

National safety priorities in mental health: a national plan for reducing harm



effective
appropriate
efficient
responsive
accessible
safe
continuous
capable
sustainable

National safety priorities
in mental health:
a national plan for
reducing harm

ENDORSED BY THE AUSTRALIAN HEALTH
MINISTERS' ADVISORY COUNCIL
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Foreword

This Plan is the first national statement about safety improvement activity in mental health. Safety is a critical component of quality, and this Plan builds on the other significant quality improvement work progressing under the National Mental Health Strategy, as well as the recent developments in other health care sectors that have been progressed by the Australian Council for Safety and Quality in Health Care.

The National Mental Health Working Group seeks to use the plan to provide leadership in the four national priority areas where stakeholders agree collectively we can prevent adverse events, do less harm, and make mental health services safer. The plan also provides a blueprint and access to tools that are important in identifying, measuring and developing system changes that can reduce harm in all areas of need in the sector.

The selected priorities are the starting points for galvanising action and they signal the intention of all jurisdictions to act to improve the safety of mental health services. It is also hoped that the Plan will be understood and supported in other sectors, such as primary care services and support services delivering care to people with mental disorders, to think about how they can make mental health care safer.

The delivery of health care in Australia is complex. Care is provided across a range of settings and services, in both the public and private sector, and across health and community sectors. The Plan acknowledges this complexity. Activities such as those aimed at reducing, and where possible eliminating, seclusion and restraint by their nature relate to acute service settings. While others, such as those aimed at reducing adverse drug events, are relevant to a range of sectors and settings in which mental health care is delivered.

There are strong links between the safety work of the National Mental Health Working Group and the work of the Australian Council for Safety and Quality in Health Care. They share a message that strong commitment, adequate resources, and effective and appropriate governance structures are essential for safety and quality improvement. The Plan recognises that many individuals play an essential role in implementing the identified strategies and that action is needed not only by those providing mental health care, but by **those** who have governance responsibility for health care and those working in other health sectors where patients need care for both physical and mental illness.

The National Mental Health Working Group is committed to monitoring key activity under the Plan and will prioritise strategies for nationally coordinated implementation. The Working Group will also actively seek partnership opportunities with the recently announced Australian Commission on Safety and Quality in Health Care and other safety and quality stakeholders, just as it has with the Australian Council for Safety and Quality in Health Care.

Partnerships will also be fostered with those involved in emergency mental health care, including those working outside mental health services like ambulance and police services. Everyone is encouraged to take forward safety improvement activities and form partnerships based on analysis of local issues.

The inclusion of consumers, carers and families is an essential and valued aspect of the successful implementation of many of the strategies in this Plan.

Our appreciation and thanks is extended to the members of the Safety and Quality in Mental Health Partnership Group, in particular the Chair, Dr Aaron Groves, for their hard work and to the Australian Government for their support in developing a Plan that provides the basis for substantial improvements in the safety of mental health services.



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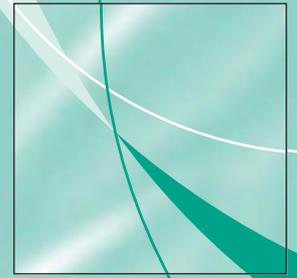
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Note: Words highlighted in **bold** text are words defined in the **Glossary**.

Section 1:

Introduction and context



Goal

The goal of this Plan is to:

Identify, avoid, or reduce, actual or potential harm from mental health care delivery in all environments in which it is delivered.

This goal is adapted from the *National Health Performance Framework* definition of a safe health care system. It encompasses the *National Mental Health Plan 2003-2008* definition of **safety** as minimising the potential **harm** from mental health care.

Purpose and rationale

The purpose of this Plan is to provide national direction in identifying, avoiding and reducing harm across all environments in which care of people with mental health disorders is provided. Primarily it aims to provide guidance for achieving safer **mental health services**. The Plan also identifies the importance of an underlying information infrastructure critical to safety and quality improvement.

This Plan aims to enhance the patient safety improvement initiatives led by the Australian Council for Safety and Quality in Health Care for the acute health care sector. Integral to this approach is improving the *systems* of delivering care and adopting a transparent culture in which health care providers can report safety **incidents** without fear of inappropriate blame. This Plan emphasises that information generated from **adverse events** can be used to enhance safety in mental health service delivery for all people involved. The focus of the Plan includes the safety of mental health **consumers**, **carers**, families, the community and the workforce. It recognises that understanding and addressing the safety concerns of all stakeholders is critical to improving safety in the **mental health sector**.

The Plan identifies priority areas agreed by the National Mental Health Working Group as key areas for galvanising safety improvement action nationally, while acknowledging that local priorities will also need to be developed. The roles and responsibilities for progressing activity under the Plan will be guided by those outlined in the *National Mental Health Plan 2003-2008*. While the primary focus will be public specialised mental health services, the Plan also aims to influence activities in the acute care sector outside mental health, **private sector mental health services** (especially private hospital services) and broadly influence other sectors such as primary care services and support services that deliver care to people experiencing mental disorders. It is acknowledged that the strategies identified will have differing applicability in different settings and sectors, and many strategies will need to be progressed in partnership with stakeholders outside public specialised mental health services.

It is important to acknowledge that mental health service delivery, while it shares much in common with health care delivery generally, can also present quite different challenges from most other areas of health care. This is primarily because of the responsibilities related to administering legislative powers for mandatory treatment. It is critical that a balance is achieved between individual rights to dignity, respect and privacy and the need to protect the personal safety of consumers, staff and others, including families, other consumers, visitors, and the public. A basic tenet underpinning this plan is

that mandatory treatment is to be used only when less restrictive options are not available, and should not be perceived or used by anyone as a punishment or coercion. The existence of powers of mandatory treatment behoves mental health services and professionals to actively identify, prevent and reduce iatrogenic harm.

Context

Over the last decade, under the direction of the Australian Health Ministers Advisory Council (AHMAC) National Mental Health Working Group, the National Mental Health Strategy has provided national direction and leadership for quality improvement in mental health services. Commitment to the implementation of the *National Standards for Mental Health Services* and national initiatives to implement routine consumer and carer outcomes measurement in mental health services continue to be supported nationally. This Plan is designed to complement and extend these and other quality improvement initiatives.

It is also important to acknowledge the changing nature of mental health care delivery that is increasingly, and appropriately, provided in the community. Acute inpatient psychiatric care is now being provided in general hospitals along with other health care, rather than just in stand alone psychiatric hospitals separate from the mainstream health system. Public specialised mental health services need to be integrated and include inpatient care and community care services. Private mental health facilities treat a wide range of mental health conditions, and provide more than two-thirds of all same-day mental health services. A significant and increasing proportion of mental health care is provided by the primary health care sector rather than specialist mental health services. These changes in the delivery of mental health care, combined with increasing awareness of mental disorders and the chronic, disabling and episodic nature of some mental disorders, present a variety of new demands on the health system.

National Mental Health Plan 2003-2008

Strengthening quality is a key theme of the *National Mental Health Plan 2003-2008*. Safety is a key component of quality and relates to minimising potential harm from mental health care. The *National Mental Health Plan 2003-2008* specifically focuses on increasing the safety of consumers, carers and families, staff and the community and reducing adverse incidents.

Australian Health Care Agreements

The Australian Health Care Agreements 2003-2008 have been signed by each State and Territory Government with the Australian Government. The Agreements include the objectives of improving the focus of public hospitals and mental health services on safety, quality and improved patient outcomes, as well as increasing the responsiveness of services for people in need of mental health services. The Agreements commit governments to the ongoing implementation of the National Mental Health Strategy, including consolidation of the reforms undertaken over the last decade, along with additional areas of focus as identified by stakeholders.¹ No such similar agreement exists between the Australian Government and private sector mental health facilities.

Australian Council for Safety and Quality in Health Care

The Australian Council for Safety and Quality in Health Care was established by Health Ministers in 2000 to lead the improvement of the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error.

1 See Clauses 8(c), 8(f) and 14. The Australian Health Care Agreements 2003-2008 are available at www.health.gov.au.

The Council is funded by the Australian Government and all State and Territory governments and is answerable to all nine Health Ministers. Its task is to oversee a national approach to the improvement of the safety and quality of the health system to minimise the numbers of adverse events and to reduce harm from adverse events that do occur. It aims to develop and sustain a culture of safety and to build skill and capacity for change.

The development of a culture of safety requires strong and visible leadership with a commitment to learning and to improving systems rather than blaming individuals inappropriately. It is a long-term task and relies on building effective **incident reporting** systems which support the measurement and analysis of data and opportunities for system improvement.

To support this approach, Council has focused on five priority areas:

- Supporting those who work in the health system to deliver safer patient care;
- Improving data and information for safer health care;
- Involving consumers and the community in improving health care safety;
- Redesigning systems of health care to facilitate the culture of safety; and
- Building awareness and understanding of health care safety.

The Council has to date focused on safety in acute services and their activities are also relevant for acute mental health services. A compendium of Council publications is at Appendix 2.

Safety and Quality in Mental Health Partnership Group

The AHMAC National Mental Health Working Group established the Safety and Quality in Mental Health Partnership Group to facilitate a safety focus in mental health, as part of a broader role of providing advice on improving the quality of mental health services. The Partnership Group initially oversaw a consultancy that aimed to examine the quality and safety activities in mental health, the activities of the Australian Council for Safety and Quality in Health Care, and to identify gaps and opportunities for improving the safety and quality of mental health services (see Appendix 3 for a copy of the recommendations of this report). The Partnership Group continues to play a key role in the safety and quality agenda.

Identified priorities

In early 2004, the Safety and Quality in Mental Health Partnership Group undertook a consultation process with stakeholders to identify key priority safety issues. Of the identified priorities the Partnership Group strongly supported four priorities for immediate national attention. These priorities reflect areas where there is much scope for improvement and where the consequences of errors, omissions and complications are great. They are all areas where consumers, carers, service providers and policy makers agree safety can be improved for all concerned.

The priority areas agreed for first attention nationally are:

- Reducing suicide and deliberate self-harm in mental health and related health care settings;
- Reducing use of, and where possible eliminating, restraint and seclusion;
- Reducing adverse drug events in mental health services; and
- Safe transport of people experiencing mental disorders.

These nationally identified priorities do not preclude identification of additional priorities or strategies for action. It is recognised that jurisdictions, services and sectors will have differing priorities and capacity when implementing safety improvement initiatives. It is recognised that the priorities, objectives and strategies have particular relevance to public specialised mental health services.

The list of safety issues identified in the consultation has been included in Appendix 4 for consideration when mental health service organisations are undertaking quality improvement activities.

Target audience

The primary target audience for the Plan is:

- Public and private mental health services: mental health service managers; providers; professionals; and other staff ²;
- Mental health consumers and their carers and families;
- Mental health policy makers; and
- Mental health **advocates**.

The primary target audience reflects stakeholders that are primarily concerned with mental health **consumers**. It is recognised that there may be specific considerations for different mental health service settings, for example child and adolescent mental health services, older persons mental health services, forensic mental health services and for different groups of consumers, including Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds. These considerations need to be addressed when planning and implementing safety improvement strategies and activities.

The secondary audience reflects sectors other than mental health services, where there is an opportunity to influence policies and protocols, processes or to improve working relationships. These secondary audiences include:

- Acute health care services more broadly than acute mental health care, particularly rural acute health care services;
- Emergency primary care services including emergency departments;
- Emergency services: ambulances, police, air services, and other transport providers;
- Primary health care services including general practitioners and allied health services;
- Health professionals and health policy makers working in the area of safety and quality;
- Non-government organisations providing support services to people experiencing mental illness and mental disorders; and
- Other service sectors, such as drug and alcohol, housing, disability and community services.

Each priority area may emphasise slightly different priority audiences while some priorities have broader relevance across a range of sectors. The extent to which each target audience is actively involved will also vary depending on the strategy being implemented.

2 This audience is intended to be inclusive of specialist public mental health services in all settings, (adult services, child and adolescent services, older persons services and other services) and private hospital mental health services, and where applicable private office-based psychiatry. Public specialised mental health services is inclusive of acute and community health services.

Section 2:

Improving safety in mental health services

This Plan identifies four priority areas where there is national agreement for progressing safety improvement activity. States and Territories and local mental health services (whether public or private) are also encouraged to determine their own priorities for improving the safety of consumers, carers, staff and others and for creating an environment where people are free to speak without fear or threat. Other sectors are also strongly encouraged to consider safety issues related to mental health care when determining their own risk management and safety improvement activities. This recognises that different jurisdictions, services and sectors will have differing priorities and capacity when implementing safety improvement initiatives.

There can be tension between the realisation of safety initiatives and the realisation of initiatives related to other dimensions of quality. It is hoped that when implementing safety initiatives, mental health services will carefully consider the balance between protection from harm and providing comprehensive high-quality care for mental health consumers. Recovery orientated mental health services that are focused on the individual needs, choices and desires of consumers come with a higher tolerance of risk from a consumer perspective, especially with interventions such as seclusion and restraint. To assist in guiding safety improvement activities and ensuring the safety of mental health services a set of principles have been agreed.

Principles³

The following principles have been identified for planning, developing and implementing safety activities and safety improvement processes in mental health services. They are to be used in conjunction with, and do not replace, other agreed National Mental Health Strategy quality improvement directions, State and Territory mental health legislation, legislation and guidelines governing the provision of private hospital mental health services, and other existing protocols, procedures, **standards** and clinical guidelines.

