Actionable Patient Safety Solutions (APSS) #13B:

Collaborative care planning in mental health

How to use this guide

This guide gives actions and resources for creating and sustaining safe practices for collaborative care planning in mental health. In it, you'll find:

Patient Safety MOVEMENT

Executive summary checklist

Patient safety events in psychiatry are a serious concern. About 1,500 suicides take place at inpatient psychiatric units in the U.S. each year—over 70% by hanging (Mills, King, Watts, and Hemphill,2013). Patients who are in acute psychiatric distress have a higher chance of harming themselves or others. Collaborative care planning is a tool designed and used to help patients and their family caregivers recognize when they are reaching levels of acute psychiatric distress.

Use this checklist to help you prioritize your actions and measure your organization's progress in each area.

- ☐ Create opportunities for staff and patients and family to collaborate on mental health care planning
- ☐ Encourage and teach patients to take an active role in and management of symptoms
- ☐ Promote family (as defined by the patient) involvement in support of established plan of care throughout the patient's psychiatric care
- ☐ Determine which 2 pieces of information your facility should collect so you can better measure your facility's progress in improving patient safety outcomes
- ☐ Increase patient safety by increasing awareness of and interventions for strong negative emotional states which may precede harm of self or others
- ☐ Track your outcomes with metrics, such as:
  - ☐ Patient satisfaction surveys
  - ☐ Patient lengths of stay
  - ☐ Patient readmission rates
  - ☐ Crisis incidents (i.e. "cCode white" frequency, acute psychiatric crisis, violence and aggression)
  - ☐ Seclusion room use
- ☐ Utilize patient stories – in written and video form – to help teach and inspire change in your staff

What we know about mental health and patient safety

Collaborative care planning in mental health

Patient safety events in psychiatry are a serious concern. Patients who are in acute psychiatric distress have a higher chance of harming themselves or others. Collaborative care planning is a tool designed and used to help patients and their family caregivers recognize when they are reaching levels of acute psychiatric distress. The term "family" throughout this document refers broadly to lay caregivers that the patient considers family and consents to being identified by staff as family, even if not biologically or legally related.

This self-recognition translates into preventing patients from reaching a point of crisis where they are at a higher chance of harming themselves or others. Collaborative care planning refers to the combined efforts of staff, patients, and their family caregivers working together to set and achieve health goals, and involves greater patient involvement in the planning, delivery, and evaluation of care.

Ideally, collaborative care planning leads to better treatment by focusing on improving and maintaining health rather than just dealing with problems as they arise (Victoria State Government, 2012). Improved clinical outcomes are known to result from collaborative care planning (Craven and Bland, 2006).

Acute inpatient settings often do a good job of using the environment and medications to promote patient recovery. Patients are admitted to a relatively safe, calm environment removed from the complexities of life that may have triggered the acute psychiatric crisis. Patients receive medication trials under close medical supervision to determine the best pharmacological treatment plan.

The risks with the standard treatment

About 1,500 suicides take place at inpatient psychiatric units in the U.S. each year—over 70% by hanging (Mills, King, Watts, and Hemphill, 2013). Suicide is not the only metric for patient safety in behavioral health settings, which has other unique patient safety issues, such as:

- Violence and aggression
- Suicide and self-harm
- Seclusion and restraint
- Absconding and missing patients
- Access to hazardous materials
- Lack of supervision

Seclusion rates in an acute inpatient psychiatry unit can reach as high as 31%, with the most common indicator of seclusion being risk to others (74%) followed by risk to self (61%) and risk of absconding (55%) (Tunde-Ayinmode and Little, 2004). Up to 47% of mental health care providers have experienced violence at work (Nolan, 1999). As such, there is an urgent need to reduce and alleviate unsafe behaviors within the mental health care system.

However, a third arm of treatment, collaborative care planning, is often underutilized (Anthony and Crawford, 2000). Lack of collaborative care planning often manifests as:

- Patients being unaware of their treatment plan
- Patients feeling helpless

- Weak therapeutic relationships between patients and staff
- Ineffective communication of the mental health treatment plan through the healthcare system (between the supports for the patient)
- Lack of integration into more easily-accessible, preventative facilities, such as primary care
- Wider gap in unequal access to care based on socioeconomic factors
- Poor recognition of comorbidities

This, in turn, may result in poorer outcomes and increased number of patient safety events.

