hospital
Attard.

Dear Mr. Hili
For the past twenty-one years I have been working as a Staff Nurse at Mount Carmel Hospital at various wards and for these past six months I have been working as A/DNO at female ward 2. I graduated in BSc (Hons.) in Mental Health Nursing in December 2008 and currently I am reading a Masters degree in Health Services Management at the Institute of Health Care - University of Malta. As part of my studies I have to submit a dissertation in a year's time.

My study will be focusing on 'The importance of improving patient safety in a mental health setting'. The aim of the study is to establish the current level of knowledge and perception of the staff in the hospital regarding patient safety. This will achieve improvement in the quality of care.

I would like your permission to conduct this qualitative study by collecting data through focus group interview with different categories of employees and through ten personal interviews with selected personnel working in a mental health hospital in Malta. These persons with experience in mental health and patient safety are a source of information on current practices, upcoming initiatives and other issues. I shall be conducting an hour discussion with the focus group and an hour interview with each of the respondents in a one to one basis. I would like to ascertain you that I will follow the ethical considerations especially confidentiality and the interviewee's consent. I will give the respondents an oral explanation about my procedures, hopes and benefits. I will also read a declaration of principles to each and every respondent.

Whilst thanking you in advance

I remain

Yours truly,

Josephine Cassar Staff Nurse; BSc (Hons) in Mental Health Nursing
MSc in Health Services Management (student)

Appendix 3

Declaration of Principles

Declaration of Principles

- I will folow the ethical consideration especially confidentiality.
- I will interview the participants of my study with all due respect.
- I will only ask questions which are relevant to my research question.
- The interviewees should not hesitate to ask any questions prior, during and after the interview.
- At no point should any interviewee feel uncomfortable or unsafe.
- The interviewees will be given an oral explanation about the procedure of the interview and about my hopes for benefits.
- The interviewees should not feel obliged to answer any questions; they should collaborate freely and with their free consent.
- If they feel uncomfortable at any point during the interview, they should feel free to stop the interview.
- I will explain to them that I will be using an audio-tape recorder for the purpose of my study and not for any other purpose. I will assure them that I would be the only one to get hold of the tape.
- The interviewees can choose the setting where they feel most comfortable to be interviewed in.
- The reason behind the interview and focus group discussion is to establish the current level of knowledge and perception of staff in a mental health setting regarding patient safety.

Josephine Cassar

Appendix 4

Interview Schedule

Interview Schedule to Participant

Introduction

The interview is opened with a greeting and introduction of the researcher. This is then followed by an explanation of the purpose of the interview, aim of the research study, method to be used during the interview and reassurance regarding confidentiality.

Following this, the interviewee will be given a consent form once again, offering written information regarding the aim of the research to be conducted, confidentiality and what the study entitles in relation to the participant. Subsequently, a written consent will be obtained from the participant.

Document 5a: Key informant interview questions (Maltese Version)

Mistoqsijiet gwida għall-intervista

Tul ta' L-intervista: madwar 60 minuta

1. X'kariga għandek bħalissa fil-post tiegħek tax-xogħol?

2. X'inhuma l-esperjenzi tiegħek fuq ix-xogħol rigward is- saħħa u s- sigurta lejn il-pazjent li qiegħed għal-kura tas-saħħa mentali?

3. Fl-opinjoni tiegħek min għandu r-responsabbilita biex jara li l-problemi tas-saħħa u s-sigurta qegħdin jiġu attwati u mħarrsa?

4. Bħala mpjegat, tħoss li l-problema qegħda tiġi attwata sew fl-isptar? Jekk le, x'taħseb li għandu jsir biex titrranġa s-sitwazzjoni rigward is-saħħa u s-sigurta lejn il-pazjent fl-isptar. (Hemm xi suġġerimenti).

5. X'tinkunsidra li huma l-punti prinċpali rigward is-saħħa u s-sigurta lejn il-pazjent fl-isptar?

6. X'tipi ta'grajjiet graw li jmorru kontra l-principju tas-saħħa u s-sigurta lejn il-pazjent li qiegħed għal-kura tas-saħħa mentali fuq il-post tax-xogħol tiegħek?

7. Kif l-organizzazzjoni/ is-sala/ l-ispiżerija/ d-dipartiment tiegħek irrispondiet għal dawk il-ġrajjiet?

8. Kemm taħseb li l-istituzzjoni tiegħek kapaċi timmaniġġja s-saħħa u s-sigurta lejn il-pazjent li qiegħed għal-kura tas-saħħa mentali bħallissa?

a) Mhu kapaci xejn

b) Ftit kapaci

c) Kapaci

d) Kapaci hafna

e) Kapaci iżżejjed

Jekk jogħġbok spjega r-raġuni għal din it-tweġiba?

