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Assessment of the Quality of care for patients with history of self-harm and suicidal attempt through the lens of health-workers from a Caribbean psychiatric hospital

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Abstract

Aim: This study is an attempt to improve the quality of management for individuals diagnosed with self-harm or suicidal attempt admitted to a major psychiatric hospital in Trinidad and Tobago. To this end, the investigators aimed to ascertain the perceptions of staff in relation to the quality of care patients with self-harm or attempted suicide received at this major psychiatric hospital in Trinidad and Tobago.

Methods: A quantitative descriptive study design was undertaken. It accessed a proportional cadre of staff members from the medical, nursing and health assisting cadre of the health staff, totally 45, using a researchers'-developed questionnaire previously pre-tested. The data analysis was done using the SPSS programme.

Result: Findings show that perceptions were mostly neutral on three of the four identified dependent variables (Assessment of admission, Treatment, staff collaboration and Discharge planning). Also, result shows some associations between aspects of staff collaboration, treatment procedures and aspect of the dependent variable.

Discussions: The implications of these findings were highlighted.

Keywords: Psychiatric patients, Quality of care, Caribbean, Nursing

1. Introduction

The World Health Organization [WHO] [1] identified suicide as a global public health issue. Suicide is the intentional taking of one's life by self-inflicted actions [2]. Self-harm is a deliberate act of violence against oneself which can result in death without the conscious thought to kill oneself [3]. Trinidad and Tobago has the second highest suicide rate in the Caribbean according to a World Health Organization report of 2000 and 2012 [4, 5, 6].

Determination of suicidal intent or tendencies for diagnosis will be based on the criteria as stipulated in the Diagnostic Statistical Manual of Mental Disorders (DSM IV) and utilization of its five point multi-axial system of assessment for data collection(8). Understanding how cultural influences and social issues in different countries impact on suicide and self-harm had long been explored. Authors have documented these among many cultures in the world [7, 8, 9, 5, 10, 11].

Also, the influence of psychiatric illness on suicidal attempts have been documented [12, 13, 14]. Understanding the 'trajectory' of suicide in developmental stages can help in the development of management models. The cumulative effect of genetic, social and maturational (developmental) crisis on an individual can result in the development of mal-adaptive coping skills resulting in self-harm and attempted suicide in the individuals [15].

Assessment of the service quality is also impacted on by the variability of management and implication of the risk assessment tools. The inconsistency in the use of assessment tools and policy management of same have resulted in inaccurate figures of assessment, non-identification of some potentially serious instances of repeat self-harm and attempted suicide(16). Cooper, Kapur and Mackway-Jones [17] identified that among the many tools used; the Manchester Self-Harm Rule has the lowest rate of error amongst the risk assessment tools. Quinlivan, Cooper, and Steeg *et al.*, [17] asserts that accuracy of the tool is dependent on its collaborative use with general individual assessment of patients by trained mental health professionals as well as its use within a structured timeframe.

Several studies were conducted in relation to suicide and self-harm in Trinidad and Tobago on self-inflicting violence, cultures, and parquet-induced suicide [3, 4, 18]. No study has focused on areas related to the quality of care particularly seeking the views of the health staff of this group of patients.

The investigators envisaged that understanding this can assist in the evaluation of the policy in place as well as assist to address any concerns or discrepancies related to international protocols and procedures on this research issue.

We are of the opinion that determining the views of frontline staff tasked with the monitoring, evaluation and treatment of patients admitted for suicide attempt and self-harm will commence the development of research-based treatment protocol tools as well as fill the perceived gap between theoretical research and practical application related to this group of patients in Trinidad and Tobago.

1.1 Purpose of the Study

The study seeks to examine the perception of staff of a major Caribbean Psychiatric hospital about quality of care patients with history of self-harm and suicidal attempt. The study also sought to determine if the staff's perceptions are related to their demographics.

1.2 Research Questions
1. What are the perceptions of the health workers related to the (a) assessment of admission (b) treatment (c) environmental conditions; and (d) discharge planning; for patients with self-harm and attempted suicide history at the psychiatric hospital?
2. To what extent are the health workers views, of patients with self-harm and attempted suicide history, associated with their demographics namely:(a) Age, (b) religion, (c) years of experience, (d) Type of staff, and (f) International experience?

2. Research Methodology
2.1 Research Model
The study sought to explore the perceptions of staff at a local psychiatric hospital as they relate to the quality of care received by patients treated at the facility with a history of self-harm and or attempted suicide. This study used a Quantitative descriptive analysis method [17].

