

RISK WATCH

October 2020

Selected research, publications, and resources to promote evidence-informed safety and risk management in Canadian healthcare organizations. Prepared by Healthcare Risk Management staff at the Healthcare Insurance Reciprocal of Canada (HIROC). Titles with an open lock icon  indicate that a publication is open access. For all others a subscription or library access is required; the librarian at your organization may be able to assist you. Please contact riskmanagement@hiroc.com for assistance if required.

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EDITOR'S NOTE



Dan Altenberg

Themes in the October issue of Risk Watch include risk and safety interventions in acute care mental health, and communication strategies for a wide range of services. Chaimowitz et al. found that the clinical utility of risk assessment tools are more effective in acute care mental health facilities if they are concise, efficient to administer, have the endorsement of accreditation or licensing bodies, and relate to organizational culture and strategic plan. Specifically, they describe the implementation of a structured professional judgment tool designed to assess patient violence. Similarly, Gabet et al. found that effective implementation of psychiatric emergency interventions relies on early staff involvement, particularly among physicians, and especially in cases of potential cultural clash between staff and organizations. Communication problems between staff and organizations were often related to their distinct cultures, values and practices. Implementation issues identified in these studies were similar to those reported in the general implementation literature.

These concepts dovetail nicely with the findings offered by the other open articles including: Blazin et al.; Reid et al.; Harasym et al., and Lord et al. Each of these studies identify communication barriers, and strategies to enhance communication between providers, patients and families within a wide range of health care services. Studies demonstrate that patient safety in hand-off transitions, palliative advance care planning, and medication double checks are improved with the planned implementation of standardized, structured communication. Each study explores specific tools, common sources of error, and attempts to demonstrate how to enhance current communication procedures and strengthen a safety culture in healthcare.

If you have feedback about this month's articles or Risk Watch, please send them to me at daltenberg@hiroc.com.



QUALITY IMPROVEMENT/MENTAL HEALTH

Implementation of three innovative interventions in a psychiatric emergency department aimed at improving service use: a mixed-method study

Gabet M, Grenier G, Cao Z, et al. *BMC Health Serv Res.* 2020 (September);20(1):854.

Study in Canada describing the implementation of three innovative interventions in a psychiatric emergency department, implementation barriers, and the impact of these on mental health service use and response to needs for high-frequency patient populations.

QUALITY IMPROVEMENT/SURGERY

Shared care in surgery: practical considerations for surgical leaders

Reid M, Lee A, Urbach D, et al. *Healthc Manage Forum.* 2020 (online, September):1-4.

Article from Canada in which surgical leaders share a toolkit for team-based shared care to address the challenges in meeting the surge in demand for surgical services following the initial COVID-19 response. This article outlines benefits to the healthcare system, patients and providers and also offers tools to support organizations with implementation of this intra-disciplinary model. Authors noted an opportunity to revise the existing model of care to improve the delivery of surgical services and improve outcomes for patients and the health care system.

QUALITY IMPROVEMENT/PAEDIATRICS

Improving patient handoffs and transitions through adaptation and implementation of I-PASS across multiple handoff settings

Blazin L, Sitthi-Amorn J, Hoffman J, et al. *Pediatr Qual Saf.* 2020 (July/August);5(4):1-9.

Article describing a quality improvement initiative in a US paediatric hospital using a validated tool to improve patient handoff and reduce the incidence of medical errors. The tool uses a mnemonic, which represents 5 components of quality patient handoff: illness severity (I), patient summary (P), action list (A), situational awareness and contingency plans (S), and synthesis by the receiver (S) (I-PASS). Participants included pediatric patients with complex medical diagnoses and ongoing inpatient and outpatient treatment needs over extended time periods requiring multiple patient handoffs. This initiative aimed to broaden the applicability and increase use of the formal I-PASS process.

ADVANCE CARE PLANNING/PAEDIATRICS

Assessment of bereaved caregiver experiences of advance care planning for children with medical complexity

Lord S, Moore C, Beatty M, et.al. *JAMA Netw Open.* 2020 (July);3(7):1-10.

Study in Canada to explore the experiences of bereaved family caregivers with advance care planning for children with medical complexity. Participants were from a single tertiary care paediatric centre. Themes were divided into three categories: structure of care, advanced care planning process, and end of life experience.