1. Consumer and carer rights to dignity, respect, and privacy irrespective of cultural background, gender, religion, sexual identity, or age are upheld in accordance with the United Nations *Principles on the Protection of People with Mental Illness* and the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities* that protect human rights.
2. Consumers and carers have the right to access accurate and complete information on their rights, access advocacy services, and access appropriate mechanisms for complaints and redress. Information provided is user-friendly and in a language the person understands.
3. Consumers are actively involved in individual treatment planning and review, and service planning, implementation, evaluation and quality improvement processes. Carers are actively involved in service planning, implementation, evaluation and quality improvement processes, and with consent, also individual treatment planning and review.

³ These Principles are based on *National Standards for Mental Health Services*, *National Practice Standards for the Mental Health Workforce*, United Nations Principles and *Mental Health Statement of Rights and Responsibilities*.

4. Mental health consumers have the right to receive care in the least restrictive environment, and with the least restrictive or intrusive treatment, that is appropriate to their health needs and their immediate circumstances.
5. The activities and environment of mental health services are safe for consumers, carers, families, staff and the community. The environment is used in ways that make it conducive to building quality therapeutic relationships.
6. Mental health professionals uphold the rights of people affected by mental health problems and mental disorders and those of their family members and/or carers, by maintaining their privacy, dignity and confidentiality and actively promoting their safety.
7. Treatment, support and safety interventions are non-discriminatory and provided in a manner that is sensitive to, and understanding of, the social and cultural values of consumers, the consumer's family and community.
8. The onus is upon mental health services to foster a transparent culture that encourages incident reporting and facilitates processes for staff feedback and involvement in improvement processes.
9. Mental health services and mental health professionals provide treatment interventions that are evidence based and informed by existing clinical practice guidelines and professional standards.
10. Mental health services meet their legal and moral occupational health and safety obligations to provide a safe workplace and this is respected by all stakeholders.

Quality infrastructure

There are a range of processes, systems and activities that affect the capacity of mental health service providers to implement the identified safety improvement principles.

Legislation

Legislation provides an important framework in which mental health services are delivered. Critically, it delineates between the voluntary or involuntary status of individuals, which is an important factor in how consumers and their carers experience the mental health system.

Between 1990 and 2000, each State and Territory developed and enacted mental health legislation consistent with the *Model Mental Health Legislation* and the United Nations' *Principles for the protection of people with mental illness and the improvement of mental health care*. Along with the *Mental Health Statement of Rights and Responsibilities*, is legislation that provides for minimum requirements for specific aspects of mental health care. While the precise nature of the safety measures and legislation varies between jurisdictions, the Acts regulate specific requirements in relation to treatment and interventions, such as electric convulsive therapy, seclusion, restraint and psychosurgery. They also include provisions for involuntary inpatient treatment and provisions requiring community-based treatment, such as provisions that can be used to require consumers to take specific medication whilst living in the community.

The *National Mental Health Plan 2003-2008* acknowledges the need to review mental health and related legislation to ensure protection of the rights of consumers and the community.

Standards

The *National Standards for Mental Health Services* were endorsed by AHMAC National Mental Health Working Group in 1996. Implementation of the *National Standards for Mental Health Services* involves formal in-depth review of mental health services against the *Standards* by an external accreditation body.

The *Standards* are a guide to high-quality service delivery and a key tool for continuous improvement, including safety improvement in mental health services (see Appendix 5). Standard 2 specifically relates to the activities and environment of mental health services being safe for consumers, carers, families, staff and the community.

The National Mental Health Working Group also endorsed the *National Practice Standards for the Mental Health Workforce* in 2002. The *Practice Standards* were designed to complement the *National Standards for Mental Health Services*. They outline and address the shared knowledge and skills required when working in a multi-disciplinary mental health environment and supplement each of the professional groups' discipline-specific practice standards or competencies. The *Standards* apply to the mental health professions of psychiatry, nursing, psychology, social work, and occupational therapy (see Appendix 6).

Other national standards, such as evidence-based clinical practice guidelines⁴, are also important for quality and safety improvement and systems need to be in place to use, review and update existing guidelines.

Governance and leadership

Governance, including **clinical governance**, is essential to improving quality and safety. Good clinical governance implies that there are well articulated processes for clinical performance and evaluation, clinical risk management, **clinical audit**, ongoing professional development, and full consumer and carer participation in quality improvement processes. Failure of a system to react appropriately to adverse events often points to inadequacies of leadership and accountability, and in particular to a lack of clarity about reporting processes.

Governance arrangements related to the provision of mental health care are complex. There are a variety of funding arrangements and responsibilities across a range of services and programs provided by State and Territory governments, the Australian Government and private sector organisations. Governing bodies are responsible for improving governance arrangements where these can further improve the safety and quality of mental health care.

Both clinical and managerial leadership is required to bring about change in organisations and to create a culture of quality improvement, including safety improvement. This includes actively supporting a range of quality and safety initiatives. Organisational safety initiatives encompass a range of strategies such as supporting risk management, adverse events and incident management and monitoring systems, workforce development and innovation, complaints mechanisms, information collection and performance monitoring, implementation of national standards, and external evaluation through accreditation and related in-depth reviews.

Culture of continuous quality improvement

Integral to continual quality improvement is the development of a respectful, transparent and just culture within which health care providers and others can report safety incidents without fear of inappropriate blame. The organisational culture needs to encourage and support reflective practice, learning from experience, use and dissemination of knowledge, partnerships with stakeholders and effective leadership in order to enable systematic improvement in service quality. However this can only be implemented once systems for adequately acknowledging and acting promptly on identified problems are instituted in mental health services within a governance framework, where responsibility, commitment and involvement in safe practice and improvement is identified at all levels.

4 For example, RANZCP Clinical Practice Guidelines.

Consumer focus and value

To improve health outcomes, mental health services need to be responsive to consumers. This includes being sensitive to a range of individual needs, including needs related to age, gender, cultural and linguistic diversity, disability, and other health and dietary needs. Providing consumers with relevant information and opportunities to provide feedback, as well as access to advocacy and complaints mechanisms without fear of any form of retribution are necessary. Systems also must be in place for seeking consumer consent for sharing information with carers and/or family members to enable their participation in care planning.

Positive consumer participation in mental health services can also be assisted through implementing processes that ensure participation in planning, implementation, evaluation and quality improvement. These include individual care planning, and the routine implementation of consumer self-report outcome measures and consumer perceptions of service quality measures⁵. Consumers must be provided with appropriate support as needed.

The participation of mental health consumers, as full partners, in their health care is expected in all treatment settings. This is an evidence-based practice and one of critical importance. Identifying and addressing stigmatising attitudes and cultures of control within mental health services that undermine this valuing of consumers is essential to a recovery oriented mental health service.

Carer focus and value

Mental health services need to be responsive to carers and families of mental health consumers, unless there are clear, specific and documented reasons for not involving them in a consumers care such as the consumer does not consent to their involvement. This includes being sensitive to a range of individual needs, including needs related to age, gender, cultural and linguistic diversity, disability, and other needs. Providing carers with relevant information, opportunities for feedback on progress and enabling their participation in care planning when **informed consent** is provided by consumers. Systems also must be in place for seeking consumer consent for sharing information with carers and/or family members to enable their participation in care planning.

Positive carer participation in mental health services can also be assisted through implementing processes that ensure participation in planning, implementation, evaluation and quality improvement. These include the routine implementation of carer 'burden of care' measures, carer perceptions of service quality measures⁶, and individual care planning where the consumer consents to such participation. Carers must be provided with appropriate support as needed.

Continuity of care

Continuity of care is a cornerstone of the National Mental Health Strategy and the *National Standards for Mental Health Services* and a specific focus of the Australian Health Care Agreements 2003-2008. Safe and quality care for people with mental disorders and mental illness cannot be achieved without effective processes for continuity of care, especially given the episodic nature of mental illness. Continuity of care means continuity between different elements of mental health services (inpatient and community), between mental health services and other acute and primary health care services, including emergency departments, as well as with other service sectors such as drug and alcohol, disability and housing etc. It means not only continuity across the course of illness, but also in recovery and coordination of services across the consumer's lifespan and life circumstances. It requires an integrated specialist mental health system with appropriate inpatient-community and public-private links.

5 At a minimum – as based on the work of the Information Strategy Committee and its development and implementation of National Outcomes and Casemix Collection and key performance indicators.

6 At a minimum – as based on the work of the Information Strategy Committee and its development and implementation of National Outcomes and Casemix Collection and key performance indicators.

Clear protocols and processes that facilitate continuity of care are very important, including high-quality **discharge planning**. Improving systems and ensuring continuity of care, particularly within a sector that increasingly focuses on care within the community, is essential for improving the safety and quality of mental health care for consumers.

Workforce

The knowledge, skills and attitudes of the mental health workforce are crucial to providing safe mental health services. Mental health services need a mix of professions and skills, and to foster a team approach to service provision. The workforce needs to be skilled in quality improvement processes and be able to access appropriate clinical supervision, support and professional development. The workforce needs to be trained in safe work practices, adverse events identification and incident prevention, monitoring and management processes. Such training and work practices need to be supported by management.

The *National Practice Standards for the Mental Health Workforce* are being implemented to: promote best practice; guide and support clinical supervision and mentoring; structure continuing education and curricula development; assist in recruitment and staff retention; and complement other competency standards.

'Investment in the workforce is essential'. This principle underpins the *National Mental Health Plan 2003-2008* and acknowledges that 'the supply, distribution and composition of the mental health workforce are fundamental to quality services'.⁷

Information infrastructure for quality improvement

Information infrastructure that supports the collection, interpretation and use of relevant information is essential to quality improvement. Recent significant changes to the information infrastructure in public specialised mental health services and private hospital mental health services has led to standardised processes for data collection at assessment, review and discharge. This information is clinically useful as well as providing information on outcomes at the service level. The availability and use of comparable data enables monitoring and evaluation of service performance and outcomes, and provides opportunities for **benchmarking**.

Service level research and evaluation for quality improvement is also important, and can make effective use of routinely collected information for development and dissemination of evidence-based best practice. Participation in collaborative research and evaluation should be encouraged and should use available information sources for local quality improvement. Health service research and evaluation can support safety improvement, for example, through clinical audits that focus specifically on the priorities identified in this plan and other locally identified safety issues.

7 National Mental Health Plan 2003-2008, p 11.

Risk identification and management

Incident reporting and management play a vital role in an organisation's approach to collecting, analysing and learning from information about when things go wrong in health care. There are a variety of ways of identifying risks and the likely outcomes of adverse events, however, there is no nationally agreed approach for the use of this information in the health or mental health sector.

Risk matrices are commonly used tools. The Australian Council for Safety and Quality in Health Care, in its **Open Disclosure** Standard, provides the example of an incident grading matrix from AS/NZS 4360 *Risk management* – a standard that is relevant beyond the health sector. Similarly, the Safety Assessment Code (SAC) promoted by the US Department of Veterans Affairs' National Centre for Patient Safety and the Severity Assessment Code (SAC) are widely used. These matrices (see Appendix 7 for examples) provide a system for mapping the likely or expected frequency of an adverse outcome by the severity of the outcome/impact.

Mental health services are encouraged to use such tools when prioritising actions to prevent adverse outcomes or when determining appropriate responses to incidents. Risk management or incident classification tools can assist to determine what outcomes and incidents automatically prompt further inquiry or response, can assist in managing the response, and raise awareness of incidents and incident reporting requirements.

These risk matrices, and other documents and tools developed by the Australian Council for Safety and Quality in Health Care (see Appendix 2) are appropriate for use, or could be adapted for use, in mental health services.

Risk management and incident management relies on strong governance arrangements, a culture of quality improvement and associated processes, as well as support from information systems that provide good quality reliable data about adverse events for quality improvement.

Priorities for strengthening the safety building blocks in mental health services

Rationale

To ensure safe mental health service environments generally, strategies are needed that strengthen the information infrastructure and other building blocks underpinning the ability to provide safe mental health services that continuously improve quality.

Objectives

- Mental health services use safety Key Performance Indicators for detecting and monitoring adverse events and in quality improvement processes such as benchmarking.
- Mental health services use available adverse event data to develop local action plans to improve safety, as part of continuous quality improvement processes.
- Mental health services use **incident monitoring and management systems** to improve the safety of mental health services for consumers, staff and others.
- Mental health services actively engage in training and development opportunities that will increase their ability to analyse and respond to adverse events.
- Mental health services engage in ongoing quality improvement processes, including in-depth external review against *National Standards for Mental Health Services* by accreditation agencies, and implementation of *National Practice Standards for Mental Health Workforce*.

- Mental health services develop and maintain working relationships and protocols with relevant acute, emergency and primary care services, as well as other relevant services sectors.
- Mental health services have formal structured mechanisms for mental health consumers and carers to provide feedback including complaints, and actively participate in service planning, policy, implementation, evaluation and quality improvement processes.

