A co-produced model for investigation and learning from suicide cases in healthcare

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Aims

- ✔ Understand patient safety as risk management over time with suicide as an example
- ✔ Understand the importance and benefits of involving patients and family in the work with improving patient safety at several levels
- ✔ Have a better understanding of the complexity of incidents of severe patient harm
- ✔ Understand how studying suicide can lead to improvements in the care of people with serious mental health problems

Agenda

- Presentation and introduction – Axel Ros
- Suicide as an incident of patient harm - Elin Fröding
- What makes sense to the patients?

  Involvement of own experiences - Axel Ros and Fredrik Tjulander
- Implications for incident investigation - Axel Ros and Charles Vincent
- Panel and audience discussion

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Conflicts of interest

- Elin Fröding: Employment and research funding by Region Jönköpings County, no conflicts of interests to declare
- Axel Ros: Employment and research funding by Region Jönköpings County, no conflicts of interests to declare
- Charles Vincent: no conflicts of interests to declare
- Fredrik Tjulander: Employment by Region Skåne, no conflicts of interests to declare

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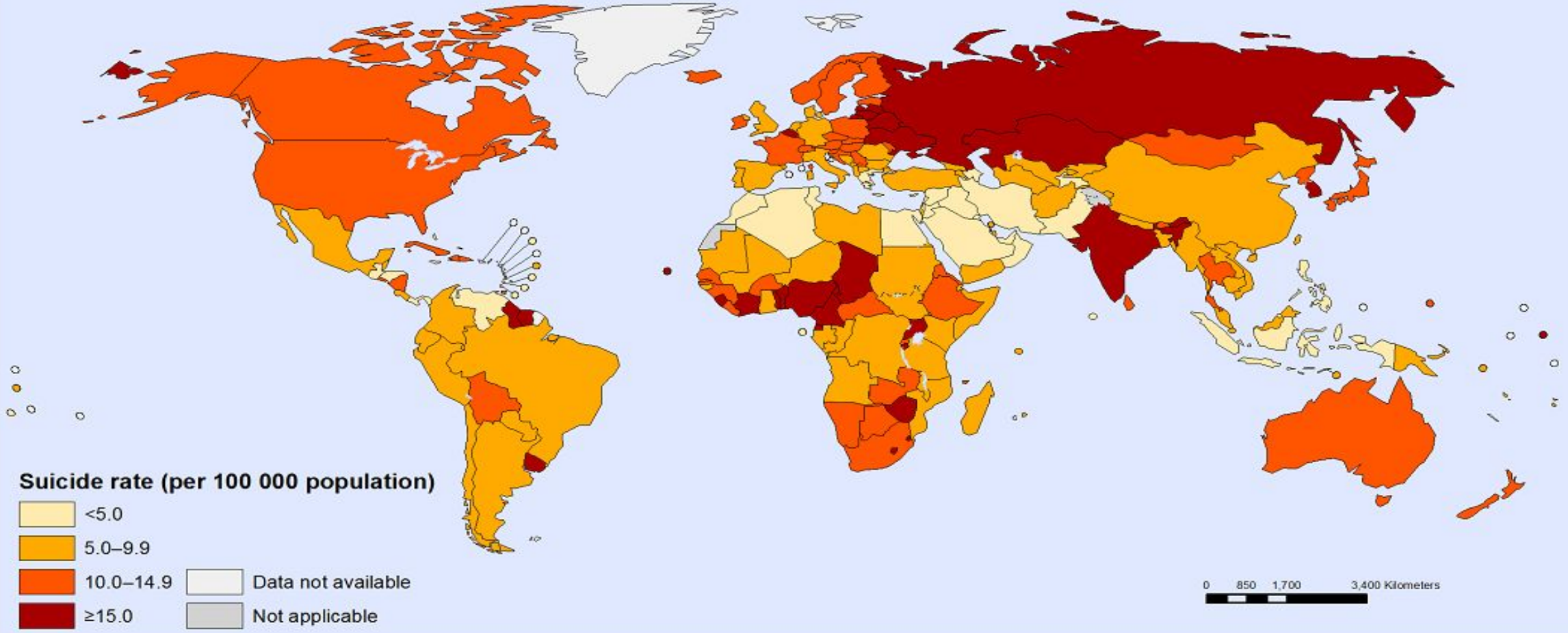
Take home messages

- Many suicides are possible to prevent
- Patient harm typically involve a complex set of contributing and interacting factors over time, including human behavior, sociocultural factors, and a range of organizational and procedural weaknesses
- Involvement of the patient and family in the healthcare, risk management and investigation contributes to understanding and learning of suicide as a preventable patient harm.