MEDICATION SAFETY/CHEMOTHERAPY

What do double-check routines actually detect? An observational assessment and qualitative analysis of identified inconsistencies

Pfeiffer Y, Zimmerman C, Schwappach D. *BMJ Open.* 2020 (online, September):1-7.

Study in oncological wards and ambulatory infusion centres in Switzerland to explore the frequency of detected potential medication errors before administering chemotherapy. Authors noted in 3.2% (22 of 690) of observed double checks, 28 chemotherapy-related inconsistencies were detected. Authors provided the kind of information detected within the double check process, subsequent and corrective actions, frequency and examples.

SAFETY/HEALTHCARE QUALITY

Making the implicit explicit: a visual model for lowering the risk of implicit bias of mental/behavioural disorders on safety and quality of care

Ungar T, Knaak S, Mantler E. *Healthc Manage Forum.* 2020 (online, September):1-5.

Article from Canada discussing how the implicit cognitive bias of mental versus physical care can result in human factor risks to quality of care, including diagnostic overshadowing, role confusion, provider conflict, and lower patient satisfaction. Authors provided examples of how quality and safety risks occur in clinical situations and propose a visual model to help manage the risk of implicit bias. "In addition to conscious and careful analytical thinking (System II thinking), clinicians' decision-making processes also include a heavy reliance on intuitive and unconscious System 1 thinking—which is where implicit biases reside" (p. 1).

RISK MANAGEMENT/MENTAL HEALTH

Implementation of risk assessment tools in psychiatric services

Chaimowitz G, Mamak M, Moulden H, et al. *J of Healthc Risk Manage.* 2020 (July);40(1):33-43.

Study in Canada to review and present lessons learned from the implementation of clinical practice guidelines on a general scale and the implementation of a tool called the *Hamilton Anatomy of Risk Management* (HARM) across a variety of psychiatric services.

VIRTUAL CARE/INNOVATION

Virtual care and the pursuit of the quadruple aim: a case example

Bearnes R, Feenstra B, Malcolm J, et al. *Healthc Manage Forum.* 2020 (online, September):1-6.

Article from a Canadian academic teaching hospital describing the development of an innovation strategy to guide the adoption and maturity of virtual care as a means of supporting the pursuit of the quadruple aim (improving the experience and outcomes of patients, improving the health of a population, reducing per capita costs, and providing an improved provider experience) and achieving the organization's mission and vision. Over a 12 month period, the organization saw a 265% increase in the number of active users and a 3,775% increase in the number of virtual visits. Authors discussed foundational characteristics, areas of focus for their virtual care innovation, challenges and suggestions for success.

SAFETY/CULTURE

Bridging the gap between culture and safety in a critical care context: the role of work debate spaces

Leuridan G. *Saf Sci.* 2020 (September);129:1-8.

Study in a critical care unit of a large university hospital in France to explore how formal and informal "work debate spaces" (WDS), which are organizational spaces that serve as a vehicle for organizational learning and practices changes, can connect organizational culture and safety. Author noted the importance of WDS for collective reconstruction of situations encountered and to ultimately ensure reliability and resilience, as well as the "role (and accountability) of organizational structure (and its leaders) in the "making of safety"" (p. 7).

Other Resources of Interest (all)

[Moving the dial in patient safety: the path from risk management and quality improvement to Safety II, resilience and restorative practices in health care](#) (August 2020). BC Patient Safety and Quality Council webinar.

[Oxygen tank storage regulations](#) (August 2020). Health Facilities Management (US) article providing considerations to help ensure compliance with NFPA 99, Health Care Facilities Code.

[Patient and Family Advisory Council Guides](#) (August 2020). The Society to Improve Diagnosis in Medicine (US) guides collating best and promising practices for use by Patient and Family Advisory Councils (PFACs) and leaders in hospitals and health systems in which PFACs are embedded.

[Reducing burden by improving EHR alerts](#) (August 2020). ECRI Institute (US) 30-minute podcast highlighting the impact of alert fatigue on safety and potential solutions to reducing the burden on providers.

[Safety competencies framework](#) (September 2020). Canadian Patient Safety Institute resource describing six domains that support moving patient safety evidence into action.