2.2 Population/Sample Size
The health facilities of the island are staffed with a myriad of clinical ward personnel. These include but are not limited to medical officers, registered mental nurses, enrolled nursing assistants, nurse's aides, patient care assistants, and aides to nurses. The licensed clinical staff on the wards that have direct contact with the patients and are responsible for assessment, treatment, and management of the patients are the medical officers, registered mental nurses, and enrolled nursing assistants.

Each ward has approximately ten (10) nurses, five (5), nursing assistants, and three (3) medical officers. This can be calculated as approximately four hundred and eighty (480) health workers meeting the criteria for inclusion within the twenty seven wards and assessment areas of the hospital. Of the twenty seven (27) wards of the hospital, the ten (10) admission wards/areas were targeted as patients admitted for self-harm and attempted suicide are assessed at and assigned to these areas.

Using a form of stratified random sampling with the population (N) being the 480 hospital health workers (clinicians), the strata within the hospital were the wards the patient can be admitted to. These 10 areas therefore have a potential staffing of 10/5/3; registered mental nurses/enrolled nursing assistants/medical officers respectively. We used 1/3 of the population for our sample (n). We therefore aimed to access 3 registered mental nurses, 2 enrolled nursing assistants, and 1 medical officer per ward (60 persons). However in all, 45 health workers constituted the sample (n) and were therefore engaged.

2.3 Instruments
The instrument developed for the study collected the demographic data related to the study parameters and a Likert-like scale to assess the perception of the health workers related to the dependent variables namely; assessment, treatment, environment, and discharge planning.

The development of the instrument was guided by literature. It was structured in a Likert-like manner and organized into (a) demographic section, and (b) perceptions of the quality of care. The use of the Likert-like scale to measure the responses of staff on their perceptions of quality of care measured as assessment of (a) Procedure for admission, (b) Treatment procedure, (c) conducive working environmental conditions of the hospital (collaboration amongst staff), and the (d) Discharge planning of the hospital for its ease of response to increase response rate, attract-ability, and expediency for completion. With a Cronbach's alpha of 0.79, the instrument was thus deemed reliable, appropriate and valid following necessary adjustments after the pre- and pilot tests [20]. The copies of questionnaires were hand-delivered and collected. The perceptions of staff is seen as attitudes or belief systems formed from previous emotional or perceptual responses to incidences and situations [18]. In this case, the staff perceptions are the views they hold on assessments of (a) admission procedures, (b) treatment given to patients, (c) collaboration amongst themselves in the [lace of work, and (d) discharge planning for their patients.

2.4 Data Analysis
The data was collated manually but analyzed using the Statistical Package for the Social Sciences (SPSS) version 14. Simple descriptive statistics were used to answer research question 1 while statistical test of ANOVA was used to answer research question 2. The p-value of 0.05 or less is deemed significant [19].

2.5 Ethical Considerations
Prior to commencement, ethical approvals were sought and received from the University of the West Indies, as well as the Regional Health Authorities. Thereafter, each respondent's consent was sought and necessary assurances were given to the respondents with regard to their rights for participation and withdrawal at any point in time**.** Participants were all given a copy of the consent form detailing the approvals, purpose, procedure and objectives of the study.

3. Results
3.1 Demographics
The participants were 45 health workers within the institution in the 10 areas where patients are assessed and admitted with a diagnosis of attempted suicide or self-harm. The frequency of ages represented showed the majority of respondents between the 36 - 45 years age group at 38.6%. The second largest group was the 22- 35 years age group at 31.8%. The 46 -55 years and 56 and above age group were 22.7% - 6.8% respectively. The standard deviation is .914.

Table 1: Distribution of Respondent according to selected Demographics: N=45

Variables	F	%
Age		
22-35	14	31.8
36-45	17	38.6
45-55	10	22.7
56 above	3	6.8
Job Classification		
Nursing Assistant	16	35,6
Reg. Nurse	25	55.6
Med Officer	4	8.9
Gender		
Male	12	26.7
Female	32	71.1
Religion		

Christianity	34	75.6
Hindu	5	11.1
Muslim	5	11.1
Other	1	2.2
Years of Experience 1-5 years	14	31.1
6-10 years	4	8.9
11 years and above	27	60
Training Attained		
Associate Degree or lower	30	66.7
Degree	12	26.7
Masters	2	4.4
PhD	1	2.2
International Experience		
Yes	7	15.9
No	37	84.1

71.1% of the participants were female the remaining 26.7% being male. The standard deviation was .484 for gender. Of the 45 respondents only 1 stated his/her gender as "other."

Of the 45 respondents 55.6% were registered nurses (psychiatric), 35.4% were enrolled nursing assistants, and 8.9% were medical officers. Based on the selection criteria, of the potential 30 registered nurses (psychiatric) respondents 25 were attained, 16 of the potential 20 enrolled nursing assistants, and 4 of the potential 10 medical officers, participated in the survey.