9. Taf b'xi mudell prattiku li jista jintuża għas-saħħa u is-sigurta tal-pazjent fil-qasam għal kura tas-saħħa mentali li inti tista tirrikkmanda biex jiġi mplimentat?

10. Hemm xi idejat ġodda rigward is-saħħa u is-sigurta lejn il-pazjent fil-kura tas-saħħa mentali li l-istituzzjoni tiegħek qegħda bħalissa tipparteċipa?

11. X'tinkunsidra bħala l-iktar punti mportanti fis-saħħa u s-sigurta lejn il-pazjent fil-kura tas-saħħa mentali?

12. Fl-opinjoni tiegħek, x'jinħtieġ li għandu jsir biex tiżdied is-saħħa u s-sigurta lejn il-pazjent li qiegħed għal-kura tas-saħħa mentali fl-isptar?

13. X'tindentifika bħala xkiel biex takwista dawk l-għanjiet?

14. X'riċerka qegħda tipparteċipa fiha l-istituzzjoni tiegħek rigward is-saħħa u s-sigurta lejn il-pazjent li qiegħed għal-kura tas-saħħa mentali fl-isptar. Taħseb li r-riċerka hija mportanti?

Nota: Dawn il-mistoqsijiet huma biss gwida għall-intervista. Peress li din hija intervista ma nistax nassigura li dawn il-mistoqsijiet nużahom eżatt fis-sekwenza preżentata, iżda bi ħsiebi nużahom skond l-andament ta' l-intervista.

Document 5b: Key Informant Interview questions (English Version)

Interview Guide for Semi-Structured Interview

Duration of Interview: approximately 60 minutes

1. What is your current position/ role?

2. What are your past experiences at work regarding patient safety in a mental health setting?

3. In your opinion, who has the duty and responsibility to foresee that health and safety issues are being tackled and adhered to?

4. As employee, do you feel that the issue of patient safety is being tackled well within your hospital? If no, according to you what should be done in order to arrange the situation with regards to patient safety in the hospital? (Any suggestions).

5. What would you consider to be the primary areas/ issues relevant to patient safety in the hospital?

6. What types of adverse events in regard to patient safety in mental health have occurred in your organization/ ward/ pharmacy/ department?

7. How did your organization/ward/ pharmacy/department respond to those adverse events?

8. How effectively would you say your institution is able to manage patient safety in mental health currently?

   0 = not at all effectively
   1 = somewhat effectively
   2 = quite effectively
   3 = very effectively
   4 = extremely effectively
   Please explain the reason for choosing this response.

9. Are you aware of any existing best- practice model for patient safety in a mental health setting that you would recommend for implementation?

10. What initiatives are your organization/ ward/ pharmacy/ department currently participating in / engaged in with in relation to patient safety in mental health setting?

11. What would you consider to be the emerging issues in patient safety and mental health?

12. In your opinion, what needs to be done to increase patient safety in mental health setting?

13. What would you identify as the obstacle to achieve those objectives?

14. What research is your organization participating in, in relation to patient safety in mental health? Do you think that research is important?

NOTE:

These questions will serve only as a guide for the semi-structured interview, which I shall be conducting with the participants. Thus, the flow of discussion will determine the questions asked and their sequence.

Appendix 5

Focus Group Schedule

Focus Group Schedule

Introduction

Focus group is to be opened by introduction of the researcher and explanation of the study's purpose. This is then to be followed by informing the participants that during the focus group, significance is placed on their perception. It is to be emphasised that there are no right or wrong or desirable or undesirable answers. They may disagree with one another, and can change their mind. I would like them to feel comfortable saying what they really think and feel.

Following this, the participants are given a consent letter once again, offering written information regarding the aim of the research to be conducted, emphasising confidentiality and anonymity, and what the study involves in relation to the participant. Also, emphasis will be given to inform the participants that notes, and audio recording of the discussion will be completed. Following this, a written consent will be obtained.

Additionally, participants will be informed that the aim of this focus group is a group discussion. However, it is to be emphasised that it is highly appreciated if only one person have to talk at a time.

Document 6a: Focus group discussion questions (Maltese Version)

Mistoqsijiet gwida għal-intervista fi grupp

Tul ta' L-intervista: madwar 60 minuta

1. Liema huma t-temiet, il- punti ewlenin u l-azzjonijiet lejn is -saħħa u s-sigurta tal-pazjent fil- kura tas-saħħa mentali?

2. Xi prattika, għodda, programmi ta'tagħrif u inizzjattivi qegħdin jintużaw bħalissa biex tissaħħaħ is-saħħa u s-sigurta tal-pazjenti li qegħdin jirċievu servizzi fil qasam tal- kura tas-saħħa mentali?

