

Developing a research tool to detect iatrogenic adverse events in psychiatric health care by involving service users and health professionals

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Accessible Summary

What is known on the subject:

- Most health professionals working in psychiatric care will experience adverse events (AE) such as service user suicide or violence, during their career
- Norway lacks measures to capture potential iatrogenic injuries, such as risk assessment measures, to evaluate patient records for AEs in both inpatient and outpatient psychiatric clinics in hospitals

What the paper adds to existing knowledge:

- We have described an approach to the validation of a research tool between different national contexts; a process that went beyond language translation
- We have incorporated the understanding of health professionals and service users; to bring together the lifeworld of the patient with the professional definition of AEs, triggers and risk areas of AEs in a psychiatric context. The service users' experiences resulted in modifications to the tool.

What are the implications for nurses:

- Applying the 'Global Trigger Tool—Psychiatry' in Norway and Sweden can help mental health nurses to prevent iatrogenic harm and reduce the occurrence of AEs through the identification of potential triggers.
- Implementing 'Global Trigger Tool—Psychiatry' might help mental health nurses to improve patient safety in Norway and Sweden.

Abstract

Introduction: There is little consensus on cross-cultural and cross-national adaptation of research instruments.

Aim/Question: To translate and validate a Swedish research tool (GTT-P) to detect iatrogenic adverse events in psychiatric health care by involving service users and health professionals in the process.

Method: The GTT-P, designed to identify events in patient records that were triggers for adverse events, was translated to Norwegian using a cross-cultural adaptation approach. This involved two focus groups with clinical staff, one of which involved service users, and a joint discussion at a Dialogue Conference to generate consensus

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on the definition of the triggers of potential adverse events identifiable in patient records.

Results: We highlight both the differences and commonalities in defining the nature of risks, the adverse events and the triggers of such events. The Dialogue Conference resulted in three modifications of the tool, based on service users' experiences. Service user involvement and co-production was essential for both the translation and adaptation of the research instrument.

Discussion: We have described an approach to the validation of a research tool between different national contexts; a process that went beyond language translation. This approach enables a more nuanced understanding of potential risks within a psychiatric context as it engages differences in the care delivery. Applying the GTT-P in hospital-based psychiatric care might help to identify processes that need to be changed in order to promote patient safety and a safer work environment for mental health nurses.

Implications for practice: When translating and validating the GTT-P from Swedish to Norwegian, we have considered the knowledge and experiences of both service users and health professionals. The application of the GTT-P can promote greater patient safety in hospital settings.

KEYWORDS

adverse event, Global Trigger Tool, patient involvement, patient safety, psychiatry

1 | INTRODUCTION

Good quality in health care means services provided are effective, secure and safe and involve patients to give them influence over their own health care (Aboaja et al., 2021; Bhugra et al., 2017; McGuire et al., 2021; Storm & Edwards, 2013; Vincent & Coulter, 2002; WHO, 2020). Developing research tools to evaluate services is well-established and beneficial (Barber et al., 2011).

The benefits of service user involvement are typically framed as ensuring greater relevance of research questions, improving response rates and increasing the impact of dissemination (National Institute of Health Research, 2014). The inclusion of service users in the development of research tools can contribute to service development, which, in turn, can reduce adverse events (AEs) and promote quality-assured healthcare services (Berzins et al., 2020; von Peter et al., (2022). Roelandt et al. (2020) argue that the International Classification of Disease (ICD) should be co-constructed by professionals, service users and carers. Such definitions should consider the emotional aspects of language as well as the diversity of linguistic and cultural contexts.

A research instrument is only valid if the instrument measures the same thing in all contexts (Gjersing et al., 2010). There is a challenge in translating that goes beyond language to acknowledge different policy, organizational and historical contexts (Beaton et al., 2000; Epstein et al., 2015). International studies rely on common indicators and tools developed in one cultural and healthcare context and adapted to permit cross-national comparisons (Cohen-Kettenis et al., 2003; Maters et al., 2013; Sajith et al., 2021; Sharma

et al., 2022). The process of adaptation is rarely made explicit, potentially undermining both the validity and replicability of such studies (Maneesriwongul & Dixon, 2004; Wang et al., 2006). There is a clear distinction between translation and cross-cultural adaptation (CCA) and the latter also considers the difference 'between the source and the target culture so as to maintaining equivalence in meaning' (Epstein et al., 2015: 436). The challenges of CCA of research tools are increasingly acknowledged in the literature, but there is little consensus on the best approach (Beaton et al., 2000; Epstein et al., 2015; Uysal-Bozkir et al., 2013).