The largest percentage of the respondents was "Christianity" (75.6%). Both Hindu and Muslim denomination respondents were equal at 11.1% and only 1 respondent stated his affiliation was other. 60% of the respondents had 11 years or more experience. The respondents having between 1-5 years of experience were at 31% while the smallest group of respondents had 6-10 years of experience at 8.9%. The largest group of respondents possessed an Associate degree or lower (66.7%), while the second largest group had attained a degree of science. 4.4% of the respondents had a Masters and 2.2% (only 1 respondent) had a PhD.

84.1% of respondents had no International experience or experience working outside the Country. The 15.9% who had some experience internationally or outside the country worked in the United Kingdom, the United States of America, Canada, Cuba, and Bermuda (Table 1)

3.2 Staff Perceptions of the quality of Care

Table 2 provided the staff perceptions of the quality of care at this institution. With a maximum score of 5, and minimum of 1, the mean responses and their standard deviations indicate that the staff were mostly neutral in their perceptions of the quality of care. They staff perceived (a) assessment of admission as 3.30, (b) treatment procedure as 3.33, (c) collaboration among team members as 2.82, and (d) discharge planning as 3.33. The mean of means of 3.2.

Tables 3 looks at the relationships between the dependent variables namely (a) assessment procedure for admission, (b) treatment procedure, (c) collaboration among team members and (d) discharge planning; and the selected independent variables namely (i) international experience, (ii) job classification, (iii) Religion (iv) Experiences of the staff and (v) age of the staff members. Results show that the staff perceptions of assessment procedure for admission and discharge planning are not associated with any of the independent variables ($p>0.05$). However, the staff perceptions of treatment procedure are associated with the staff (i) experience ($p<0.07$) and (ii) age ($p<0.027$). Also, Staff perceptions of the collaborations among team members are associated with religion (0.008).

Table 2: Mean responses to the Dependent Variables N=45

	Mean	SD
Assessment Procedure	3.30	.763
Treatment Procedure	3.33	.905
Collaboration among team members (conducive working environment)	2.82	1.018
Discharge Planning	3.33	.769

Table 3: ANOVA showing the Association between the Dependent variable with the independent Variable (N=45)

	International Experience		Job Type of staff		Religion		Experience		Age	
	F	sig	F	sig	F	Sig.	FF	Sig.	F	Sig
Assessment Procedure for admission	..896	..349	..761	..473	..805	..498	1.875	..166	1.875	..166
Treatment Procedure	..061	..807	..368	..695	1.56	..212	3.92	..027*	9.920	..027*
Collaboration among team members	1.856	..180	..042	..958	4.528	..008*	2.024	..145	2.024	..145
Discharge Planning	..397	..532	..370	..693	1.923	..141	..853	..434	..853	..434

3.3 Discussion and recommendation

It is interesting that the general perception of the respondents with regard to all the dependent variables is neutral. In order words, they are did not sure whether the quality is good or not in general pertaining to all aspects of the study. However, they were somewhat more committed to some aspects of the study, in area of staff collaboration. To express a negative perception about the collaboration among staff members who provide these services to the patients is an indication of the need for better communication amongst them. It would appear that the variability of the staff are not relating well with each other. These variability include difference in religion (Christianity, Hindu, Muslim, and others); age differences, different cadre of training (medical officers, nurses, nursing assistants), whether or not they have international experience, etc. From the result, one hopes that the lack of collaboration does not affect the quality of care. We know that cultures that promote a level of communication and inclusiveness creates a more conducive environment for both the staff and the patients [7, 8, 9, 10, and 11]. And that this perception is associated with experiences of the staff and their ages is understandable. It can be inferred that the more experienced members of staff will be more willing to collaborate and so are the older members of staff. Given that psychiatric illness is often a condition which requires the input of all to understand and manage make it imperative for concerted effort among staff members to collaborate for the good of the patients under care.

Finally, the finding that perceptions of discharge planning is related to the religions of the staff members is an indication of the role of religion in the lives of the respondents [4, 8]. Also given the importance of proper discharge plan, as indicated by a number of studies amongst others [14, 12].

We hope that these findings will interest the policy makers of the local Ministry of Health to take a deeper look into the seemingly non-committal nature of the staff with regard to commenting on as to the quality of care that the patients receive in this hospital. It should also interest the Ministry to ascertain the extent of collaboration among staff knowing that how lack of collaboration may affect the quality of care to the patients in the institution.