The purpose of this document is to increase patient safety by promoting collaborative care planning between staff, patients, and family in acute inpatient psychiatric settings. Collaborative care planning can be encouraged through a relatively simple framework utilizing:

- A Two-Step Comfort Toolkit:
  - This framework gives your staff the tools to work with patients and their support groups to build skills for both evaluation and management of emotional distress, which often happen before patient safety events

Leadership plan

Hospital and psychiatric governance, senior administrative leadership, clinical leadership, and safety/risk management leadership need to work together to implement collaborative care in mental health care. Leaders need to commit to taking these key actions.

Create the infrastructure needed to make changes

- Use the Two-Step Comfort Toolkit to systematically build patient and support skills development in an effective and efficient way
- Collaborative care planning—providers, person (patient), and family—appears to have particularly strong effects in patients with more severe mental health disorders, and even low levels of collaboration can have positive outcomes (Cravenand Bland, 2006)
- This is particularly important in acute inpatient psychiatry settings, where psychiatric severity tends to be high, and staff often are time and resource limited (Porter, 1992)

Engage staff

- Provide scope
  - Develop a guide for staff and physicians to determine appropriate family and supports to be involved in care planning
  - Prioritize information—if your team were to review the implementation of this program in 6 months, what are 2 pieces of information you wish you had so you could better gauge your facility's progress?
- Create capacity
  - Protect time to engage in patient comfort planning
- Produce capability
  - Educate staff on:
    - How to leverage comfort planning
    - How to engage patients to identify their triggers
    - When to seek additional resources
  - Educate families on:

        - How to support positive behaviors
        - How to identify triggers
        - When to ask for assistance
- Give motivation
    - Highlight the importance of patient involvement in patient outcomes
    - Empower staff to proactively assess and include patients in their treatment
    - Empower family involvement, if appropriate
- Track outcomes
    - Systematically track and improve patient engagement by collecting data about:
        - Outcomes
        - Success rates
        - Adverse events
- Use patient stories – in written and video format – to identify gaps and inspire change in your staff
    - The story of Glenn Saarinen is an inspiring story produced by the Patient Safety Movement Foundation
        - It can be viewed for free here: **http://patient.sm/dySMD2**

Action plan

The Two-Step Comfort Toolkit can be completed in as little as two 30-minute sessions. It should ideally be completed as soon as a patient is settled enough to actively and collaboratively engage with your clinicians.

- Step 1 – Comfort Planning (**Figure 2, Figure 3**)
- Step 2 – Comfort Kits (**Figure 4)**