Herdman et al. (1998), drew on evidence from the health-related quality of life (HRQoL), literature, interviews and discussions with researchers to develop a model for the translation and adaptations of HRQoL questionnaires. Some scholars argue for the importance of qualitative evidence, while others emphasize the need for a mutual interaction between service users and healthcare professionals in the process (Breugelmans, 2009; Herdman et al., 1998). Expert opinion and review of the literature are important in developing the contextual framework but require patient input, which usually is gained through patient interviews and focus groups. Research instruments need to be designed to integrate the experience of service users and health professionals.

We translated and validated a Swedish instrument (Global Trigger Tool—Psychiatry, GTT-P) for measuring AEs in psychiatric hospitals for a Norwegian hospital setting (Nilsson et al., 2020). An AE is defined as an unintended injury caused by medical management resulting in the prolongation of a hospital stay or in diminished function/disability. Similarly, 'triggers' are indicators

identifiable in patient records that are associated with a potential AE (Jayaram, 2008; Nilsson et al., 2020). There is little consistent agreement on what constitutes AEs in psychiatric environments (Berzins et al., 2020) and most studies have explored the frequency of specific AE such as suicide, absconding, medication errors or falls (Bowers et al., 2003; De Santis et al., 2015; Higuchi et al., 2015; Hunt et al., 2010; Jayaram, 2008, 2014; Keers et al., 2014; Lee et al., 2012; Mills et al., 2013; Muir-Cochrane et al., 2013; Powell et al., 1994; Powell-Cope et al., 2014; Staggs, 2015). Most health professionals working in psychiatric care will experience AE, such as service user suicide or violence, during their career (Kuosmanen et al., 2022; Martens et al., 2016; Waddell & Gratzner, 2021).

The healthcare systems in both Sweden and Norway have been shaped by similar structural conditions and contexts, as well as democratic policies promoting equality and equal access, which are central to both societies. Populations of the two countries share similar demographic and socioeconomic characteristics including public funding for the healthcare system and education of healthcare employees (Veggeland, 2016). The legal systems in both Sweden and Norway are referred to as civil law, in contrast to the common law tradition in England/Wales and the US (Sjöström et al., 2011). The mental healthcare system is similar, although there exist differences that need to be considered when interpreting research data from both countries. For example, in Norway, compulsory community care (CCC) has existed since 1961 and was expanded in 1999 Mental Health Act to include implementation without a prior hospital stay (Sjöström et al., 2011). CCC was first introduced in Sweden in 2008 and can only be initiated upon discharge from hospital-based compulsory care (Zetterberg et al., 2016).

There are benefits in increasing the knowledge of both researchers and service users (Tritter & McCallum, 2006) as well as promoting empowerment and trust (European Observatory on Health Systems and Policies & Bedlington, 2015), which is an additional justification for the approach taken in our study. The validity of a research instrument is essential for findings to be relevant. This requires accessing the lifeworld of service users as well as the clinical understanding of the delivery of psychiatric care (Scambler & Britten, 2001; Waitzkin, 1984). Indeed, involving service users and health professionals in research has been conceptualized as creating a liminal space where traditional roles and assumptions of expertise do not always hold (Maguire & Britten, 2018).

To understand and respond to service user's experience, particularly in terms of patient safety and perceptions of risk, we drew not only on the lifeworld of the patient but also on health professionals' definition of illness and treatment (Bissell et al., 2018; Britten, 2008). Mishler (1984) suggests that patients contextualize experience of events is the 'voice of the lifeworld' and contrasts with the 'voice of medicine' which decontextualizes events from particular personal or social contexts. Although much has happened over the last decades regarding user involvement in healthcare services, this contrast is still relevant. In clinician-patient interactions the voice of medicine often speaks for the system and does not adequately consider the lived experience of the patient, potentially creating a barrier to communication (Barry et al., 2001).

There is a lack of research tools in psychiatry to detect iatrogenic adverse events that have included the experiences of both service users and health personnel in the validation process (Nilsson et al., 2020; Waddell & Gratzner, 2021).