3. Liema huma l-iktar nuqqasijiet u ostakoli li qegħdin jfixklu milli jiġu mplimentati tibdiliet ġodda mixtieqa?

4. X'inhuma d-direzzjonijiet li għandna niehdu fil- futur fis-saħħa u s-sigurta tal-pasjent fil-qasam tal-kura tas-saħħa mentali?

Document 6b Focus Group discussion questions (English Version)

Interview Guide for a focus group

Duration of interview approximately 60 minutes

1. What are the themes, priority issues and actions for patient safety and mental health?
2. What best practices, tools, programmes and initiatives are currently being utilized to optimize patient safety for receiving mental health services?
3. What are the main gaps and the obstacles to implement the desired changes?
4. What are the next steps / future directions for patient safety in mental health?

Appendix 6

Letter of informed consent to the Participant

Document 7a : Letter of Informed Consent to the Participants (Maltese Version)
Part A

Għażiż / Għażiża _____

Jiena studenta li qegħda nsegwi kors (Masters degree in Health Services Management) fl-Universita ta' Malta. Bħala parti mill-istudju tiegħi, nirrikjedi li nagħmel riċerka fuq, 'L- importanza li ttejjeb is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall- kura tas-saħħa mentali'. Is-saħħa u s-sigurta' tal-pazjent huwa fattur importanti biex ikun hemm kura xierqa, positiva u ta' kwalita tajba. Biex nilħaq l-għan tiegħi, għandi bżonn nagħmel intervista lill- partiċipanti li għandhom x'jaqsmu mal-kura u s-sigurta' lejn il-pazjent li qiegħed għall-kura tas-saħħa mentali fl-isptar. Nixtieq nistiednek tieħu sehem f'din ir-riċerka billi taċċetta li nagħmillek din l-intervista li ma ddumx aktar minn sittin minuta. Għalkemm ser ikolli bżonn nirrekordja b'mod awdjo dak li jingħad, l-opinjoni tiegħek ser tibqa anonima u fl-ebda punt fir-riċerka m'hu ser jissemma ismek. Naċċertak li ħadd aktar minni m'hu ser ikollu aċċess għat-tapes li ser jintużaw waqt l-intervista. Jiena napprezza li inti tieħu sehem f'din ir-riċerka, iżda jekk f'xi ħin thoss li m'għandekx tirrispondi, jew li twaqqaf l-intervista, dan tista tagħmlu meta trid. Meta nlesti l-istudju, t-tapes u t-transkrizzjonijiet jiġu meqruda. L-iskop ta' din ir-riċerka, minbarra li ser tgħini fl-istudju tiegħi, għandha l-għan aktar biex is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall- kura tas-saħħa mentali tittejjeb. Fl-aħħar ta' dan l-istudju, jiena ninpenja ruħi li ninfurmak bir-riżultat li joħrog. Jekk inti taqbel li tieħu sehem f'dan l-istudju, nitolbok tiffirma l-formola t'hawn taħt.

Filwaqt li nirringrazzjak bil-quddiem,
Għadni dejjem tiegħek,

Josephine Cassar. Staff nurse; BSc (Hons.) in Mental Health Nursing;
MSc in Health Services Management (student)

.....

Part B **Formola ta' Approvazzjoni**

Jiena nikkonferma li qrajt l-informazzjoni dwar dan l-istudju li jitratta fuq l-importanza li ttejjeb is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall-kura tas-saħħa mentali fl-isptar. Jiena nagħti l-kunsens tiegħi biex nipparteċipa fl-intervista.

_____ _____

Firma Data

Document 7b: Letter of Informed Consent to the Participants (English Version)
Part A

Dear_____

I am a student who is currently reading for a Masters degree in Health Service Management at the University of Malta. In partial fulfilment of this course, I am carrying out a study on, 'The importance of improving Patient Safety in a Mental Health Setting'. Patient safety is a critical component of health care quality. In order for patient safety to improve, cultures of safety needs are to be embedded within all levels of an organization. Achieving a culture of safety requires an understanding of the values, beliefs and norms about what is important in an organization and what attitudes and behaviours related to patient safety are expected and appropriate. To reach this aim, I would like to conduct interviews with participants who are experienced in mental health and patient safety. Your participation is voluntary and it will be greatly appreciated. The study rigorously conforms to the required ethical principles. I will assure you that your identity and all information you provide will be kept under strict confidentiality. The interview will take about 60 minutes and the information will be audio-recorded. You are free to decline in answering any questions that make you feel uncomfortable or withdraw from the study at any time. When the study is over, the audio tapes and transcripts will be disposed of.

This study serves to establish the current level of knowledge and perception of staff in a mental health setting regarding patient safety. This will ultimately be useful in our endeavours to improve patient safety. I will be informing you about the results of this study, once it is finished. If you accept to take part in this study, kindly sign the consent form below.

Thank you in advance.