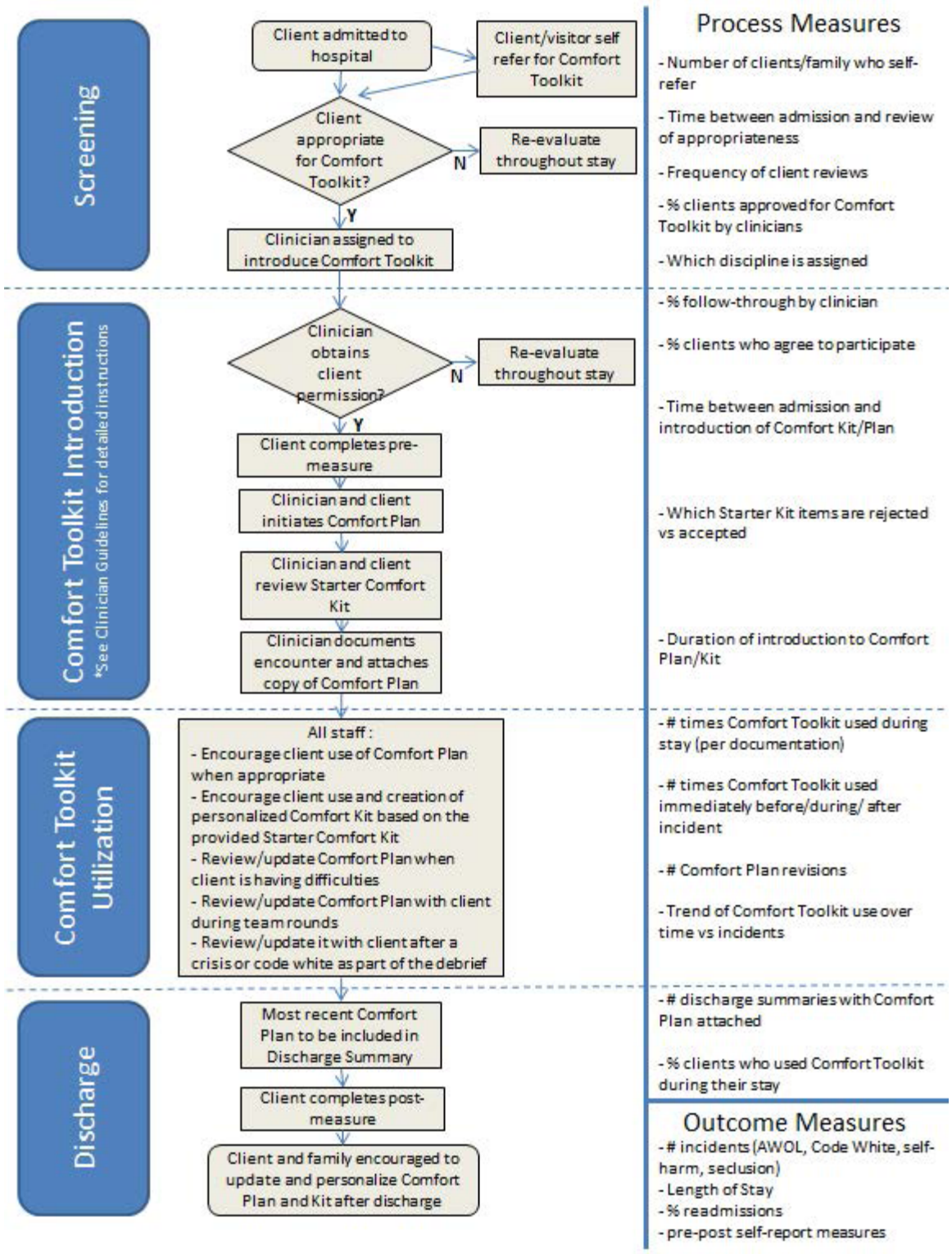

Figure 1: Comfort Plan: Collaborative Creation Guidelines and Process Measures

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Comfort Plan

Name:_____ Date:_____

A comfort plan is a way of identifying ways to cope with intense emotions. This plan is made by you to help you feel comfortable & safe.

When a challenge happens:

	What I can notice	What others notice	What I can do	How others can help
I am in crisis				
I am feeling a bit angry/anxious				
I am feeling good				

Figure 2: Comfort Plan Template (Courtesy of: Vancouver Coastal Health)

Comfort Plan Guide

When a Challenge Happens… WHAT TO DO

People	Places
• Talk or sit quietly with a staff member • Something others can say to help me calm down is: ____ • Talk to another resident/friend • Call a supportive friend/family member • Be around other people	• Sit by the care team station • Go to my room • Go outside • Be in soft/low light • Go to a quiet space • Sit in the TV room
Strategies	**Activities**
• Breathing techniques • Grounding exercises • Distraction activities • Hope statements • Naming my goals • Mindfulness • Progressive muscle relaxation • Guided imagery • Meditation • Body scan • Positive affirmations • Yoga	• Listen to music/radio • Go for a walk • Run/exercise • Spend time with a pet • Spend time alone • Write/journal/read/do art • Stretch/do yoga • Clean my room • Do something to stay busy • Play music • Watch TV • Do a word search/crossword/Sudoku
Calming/comforting sensory ideas	**Alerting/distracting sensory ideas**
Touch & Temperature • Wrap myself in a warm or heavy blanket • Drink a cup of tea or warm milk *Auditory/Listening* • Listen to soft/slow music • Relaxation or meditation CDs *Vision/Looking* • Look at pictures that calm me • Watch things in nature (trees, clouds) *Olfactory/Smelling* • The smell of herbal tea or mint • The smell of chocolate • The smell of baking or other food *Gustatory/Tasting/Chewing* • Drinking tea • Chewy toffee or candy • Chocolate • Chewing gum	*Touch & Temperature* • Lie down with a cold face cloth or ice • Splash cold water on my face • Have a cold drink *Auditory/Listening* • Listen to loud/fast music • Be around people talking *Vision/Looking* • Look through magazines *Olfactory/Smelling* • The smell of coffee • Citrus smells • Shower with good smelling soap *Gustatory/Tasting/Chewing* • Drinking something carbonated • Strong mints • Crunchy foods • Sour candy or fruit