Strategies

- Ensure mental health services have systems in place for risk management and risk analysis that are linked to organisational and clinical governance arrangements.
- Promote, encourage and facilitate a transparent and a just culture within which mental health service providers can report safety incidents without fear of inappropriate blame.
- Ensure mental health professionals are trained in risk management, including in the areas of suicide and violence, and also inpatient safety improvement methodologies.
- Include a specific focus on strengthening the safety standard in any national review of the *National Standards for Mental Health Services*.
- Promote, encourage, and facilitate recording of mental health related adverse events in incident management systems and the use of incident information in quality improvement processes.
- Improve existing **incident reporting and management systems** to ensure that mental health specific adverse events are recorded and fed-back into safety improvement processes at the service level, provide meaningful aggregation of incidents data and have some capacity for benchmarking.
- Identify what mental health information should be collected and reported nationally, in addition to the national sentinel event reporting of suicides that occur in an inpatient unit. This would require further work with jurisdictions and relevant expert groups in the existing health and mental health data environments to ensure national consistency in data definitions, classifications and reporting that can contribute to improvements in safety and quality of mental health care in hospital and community based services.
- Develop, in collaboration with the National Mental Health Working Group's Information Strategy Committee, nationally agreed key performance indicators for safety.
- Ensure that mental health services consider coronial findings and other relevant inquiries, and feed these into incident management and quality improvement processes.
- Ensure that local services use all available data on incidents and adverse events (complaints data, reports from external scrutiny bodies such as Australian Council on Healthcare Standards clinical data, **accreditation** reports or reports from official/community visitors) to analyse and determine local priorities for safety and quality improvement.
- Ensure that mental health services have in place arrangements for information sharing with criminal justice agencies, transport providers and primary health care professionals.
- Ensure that if a mental health consumer is involved in a safety incident that this automatically prompts the review of the mental health consumer's care within a reasonable time period that is specified in relevant procedural documentation.
- Ensure that mental health services have in place activities that reduce stigma experienced by people with mental health disorders, promote mental health and foster recovery oriented services.
- Promote mental health consumer participation in their health care through the use of *10 tips for safer healthcare*⁸, in addition to other mental health service specific consumer and carer participation strategies.

8 Australian Council for Safety and Quality in Health Care (2003), *10 tips for safer health care*, Commonwealth of Australia, 2003.

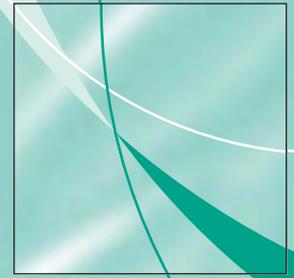
- Ensure all mental health consumers have in place an individual care plan on discharge from mental health inpatient care and that they receive a copy, and if agreed a copy is also provided to a carer.
- Identify good practice for the involvement of carers in treatment including following discharge from inpatient mental health care, with a focus on relapse management and discharge documentation when developing individual care plans.
- Promote a consistent and effective approach to complaints management through the use of the *Better Practice Guidelines for Complaints Management for Health Care Services*⁹ and the accompanying *Complaints Management Handbook for Health Care Services*.
- Promote use of national falls prevention guidelines¹⁰ within mental health services.

9 Australian Council for Safety and Quality in Health Care (2004), *Better Practice Guidelines on Complaints Management for Health Care Services*, Commonwealth of Australia, July 2004.

10 Australian Council for Safety and Quality in Health Care (2005), *Preventing falls and harm from falls in older people*. A resource suite for Australian hospitals and residential aged care facilities, Commonwealth of Australia.

Section 3:

Priority areas



Reducing suicide and deliberate self-harm in mental health services and related health service settings

Rationale

Suicides in mental health service settings may indicate a catastrophic system failure and can undermine public confidence in the mental health care system. They are tragic events that cause much grief and distress for families and friends, as well as for mental health professionals and other workers involved in their care, and for other consumers within the **mental health service**. Although suicides of people in the care of mental health services are not always preventable, it is acknowledged that there is scope for reducing some of these tragic events through improved systems of care.

Health Ministers agreed that 'suicide of a patient in an inpatient unit' is a **sentinel event** in health care, to be publicly reported by jurisdictions as one of a number of nationally agreed core sentinel events (see Appendix 8). This data will be included in the National Sentinel Event Report due to be released by the Australian Council for Safety and Quality in Health Care by the end of 2005.¹¹

In addition to suicides in inpatient units, **adverse events** also include suicides occurring while mental health consumers are on day leave, or are absent without leave, and in the days and weeks immediately following discharge. This recognises that preventable suicides can occur as the result of omissions in care, for example as a result of lack of follow-up and continuity of care post-discharge. It is also argued that suicides occurring for periods up to a year following discharge from an inpatient unit are also serious events, particularly where consumers are in the care of community mental health services. Such suicides are commonly perceived by members of the community as a failure of the health care system.

Suicides are often preceded by suicide attempts and/or other acts of deliberate self-harm. However, not all self-harm behaviour is suicidal behaviour or related to suicidal thinking. Improved systems of assessment and management of deliberate self-harming behaviours may help to reduce suicides. A systems oriented approach to reducing suicides, suicide attempts and deliberate-self harm is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

The consultation (refer Appendix 4) indicated that improved suicide assessment and management was a shared safety priority across the range of stakeholders consulted.

Strategies developed for this action plan have been conceived to be complementary to efforts under the National Suicide Prevention Strategy and State and Territory suicide prevention policies.

11 All jurisdictions have commenced to collect sentinel event data. Two jurisdiction have publicly reported – Department of Human Services (2004) *Sentinel Events Program: Annual Report 2002-03*, Victorian Government Department of Human Services, Melbourne, May 2004 and NSW Health (2005) *Patient Safety and Clinical Quality Program: First report on incident management in the NSW public health system 2003-2004*, Sydney, January 2005.

TABLE 1:
Reducing suicide and deliberate self-harm in mental health services and related health service settings

<p>Objectives</p>	<p>Reduced suicide in mental health services.</p> <p>Reduced suicide in acute health care services.</p> <p>Reduced suicide in the days immediately following discharge from inpatient care.¹²</p> <p>Reduced suicide within 28 days following discharge from inpatient care.¹³</p> <p>Reduced instances of suicide attempts in mental health services.</p> <p>Reduced instances of deliberate self-harm in mental health services.</p> <p>Reduced instances of suicide attempts within 28 days following discharge from inpatient care.</p> <p>Routine suicide risk assessment and management, and post-discharge follow-up within existing policies, protocols and clinical guidelines.</p> <p>Routine consideration of Coroner’s recommendations for improving systems of care in mental health services to reduce suicides.</p>
<p>Priority settings</p>	<p>Mental health services (including the interface with public and private facilities).</p> <p>Acute care services outside mental health services, particularly emergency departments.</p> <p>Interface between mental health services and primary care sector, such as general practitioners, and non-government organisations.</p> <p>Other relevant settings as applicable, such as ambulance services and other approved transport providers and police services.</p>
<p>Known problem areas</p>	<p>Specialised mental health services (first days of admission, periods of leave, discharge planning, follow-up post-discharge, continuity of care between hospital and community based services and primary care services such as general practitioners and non-government organisations).</p> <p>Issues specific to accident and emergency hospital-based settings (triage, discharge planning, timely access to mental health assessments and staffing/resources/workflow issues).</p> <p>Appropriate information and support for consumers and carers post-discharge, especially when current hospitalisation involves suicide attempt in care or prior to care, or where it is the first diagnosis of mental illness for a consumer.</p> <p>Absence of identified good practice in suicide risk assessment. Variability in protocols and application of protocols across hospitals/services and jurisdictions.</p> <p>Communication across the jurisdictions.</p> <p>Over-reliance on junior/trainee clinicians in emergency departments and mental health services.</p> <p>Risk factors related to the health service environment such as access to hanging points and belts, and other well documented risk factors.¹⁴</p>

12 Jurisdictions have differing protocols and information collection requirements. There is consensus that monitoring is needed but the time period for monitoring varies across jurisdictions from 5-28 days post discharge.

13 Agreed Phase 1 KPIs for public specialised mental health services include ‘28 day readmission’.

14 Refer to National Suicide Prevention Strategy documents and other evidence-based sources.

TABLE 1: (continued)

Reducing suicide and deliberate self-harm in mental health services and related health service settings

Strategies	
	Identify and disseminate good practice in suicide risk assessment and management, and review existing protocols and clinical guidelines of mental health services and related health services. This will include examining good discharge planning, risk assessment, and outcomes measurement. This will include consideration of variations in good practice related to particular settings, eg child and adolescent mental health services.
	Identify good practice services/leaders and facilitate their role in influencing clinical and service management change system-wide.
	Implement and use incident monitoring and management systems for monitoring instances of deliberate self-harm, suicide attempts and suicides.
	If a sentinel event of ‘suicide in an inpatient unit’ occurs ensure that the relevant service policy on open disclosure is followed and post suicide bereavement information resources are available to families and significant others ¹⁵ Ensure appropriate processes are in place to support staff.
	Investigate, using tools such as root cause analysis , all suicides that occur whilst consumers are in the care of hospitals (mental health services and other parts of the hospital) and community components of public specialist mental health services.
	Investigate, using tools such as root cause analysis , all suicides that are known to have occurred within one year post-discharge from acute care or specialist mental health service care.
	Develop education and training strategies for supporting services to use tools such as root cause analysis after suicides.
	Develop nationally consistent measures for recording, classifying and reporting of all suicides of mental health consumers in the care of mental health services and acute care, as well as for reporting of suicides within one year of discharge.
	Implement existing clinical practice guidelines for the management of deliberate self-harm. ¹⁶
	Ensure that systems are in place to automatically consider Coroner’s findings, disseminate lessons, and ensure appropriate changes to systems.
	Evaluate changes in practice and outcomes.

15 Some resources have been prepared under the National Suicide Prevention Strategy that may be appropriate here. See www.community-life.org.au for information support packs for suicide and sudden death. This web site also provides information on training and education opportunities for carers and others who want to be able to assist their loved ones who are suicidal, for example ASSIST training (LivingWorks) that is specifically targeted at carers.

16 Australasian College for Emergency Medicine, *Guidelines for the management of deliberate self-harm in young people* and Royal Australian and New Zealand College of Psychiatrists, *Guidelines for the management of deliberate self-harm in adults*.

TABLE 1: (continued)

Reducing suicide and deliberate self-harm in mental health services and related health service settings

<p>Complementary/ linked strategies/ activities</p>	<p>National Suicide Prevention Strategy.</p> <p>Existing State and Territory suicide prevention strategies.</p> <p><i>National Action Plan for Promotion Prevention and Early Intervention in Mental Health 2000.</i></p> <p>Australian Council for Safety and Quality in Health Care, particularly national sentinel event reporting, Open Disclosure Standard.</p> <p>Existing State/Territory initiatives targeting areas identified in the above strategies, for example South Australian guidelines for reporting and managing sentinel events that include compulsory root cause analysis for suicide within 28 days of discharge.</p> <p>Implementation of Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Practice Guidelines for management of deliberate self-harm (adults).</p> <p>Australasian College for Emergency Medicine <i>Guidelines for the management of deliberate self-harm in young people.</i></p> <p>Existing non-government initiatives, for example Lifeline’s ‘buddy’ program to support consumers post-discharge from mental health services.</p>
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Reducing use of, and where possible eliminating, restraint and seclusion

Rationale

The United Nation's *Principles for the protection of people with mental illness and the improvement of mental health care* states that:

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.¹⁷

This Plan endorses the United Nation Principle and supports the enactment of the Principle in domestic legislation.

There is considerable variation in the clinical **standards** governing the use of **restraint** and **seclusion** in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The goal of the Plan is to reduce the use of these interventions, and the **adverse events** that accompany them. However, it is acknowledged that there are situations where it is appropriate to use interventions such as restraint and/or seclusion but only as a safety measure of last resort. It is clear that restraint and seclusion are not a substitute for inadequate resources and are not to be used as a method of punishment, and if used in either of these ways is a serious contravention of consumer rights.

A systems oriented approach to reducing restraint, seclusion and associated adverse events is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

There is a close relationship between the use of restraint and seclusion and serious adverse events. The known adverse events associated with use of restraint and seclusion include dehydration, choking, circulatory and skin problems, loss of muscle strength and mobility, pressure sores, incontinence and injury from associated physical/mechanical restraint, injury from other patients, increased psychological distress and, in rare circumstances, death. It is essential that restraint and seclusion be used in a manner consistent with defined protocols for safe management of the consumer.

Rapid sedation, where it is used in mental health emergency situations as an alternative to mechanical/physical restraint, is considered restraint by consumers, carers and others, and carries its own risk of adverse events. However, at this time there is no definitive agreed definition of restraint that includes rapid sedation. Incidents and adverse medication events related to sedation, however, are considered adverse drug events.

Currently States and Territories and mental health services have a range of documented policies and/or protocols for use of these interventions. State and Territory mental health legislation includes specific requirements related to use of these interventions. The *Model Mental Health Legislation* funded under the National Mental Health Strategy for use by States and Territories when reviewing their mental health legislation, included model clauses on seclusion and restraint.

The consultation (refer Appendix 4) indicated that the safety of consumers, staff and others in situations related to restraint use was a high safety priority across sectors.