Age-standardized suicide rates (per 100 000 population), both sexes, 2016

700 000 deaths annually



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
World Health Organization

World Health Organization

Mental disorders

Personality

Suicide behaviour

Male gender

Family history of suicide

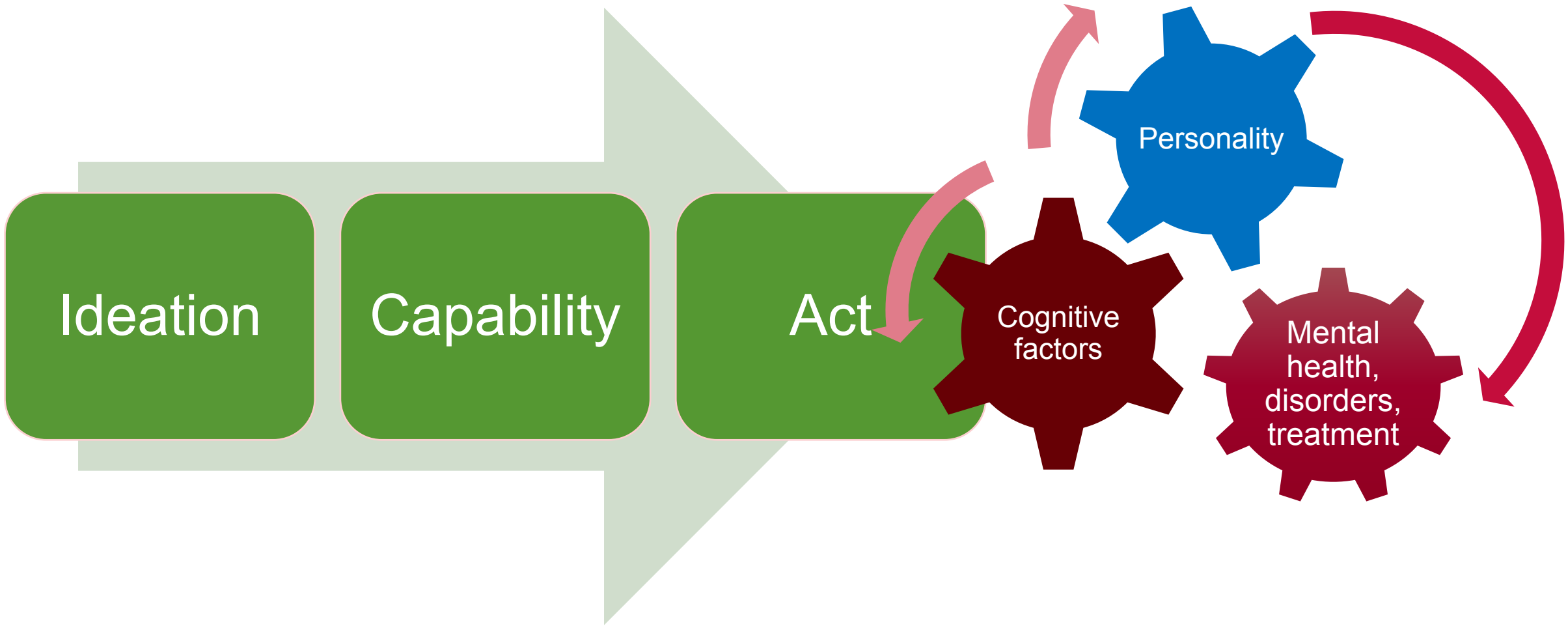
Genetics

Psycho-social problems

Interpersonal conflicts

Suicide prevention interventions

Interplay of mutliple factors' interaction over time



Psychosocial context, life events and culture

O'Connor (2015), Klonsky (2020), Turecki (2019)

Suicide as an incident of patient harm

- Patient harm typically involve a complex set of contributing and interacting factors over time, including human behavior, sociocultural factors, and a range of organizational and procedural weaknesses
- Healthcare of patients with suicide behavior is often carried out over long time, by different healthcare providers, and harm and failures of care of longer courses are often due to an accumulation and combination of problems, errors and system vulnerabilities over time and across multiple contexts.