Figure 3: Comfort Plan Guide (Courtesy of Vancouver Coastal Health)

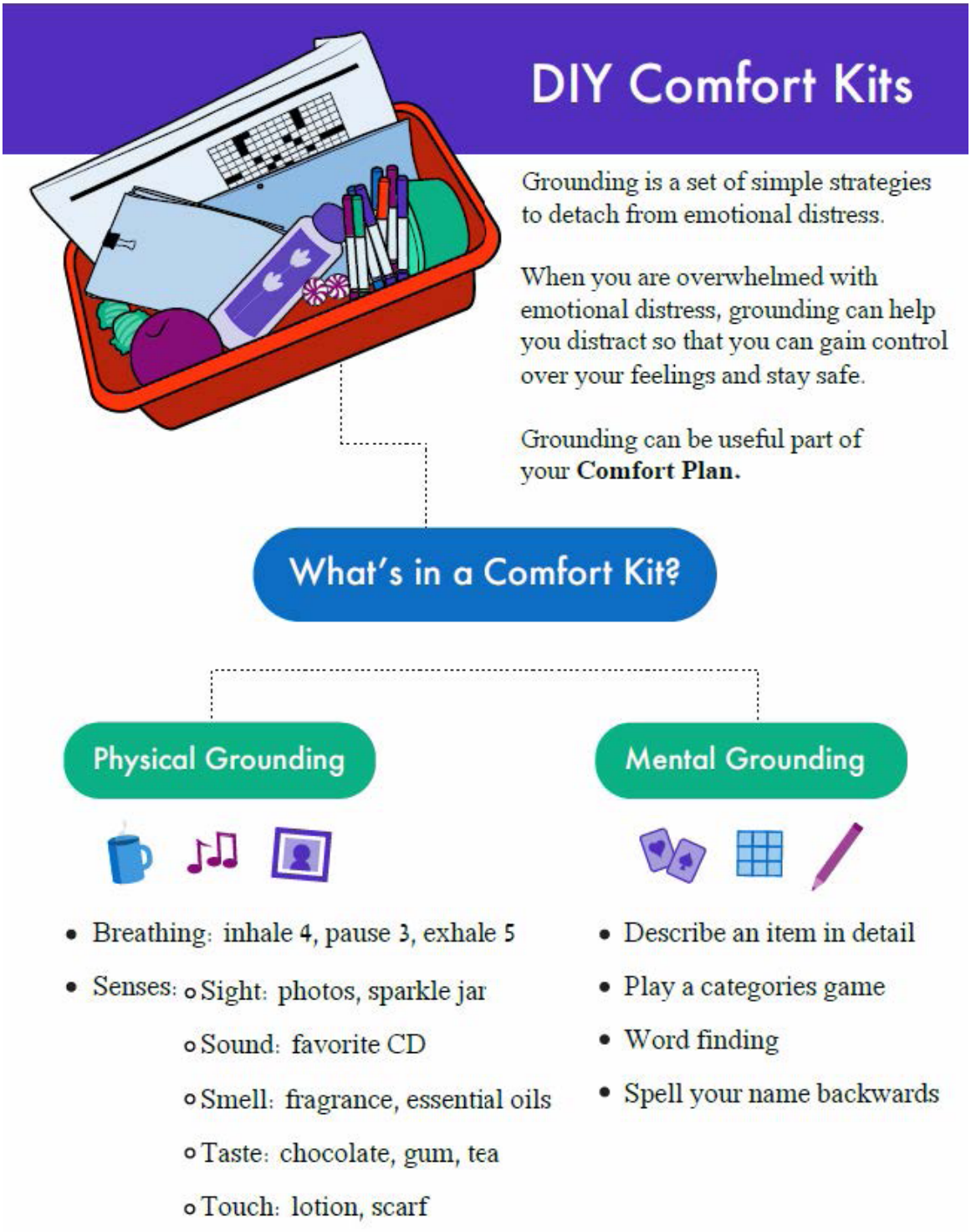

Figure 4: DIY Comfort Kits (Courtesy of Vancouver Coastal Health)

Detailed clinician guidelines:

Comfort Toolkit

1. Introduce yourself to the patient:
    - "A Comfort Plan is a way of identifying strategies you can use to cope with intense emotions. This is a plan made by you to help you feel comfortable and safe
    - By filling out a Comfort Plan, both you and the staff will have better awareness of:
        - The main challenges you experience
        - What strong emotions look like and feel like when you experience them
        - How you can deal with those challenges and intense emotions
        - How staff can help"
2. Fill out the Comfort Plan:
    - Encourage the patient to contribute as many ideas as possible and to do the writing—if they are able—to better gain a sense that the Comfort Plan is their own
    - Ideas from community teams/families are welcome at patient's consent
    - "When a challenge happens…what I/others notice"
        - Discuss how emotions are on a spectrum
        - A crisis happens when emotions are so strong that the emotion exceeds the window of tolerance and may feel unmanageable
        - The more we are aware of the "level" of our emotions, the more control we gain in making them more manageable
    - "When a challenge happens…what to do/how others can help"
        - Use the Comfort Plan Guide on page 8 for ideas
        - Discuss how there are things we and others can do to manage emotions and how these strategies may be different depending intensity of emotions
        - Strategies may change over time and the Comfort Plan can be revised
3. Introduce the Comfort Kit to strengthen the Comfort Plan
    - Use the Starter Comfort Kit to build a range of self-regulation resources for the patient
    - Display and discuss all items
    - Invite the patient to keep the items identified as useful, and make sure to reclaim the declined items
    - Explain to the patient that the Starter Comfort Kit is only a sample of sensory modulation and distraction techniques
    - Encourage the patient to build a personalized kit during the rest of their stay and after discharge
    - Encourage brainstorming of specific items the patient can use to personalize their own Comfort Kit

4. Document
    - The Comfort Plan is initiated by one clinician but should be used by all clinicians managing the patient's care
    - It's important to document the status of the Comfort toolkit for other staff
    - Comfort Plan copy is attached in patient chart
        - Update with revised versions
    - Clinical notes should be written about when and how the Toolkit was used
5. Promote ongoing use of the Comfort Plan and Kit:
    - Patient can hang their Comfort Plan on their wall or keep it in an accessible place to remind them of all the things they can do when a challenge arises
    - Staff can:
        - Keep Comfort Plan in Kardex next to care plan
        - Use it to help patients deal with challenging emotions
        - Review it during morning huddles if the patient is having difficulties
        - Review and update it during iCare with team, and with patient during rounds
        - Review and update it with patient after a crisis or code white as part of the debrief
        - Encourage use and creation of personalized Comfort Kit based on the Starter Kit provided

Starter Comfort Kit

Starter Comfort Kits (go to **Figure 5**) are given to patients to experiment with and brainstorm grounding skills. They consist of examples of both mental grounding and physical grounding. The Starter Comfort Kits are designed to be:

- Low cost (go to **Table 1**)
- Low risk:
    - Items in the Kit should not be more dangerous than other items that can be accessed in the unit
    - Patients should be able to use the Kit without staff supervision
- Given to patients to keep
    - The Kit does not need to be returned to staff
- Optional
    - Patients may choose to keep or decline various items in the Starter Kit
- Introductory
    - Patients should be informed that this Starter Kit contains only examples of different grounding strategies, and the patient should build their own personalized kit throughout the duration of their hospital stay and after discharge
    - Patients Can create larger Comfort Kits with more expensive items such as MP3 players, essential oils, etc.
        - Go to page 8 of Comfort Plan for more ideas