Yours truly,

Josephine Cassar - Staff Nurse; BSc (Hons.) in Mental Health Nursing;
MSc in Health Services Management (student)

.....

Part B **Consent Form**

I have thoroughly read the information sheet about the study on the importance of improving patient safety in a mental health setting. I confirm that the explanation is adequate. I have understood my involvement in the study and agree to participate in it.

_____ _____

Signature Date

Appendix 7

Letter of informed consent to Focus Group

Document 8a : Letter of Informed Consent to Focus Group (Maltese Version)
Part A

Għażiż / Għażiża _____

Jiena studenta li qegħda nsegwi kors (Masters degree in Health Services Management) fl-Universita ta' Malta. Bħala parti mill-istudju tiegħi, nirrikjedi li nagħmel riċerka fuq, 'L- importanza li ttejjeb is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall- kura tas-saħħa mentali'. Is-saħħa u s-sigurta' tal-pazjent huwa fattur importanti biex ikun hemm kura xierqa, positiva u ta' kwalita tajba. Biex nilħaq l-għan tiegħi, għandi bżonn nagħmel intervista ma grupp ta' parteċipanti li għandhom x'jaqsmu mal-kura u s-sigurta' lejn il-pazjent li qiegħed għall-kura tas-saħħa mentali fl-isptar. Nixtieq nistiednek tieħu sehem f'din ir-riċerka billi taċċetta li nagħmillek din l-intervista li ma ddumx aktar minn sittin minuta. Għalkemm ser ikolli bżonn nirrekordja b'mod awdjo dak li jingħad, l-opinjoni tiegħek ser tibqa anonima u fl-ebda punt fir-riċerka m'hu ser jissemma ismek. Naċċertak li ħadd aktar minni m'hu ser ikollu aċċess għat-tapes li ser jintużaw waqt l-intervista. Jiena napprezza li inti tieħu sehem f'din ir-riċerka, iżda jekk f'xi ħin thoss li m'għandekx tirrispondi, jew li twaqqaf l-intervista, dan tista tagħmlu meta trid. Meta nlesti l-istudju, t-tapes u t-transkrizzjonijiet jiġu meqruda. L-iskop ta' din ir-riċerka, minbarra li ser tgħini fl-istudju tiegħi, ghandha l-għan aktar biex is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall- kura tas-saħħa mentali tittejjeb. Fl-aħħar ta' dan l-istudju, jiena ninpenja ruħi li ninfurmak bir-riżultat li joħrog. Jekk inti taqbel li tieħu sehem f'dan l-istudju, nitolbok tiffirma l-formola t'hawn taħt.

Filwaqt li nirringrazzjak bil-quddiem,
Għadni dejjem tiegħek,

Josephine Cassar. Staff nurse; BSc (Hons.) in Mental Health Nursing;
MSc in Health Services Management (student)

.....

Part B **Formola ta' Approvazzjoni**

Jiena nikkonferma li qrajt l-informazzjoni dwar dan l-istudju li jitratta fuq l-importanza li ttejjeb is-saħħa u s-sigurta' lejn il-pazjent li qiegħed għall-kura tas-saħħa mentali fl-isptar. Jiena nagħti l-kunsens tiegħi biex nipparteċipa fl-intervista.

_____ _____
Firma Data

Document 8b: Letter of Informed Consent to Focus Group (English Version)
PartA

Dear_____

I am a student who is currently reading for a Masters degree in Health Service Management at the University of Malta. In partial fulfilment of this course, I am carrying out a study on, 'The importance of improving Patient Safety in a Mental Health Setting'. Patient safety is a critical component of health care quality. In order for patient safety to improve, cultures of safety needs are to be embedded within all levels of an organization. Achieving a culture of safety requires an understanding of the values, beliefs and norms about what is important in an organization and what attitudes and behaviours related to patient safety are expected and appropriate. To reach this aim, I would like to conduct a focus group with participants who are experienced in mental health and patient safety. Your participation is voluntary and it will be greatly appreciated. The study rigorously conforms to the required ethical principles. I will assure you that your identity and all information you provide will be kept under strict confidentiality. The interview will take about 60 minutes and the information will be audio-recorded. You are free to decline in answering any questions that make you feel uncomfortable or withdraw from the study at any time. When the study is over, the audio tapes and transcripts will be disposed of.

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If you accept to take part in this study, kindly sign the consent form below.

Thank you in advance.

Yours truly,

Josephine Cassar
Staff Nurse; BSc (Hons.) in Mental Health Nursing;
MSc in Health Services Management (student)

.....

Consent Form

I have thoroughly read the information sheet about the study on the importance of improving patient safety in a mental health setting. I confirm that the explanation is adequate. I have understood my involvement in the study and agree to participate in it.

_____ _____

Signature Date