The aim of the study was to validate a research tool for assuring quality in psychiatric health care by involving service users and health professionals. This article presents a validated version of a Swedish instrument (GTT-P) to a Norwegian setting that incorporated the understanding of service users, health professionals and research of the risk for AEs in Norwegian hospital-based psychiatric care. By involving service users and health professionals we ensure that the Norwegian GTT-P incorporates both the 'voice of medicine' and the 'lifeworld of the patient'. In the study, we explore the differences and points of similarity between the issues raised by service users and health professionals about the experience and risk of AEs in psychiatric care. The process we adopted, we argue, addresses some of the problematic issues of CCA by taking into account of differences in both the language and clinical context of Norwegian psychiatric care from a Swedish setting. It creates a model for more robust cross-cultural research, particularly for assessing patient safety and risk.

2 | MATERIALS AND METHODS

The study is based on a Swedish questionnaire (Nilsson et al., 2020). The translation of the GTT-P handbook using a series of steps including language translation from Swedish to Norwegian. Drawing on focus group interviews with different categories of clinical staff and service users as well as a Dialogue Conference involving all the participants explicitly reviewing the content of the instrument. The Global Trigger Tool (GTT) was designed to review medical records, generating data on the frequency and types of AEs in somatic care (Resar et al., 2003). To our knowledge, Sweden was the first country where the GTT has been adapted to measure AEs and describe the incidence, nature, preventability and severity of AEs in adult psychiatric healthcare (GTT-P) (Nilsson et al., 2020).

2.1 | Step 1

We created three focus group with service users and health professionals. The purpose of the focus groups was to identify and define AEs in psychiatric care from the perspective of both health professionals and people who had experience of psychiatric treatment (service users). The discussion in a focus group is not intended to generate consensus but rather to share experiences and understand how they relate to the views of other participants (Patton, 2001).

Purposive sampling was used to recruit participants to the study (Tong et al., 2007). Focus groups 1 (six participants) and 2 (seven participants) consisted of health professionals recruited from all three geographical locations located under the Psychiatry Department at a hospital in Norway. Participants in focus group 1 consisted of psychiatrists, psychiatric nurses and psychologists and focus group 2



consisted of psychiatrists and psychiatric nurses (see Table 1). Focus group 3 consisted of four service users recruited by the Service User Involvement Board at the hospital drawing on Mental Health Norway (the largest Norwegian mental health user group) and KBT (the Norwegian Competence and Resource Center for Service Experience and Service Development). The service users had experience of psychiatric care delivered by the hospital (see Table 1).

The leader of each geographical location selected members for focus group 1 to ensure participants had a range of key characteristics: gender, clinical roles, age and a length of time working in the hospital. The Head of the Psychiatry Department selected the clinicians for focus group 2 with the same criteria as for focus group 1. The leaders of the hospital's User Involvement Board, Mental Health Norway and KBT recruited service users for focus group 3. Seven service users, with experience of psychiatric care, were invited to participate, but only four were able to attend the focus group due to illness on the day of the meeting.

The topic guide for the focus groups (see Table 2) explored the patient journey and specific points with a risk of AE. The themes were developed from the research literature, The Swedish handbook for GTT-P (SKL, 2015) and discussions with the Swedish research group that had validated the original GTT. The focus groups were held in Norwegian and co-facilitated by a senior hospital trust manager and researcher and a specialist psychiatric nurse. The final section of the focus group was devoted to considering what, in a written patient record, could be an indicator of AE or might be understood as a trigger of AEs; an indicator might also be the absence of an action or intervention.

2.2 | Step 2

The Swedish version of the GTT-P was translated from the source language Swedish into the target language Norwegian (forward translation) according to the cross-cultural adaptation of research instruments as described by Gjerset et al. (2010) and

Breugelmans (2009). We conducted a quality-control step in which the target language version was translated back into the source language (back translation) (Breugelmans, 2009). The translations were undertaken by the last author who is fluent in both Norwegian and Swedish.

2.3 | Step 3

We conducted a Dialogue Conference, providing the opportunity for all the participants from the focus groups, who agreed to participate, coming together to review the content of the translated tool developed from the previous steps of the validation process. The Dialogue Conference included 10 participants: three service users and seven health professionals (two psychiatrists, one psychologist and four psychiatric nurses). We arranged the conference in a pleasant meeting room, where we starting by drinking coffee/tea together and chatting about everyday life. The participants could choose where to sit around a table in the room. The service users chose to sit together. We then had a presentation round so that the participants could get to know each other a little better.