17 UN principles for the protection of people with a mental illness, Principle 11, paragraph 11.

TABLE 2:
Reducing use of, and where possible eliminating, restraint and seclusion

<p>Objectives</p>	<p>Reduced use of, and where possible elimination of, restraint in mental health emergency situations.</p> <p>Reduced use of, and where possible elimination of, restraint in mental health services.</p> <p>Reduced use of, and where possible elimination of, seclusion in mental health services.</p> <p>Reduced adverse events associated with use of restraint.</p> <p>Reduced adverse events associated with use of seclusion.</p> <p>Clear protocols guiding the use of restraint are in use in mental health services and other health services.</p> <p>Clear protocols guiding the use of seclusion are in use in mental health services and other health services.</p>
<p>Priority settings</p>	<p>Mental health services (particularly inpatient settings).</p> <p>Acute care services outside mental health services, particularly emergency departments.</p> <p>Any setting in which restraint and seclusion of consumers is practiced based on a view that they are suffering from a mental health problem.</p>
<p>Known problem areas</p>	<p>Lack of identified good practice/agreed clinical standards for the use of restraint. No national standards on appropriate use of restraint currently exist.</p> <p>Lack of identified good practice/agreed clinical standards for the use of seclusion. No national standards on appropriate use of seclusion currently exist.</p> <p>Inappropriate use of interventions and variation in practice, for example using threat of restraint or seclusion to coerce particular behaviour.</p> <p>Known adverse events associated with use of restraint and seclusion.</p> <p>Lack of staff knowledge or skills to prevent use and identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations.</p> <p>Lack of staff knowledge or skills regarding appropriate triaging of mental health presentations, particularly in emergency departments.</p> <p>Despite restraint being commonly practised in emergency departments, there is a lack of training about restraint practices and a lack of documentation and clinical audit of restraint practices.</p> <p>Aggressive and violent behaviours are common triggers for the use of restraint and seclusion. Lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint.</p>

TABLE 2: (continued)

Reducing use of, and where possible eliminating, restraint and seclusion

<p>Strategies</p>	<p>Implement and use incident monitoring and management systems for quality improvement by monitoring and managing:</p> <ul style="list-style-type: none"> • instances where restraint is used; • instances where seclusion is used; • adverse events that occur whilst a consumer is restrained (whether the injury is to consumer or other); and • adverse events that occur whilst a consumer is secluded (whether injury to consumer or other). <p>Investigate adverse events proximal to restraint and seclusion using known tools/methodologies such as Root Cause Analysis. Ensure that outcomes of such analysis are fed into quality improvement processes.</p> <p>Propose that the Australian Council for Safety and Quality in Health Care support the inclusion of all deaths in acute health care that are proximal to use of restraint and seclusion in the national set of core sentinel events.</p> <p>Develop national standards for the use of restraint. Identify good practices in the prevention, reduction and, where possible, elimination of restraint that are applicable across jurisdictions and settings.</p> <p>Develop standards for the monitoring and reporting of restraint and identifying alternatives to the use of restraint that are applicable across settings and jurisdictions.</p> <p>Develop national standards for the use of seclusion. Identify good practices in the prevention, reduction and, where possible, elimination of seclusion that are applicable across jurisdictions and settings.</p> <p>Develop standards for the monitoring and reporting of seclusion and identifying alternatives to the use of seclusion that are applicable across settings and jurisdictions.</p> <p>Develop an education and training strategy for management of aggression including techniques for prevention and de-escalation as an alternative to using restraint and seclusion. Consumer and carer experiences and participation are integrated into education and training strategies, products and activities.</p> <p>Implementation and staff education about the national triage guidelines for emergency departments and the Mental Health Triage Scale.</p> <p>Ensure mental health services and related health services (especially emergency departments and other acute care services) have in place policies and procedures for use of restraint and seclusion and consider clinical audits of restraint and seclusion as part of quality improvement processes.</p> <p>Evaluate changes in practice and outcomes.</p>
<p>Complementary/ linked strategies/ activities</p>	<p>Existing State/Territory initiatives (such as mandatory reporting of use of mechanical restraint in some States, existing legislation, protocols and policies).</p> <p>Australian Council on Healthcare Standards (ACHS) Clinical Indicators for Mental Health include seclusion indicators.</p>

Reduce adverse drug events in mental health services

Rationale

The primary focus of this priority area is to reduce **adverse drug events** in a mental health service delivery context. **Medicines** are a critical element in the treatment of many mental health disorders. However, it is essential that medicines are administered in accordance with evidence based guidelines and closely monitored. **Medication errors** can lead to serious consequences for mental health consumers, including death. Health Ministers have agreed that ‘Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs’ is a publicly reportable sentinel event. The consultation indicated that medication prescribing and administering errors were a high safety priority.

Psychotropic medicines have well known side-effects and contraindications, some of which are associated with serious adverse medication reactions if not adequately monitored. There are also a range of other adverse drug events that occur in mental health care, such as medication errors, which can be reduced through enhanced monitoring and management of psychotropic medicines. Consumers can be on psychotropic medications for long periods of time and may also be taking other medications for other conditions (eg concurrent physical illness or concurrent substance use disorders) or may be under the care of multiple health care professionals.

Mental health professionals are well aware of the occurrence of **adverse drug reactions**, however, adverse drug events in mental health service settings, including medication errors, are not well researched. A systems oriented approach to reducing adverse drug events is needed, along with a non-punitive culture that rewards error reporting and supports its use in continuous quality improvement.

The *National Mental Health Plan 2003-2008* identifies the safe and **quality use of medicines** as a key action towards improving safety. The *National Standards for Mental Health Services* state that medicines and other medical technologies are provided in a manner that promotes choice, safety and the best possible quality of life for the consumer. Standard 11.4.C specifically states that mental health services must ensure a system exists for monitoring medicines and properly treating any adverse drug events.

There are a range of initiatives in the area of quality use of medicines and medication management that are complementary to the focus of this Plan and that aim to improve the safe and quality use of psychotropic and other medicines.

TABLE 3:
Reduce adverse drug events in mental health services

<p>Objectives</p>	<p>Reduced adverse drug events (ADEs) in mental health services.</p> <p>Reduced medication errors involving psychotropic medicines within mental health services and other health services.</p> <p>Increased safe and quality use of psychotropic medicines in mental health services and other health services.</p>
<p>Priority settings</p>	<p>Mental health services.</p> <p>Hospital pharmacy services.</p> <p>Other settings, such as primary care settings and mental health consumer home/community settings (see linked strategies below).</p>
<p>Known problem areas</p>	<p>Known side-effects of common psychotropic medicines (such as the anti-psychotic clozapine and movement disorders).</p> <p>Contraindications.</p> <p>Problems related to concurrent medicines (polypharmacy) and comorbidities, for example with depression and diabetes.</p> <p>Problems related to concurrent drug and alcohol use and medicine use.</p> <p>Problems with identifying and recording all medicines that may have contributed to an adverse drug event, including prescribed medicines, illicit drugs, over-the-counter drugs and complementary medicines.</p> <p>Non-oral sedation, particularly when used in emergency psychiatric care.</p> <p>Medication error (dosage, dispensing, prescription, wrong person).</p> <p>Problems related to changing medicines, such as switching between antidepressants particularly those within the Selective Serotonin Reuptake Inhibitors (SSRI) group.</p> <p>Overdose, both intentional and accidental.</p> <p>Consumer concerns about side-effects of medicines and their impact on quality of life.</p> <p>Lack of clear mechanisms for consumers and carers to: report adverse drug events; to input into quality improvement in the use of medicines; and to provide information on their perceptions of care in relation to medicines.</p> <p>Lack of information provided to consumers about their medicines.</p> <p>Lack of information provided to carers about medicines and changes to medicines, affecting their ability to support consumers.</p> <p>Lack of knowledge of the effects of psychotropic medicines, particularly antidepressants and antipsychotics for which there is a high demand for information.</p> <p>Differing effects of prescription medicines on people from differing gender, cultural and linguistic groups, including Aboriginal and Torres Strait Islander peoples, and the need for further work to identify appropriate and safe use of prescription medicines for specific populations, such as children and adolescents, where needed.</p> <p>Related adverse events such as injury through falling. People on psychotropic medicines are at increased risk of falls.</p> <p>Weight gain as a side effect of antipsychotic medicines.</p>

TABLE 3: (continued)

Reduce adverse drug events in mental health services

Strategies	
	<p>Identify good practice in prescribing and monitoring psychotropic medicines and other evidence-based medicines in mental health services, including specific protocols to document variance from recommended prescribing guidelines, lessons and principles with potential application in other settings, consumer and carer input into decision-making and monitoring processes, communication between different treatment services, and the use of new technologies, such as electronic/computerised prescribing tools.</p>
	<p>Develop and implement medication monitoring protocols, electronic systems and documentation practices to flag safety and quality issues and improve medication management systems in mental health services. Include decision support algorithms in such electronic systems.</p>
	<p>Establish information management systems to detect and report adverse drug events in mental health services at a national level. Such systems to be integrated within existing information management systems and processes.</p>
	<p>Raise awareness of medication errors in mental health care delivery, drawing on lessons from other areas of health care in regards to systems changes and improvements.</p>
	<p>Identify good practice services/leaders and facilitate their role in influencing clinical and service management change. Include consumer and carer perspectives in clinical and service management change processes.</p>
	<p>Implement clinical practice guidelines in public and private specialised mental health services and other related services, such as primary care, hospital pharmacies, and private office-based psychiatric services.</p>
	<p>Develop information packages on the use of medicines that are designed for use by consumers and carers as part of individual care planning and integrated into discharge planning and practice. Use existing information packages where available and where they match the consumer and carer information needs.</p>
	<p>Ensure provision of accurate information to consumers, and where appropriate their carers, about the safe and quality use of their medicines. Ensure such information is integrated into the routine care planning and monitoring. This may require education of health professionals about the need to communicate with consumers about matters of concern to them, such as adverse medicine events.</p>
	<p>Evaluate changes in practice and outcomes.</p>

TABLE 3: (continued)

Reduce adverse drug events in mental health services

<p>Complementary/ linked strategies/ activities</p>	<p>The Quality Use of Medicines in Mental Health Subgroup of the Better Outcomes Implementation Advisory Group was established to work collaboratively with the Pharmaceutical Health and Rational Use of Medicines Committee (PHARM) to improve quality use of medicines in primary mental health care through the Better Outcomes in Mental Health Care initiative.</p> <p>Mainstream health policies and strategies such as National Medicines Policy, National Strategy for Quality Use of Medicines and the activities of bodies such as the Adverse Drug Reactions Advisory Committee (ADRAC), PHARM, the Australian Pharmaceutical Advisory Council (APAC), National Prescribing Service, <i>HealthConnect</i>, and the Therapeutic Goods Administration.</p> <p>Professional practice standards for the provision of Consumer Medicine Information (CMI) by pharmacists.</p> <p>Australian Council for Safety and Quality in Health Care initiatives, eg such as the national medication alert system, national sentinel event reporting, Medication Breakthrough Collaboratives, Medication Safety Innovation Awards Program, development of a common inpatient medication chart, <i>10 tips for safer health care</i>.</p> <p>Implementation of RANZCP Clinical Practice Guidelines for: major depression; schizophrenia; anorexia nervosa; bipolar disorder; and panic disorder and agoraphobia.</p> <p>Improved use of existing information products and services, for example CMI, <i>Medimate</i>, <i>Medicines Line</i>, <i>Adverse Medicine Events (AME) Line</i>, <i>Australian Adverse Drug Reactions Bulletin</i>, SANE Australia's information for consumers and carers on antipsychotic and antidepressant medicines.</p> <p>National Institute of Clinical Studies (NICS) projects and initiatives.</p> <p>Existing State and Territory initiatives, such as the Queensland Health Medication Management Service, and information pamphlets.</p> <p>ACHS Clinical Indicators for Mental Health include indicators related to prescribing patterns of psychotropic medicines.</p>
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Safe transport of people experiencing mental disorders

Rationale

A range of agencies have statutory or service responsibility for providing transport of people experiencing mental disorders, or suspected of experiencing mental disorders. Arrangements vary across jurisdictions. Frequently transport of mental health consumers, when it is not provided by carers, families or consumers themselves, is organised and undertaken by community mental health professionals. Ambulance services, police services, air services, and occasionally private companies, may also play a role in transporting mental health consumers to treatment and assessment services. While generally the transport of mental health consumers by service providers is **incident free**, it is apparent that incidents are more likely to arise in **mental health crisis situations**.

Clearly mental health consumers have the right to safe transport that minimises interference with their rights, dignity and self-respect and that avoids traumatising family members, particularly children. This right, however, needs to be balanced with the safety of the transport provider.

In the consultation (refer Appendix 4) transport providers indicated that transportation of people experiencing mental disorders is a high priority, both in terms of the safety of mental health consumers and the personal safety of staff and others. The use of **restraint**, including sedation, during transportation was also a high priority issue for transport providers.

Mental health consumers are frequently sedated and/or restrained by service providers during transportation. They may also experience significant stigma that adds to psychological distress and creates a negative perception of care.

A systems oriented approach to reducing adverse events and overly restrictive interventions during transportation is needed, along with a non-punitive culture that rewards incident reporting and supports its use in continuous quality improvement.

The least restrictive safe transport of people experiencing mental disorders cannot be achieved without considerable partnership activity between all services involved and processes that include consumer and carer participation. As many transport provider services are outside the governance structures of mental health services, developing strategies for improving safety needs to occur in consultation with the police services, ambulance services and other transport services.