4. References

1. World Health Organization [WHO]. Suicide fact sheet. World Health Organization. Retrieved 28/10/2014 from http://www.who.int/mediacentre/factsheets/fs398/en/
2. Merriam-Webster. Suicide. Merriam Webster. Retrieved 29/10/2014 from http://www.merriam-webster.com/dictionary/suicide
3. Crawford T. An analysis of self-inflicting violence in the English-speaking Caribbean. Arts and Social Sciences Journal. 2010; 13. Retrieved 2/1/2015.
4. Maharajh HD, Abdool PS. Cultural aspects of suicide. The Scientific World Journal. 2005; 5:736-746. Retrieved 2/1/2015.
5. Maharajh HD, Abdool PS, Mohammed-Emamdee R. The theory and practice of Consultation Liaison (CL) psychiatry in Trinidad and Tobago with reference to suicidal behavior. The Scientific World Journal. 2008; 8:920-928. Retrieved 2/1/2015.
6. Emmanuel MK, Campbell MH. Commentary: homicide-suicide in the Caribbean. Journal of American Academy of Psychiatric Law. 2014; 40:469-471. Retrieved 2/1/2015.
7. Runeson B, Tidemalm D, Dahlin M, Lichtenstein P, Langstrom N. Method of attempted suicide as predictor of subsequent successful suicide: natural long term cohort study. The British Journal of Psychiatry. 2010; 341(03222). Retrieved 8/3/2015 from http://www.bmj.com/content/341/bmj.c3222.short
8. Zhou XM, Jia SH. Suicidal communication signifies suicidal intent in Chinese completed suicides. Social Psychiatry and Psychiatric Epidemiology, The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services. 2012, Retrieved 9/4/2015.
9. Joe S, Baser RE, Breeden G, Neighbors HW, Jackson JS. Prevalence of and risk factors for lifetime suicide attempts among blacks in the United States. The Journal of American Medical Association. 2006; 296(17):2112-2123. Retrieved 8/3/2015 from http://jama.jamanetwork.com/article.aspx?articleid=203885
10. Vijayakumar L. Indian research on suicide. Indian J Psychiatry. 2010; 52. Retrieved 9/4/2015.
11. Rodriguez AH, Caldera T, Kullgren G, Renberg ES. Suicidal expressions among young people in Nicaragua: a community based study. Social Psychiatry and Psychiatric Epidemiology. 2006; Retrieved 9/4/2015 from http://link.springer.com/article/10.1007/s00127-006-0083-x/fulltext.html
12. Nordentoft M, Laursen TM, Bo Mortensen P. Change in suicide rates for patients with schizophrenia in Denmark. 1981-97: nested case-control study. BMJ; 2004; 329(7460):261. Retrieved 8/3/2015 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC498022/
13. Petteri Sokero T, Melartin TK, Rytsala HJ, Leskela US, Lestela-Mielonen PS, Isometsa ET. Prospective study of risk factors for attempted suicide among patients with DSM-IV major depressive disorder. The British Journal of Psychiatry. 2005; 186(4). Retrieved 8/3/2015 from http://bjp.rcpsych.org/content/186/4/314.full
14. Dougall N, Lambert P, Maxwell M, Dawson A, Sinnott R, McCafferty S, *et al.* Deaths by suicide and their relationship with general and psychiatric hospital discharge: 30-year record linkage study. British Journal of Psychiatry. 2014; 204(4):267-273. Retrieved 30/3/2016 from http://bjp.rcpsych.org/content/204/4/267
15. Seguin M, Beauchamp G, Robert M, Di Mambro, Turecki G. Developmental model of suicide trajectories. British Journal of Psychiatry. 2014; 205(2):120-126. Retrieved 30/3/2016 from http://bjp.rcpsych.org/content/205/2/120
16. Quinlivan L, Cooper J, Davies L, Hawton K, Gunnell D. *et al.* Which are the most useful scales for predicting repeat self-harm? A systematic review evaluation risk scales using measure of diagnostic accuracy. BMJ Open. 2016; 6. Retrieved 30/3/2016 from http://bmjopen.bmj.com/content/6/2/e009297.full?trendmd-share=0
17. Polit DF, Beck CT. Nursing research: principles and methods (7th edition). Lippincott, Williams, and Wilkins, Philadelphia PA. 2004.
18. Rathus SA. Essentials of psychology, Montclair University, 6th edition, Thomson, Wadsworth, United States, 2001.
19. Keller G. Statistics for management and economics. Belmont, California, Thomson Brooks-Cole, 2005, 7.
20. Onuoha P, Sergeant-Richards O. Knowledge of breast cancer: A case study of the primary health care (PHC) nurses of the Caribbean Island of St. Vincent and the Grenadines. International Journal of Current Research. 2014; (6)12:11023-11030.