The Dialogue Conference adopted principles of a democratic dialogue to create symmetry between the participants according to contributions and arranging the conversation (Ekman Philips & Huzzard, 2007).

The Dialogue Conference began with a discussion of how to define AEs in psychiatric care and distinguishing between avoidable and unavoidable events. AE can occur when health personnel have not followed guidelines or as a result of delays in examination and treatment/follow-up. These can result in an injury that could have been prevented. The participants discussed the key issues raised in the focus groups and was followed by a review of the translated version to highlight differences related to the Norwegian context. Specifically, participants were asked to consider the similarities and differences in the translation and meaning, to note the triggers identified in the Swedish version but excluded from the Norwegian

TABLE 1 Research participants.

	Service users	Health professionals	Male	Female	Age Range	Experience of psychiatric care (years)
Focus Group 1	0	6	2	4	31–62	2–32 Median = 10
Focus Group 2	0	7	0	7	34–56	1–21 Median = 9
Focus Group 3	4	0	3	1	29–69	
Dialogue Conference	3	7	3	7	29–58	

1	What constitutes patient injury (AEs) within mental health care and interdisciplinary specialized treatment for drug abuse in specialist health service?
2	In what situations is there a risk that a patient injury (AE) may occur? (Help text if needed: Within the system level, medication, treatment, transitions, coercion, drug abuse)
3	What could be possible triggers in Norwegian psychiatric records that could identify potential patient injury?

TABLE 2 Topics for the focus groups interviews.

version and whether any additional triggers were needed. These results were used to modify the final Norwegian version of the GTT-P.

2.4 | Analysis

All focus groups were audio-recorded and transcribed verbatim by a secretary at the hospital generating 59 pages of transcribed text and an additional 32 pages from the Dialogue Conference. In addition, field notes were made during and after the focus groups and the Dialogue Conference (Tong et al., 2007).

The transcripts of the audio tape recording from the focus groups and Dialogue Conference were analysed using content analysis (Graneheim & Lundman, 2004). The first author used Microsoft Excel 2016 as software to develop a coding tree which was checked by the other authors. Content analysis allowed the identification of similarities and differences in textual content. These differences were expressed through categories where context is of importance. The interpretation of texts, therefore, presumes knowledge of the context within which a study is carried out (Lundman & Graneheim, 2012). For example, the present study was conducted in a psychiatric unit in a hospital setting. The analyses of the data from the professionals in focus groups 1 and 2 generated similar findings, and we, therefore, chose to present data from focus group 1 in the comparison to the service users in focus group 3.

Author one and three reviewed each transcript individually and then met to review their understandings and specify different risk areas and the coding of AEs and triggers identified in each focus group. In total, our analysis identified codes for 32 AEs grouped into seven categories: mental injury, prolonged disease progression, self-harm, drug-related injury, physical injury, illegal/unethical treatment and other. In terms of triggers, we identified 50 codes grouped into five categories; treatment, continuity of care, drug/alcohol misuse, medication and coercive treatment. We were particularly attentive to highlighting the differences between health professionals and service users. Often these dissimilarities were more about the language used to describe a particular AE rather than differences in conceptualization. In addition, we reviewed the transcript from the Dialogue Conference and counted the utterances made by the health personnel and the service users to look for differences in content and the number of statements. The study was in accordance with the consolidated criteria for reporting qualitative research (Tong et al., 2007).

3 | RESULTS

Our analysis explored the differences and points of similarity or consensus between the service users and health professionals about the risk and experience of AEs in psychiatric care. In psychiatric care, AEs can engender both physical and mental harm, relating to two categories of AEs: *mental injury* and *physical injury* and three clinical

management trigger categories: *Coercive treatment*, *Inadequate treatment* and *Continuity of care and transition*. Initially, we present key findings associated with the focus groups with health professionals (focus group 1) and service users (focus group 3) before considering how the deliberations in the Dialogue Conference modified the final version of the Norwegian GTT-P.