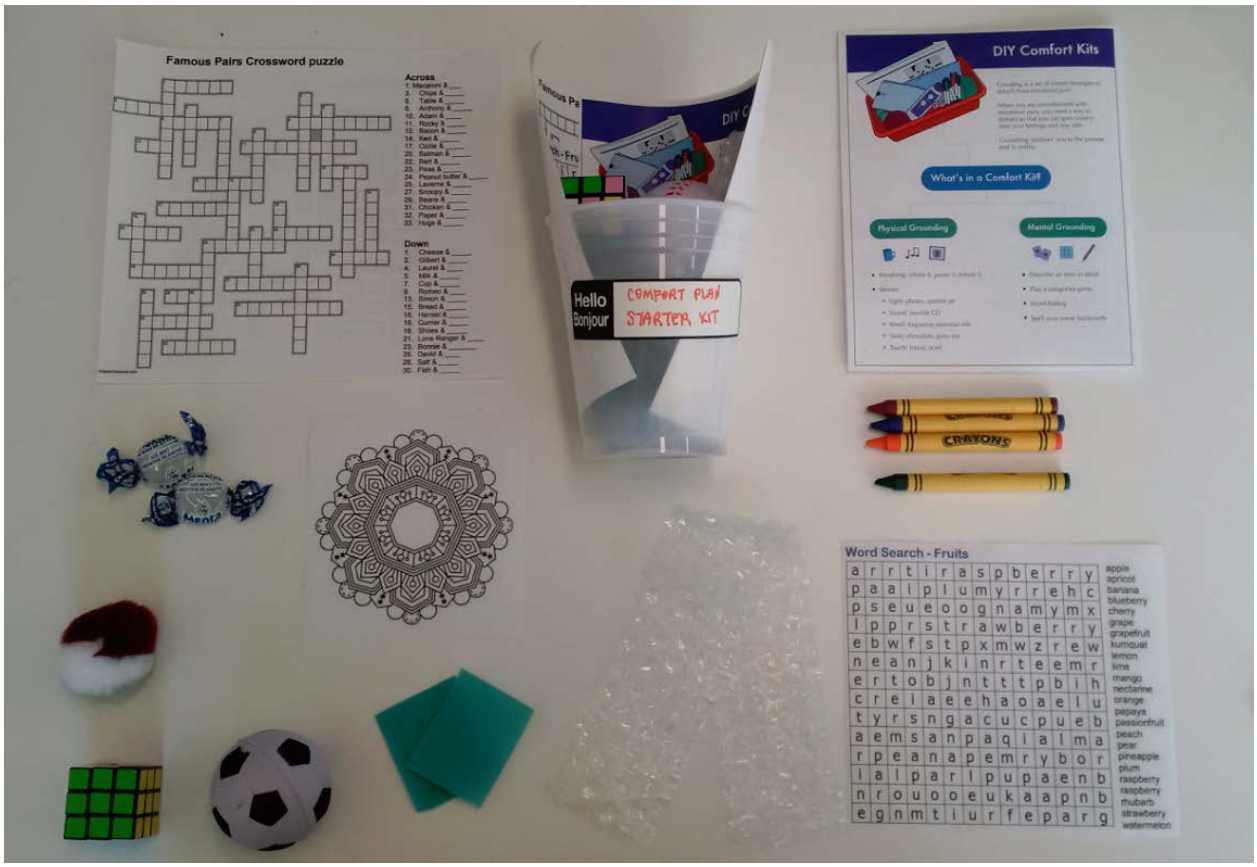

Figure 5: Example of $2 Starter Comfort Kit

Table 1: Cost of Starter Comfort Kit

Item	Price CAD (when purchased in bulk)
DIY Comfort Kit Instruction Sheet (photocopy)	$0.01
Crosswords, Word Searches, Mandalas (photocopy)	$0.04
Stress Ball	$0.90
Rubik's cube	$0.40
Pom pom	$0.05
Velcro strip	$0.05
Bubble wrap	$0.05
Crayons	$0.40
Candy	$0.05
Cup (container)	$0.05

Engage support persons and family

The inclusion of a patient's family and/or support persons (friends, religious leaders, private mental health clinician, etc.) in a patient's care planning while in hospital is vital to providing complete care for the patient. We have identified the involvement of family and other supports as a key factor in promoting optimal patient outcomes, and propose to:

- Create a conceptual model of family and support engagement in acute psychiatric settings
- Create tools to help clinicians better assess and map out a patient's family and support system e.g. genograms
- Provide identified family and supports with psychoeducation about ways to best support a patient during an acute psychiatric crisis
- Develop metrics for quantifying the impact of family and support on patient outcomes to contribute to the existing body of research

Technology plan

Technology can be used to complement the Comfort Toolkit but is not a requirement. The technology outlined below may already be owned by users (e.g. smartphones, smartwatches), thus increasing the accessibility of comfort planning. An assessment is necessary to use technology to the full potential.