Vincent (2016), Hawton (2009), Mann (2010), O'Connor (2014), Wasserman (2001)

Investigations of patient harm

- The pre-dominant approach is the safety-I perspective; a linear cause-and-effect approach with a focus on deviations and non-adherence (root cause analysis)
- This model is most effective where activities are well understood, relatively stable and have limited external influences, but is criticized to fail in adequate considerations of central aspects of the phenomenon such as patient factors, as the focus is at a systemic level
- The expectation of finding a single or limited number of “root causes” seems a gross oversimplification.

Anderson (2013), Braithwaite (2015), Dekker (2009), Hollnagel (2015), Leape (2002), Vincent (2003), Vrklevski (2018)

Vincent et al. Implementation Science (2017) 12:151
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Implementation Science

DEBATE Open Access

Safety analysis over time: seven major changes to adverse event investigation

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Abstract

Background: Every safety-critical industry devotes considerable time and resource to investigating and analysing accidents, incidents and near misses. The systematic analysis of incidents has greatly expanded our understanding of both the causes and prevention of harm. These methods have been widely employed in healthcare over the last 20 years but are now subject to critique and reassessment. In this paper, we reconsider the purpose and value of incident analysis and methods appropriate to the healthcare of today.

Main text: The primary need for a revised vision of incident analysis is that healthcare itself is changing dramatically. People are living longer, often with multiple co-morbidities which are managed over very long timescales. Our vision of safety analysis needs to expand concomitantly to embrace much longer timescales. Rather than think only in terms of the prevention of specific incidents, we need to consider the balance of benefit, harm and risks over long time periods encompassing the social and psychological impact of healthcare as well as physical effects.
We argued for major changes in our approach to the analysis of safety events: assume that patients and families will be partners in investigation and where possible engage them fully from the beginning, examine much longer time periods and assess contributory factors at different time points in the patient journey, be more proportionate and strategic in analysing safety issues, seek to understand success and recovery as well as failure, consider the workability of clinical processes as well as deviations from them and develop a much more structured and wide-ranging approach to recommendations.

Conclusions: Previous methods of incident analysis were simply adopted and disseminated with little research into the concepts, methods, reliability and outcomes of such analyses. There is a need for significant research and investment in the development of new methods. These changes are profound and will require major adjustments in both practical and cultural terms and research to explore and evaluate the most effective approaches.

Keywords: Patient safety, Incident analysis, Safety interventions

Moving forward – use current knowledge

- Consider the whole **patient journey**
- Make efforts to understand the perspectives of the **patient,** and consider whether the patient received the care needed
- Widen the perspective of **time** - start the analysis from the beginning of suicidality
- Widen the **system** perspective - involve all current healthcare providers and family
- Integrate **variables of significance** for suicide behavior, prevention and safety
- **Learn from recoveries and periods of stability** and identify factors that

Requirements for effective investigation and learning after suicide: the views of patients, family and professionals

Holistic approach

- Time
- System
- Patient's expectations
- Suicidality
- Factors of significance to analyse

Effectiveness of investigation

- Involve all current stakeholders
- Competence of investigator and analysis team
- Prioritised cases for extensive analysis
- Template

Time

“You need to look back on the whole care period. I think that illustrates what I name ‘chafes’, that has been abraded over time, bit by bit. It becomes a little wrong, not a huge mistake, but a little wrong and then a little wrong again and then a break in the continuity. Small chafing which then in the end results in a rather hopeless situation.”

“You can learn a lot from the care process. Learn what was effective and helpful, and when it failed. I think the time axis is extremely important, to avoid too much focus on the last months.”

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System

“I experienced that there was a gap between the stakeholders; primary care, hospital, and enforcement services. You did not see the whole picture. You are so inside your own little box, I think you could gain a lot from that, to really involve all the different legs, not only emergency care or the final stage.”

Patient’s perspective and expectations

“In what way has the patient been allowed to express what he wants? How does the patient perceive the treatment, and the therapist? Evaluation together with the patient is an important part of the care, and evaluation together with next-of-kin.”

“We ignored attending some appointments, even me! Because the care did not respond to our needs. But it does not say so in the medical records, it is documented in other terms. Missed appointments are more important than you can imagine.”

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What makes sense to the patient?

Axel Ros and Fredrik Tjulander

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Implications for incident investigation

Axel Ros and Charles Vincent

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Take home messages

- Many suicides are possible to prevent
- Patient harm typically involve a complex set of contributing and interacting factors over time, including human behavior, sociocultural factors, and a range of organizational and procedural weaknesses
- Involvement of the patient and family in the healthcare, risk management and investigation can contribute in the understanding and learning of prevention of suicide.