Both service users and health professionals separately identified mental injuries as potential AEs associated with psychiatric treatment. For the health professionals, this was framed in terms of the importance of respecting the person behind the diagnosis, while for service users this was understood more in terms of the additional consequences associated with a diagnosis (labelling, stigma). As an elaboration, service users considered mental injury, or 'suffering', as one of the most important AEs and identified stigmatization as a possible cause of mental injury. Another AE discussed in the focus groups related to physical injury but this was only raised by the health professionals.

3.1 | Adverse event—Mental injury

The potential for treatment to lead to mental injury was discussed at length. For service users, in approaching treatment it was vital to consider holistic needs and the challenges of labelling while for health professionals it was primarily the unintended consequences of treatment that was most important. This resulted in conceptualizing the entire patient experience as generating potential AEs related to mental injury; such AEs were understood to be caused indirectly by treatment. As one health professional explained,

If there is an emergency event in the department and someone is seriously injured or something is happening, other patients may feel quite traumatized when they see how the patient is being treated, maybe they even see the incident.

(Health Professional, HP1)

For this health professional participant, there is a possibility of mental harm to service users through exposure to incidents that occurred to others within the psychiatric unit. Even when an intervention to another service user was handled appropriately, the fact that it took place could be traumatic. Therefore, it was important to this participant that not only the direct effects of treatment but also the context of that treatment and the extent to which it could be seen were an AE.

To some extent, the service users also considered the relevance of indirect effects but tended to link these to broader responses to treatment and particularly the consequences of labelling rather than specific incidents. As one service user noted,

A patient injury may be related to an aversion to the healthcare system. ... Something I'm busy with at present is the pathologizing and infantilization of



patients. You [the patient] receive a treatment where you feel that you are not necessarily seen and treated as a person.

(Service User, SU1)

For this service user, it was the interface between service users and the psychiatric system that often led to paternalism and a lack of attention to holistic care that generated AE. Thus, AEs causing mental injury were understood by service users in a broader sense than for health professionals who linked them to a specific treatment interaction or incident.

3.2 | Adverse event – Physical injury

The potential of physical injury from treatment in a psychiatric setting was only raised in the health professional focus groups but when raised in the Dialogue Conference engendered a response from service users. As one health professional explained,

That is something we are very concerned with at the outpatient clinic... It is that we have too few doctors so we overlook somatic illness. That we persuade ourselves that issues are psychiatric rather than considering them as somatic.

(HP4)

In general, however, health professionals consider the likelihood of physical harm to be less related to the consequences of psychiatric treatment and more to the presence of somatic illness. However, due to a shortage of doctors, the clinic ignores the possibility of somatic illness.

The GTT-P is designed to be applied to patient records; therefore, our analysis went on to consider data concerning triggers that might be related to potential AEs that could be identified in patient records. In terms of triggers both focus groups identified *insufficient continuity of care* as problematic and a potential trigger of an AE, but for service users, this was explicitly defined in relation to the transition at the end of treatment or limited follow-up after discharge. Both groups considered *inadequate treatment* as an important trigger, but this engendered more discussion by the health professionals who were particularly concerned with a lack of attention to protocols and treatment plans. The final key issue raised in the focus groups was *coercive treatment* and both groups viewed this as an important potential trigger of an AE.

3.3 | Trigger—Coercion

Psychiatric treatment has typically relied on different forms of coercion ranging from confinement and restraint to the imposition of treatment. Health professionals considered coercion as an aspect of

treatment while service users considered coercion to be a characteristic of the psychiatric system.

The health professionals in our study expressed concern about the consequences of coercive treatments and their potential to create trauma and AEs.

I think of the trauma that we can inflict on them [service users] because they are hospitalized because of risks of self-harm or suicidal thoughts and to protect them from it, then we may need to use mechanical coercive instruments that we subsequently hear create problems for them like PTSD, trauma.

(HP3)

For this health professional, coercion could create problems as significant as those that the treatment was designed to alleviate.

For service users, coercion was embedded in the penalties and rewards associated with particular behaviours and linked to how rules in the system limited their individual freedom. As one service user explained:

I was an inpatient on a voluntary basis. I snuck out, and outside the door there were three police officers who drove me straight to the emergency [out-of-hours] doctor and had me admitted coercively. ... It did not feel good at all that there were three uniformed policemen outside there.