These suggested practices and technologies have shown proven benefit or, in some cases, are the only known technologies for certain tasks. If you know of other options not listed here, please complete the form for the PSMF Technology Vetting Workgroup to consider: **patient.sm/dgQogJ**

System or Practice	Available Technology
Psychiatric settings vary widely, please adapt as necessary for your area	
Tech tools for building patient awareness about mood state:	
Physiological measures • Heart rate • Blood Pressure	• Mobile nursing medical cart • Smartwatch: Heart Rate Monitor • Smartphone App for measuring blood pressure or heart rate • Traditional heart rate monitors and blood pressure cuffs
Symptom rating/mood diary	• Websites and smartphone apps for tracking mood and symptoms
Tech Tools for Grounding	
Daily reminders to engage in self-care	• Smartphone App for tracking gratitude

Physical grounding	• Smartphone App for tactile sensory modulation, e.g., acupressure • Smartphone App for breathing exercises • Smartphone App for stretching • MP3, Ipod, or cellphone as a music player • Hand held video games • MP3 preloaded with soothing music • MP3 preloaded with guided meditation
Mental grounding	• Smartphone App for meditation • Smartphone App for cognitive games and exercises

Measuring outcomes

The following surveys (pre- and post- surveys) have been implemented at Vancouver Coastal Health as part of their collaborative care planning pilot program. The surveys are being provided as examples that can be adapted within your facility.

VGH Segal Comfort Toolkit Pilot Program: Pre-measure

Patient initials:_____ Unit:_____Date:_____Clinician:_____

1. How many times do you experience highly distressing emotions per day?

   _____ times per day

2. How confident are you in managing these periods of high distress?

   Low confidence 1 2 3 4 5 6 7 High confidence

3. How interested are you in learning how to better manage these periods of high distress?

   Low interest 1 2 3 4 5 6 7 High interest

4. How early on do you notice these periods of high distress?

   Early enough that I can manage them 1 2 3 4 5 6 7 Not until it is too late to manage them

5. How interested are you in non-pharmacological treatment? (e.g., grounding, therapy, counseling)

   Low interest 1 2 3 4 5 6 7 High interest

6. How interested are you in pharmacological treatment? (e.g., medications)

Low interest 1 2 3 4 5 6 7 High interest

7. Would you be willing to give feedback and suggestions about this pilot project?

During hospitalization: yes no
After discharge: yes no

8. What skills would you like to build during your stay at the hospital?

_____

_____

_____

_____

VGH Segal Comfort Toolkit Pilot Program: Post-measure

Patient initials:_____ Unit:_____Date:_____Clinician:_____

1. How many times do you experience highly distressing emotions per day?

_____ times per day

2. How confident are you in managing these periods of high distress?

Low confidence 1 2 3 4 5 6 7 High confidence

3. How interested are you in learning how to better manage these periods of high distress?

Low interest 1 2 3 4 5 6 7 High interest

4. How early on do you notice these periods of high distress?

Early enough that I can manage them 1 2 3 4 5 6 7 Not until it is too late to manage them

5. How interested are you in non-pharmacological treatment? (e.g., grounding, therapy, counseling)

Low interest 1 2 3 4 5 6 7 High interest

6. How interested are you in pharmacological treatment? (e.g., medications)

Low interest 1 2 3 4 5 6 7 High interest

7. How likely are you to keep using your Comfort Plan and Kit after discharge (including sharing Comfort Plan with others, adding to/making a new Comfort Kit)

Low likelihood **1** **2** **3** **4** **5** **6** **7** **High likelihood**

8. How effective was Comfort Planning in helping you manage distressing emotions during your stay?

Not effective **1** **2** **3** **4** **5** **6** **7** **Very effective**

9. What advice about Comfort Planning would you give to new patients?

_____

_____

_____

Consider adding the selected measures under the facility's process improvement plan, refer to **Figure 1** for a comprehensive list of process and outcome measures. A general process measure to track your adverse events specific to high-risk events is listed below.

Topic: Adverse Events (e.g.: AWOL, Violence, Self-Harm, Suicide, Seclusion Use)

Adverse Events (AE) in mental health include events deemed preventable that result in harm to patients.

Outcome/Process Measure Formula

Numerator: Number of reported adverse events with harm (as defined above)

Denominator: Patient days (The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period)

**Measure typically displayed as a percentage: Numerator/Denominator *100*

**Fraction to be measured twice - at Baseline, and after Intervention*

Metric recommendations

Direct Impact:
All patients

Lives Spared Harm:
Lives Spared Harm = (AE $_{\text{baseline}}$ - AE $_{\text{intervention}}$) X patient days $_{\text{intervention}}$

Conflicts of interest disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Some of the APSSs recommend technologies that are offered by companies involved in the Patient Safety Movement Foundation. The workgroups have concluded, based on available evidence, that these technologies work to address APSS patient safety issues. Workgroup members are required to disclose any potential conflicts of interest.

Workgroup

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