TABLE 4:
Safe transport of people experiencing mental disorders

<p>Objectives</p>	<p>Mental health consumers are safe during transportation.</p> <p>Staff involved in transportation are safe.</p> <p>Reduced adverse events associated with transport of people experiencing mental disorders.</p> <p>Clear policies and protocols to ensure that the least restrictive safe transport of people experiencing a mental illness are used.</p>
<p>Priority settings</p>	<p>Mental health services.</p> <p>Ambulance services.</p> <p>Air services, for example the Royal Flying Doctor Service.</p> <p>Police services.</p> <p>Other services, such as private contractors that provide transport of mental health consumers.</p>
<p>Known problem areas</p>	<p>Emergency transportation in mental health crisis situations.</p> <p>Restraint use during transport.</p> <p>Routine use of sedation during transportation regardless of circumstances.</p> <p>Heavy sedation that requires consumers to be intubated is a major medical intervention that carries its own risks of adverse drug events.</p> <p>Reliance on police to apprehend and transport consumers known to mental health services when alternative means are available.</p> <p>Police transporting consumers without the support of clinical staff.</p> <p>Adverse events associated with transport with or without restraint use, including adverse drug events.</p> <p>Stigma experienced by consumers from emergency care providers.</p> <p>Transport from and within rural/remote settings.</p> <p>Timeliness of transport between hospitals, particularly between private and public mental health services.</p>

TABLE 4: (continued)

Safe transport of people experiencing mental disorders

Strategies	<p>Convene a cross-sector workshop to develop common directions in identifying best practice in the safe transport of people with mental illness.</p> <p>Identify good practices and policies for the safe transport of people with mental disorders, in consultation with mental health consumers and carers, mental health services and emergency services, such as emergency departments, police, ambulance, air ambulance/Royal Flying Doctor Service. Assessment/review of the suitability and design of vehicles used in transportation, including air and road ambulance and police vehicles.</p> <p>Best practices and innovations are identified and disseminated. This includes staff education and training being provided where required.</p> <p>Monitor and report instances of incidents during transportation between services and use this information for quality improvement.</p> <p>Identify good practice services/leaders and facilitate their role in influencing clinical and service management change across the services that provide transport.</p> <p>Mental health services develop protocols about working with other agencies and training staff in transporting mental health consumers.</p> <p>Clarify legislative issues in existing and future protocols about working with emergency services.</p> <p>Implement existing recommendations for joint information sharing protocols and practices in mental health crisis situations.¹⁸ Ensure clear joint protocols and practices for sharing information in mental health crisis situations between mental health services and relevant emergency services are in place.¹⁹</p> <p>Develop mechanisms to improve skills, competence and confidence of mental health professionals in engaging with their consumers and carers.</p> <p>Identify and/or develop models of transportation practice where mental health consumer or carer advocates/representatives are involved in supporting mental health consumers and carers during, or prior to, transportation.</p> <p>Evaluate changes in practice and outcomes.</p>
Complementary/ linked strategies/ activities	<p>Existing State/Territory initiatives, such as the South Australian policy on emergency transport of mental health consumers from country locations.</p>

18 Recommendations regarding establishing such information sharing protocols can be found in – Expert Advisory Committee on Information Sharing in Mental Health Crisis Situations (2000) *Toward a national approach to information sharing in mental health crisis situations*, Commonwealth Department of Health and Aged Care, February 2000.

19 *ibid.*

Section 4: Glossary

The definitions in this glossary, where possible, are drawn from the *National Mental Health Plan 2003-2008* glossary and from the Australian Council for Safety and Quality in Health Care shared meanings project.

- Accreditation** A formal process to ensure delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services.
Source: Australian Council for Safety and Quality in Health Care
Public recognition of achievement by a healthcare organisation, of requirements of national healthcare standards.
Source: International Society for Quality in Health Care Inc
- Adverse drug event** A particular type of adverse drug event where a drug or medication is implicated as a causal factor in the adverse event. This encompasses both harm that results from the intrinsic nature of medicine (an adverse drug reaction) as well as harm that results from medication errors or system failures associated with the manufacture, distribution or use of medicines.
Source: Australian Council for Safety and Quality in Health Care
- Adverse drug reaction** A response to a drug which is noxious and unintended, and which occurs at doses normally used or tested in humans for the prophylaxis, diagnosis, or therapy of disease, or modification of physiological function.
Source: Therapeutic Goods Administration
- Adverse event** An incident in which unintended harm resulted in a person receiving health care.
Source: Australian Council for Safety and Quality in Health Care
NB: This includes suicide and self harm.
- Advocacy** Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.
Source: *National Mental Health Plan 2003-2008*
- Advocates** People who have been given the power by consumers to speak on their behalf, who represent the concerns and interest of the consumer as directed by the consumer, and seek the outcomes desired by the consumer. Although government and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer.
Source: *Mental Health Statement of Rights and Responsibilities*
An advocate might also speak on behalf of a carer.

Benchmarking	<p>Benchmarking is concerned with the systematic process of searching for and implementing a standard of best practice within individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture.</p> <p>Source: Bullivant JRN (1994) <i>Benchmarking for continuous improvement in the public sector</i>. Longman, United Kingdom. As used in <i>National Mental Health Plan 2003-2008</i>.</p>
Breakthrough collaborative	<p>A cooperative effort which brings together health care organisations with a common commitment to redesign an aspect of their care (such as medication) and make rapid and sustainable changes to produce positive results in their organisations. It relies on the spread and adaptation of existing knowledge to multiple sites in order to accomplish a common aim, engaging multidisciplinary teams and creating partnerships between managers and clinicians.</p> <p>Source: Australian Council for Safety and Quality in Health Care</p>
Carer	<p>A person whose life is affected by virtue of a family or close relationship and caring role with a consumer.</p> <p>Source: <i>National Mental Health Plan 2003-2008</i></p>
Casemix	<p>A classification system that combines episodes of care into clinically meaningful groups, such that episodes within a given group require the same level of resources.</p> <p>Source: <i>National Mental Health Plan 2003-2008</i></p>
Clinical Audit	<p>The process of reviewing the delivery of care against known or best practice standards to identify and remedy deficiencies through a process of continuous quality improvement.</p> <p>Source: Australian Council for Safety and Quality in Health Care – Management Information Group</p>
Clinical governance	<p>See Governance.</p>
Indicator	<p>A measure of clinical management and outcomes of care; a method of monitoring care and services which attempts to identify problem areas and evaluate trends, in order to direct attention to issues requiring further review.</p> <p>Source: <i>National Mental Health Plan 2003-2008</i></p>
Clinical privileges	<p>The scope of clinical practice which a health professional is authorised to undertake within an organisation.</p> <p>Source: Australian Council for Safety and Quality in Health Care</p>
Consumer	<p>A person who is currently using, or has previously used, a mental health service.</p> <p>Source: <i>National Mental Health Plan 2003-2008</i></p> <p>NB: The Australian Council for Safety and Quality in Health Care refers to patient safety. In this Plan consumer is used rather than patient.</p>

Consumer Medicine Information	Consumer Medicine Information (CMI) is designed to inform consumers about prescription and pharmacist only medicines. CMI leaflets are produced by the pharmaceutical company that makes the particular medicine. They might be included in the medicine package, but can always be requested from the pharmacist or doctor.
Corporate governance	See Governance.
Crisis assessment teams	Mental health teams that provide 24-hour mobile support and intervention for people who are being considered for psychiatric hospital admission. Crisis assessment teams also provide treatment and support for people whose acute mental illness can be managed in the community. Source: <i>National Mental Health Plan 2003-2008</i>
Discharge planning	Discharge planning is a process for ensuring transfer of care of a consumer between service providers. Discharge planning results in a formal written discharge plan, the aim of which is to ensure continuity of services that are necessary for successful community living. The discharge plan is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit. It includes medical information, follow-up appointments and the desired outcomes of treatment. The process of discharge planning begins at the time of admission. Barriers to discharge are identified at the time of admission and specific planning initiated to address these barriers, for example anticipated difficulties in finding suitable accommodation. The relevant stakeholders who are not directly involved in the discharge planning should also be notified of the anticipated discharge date, for example general practitioner, supported accommodation provider. Source: Adapted from a SA Department of Human Services definition.
Early Intervention	Timely interventions that target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of a patient suffering from a first episode of disorder. Source: <i>National Mental Health Plan 2003-2008</i>
Error	Error will be taken as a generic term to encompass all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some change agency. Error (active) – an error in which the effects are felt almost immediately. Source: Reason 1990, obtained from Australian Council for Safety and Quality in Health Care shared meanings project. Error (latent) – an error whose adverse consequence may lie dormant within the system for a long time, only becoming evident when they combine with other factors to breach the system's defences. Source: Rasmussen, Pejtersen and Goldstein 1994 – obtained from Australian Council for Safety and Quality in Health Care shared meanings project.

Governance

The traditions and institutions by which authority in a country is exercised for the common good. This includes (i) the process by which those in authority are selected, monitored and replaced, (ii) the capacity of the government to effectively manage its resources and implement sound policies, and (iii) the respect of citizens and the state for the institutions that govern economic and social interactions among them.

Source: World Bank Institute

Clinical governance: The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Source: National Health Service (UK)

Corporate governance: Corporate governance encompasses the arrangements by which the power of those in control of the strategy and direction of an entity is both delegated and limited to enhance prospects for the entity's long-term success, taking into account risk and the environment in which it is operating...it is noted that there is no universally accepted definition of corporate governance, or agreement on structures and practices that are required to achieve good governance.

Source: Department of Finance – www.finance.gov.au/governancestructures/

Harm

Death, disease, injury, suffering, and or disability experienced by a person.

Source: Australian Council for Safety and Quality in Health Care

Iatrogenic

Arising from or associated with health care rather than an underlying disease or injury. Consequences of omission (failing to do the right thing) as well as commission (doing the wrong thing) are included.

Source: Australian Council for Safety and Quality in Health Care

Incident

An event or circumstance which could have, or did lead to, an unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage.

Source: Australian Council for Safety and Quality in Health Care

Incident Reporting

A method of collecting detailed qualitative data about any unintended incident, no matter how seemingly trivial or commonplace, which could have or did harm anyone, patient, staff or visitor. The incident may or may not have been preventable, and may or may not have involved an error on the part of the health care team.

Source: Tito F. *Compensation and Professional Indemnity in Health Care*. Canberra AGPS 1996.

Incident reporting and management system

Incident reporting and management systems collect information about the number, nature and causes of adverse events in health care. Incident management systems are a valuable tool for identifying trends in incident types and identifying improvement opportunities across health service organisations and health-care systems for better management of risks and systems of care.

Based on ACSQHC fact sheet on incident management systems.

Informed consent

Informed consent is consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered, after appropriate disclosure to the patient, adequate and understandable information in a form and language demonstrably understood by the patient.

Such answers and disclosures must be sufficient to enable the consumer to make a fully informed decision based on all relevant factors including the nature of treatment involved, the range of other options and the possible outcomes and implications for the consumer and others.

Source: *National Standards for Mental Health Services*. Acknowledged in the Standards as adapted from *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, June 1992 with the assistance of the Mental Health Legal Centre (Vic).

Quality Use of Medicines (QUM)

Quality use of Medicine (QUM) means:

- selecting management options wisely;
- choosing suitable medicines if a medicine is considered necessary; and
- using medicines safely and effectively.

Source: Commonwealth Department of Health and Ageing (2002) *The National Strategy for Quality Use of Medicines*

Medicine

The term medicine includes prescription, non-prescription and complimentary medicines.

Source: Commonwealth Department of Health and Ageing (2002) *The National Strategy for Quality Use of Medicines*

Medication Error

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, products labelling, packaging, and nomenclature, compounding, dispensing, administration, education, monitoring, and use.

Source: National Coordination Council for Medication Error Reporting and Prevention – <http://www.nccmerp.org>

Medimate

Medimate is a brochure produced by the National Prescribing Service (NPS) to help consumers find, understand and use information about medicines. *Medimate* encourages consumers to do this in partnership with their doctors, pharmacists and other health care professionals.

Mental disorder

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may be a recognised, medically diagnosable illness or disorder.

Source: *Mental Health Statement of Rights and Responsibilities* 1991

Mental illness

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-IVR) or the *International Classification of Diseases*, 10th Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10). Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003-2008. In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

Source: *National Mental Health Plan 2003-2008*

Mental health crisis situation

A series of events and a combination of circumstances in which a person appears to be mentally disturbed, or impaired in judgement and/or exhibiting highly disordered behaviour. It is a situation that may involve serious and imminent risk to the health and/or safety of the person or another person. It is a situation that requires communication and coordination between relevant services and assessment at the earliest possible point to:

- ascertain the need for treatment;
- prevent further deterioration in the mental condition and or physical health of the person;
- thereby prevent or lessen harm to the safety and health of the person or any other person or to the safety and health of the public in general.

Source: Expert Advisory Committee on Information Sharing in Mental Health Crisis Situations (2000) *Toward a national approach to information sharing in mental health crisis situations*, Commonwealth Department Health and Aged Care, February 2000.

Mental health sector

Includes the specialist mental health sector (both public and private) and elements of the primary care sector providing mental health care.

Source: *National Mental Health Plan 2003-2008*

Mental health services

Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

Source: Mental Health Establishment National Minimum Data Set Specifications

Open disclosure

The process of reporting of adverse events which have resulted in unintended harm to a patient while receiving health-care and the associated investigation and recommendations for improvement.

Source: Australian Council for Safety and Quality in Health Care

Polypharmacy

Polypharmacy is the concurrent use of multiple medications. It can be associated with the prescription use of too many or unnecessary medicines at dosages or frequencies higher than therapeutically essential. However, multiple medications are often necessary and can constitute best care for patients.

Source: National Prescribing Service (2000) *NPS News 13*, October 2000

Private sector mental health services

Specialised health services that are specifically designed for people with a mental problem or mental disorder seeking treatment in the private sector. In Australia, private sector mental health services include the range of mental health care and services provided by psychiatrists in private practice, and those inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits. Private sector services may also include services provided in general hospital settings and services provided by general practitioners and by other allied health professionals.