(SU1)

For some service users, the method by which rules were enforced was considered a form of coercion and limited their rights, as a conversation within focus group 3 illustrates.

SU1: It involves so much that can cause a patient to avoid seeking help.

SU2: They [service users] get an aversion to psychiatric unit

SU1: Only one [the acute psychiatric clinic] has a smoking time. Such an approach may simply be enough for a patient not to seek help.

If someone is not allowed to smoke before 07:00, the patient is used to waking up at 05:00 and is told to stay in the room, without smoking, without any thing. It's enough to make people not seek help, so ... I think it's more than coercion. Because this anti-smoking policy does not have a really good treatment function.

For these service users, how the rules about smoking were enforced was coercive and might lead to an unwillingness to seek help, an indirect trigger of a potential AE.

3.4 | Trigger—Inadequate treatment

Service user concerns about inadequate treatment related to limited information and scope for shared decision-making, while for health professionals this related to insufficient attention to formal diagnostic procedures and care planning.

Especially in outpatient clinics, but it also applies during hospitalization when no diagnosis or an incorrect diagnosis is made. This may lead to patient injury because the patient would not receive an available treatment so that he [sic] has missed an opportunity to recover, or at least be helped. ... because one avoids diagnosing or the diagnostic quality is too low, this is a common issue. Also, the diagnosis could be confirmed too late. A lot of time is wasted.

(HP4)

For this respondent, inappropriate diagnoses were a trigger of potential AEs but also lead to delayed diagnoses and interventions being given too late. While service users did discuss inappropriate diagnosis and treatment, they were particularly concerned with the lack of engagement between health professionals and individual service users about their diagnosis and the consequences this had for care and recovery.

3.5 | Trigger—Insufficient continuity of care and transition

Continuity of care was important for all the participants, and problems stemming from moves between departments within a hospital as well as within a psychiatric unit were highlighted. As one health professional explained:

I think about the risk of transitions. From one department to another and from department to primary care. The transitions there may ever slip away, especially when I think about medication.

(HP2)

For service users transitions were also problematic but primarily in terms of discharge and becoming an outpatient.

SU3: So, one thing I'm thinking about, because we have talked about hospitalization and so on. And, oh, I think there's a lot happening after hospitalization, right. Depending on how long one has been admitted and so, but I think it's an important time when things happen a lot and I think if you do not get enough follow-up afterwards, I think you can find yourself, suddenly, in some bad life situations ...

SU3: Yes, it is like a kind of vacuum for me who's used to being in a ward with a lot of people and other patients and so and then you get home and maybe you have an appointment to the outpatient clinic: 'Yes, we'll talk about that in a week then'. I think transitions are very important ... because it's very scary ...

For the service users the lack of follow-up and support in managing the transition from the security of the hospital ward the relative isolation of 'outside' held the potential for generating AEs more than shifts between settings within the hospital.

3.6 | The Dialogue Conference

The Dialogue Conference generated two specific modifications to the draft Norwegian tool. The first change related to a key point from a service user regarding a trigger linked to treatment planning where the description of service user demands for information to justify a particular treatment plan was insufficiently articulated. This led to the description of two triggers—*Individual Plan* and *Treatment Plan*—being changed to incorporate whether sufficient information had been provided to service users as part of the planning process.

The second change concerned medication; being prescribed two or more benzodiazepines as a potential risk compared to the threshold of three or more in the Swedish tool. This issue was raised by one service user (SU5) and confirmed by a participating psychiatrist (HP7).

Researcher 1: Is there really someone who is taking three or more benzodiazepines?

SU5: Oh my God I haven't heard of a person having three or more different benzodiazepines? ... But if you have *Sobril* during the day and *Imovane* in the evening then you have two [benzodiazepines] then you really can't drive a car. Should it be three as they have in the Swedish tool?

HP7: No, let us go for two [benzodiazepines].

Despite these changes, the discussion within the Dialogue Conference was essentially a consideration of the problems of diagnoses and dominated by health professionals as the three participating service users spoke very little: 74% of all sentences were vocalized by psychiatrists and specialist psychologists while specialist psychiatric nurses spoke 21% of all sentences and service users only uttered 5% of the sentences.

4 | DISCUSSION

We have described an approach to the validation of a research tool between different national contexts; a process that went beyond



language translation. We sought to incorporate the understanding of Norwegian service users and health professionals; to bring together the lifeworld of the patient with the professional definition of the treatment in psychiatric care. The process of drawing on each group separately to identify potential AEs and triggers, to elaborate an approach to mitigate or manage the risk of patient injury was followed by a space for dialogue, debate and deliberation between all the participants. This resulted in modifications in the translation of the Swedish tool to reflect both the views of service users and the culture of clinical practice in Norway. We suggest that this is a good approach to validating a tool for cross-national research. More importantly, this is an approach that enables a more nuanced understanding of potential risks within a psychiatric context as it engages differences in the care delivery and the social construction of illness. The potency of this approach, we suggest, is that it identifies the areas of agreement in the definition of risks, AEs and triggers. As importantly it also reveals the different ways that service users and health professionals make sense of treatment. This is in line with previous research (Aboaja et al., 2021; Follevåg & Seim, 2021; von Peter et al., (2022) which shows that this interaction and the sharing of experience is useful for improving practice.

Applying the GTT-P in hospital-based psychiatric care might help to identify processes that need to be changed in order to promote patient safety and a safer work environment for mental health nurses, as well as preventing a downward spiral of psychopathology for patients (Martens et al., 2016; Nilsson et al., 2020). Validation of the GTT-P through a process of engaging patients and health professionals might create and promote a safety culture and improve the quality of inpatient mental health care (True et al., 2017).

This research is an example of patient involvement. Service users had equal standing as researchers and health professionals in generating data and interpreting the findings developing the GTT-P. Despite exercising their voice less in the Dialogue Conference, participation by service users led to changes in the research tool and the inclusion of AEs that were specific to their experience in the Norwegian clinical context. Research in mental health has a long history of patient involvement (Askheim, 2017; Barber et al., 2011; Storm & Edwards, 2013) and our findings, particularly in terms of the 'mental harm' that treatment and the clinical context can create, is grounded in service users' knowledge. The imposition of clinical constructs on service users, particularly in psychiatry, can be a significant source of iatrogenic harm (Sue, 2015). Our study contributes to the methodological literature on cross-national comparative research and the understanding of risk and harm in psychiatric treatment, highlighting that harm could be a mental injury expressed through feelings of rejection, being misunderstood, infantilized or ignored and a lack of co-determination as shown from the focus group discussion with service users. This is in line with earlier research (Axelsson et al., 2020; Berzins et al., 2020; Oeye et al., 2009).

Our research shows, that service users understood AEs in a broader way than health professionals. The identification by service users of 'mental injury' including the stigma associated with labelling,

was broader than the conceptualization by health professionals who understood AEs primarily in relation to treatment. Thus, the lifeworld of the patient was more holistic than from health professional's view. Coercion too, was an issue where there were contrasts in the two conceptualizations. For health professionals, there was an acceptance that treatment incorporated some forms of coercion, but this was a source of moral discomfort. For service users, however, coercion also included freedom and rights-limiting rules often enforced within inpatient psychiatric units; a broader understanding embedded in their lived experience.

Despite evidence that clinical engagement acknowledging the lifeworld of the patient is common in psychological consultations, our research suggests that service users maintain a broader understanding of AEs and their consequences than health professionals who considered primarily the potential injurious consequences of treatment (Barry et al., 2001). Like Maguire and Britten (2018) we found that service users, but not health professionals, had found a way to repress their lifeworld roles. For instance, health professionals found it difficult to accept the broader definition of harm associated, not only with treatment, but with the felt stigma experienced by service users. The differential participation in focus group and the relatively few utterances apparent in the Dialogue Conference reflects differences in the number of participants but also, inevitable underlying power differences and perhaps the continued dominance of the health professionals. Such power asymmetries are a well-established characteristic of both clinical settings and mental health contexts (Hodge, 2005; Pilnick & Dingwall, 2011), although there has been focus on co-determination in one's own treatment which reduces the risk of 'non-therapeutic power' (Kaminskiy et al., 2017). Being met with skilled, respectful professionals, who treat patients with dignity is important for feelings of co-determination (Dahlqvist Jönsson et al., 2015; Steinsbekk et al., 2013) and in addition, it helps to improve mental health services (Axelsson et al., 2020). The pattern of interaction we observed suggests an invisible struggle between the value and purposive rationalities of service users and health professionals.