Source: *National Mental Health Plan 2003-2008*

Primary care sector

The primary care sector includes general practitioners and other primary care providers, such as emergency departments and community health centres, as well as others who are integrally involved in the detection, diagnosis and treatment of mental illness and/or have much to offer in terms of promoting mental health.

Source: *National Mental Health Plan 2003-2008*

Rapid tranquilisation (also known as rapid sedation)

The use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquilisation may lead to deep sedation/anaesthesia.

Source: National Institute of Clinical Excellence (2005) *Clinical Guideline 25: Violence: the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*. UK.

Restraint²⁰

Restraint is a restrictive intervention that relies on external controls to limit the movement or response of a person.

Restraint can be viewed in three modalities: physical (or bodily) restraint, mechanical restraint, or rapid tranquillisation only where it is used as an alternative to physical or mechanical restraint (pharmacological restraint).

Physical (or bodily) restraint refers to the use of physical force to prevent a person from placing themselves in a dangerous situation or harming themselves or others.

Mechanical restraint refers to the application of a device, materials or equipment (including belt, harness, manacle, sheet and strap) to prevent, restrict or subdue the voluntary movement of any part of the person's body without consent.

²⁰ Views of what is restraint vary in this difficult area of intervention. The definitions in this glossary are the agreed working definitions of the Safety and Quality in Mental Health Partnership Group and have been drawn from a variety of sources.

Pharmacological restraint is where mental health consumers are rapidly and heavily sedated in emergency situations, or for transportation, as a direct alternative to mechanical or physical restraint. This is often referred to as ‘chemical restraint’, but this term is not preferred and is considered inappropriate.

Root Cause Analysis (RCA)

A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence of adverse events. Typically, the analysis focuses on systems and processes, and not just individual performance.

Source: Braithwaite J, Healy J & Dwan K (2005) *The Governance of Health Safety and Quality: A Discussion Paper*, Commonwealth of Australia.

Safety

Avoidance, or reduction to acceptable levels, of actual or potential harm from mental health care delivery or the environment in which mental health care is delivered.

Source: adapted from the National Health Performance Committee’s National Health Performance Framework.

Safety is a key component of quality and involves minimising the likelihood of potential harm from mental health care.

Source: *National Mental Health Plan: 2003-2008*.

Seclusion

The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of ‘time out’ where a patient is requested to seek voluntary social isolation for a minimum period of time.

Source: United Nation’s *Principles for the protection of people with mental illness and the improvement of mental health care*.

Sentinel events

Events in which death or serious harm to a patient has occurred. They signal catastrophic system failure and have the potential to seriously undermine public confidence in health-care system.

Source: Australian Council for Safety and Quality in Health Care.

Standards

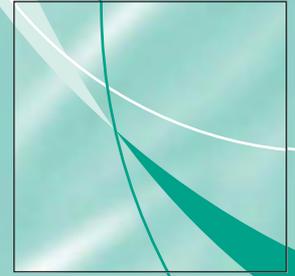
Clinical practice standards are defined in agreed clinical procedures and practices for the optimal treatment and care of people with mental illness. Service standards define what is required for quality mental health services.

Source: *National Mental Health Plan 2003-2008*

Agreed attributes and processes designed to ensure that the product, service or method will perform consistently at a designated level.

Source: Australian Council for Safety and Quality in Health Care

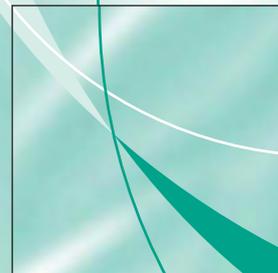
Section 5: Appendices



- Appendix 1** Safety and Quality in Mental Health Partnership Group Membership
- Appendix 2** Australian Council for Safety and Quality in Health Care Resources
- Appendix 3** Patient Safety and Quality in Mental Health Services Project Report Recommendations
- Appendix 4** Consultation on priority safety issues in mental health
- Appendix 5** National Standards for Mental Health Services
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- Appendix 7** Examples of risk matrices
- Appendix 8** National Core Sentinel Events
- Appendix 9** Governance structure for mental health safety and quality
- Appendix 10** References
- Appendix 11** Selected resources for further reading

Appendix 1:

Safety and Quality in Mental Health Partnership Group Membership



The membership of the National Mental Health Working Group's Safety and Quality in Mental Health Partnership Group as at February 2005 is:

Dr Aaron Groves, National Mental Health Working Group (Chair)
Dr Rowan Davidson, Western Australian representative
Dr Cassandra Griffin, Queensland representative
Associate Professor Amgad Tanaghow, Victorian representative
Dr Peter Norrie, Tasmanian representative
Dr Peggy Brown, Australian Capital Territory representative
Dr Grant Sara, New South Wales representative
Dr Jonathan Phillips, South Australian representative
Ms Bronwyn Hendry, Northern Territory representative
Ms Anna Saminsky, consumer nominee
Mr Tony Fowke, carer nominee
Dr Yvonne White, Strategic Planning Group for Private Psychiatric Services
Ms Suzy Saw, Australian Government representative
Ms Liz Ruck, Office of the Safety and Quality Council representative
Dr Andrew Wilson, Royal Australian and New Zealand College of Psychiatrists
Ms Ruth Catchpoole, Information Strategy Committee representative
Mr Jeremy Skipworth, New Zealand Ministry of Health representative

Alternate membership and delegates:

Dr Bill Pring, Strategic Planning Group for Private Psychiatric Services
Mr Phillip Taylor, Strategic Planning Group for Private Psychiatric Services
Dr David Barton, Royal Australian and New Zealand College of Psychiatrists
Ms Rebecca Graham and Ms Magdalena Madden, South Australia
Ms Christine Waller, Australian Capital Territory

Appendix 2:

Australian Council for Safety and Quality in Health Care Resources

Resources published by the Australian Council for Safety and Quality in Health Care are available at: www.safetyandquality.org.

A selected list of resources follows. Many of these resources are directly relevant to mental health service provision, particularly inpatient care.

Fact Sheets

- National Open Disclosure Standard
- Minimum data set for safety and quality
- Hospital assessment and review
- Adverse event rates
- Charting the safety and quality of health care
- Better practice guidelines on complaints management
- Credentialling and finding the scope of clinical practice
- Human Factors in Health Care
- Safety Innovations in Practice program
- 5 step correct patient, correct site, correct procedure protocol
- Incident Management Systems
- National Medication Chart
- Pharmaceutical Review: Improving Medication Safety in Hospitals
- Sentinel Events
- Ten Tips for Safer Health Care
- Introducing the Australian Council for Safety and Quality in Health Care

Recent publications

- Achieving Safety and Quality Improvements in Health Care – Sixth Report to the Australian Health Ministers' Conference
- Partnerships for health in action: promoting consumer and community involvement in health care improvement
- State and Territory Highlights: Improving Patient Safety
- The Governance of Health Safety and Quality – A Discussion Paper
- National Patient Safety Education Framework and Bibliography
- A Patient Safety Management Systems Checklist
- Clinical Handover and Patient Safety – Literature Review Report
- Safe Staffing Consultation Report

- Credentialling and Defining the Scope of Clinical Practice Handbook
- Charting the Safety and Quality of Health Care in Australia
- Standard for credentialling and defining the scope of clinical practice
- Better Practice Guidelines on Complaints Management for Health Care Services and accompanying Complaints Management Handbook
- Report on the Safety Innovations In Practice (SIIP) Program Mark II
- Setting the human factor standards for health care: Do lessons from Aviation Apply?
- Emerging Issues for Systems' Improvement: National Implications

Appendix 3:

Patient Safety and Quality in Mental Health Services Project Report Recommendations

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

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

D. Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

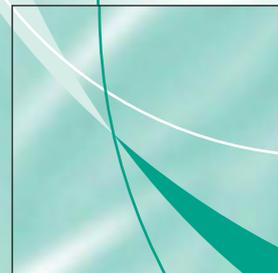
Recommendations 15: A national agreed clinical governance framework for mental health services should be developed, to improve public reporting of progress, and enhance the development of tools, in improving quality and safety in the National Mental Health Report.

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

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

Appendix 4:

Consultation on priority safety issues in mental health



In March 2004 a survey was sent to a wide range of stakeholders to seek their views on national priority safety issues in mental health. The survey asked each organisation to indicate the most relevant identified issues, and to prioritise the issues for their area of service delivery/representation. The survey also provided an opportunity for additional safety issues of specific relevance to their organisation to be specified.

Stakeholders consulted

The survey was sent to 72 organisations, including:

- National consumer and carer organisations, including the Mental Health Council of Australia
- State and Territory mental health representatives of the Safety and Quality in Mental Health Partnership Group
- Royal Australian and New Zealand College of Psychiatrists
- Australian New Zealand College of Mental Health Nurses (all branches)
- Australian Psychological Society
- Australian Association of Social Workers
- Occupational Therapy Association
- Strategic Planning Group for Private Psychiatric Services
- Australian Council for Safety and Quality in Health Care
- The Australian Council on Healthcare Standards
- Australian Government Health Priorities and Suicide Prevention Branch
- Police services agencies at the State and Territory and Federal level
- Ambulance services in each State and Territory
- Royal Flying Doctor Service and air ambulance services in each State and Territory
- Australasian College for Emergency Medicine
- Divisions of General Practice in each State and Territory

Priorities identified

This consultation identified a number of consensus issues:

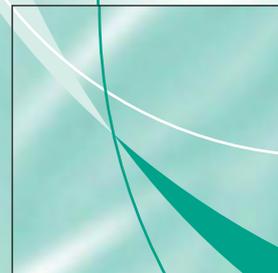
- Suicide assessment and management
- Clinical governance
- Personal safety
- Deliberate self-harm
- Restraint
- Transport of people in involuntary care
- Medication prescribing and administering errors
- Seclusion

The survey respondents also raised a number of other key safety issues of concern in mental health. Issues raised are listed below.

- **Aggression**
 - Inpatient and Emergency Department patient assaults.
 - Physical aggression towards staff and other patients.
 - Verbal abuse towards staff and other patients.
 - Home visiting clients – especially when there may be a past history of aggression in particular circumstances (from the client or other household member).
 - The identification of past/current history of violence at the point of assessment which is communicated to treating team.
 - Deliberate harm to others, in particular homicide.
 - Elimination of sexual harassment / assault.
- **Resource issues**
 - Access to involuntary beds-occasions when involuntary beds can not be accessed when required for an at risk person.
 - Emergency department overcrowding.
 - Lack of appropriate funding for specialising and close observation of at risk people.
 - The inappropriate use of police officers as guards of mental health patients in health facilities.
 - The lack of intensive case management and support for people with exceptional needs, specifically where mental illness is aligned with substance abuse.
- **Workforce issues**
 - Accreditation and training of overseas psychiatrists
 - Duty of care in relation to the management of voluntary patients who abscond from a health service.
 - Ensuring adequate education of mental health workers in both clinical and risk management/safety areas – undergraduate, postgraduate and ongoing workplace education.
 - Interface between private and public mental health services, ie difficulties related to responsibility for involuntary patients.
- **Discharge process and continuity of care**
 - Lack of adequate resources in the community upon discharge.
 - Premature discharge from a mental health unit because of bed shortages.
 - Appropriate discharge planning/risk assessment.
- **Medications and illicit drugs**
 - Illicit substance control whilst a consumer is in a mental health facility.
 - The development of strategies to educate culturally and linguistically diverse consumers, carers, and families in the safe and quality use of medicines.
 - The development of education materials for the mental health workforce on prescribing and dispensing of medications for people of culturally and linguistically diverse background
- **Electro convulsive therapy pathway/standards of practice**
- **Protection of vulnerable patients**

Appendix 5:

National Standards for Mental Health Services



The *National Standards for Mental Health Services* are a key mechanism for assuring the quality of mental health services. They were endorsed by the AHMAC National Mental Health Working Group in 1996, with a commitment from all jurisdictions to implementation. This commitment was affirmed in the Australia Health Care Agreements 1998-2003 and the related mental health Information Development Plans agreed between the Australian Government and each State/Territory.

The *National Standards for Mental Health Services* were developed based on widespread consultation and field trialling to ensure their applicability to public specialised mental health services. The standards are intended to:

- Work alongside existing accreditation standards for the health care system, such as the disability service standards;
- Serve as a tool for states and territories in monitoring the achievement of standards through service/funding agreements;
- Provide a blueprint for development of new and changing mental health services; and
- Provide a basis for informing consumers and carers of what they can expect from mental health services; and
- Be used by consumers and carers when providing feedback on the services they receive.

Implementation of the *National Standards for Mental Health Services* means formal in-depth review of mental health services against the Standards by an external accreditation body.

External accreditation agencies, such as the Australian Council on Healthcare Standards (ACHS) and the Quality Improvement Council (QIC), undertake accreditation processes in relation to a parent health organisation (for example a hospital, a community mental health service) which may cover a number of specialist services including mental health services.

Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the *National Standards for Mental Health Services*. Accreditation of a parent health organisation per se does not assess for, or provide information on, implementation of the *National Standards for Mental Health Services*. Assessment of a service against the Standards must be requested and involves a separate review process. Such reviews may take place in conjunction with, or separately to, overall accreditation of a parent organisation. Review against the Standards will, in some cases and in some jurisdictions, be delayed until an appropriate point is reached within the mid-term overarching accreditation cycle (for example mid-term review).

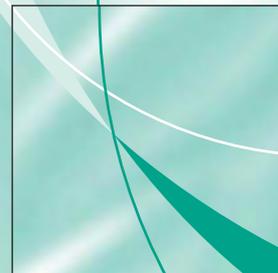
The *National Standards for Mental Health Services* cover :

1. Rights
2. Safety
3. Consumer and carer participation
4. Promoting community acceptance
5. Privacy and confidentiality
6. Prevention and mental health promotion
7. Cultural awareness
8. Integration
 - Service integration
 - Integration with the health system
 - Integration with other sectors
9. Service development
10. Documentation
11. Delivery of care
 - Access
 - Entry
 - Assessment and review
 - Treatment and support
 - Community living
 - Supported accommodation
 - Medication and other medical technologies
 - Therapies
 - Inpatient care
 - Planning for exit
 - Exit and re-entry

Progress in implementing the *National Standards for Mental Health Services* is reported annually in the *Report on Government Services* and in the *National Mental Health Report*.

Appendix 6:

National Practice Standards for the Mental Health Workforce



The *National Practice Standards for the Mental Health Workforce* were endorsed by the AHMAC National Mental Health Working Group in September 2002. They are based upon, and are designed to be used in conjunction with, the *National Standards for Mental Health Services*.

The *National Practice Standards for the Mental Health Workforce* are specifically targeted to the following professions: psychiatry, nursing, social work, psychology, and occupational therapy. They are intended to complement each of the professional groups' discipline specific practice standards or competencies, and to address the shared knowledge and skills required when working in a multi-disciplinary mental health environment.

The *National Practice Standards for the Mental Health Workforce* outline the knowledge, skills and attitudes required when individual members of these five professions work in a mental health service. Others involved in service provision for people with a mental illness may find these national practice standards useful, including: general practitioners, home and community care service providers, hospital staff providing acute care, and family and other carers. They also offer a strategic national framework for the education and training of the future mental health workforce and it is anticipated that they could be utilised to:

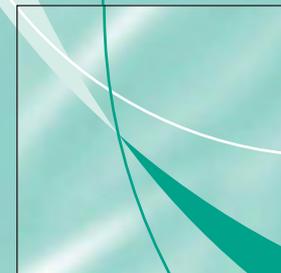
- promote clinical best practice;
- identify appropriate skill levels and workplace training and education needs;
- guide clinical supervision, mentoring and continuing education; and
- influence the development of relevant undergraduate and postgraduate curricula.

The twelve practice standards are:

1. Rights, Responsibility, Safety and Privacy
2. Consumer and Carer Participation
3. Awareness of Diversity
4. Mental Health Problems and Mental Disorders
5. Promotion and Prevention
6. Early Detection and Intervention
7. Assessment, Treatment, Relapse Prevention and Support
8. Integration and Partnership
9. Service Planning, Development and Management
10. Documentation and Information Systems
11. Evaluation and Research
12. Ethical Practice and Professional Responsibilities

Appendix 7:

Examples of risk matrices



Example 1. Open Disclosure Standard – Appendix D

Example of matrix for initial assessment of level of response

The following table is an example of a matrix to assess the level of response to an adverse event/incident. The matrix used will vary depending on local policies.

Assessment of level of response

Level of Response	Consequence	Action
High	Death or major permanent loss of function not related to the natural condition of the patient	Immediately notify individual responsible for clinical risk management.
	Permanent lessening of bodily function not related to underlying condition of patient or where surgical intervention or transfer to higher level of care required (eg transfer to ICU)	Disclosure by senior medical practitioner or alternate with support where indicated
Low	No permanent Injury nor increased level of care required	Local management, incident report. Disclosure by senior health care professional

Example of incident grading matrix

The following table is an example of a matrix for grading an Incident to determine the level of investigation required. The matrix used will vary depending on the policy of the organisation.

The tables are reproduced from AS/NZS 4360 *Risk management*. It is strongly recommended that users of the Open Disclosure Standard consult the complete AS/NZS 4360 for the context in which this table is presented and for detailed information on its use and application.

TABLE 1:
Qualitative measures of consequence or impact

Level	Descriptor	Example detail description
1	Insignificant	No injuries, low financial loss
2	Minor	First aid treatment, on-site release immediately contained, medium financial loss
3	Moderate	Medical treatment required, on-site release contained with outside assistance, high financial loss
4	Major	Extensive injuries, loss of production capability, off-site release with no detrimental effects, major financial loss
5	Catastrophic	Death, toxic release off-site with detrimental effect, huge financial loss

Measures used should reflect the needs and nature of the organisation and activity under study.

TABLE 2:
Qualitative measures of likelihood

Level	Descriptor	Description
A	Almost certain	Is expected to occur in most circumstances
B	Likely	Will probably occur in most circumstances
C	Possible	Might occur at some time
D	Unlikely	Could occur at some time
E	Rare	May occur only in exceptional circumstances

Measures used should reflect the needs and nature of the organisation and activity under study.

TABLE 3:
Qualitative risk analysis matrix – level of risk

Likelihood	Consequences				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
A (almost certain)	H	H	E	E	E
B (likely)	M	H	H	E	E
C (moderate)	L	M	H	E	E
D (unlikely)	L	L	M	H	E
E (rare)	L	L	M	H	H

The number of categories should reflect the needs of the study.

Legend:

E extreme risk; immediate action required

H high risk; senior management attention needed

M moderate risk; management responsibility must be specified

L low risk; manage by routine procedures

Source:

Australian Council for Safety and Quality in Health Care (2003) *Open Disclosure Standard: a National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care*, Commonwealth of Australia, July 2003. pp 37-39.

<http://www.safetyandquality.org>

Example 2. Safety Assessment Code (SAC) Matrix

		Severity			
		Catastrophic	Major	Moderate	Minor
Probability	Frequent	3	3	2	1
	Occasional	3	2	1	1
	Uncommon	3	2	1	1
	Remote	3	2	1	1

How the SAC matrix works

When you pair a severity category with a probability category for either an actual event or close call, you will get a ranked matrix score:

- highest risk = 3
- intermediate risk = 2
- lowest risk = 1

These ranks, or *Safety Assessment Codes (SAC)*, can then be used for doing comparative analysis.

Severity Categories:

Key factors for the severity categories are:

- extent of injury
- length of stay
- level of care required for remedy

-and- actual or estimated physical plant costs. These categories apply to actual adverse events and potential events (close calls). For actual adverse events, assign severity based on the patient's actual condition. If the event is a close call, assign severity based on the most likely 'worst case', systems level scenario.

Catastrophic	Major
<p>Patients with Actual or Potential: Death or major permanent loss of function (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying condition (i.e., acts of commission or omission).</p> <ul style="list-style-type: none"> • Suicide (inpatient or outpatient) • Rape • Hemolytic transfusion reaction • Surgery/Procedure on the wrong patient or wrong body part • Infant abduction or infant discharge to the wrong family <p>Death or major permanent loss of function that is a direct result of injuries sustained in a fall; or associated with an unauthorized departure from an around-the-clock treatment setting; or the result of an assault or other crime.</p> <p>Visitors and Staff Death; or Hospitalization of 3 or more (includes outpatients)</p>	<p>Patients with Actual or Potential: Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying conditions (i.e., acts of commission or omission).</p> <ul style="list-style-type: none"> • Disfigurement Surgical intervention required • Increased length of stay of more than 3 patients • Increased level of care for more than 3 patients <p>Visitors More than 3 visitors requiring evaluation and treatment</p> <p>Staff More than 3 lost time or restricted duty injuries or illnesses</p> <p>Equipment or facility Damage more than \$100,000</p>

Moderate	Minor
<p>Patients with Actual or Potential: Increased length of stay for up to three patients; or Increased level of care for up to three patients.</p> <p>Visitors Evaluation and treatment for up to three visitors</p> <p>Staff Less than three lost time or restricted duty injuries or illnesses</p> <p>Equipment or facility Damage more than \$10,000 but less than \$100,000</p>	<p>Patients with Actual or Potential: No increased length of stay or increased level of care</p> <p>Visitors Evaluated and no treatment required or refused treatment</p> <p>Staff No lost time or restricted duty injuries or illnesses</p> <p>Equipment or facility Damage less than \$10,000</p>

Probability:

In order to assign a probability rating for an adverse event or close call, it is ideal to know how often it occurs *at your facility*. Sometimes the data will be easily available because it is routinely tracked. Sometimes getting a feel for the probability of events which are not routinely tracked will mean asking for a quick or informal opinion from staff most familiar with those events. Sometimes it will have to be your best educated guess.

- **Frequent** – Likely to occur immediately or within a short period of time (may happen several times in one year).
- **Occasional** – Probably will occur in time (may happen several times in 1 to 2 years).
- **Uncommon** – Possible to occur in time (may happen sometime in 2 to 5 years).
- **Remote** — Unlikely to occur (may happen sometime in 5 to 30 years).

Source:

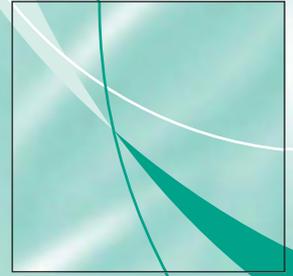
The SAC information above is reprinted directly from the US Department of Veterans Affairs National Centre for Patient Safety (NCPS):

<http://www.patientsafety.gov/> (NCPS homepage)

<http://www.patientsafety.gov/matrix.html> (direct link to matrix)

Appendix 8:

National Core Set of Sentinel Events



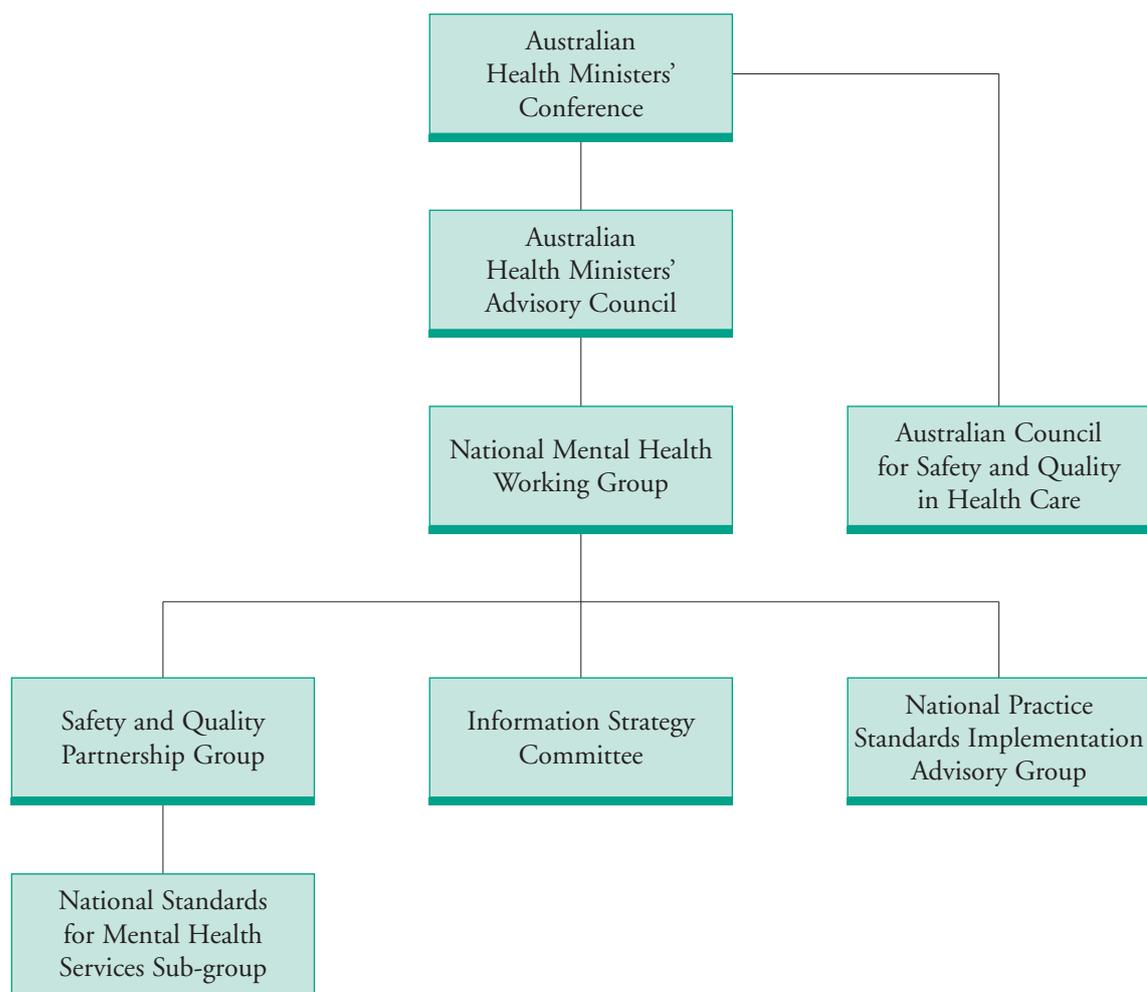
The Australian Council for Safety and Quality in Health Care has worked closely with all jurisdictions to develop a national core set of sentinel events. The agreed national list of core sentinel events consists of:

1. Procedures involving the wrong patient or body part
2. Suicide of a patient in an inpatient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurological damage
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
7. Maternal death or serious morbidity associated with labour or delivery
8. Infant discharged to the wrong family.