Health professionals have essential expertise that is necessary in order to navigate clinical systems but, we suggest, they need to expand the definition of relevant knowledge to include the lifeworld of the patient in order to understand the broader consequences of the system on the patient (Dahlberg et al., 2009). Patient safety, particularly in relation to psychiatric care, needs to account for this broader definition of AEs and accessing and acknowledging the lifeworld of those who are the recipients of this care is essential. This is particularly the case in defining what counts as an AE and the relative hierarchy of such incidents.

4.1 | Strengths and limitations

A strength of this study is that in seeking to validate a research tool from Sweden it went beyond simple language translation. Instead,

we incorporated the understanding of both service users and health professionals; bringing together the lifeworld of the patient with the professional definition of AEs, triggers and risk areas of AEs in the Norwegian context. We consider our study to be credible and reliable as we have done not only back-and-forth translation from Swedish to Norwegian, but also involved both service users and health professionals in all aspects of the research. The input from all those affected by treatment in defining the risks and harms associated with psychiatric care, and how these were visible and present in a patient record, provides perhaps a more holistic and reliable form of measurement.

A limitation is that we invited seven service users to participate but only three accepted the invitation to take part in the Dialogue Conference. Service users uttered only 5% of the sentences. Ideally, the number of service user should be equal to the number of participating health professionals (Ekman Philips & Huzzard, 2007). We created a welcoming space for discussions, but the health professionals dominated the discussion. To ensure service users taking more active part of the discussion, we could have considered alternative or complementary methods, perhaps drawing on nominal group techniques (Maguire et al., 2022; McMillan et al., 2016). This is defined as a structured method for group **brainstorming** that encourages contributions from everyone and facilitates quick agreement on the relative importance of issues, problems or solutions to more effectively bring the lifeworld of the service user together with that of health professionals. Unfortunately, we did not have time and resources for that. Nevertheless, we consider the study to be trustworthy based on the fact that we took all the data from the focus group with the service users into consideration when validating the GTT-P.

5 | CONCLUSIONS

This study details a process of developing a CCA for a particular patient safety research tool GTT-P. Both service users and health professionals were involved in all aspects of the research and defined the risks and harms in the development of the GTT-P in a Norwegian setting.

With our approach, we sought to access and link the clinical lifeworld of the psychiatric clinic with that of the service users who inhabited and were the object of the treatment in this space. With involving both the service users and the health professionals in the focus groups and a dialogue conference, it was highlighted that there are differences in the ways service users understood, prioritized and described AE compared to health professionals.

The process did challenge health professionals to think differently about treatment in a psychiatric context and gave them access to service user's constructions of the situation. We assume that the application of the GTT-P may promote patient safety and create a different clinical lifeworld. Our conclusion is that this is a good approach to adapting a tool for cross-national research.

5.1 | Further research

After validating the GTT-P, we conducted a quantitative survey to test the instrument (Okkenhaug et al., 2019). Further quantitative studies with multiple reviews of medical records should be conducted to further detect AEs. Extending the comparison to include other countries would help explore the extent to which AEs are specific to particular health systems or inherent in inpatient psychiatric care.

6 | RELEVANCE STATEMENT

Patients treated in psychiatric care are exposed to the risk of adverse events (AEs) as are patients treated in somatic care (Nilsson et al., 2020). Psychiatric nurses are likely to encounter AEs at some point in their career. Like other countries, Norway lacks measures to systematically capture potential iatrogenic injuries, such as risk assessment measures for evaluating patient records for AEs in both inpatient and outpatient psychiatric hospitals. By implementing a tool for systematically measuring patient safety, mental health nurses might improve the health care for psychiatric patients. In this study, we report the cross-cultural adaptation (CCA) involving both service users and health personnel of the 'Global Trigger Tool—Psychiatry' instrument (GTT-P) from Swedish to Norwegian. A joint discussion at a Dialogue Conference generated consensus on the definition of the triggers and AEs and resulted in modifications based on user's experiences. Applying the tool can provide new processes to promote patient safety in hospital psychiatric care.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENTS

The study was considered by the Regional Ethics Committee which concluded that it did not require formal ethical approval (2017/1779 REK Midt) and was, therefore, considered by the Data Protection Officer (DPO) at Nord-Trøndelag Hospital Trust who approved the study (2017/39–2369/2017).

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