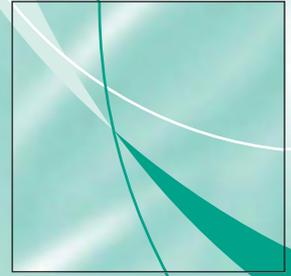
Appendix 9:

Governance structure for mental health safety and quality

The governance structure below shows the key National Mental Health Working Group subcommittees driving national safety and quality improvement initiatives in mental health services. The diagram describes the reporting lines and relationships of the main bodies responsible for leading safety and quality improvement nationally, including the directions in the Plan. Other national groups such as the National Advisory Council on Suicide Prevention and the Pharmaceutical Health and Rational Use of Medicines Committee are also important to national safety and quality improvement in mental health, as are other subcommittees of the National Mental Health Working Group not illustrated here.



Appendix 10: References



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- Australian Health Ministers (2003) *National Mental Health Plan 2003-2008*, Australian Government, Canberra, July 2003.
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- NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005) *Key Performance Indicators for Australian Public Mental Health Services. ISC Discussion Paper No. 5* Australian Government Department of Health and Ageing, Canberra.
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Appendix 11:

Selected resources for further reading

Following are some selected resources relevant to safety and quality issues in mental health. Preference has been provided to accessible resources relevant to the priorities identified in this Plan. The lists are by no means exhaustive.

Website links and phone lines were accurate at the time of printing. Responsibility for the content of the listed resources rests with the respective authors.

Safety and quality in general

Australasian Cochrane Centre
<http://www.cochrane.org.au>

Australian Council for Safety and Quality in Health Care
<http://www.safetyandquality.org>

Australian Council on Healthcare Standards
<http://www.achs.org.au>

Australian Patient Safety Foundation.
<http://www.apsf.net.au>

Australian Resource Centre for Healthcare Innovations (ARCHI)
<http://www.archi.net.au>

Doing Less Harm: Improving the safety and quality of care through reporting, analysing and learning from adverse incidents involving NHS patients – Key requirements for health care providers (UK publication).
<http://www.health.vic.gov.au/clinrisk/nhsrisk.pdf>

Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-Based Mental Health Care.
http://www.spgpps.com.au/documents/spgpps/general_documents/Guidelines_Benefits.pdf

Institute for Health Care Improvement.
<http://www.ihc.org/resources/btsguides/>

International Society for Quality in Health Care Inc.
<http://www.isqua.org.au/>

Joint Commission on Accreditation of Healthcare Organizations, USA.
<http://www.jcaho.org>

Key Performance Indicators for Australian Public Mental Health Services
<http://www.health.gov.au/mentalhealth>

Mental Health National Outcomes and Casemix Classification.
<http://www.mhnocc.org>

- National Centre for Patient Safety, US National Veterans Administration Health.
<http://www.patientsafety.gov/>. Includes the Safety Assessment Code matrix –
<http://www.patientsafety.gov/matrix.html>
- National Mental Health Strategy publications.
<http://www.health.gov.au/mentalhealth>
- National Practice Standards for the Mental Health Workforce
<http://www.health.gov.au/mentalhealth>
- National Standards for Mental Health Services
<http://www.health.gov.au/mentalhealth>
- National Triage Scale, ACEM.
<http://www.acem.org.au/open/documents/triage.htm>
- Quality Improvement Council
<http://www.qic.org.au>
- Report on Incident Management in the NSW Public Health System 2003-2004.
http://www.health.nsw.gov.au/pubs/2005/incident_mgmnt.html
- Safer Health Care (International site).
<http://www.saferhealthcare.org.uk/ihi>
- To Err is Human: Building a Safer Health System.*
<http://books.nap.edu/books/0309068371/html/index.html>
- UK National Institute of Clinical Excellence (NICE).
<http://www.nice.org.uk>
- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of
Mental Health Care
<http://www.unhcr.ch/html/menu3/b/68>
- Victorian Department of Human Services, Clinical Risk Management.
<http://www.health.vic.gov.au/clinrisk/>.
- Victorian Department of Human Services, Sentinel Event Annual Report.
<http://www.health.vic.gov.au/clinrisk/sentin.htm#anrep0304>
- Victorian Department of Human Services – Strategy for safety and quality in public mental
health services.
<http://www.health.vic.gov.au/mentalhealth/quality>
- Victorian Quality Council publications.
<http://www.health.vic.gov.au/qualitycouncil/>
- WA Office of Safety and Quality in Health Care (OSQH).
<http://www.health.wa.gov.au/safetyandquality/index.cfm>
- WA Office of Safety and Quality in Health Care publications include:
- Clinical Risk Management
 - Clinical Risk Management Guidelines for the WA Health System
 - Pocket Guide to Clinical Risk Management
 - Desktop Guide to Clinical Risk Management

Complaints Management

- Premier's Circular 2004/04 – Whole of Government Complaint Management Strategy
- Department of Health (2005). Complaint Management at the Department of Health
- Department of Health (2005). Complaint Process Flow Chart
- Department of Health (2003). Western Australian Complaints Management Policy: Driving Quality Improvement by Effective Complaints Management
- Metropolitan Hospital and Health Service Annual Complaints Report 2002 – 2003
- Metropolitan Hospital and Health Service Annual Complaints Report 2003-2004
- WA Country Health Service Annual Complaints Report 2003-2004
- Department of Health Annual Complaint Report 2003-2004
- Informed Consent
- Procedure Specific Consent Forms
- Guidelines for Health Practitioners: Patient Consent to Treatment and Disclosure of Material Risks (Oct 2000)
- Questions to Ask Your Doctor About Proposed Tests, Treatment or Procedures (See Appendix A)

Credentialing

- Credentialing an Introduction

Incident Reporting and Management

- Incident Reporting and Management Policy

Sentinel Events

- Statewide Sentinel Events Reporting Policy
- Sentinel Event Report Form
- Clinical Incident and Root Cause Analysis (RCA) Forms

Qualified Privilege

- Qualified Privilege Guidelines

WHO World Alliance for Patient Safety.

<http://www.who.int/patientsafety/en/>

Clinical resources

Australasian College for Emergency Medicine and Royal Australian and New Zealand College of Psychiatrists (2000) *Guidelines for the Management of Deliberate Self Harm in Young People*.

<http://www.acem.org.au>

Boyce P, Carter G, Penrose-Wall J, Wilhelm K and Goldney R (2003) Summary Australian and New Zealand clinical practice guideline for the management of adult deliberate self-harm (2003), *Australasian Psychiatry*, Volume 11, No. 2, June 2003

Clinical Governance, Western Australia

<http://www.clinicalgovernance.health.wa.gov.au>

Documents on this site include:

- Introduction to Clinical Governance: A Background paper
- Clinical Governance: Reference by Topics
- Clinical Governance: A Framework of Assurance and Review for Clinical Responsibility and Accountability in Western Australian Health Services
- Clinical Governance Framework

- Western Australian Clinical Governance Guidelines
- Setting Standards for Making Health Care Better: Implementing Clinical Governance in WA Health Services
- Clinical Governance Standard

Clinical Governance Guidelines (Mental Health) – Western Australia.

<http://www.chiefpsychiatrist.health.wa.gov.au/home/>

National Institute of Clinical Studies.

<http://www.nicsl.com.au/>

National Institute for Clinical Excellence – UK

<http://www.nice.org.uk/>

Royal Australian and New Zealand College of Psychiatrists (RANZCP), Clinical Practice Guidelines.

<http://www.ranzcp.org/publicarea/cpg.asp>

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, CG16 Self-harm – NICE guideline

<http://www.nice.org.uk/page.aspx?o=213665>

Standards in Care Outcomes in Licensed Psychiatric Hostel for People with a Psychiatric Disability, Office of the Chief Psychiatrist Western Australia, May 2003

<http://www.chiefpsychiatrist.health.wa.gov.au/>

Victorian Department of Human Services, Chief Psychiatrist's Guidelines.

<http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>

Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, CG25 Violence – NICE guideline – 2005

<http://www.nice.org.uk/page.aspx?o=244477>

WA Centre for Clinical Interventions (CCI).

<http://www.cci.health.wa.gov.au>

WA Framework for Clinical Risk Assessment and Management of Harm

http://www.mental.health.wa.gov.au/one/resources_view.asp?resourcesID=72

Suicide prevention

Auseinet – Australian Network for Promotion, Prevention & Early Intervention for Mental Health

<http://www.auseinet.com>

Boyce P, Carter G, Penrose-Wall J, Wilhelm K and Goldney R (2003) Summary Australian and New Zealand clinical practice guideline for the management of adult deliberate self-harm (2003), *Australasian Psychiatry*, Volume 11, No. 2, June 2003

Community Life-Building Community Capacity for Suicide Prevention

<http://www.community-life.org.au>

National Suicide Prevention Strategy

<http://www.livingisforeveryone.com.au>

NSW Mental Health Sentinel Events Review Committee, *Tracking Tragedy: A systemic look at suicides and homicides amongst mental health patients*, First Report of the Committee, December 2003.

http://www.health.nsw.gov.au/pubs/t/serc_contents.html

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<http://www.health.nsw.gov.au/pubs/2004/govtresponse1204.html>
- NSW Mental Health Sentinel Events Review Committee *Tracking Tragedy 2004: A systemic look at homicide by mental health patients and suicide death of patients recently discharged from mental health inpatient units*, Second Report of the Committee, March 2005.
<http://www.health.nsw.gov.au/policykmh/publications/tracktragedy2.pdf>
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Adverse drug events

ADRAC's, Australian Adverse Drug Reaction Bulletin.

<http://www.tga.gov.au/adr/aadrb.htm>

Australian Prescriber newsletter –

www.australianprescriber.com

Better Health Channel, Consumer Medicines Guide.

<http://www.betterhealth.vic.gov.au> (click on Library, then Medicines Guide)

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<http://www.ranzcp.org>

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MedicinesTalk – produced by consumers, for consumers to encourage and promote Quality Use of Medicines (QUM).

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Medication Safety Breakthrough Collaborative

<https://www.medicationsafety.com.au/Public.aspx?ReturnUrl=%2rDefault.aspx>

MedWatch: The United States Food and Drug Safety Information and Adverse Event Reporting Program.

www.fda.gov/medwatch

Medimate

http://www.nps.org.au/site.php?content=/resources/content/cons_medimate.html

Brochure on *Medimate* –

http://www.nps.org.au/site.php?page=2&content=/resources/content/medimate_brochure.html

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National Prescribing Service

www.nps.org.au

National Prescribing Service – Radar (Rational Assessment of Drugs & Research) –

www.npsradar.org.au

Quality Use of Medicines (QUM) Map

<http://www.qummap.health.gov.au>

RANZCP Position Statement on the Safe Use of Clozapine

<http://www.ranzcp.org/>

Victorian Mental Health Branch of the Department of Human Services. Brochures on psychotropic medication.

<http://www.health.vic.gov.au/mentalhealth/druginfo/index.htm>

Western Australian Medication Notifications.

www.chiefpsychiatrist.health.wa.gov.au/role/notifications.cfm

Western Australian Medication Review.

<http://www.chiefpsychiatrist.health.wa.gov.au>

Western Australian Psychotropic Drug Committee (WAPDC)

www.watag.org.au/wapdc/guidelines.cfm

Guidelines and Information available on the above site:

Antidepressants (January 2005)

Antidepressants – Therapeutic algorithm Part 1

Antidepressants – Therapeutic algorithm Part 2

Includes sections on:

- Guidelines for the drug treatment of depression
- Algorithm for pharmacotherapy of depression
- Clinical conditions influencing selection of antidepressants
- Switching antidepressant agents
- Adverse effects that influence selection of antidepressants
- Clinically relevant drug interactions with newer antidepressants
- Printed copies are also available by contacting WATAG.

Antipsychotic Drug Guidelines (July 2003)

Includes Therapeutic Algorithms for:

- Early Episodes
- Relapse and Exacerbation
- Acute Arousal
- Antipsychotic Induced Cardiac Arrhythmia
- Key Points for Antipsychotic therapy in clinical practice

Other Information

- Guidelines for the use of psychotropic drugs
- Prescription and supply of risperidone long acting depot injection
- Risk of hyperglycaemia and diabetes mellitus associated with use of antipsychotic drugs
- Use of SSRI and SNRI antidepressants in children and adolescents

Advisory Notes

- Caution required with olanzapine intramuscular
- Olanzapine intramuscular injection
- New Anticonvulsants as Mood Stabilisers
- Metabolic disturbances with antipsychotics
- Lithium revisited – frequently asked questions
- Clozapine & gastrointestinal adverse effects
- Atomoxetine – how useful for ADHD?
- Clozapine augmentation
- Aripiprazole – a new class of antipsychotic
- Lithium induced hypothyroidism. When to treat
- Risperdal Consta
- Combining antidepressants
- Reboxetine – a NaRI
- Profile of amisulpride

Medicines phone help lines

National Prescribing Service:

- Medicines Line – 1300 888 763
http://www.nps.org.au/site.php?page=2&content=/resources/content/cons_ml_about.html
- Therapeutic Advice and Information Service (TAIS) – 1300 138 677
TAIS online enquiry form for health professionals -
<http://www.nps.org.au/site.php?page=1&content=/resources/content/tais.php>

Consumer Adverse Medication Events Line: Ph 1300 134 237

Safe transport

Emergency Demand Policy P7-02 *Emergency Transport of Mental Health Consumers from Country Locations*, South Australian Department of Human Services 2002
<http://www.dh.sa.gov.au/mental-health-unit/publications.asp>

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http://www.chiefpsychiatrist.health.wa.gov.au/publications/docs/Protocol_Between_Wes.pdf

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