February 2022

RISK WATCH Quarterly

COVID-19 Updates on HIROC.com

For information and resources related to COVID-19, please visit HIROC.com to access our **COVID-19 Updates page.** For a Q&A of Subscriber questions, log in and select COVID-19: *Your Questions Answered* from the Member Portal Links dropdown.

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.

Anthony Soung Yee

Editor's Note

The February 2022 issue of Risk Watch includes articles on the three HIROC patient safety drivers: maternal neonatal care, mental health death by suicide while under care, and patient deterioration.

In this issue, the priority areas of opioids and COVID-19 are addressed within maternal neonatal care. An Ontario-based study from Camden et al. reports on trends in prenatal opioid cases in Ontario hospitals, providing key takeaways and recommendations. As well, Schmitt et al. provide a comprehensive overview of the effects of COVID-19 on maternity staff in OECD countries and China; including how maternity staff addressed those challenges.

The articles on mental health and death by suicide under care help to understand some critical factors in risk mitigation. Rajendran et al. analyze suicide and suicide attempts occurring at Veterans Affairs Medical Center to investigate any relationship between location on the premises and access to mental health care. Peters et al. investigate the psychometric properties of the Implementation Climate Scale (ICS), which seeks to measure organizational readiness to new programs.

Prevention of patient deterioration is approached by Burke et al. identified root caues for "failure to rescue" (FTR) events, proposing a framework of "The 3 Rs of Failure to Rescue" of recognize, relay, and react. Wiig et al. provide a comprehensive qualitative study on the involvement of next-of-kin in a new involvement method in the regulatory investigation process of adverse events causing patient death.

You will also find a collection of resources, including a framework for identifying reported breakdowns related to the diagnostic process in ambulatory care, the Induction Labour Toolkit by Champlain Maternal Newborn Regional Program, and the ECRI 2022 Top 10 Health Technology Hazards Executive Brief.

If you have feedback about this quarterly edition of Risk Watch, please send them to me at **asoungyee@hiroc.com**

MATERNAL NEONATAL

Reviewing the Evidence on Prenatal Opioid Exposure to Inform Child Development Policy and Practice

Camden, A., et al Healthc Q. 2021 Oct;24(3):7-12. doi: 10.12927/hcq.2021.26626

Report from Canada summarizing existing research related to the development of guidelines or universal programs for infants with prenatal opioid exposure. Trends in prenatal opioid among hospital births in Ontario are reviewed, and perinatal and infant health outcomes are highlighted. Key takeaways are provided and recommendations for clinical practice, as well as federal and provincial policies to improve the developmental health of infants, are included.

Effects of the COVID-19 pandemic on maternity staff in 2020 – a scoping review

Schmitt et al. BMC Health Serv Res. 2021 Dec 27;21(1):1364. doi: 10.1186/s12913-021-07377-1.

Scoping review from Germany gives a comprehensive overview of the effects the COVID-19 pandemic had on maternity staff in OECD countries and China. Authors highlighted the impacts of trying to maintain the care for pregnant, birthing, and breast-feeding women during the pandemic crisis. Maternity staff abandoned normal standards of obstetric care and were confronted with enormous challenges and structural adjustments. The review included how maternity staff addressed challenges posed by the pandemic and provided examples of the negative subjective effects including ethical-moral dilemmas.

MENTAL HEALTH - DEATH BY SUICIDE UNDER CARE

Suicide and Suicide Attempts on Veterans Affairs Medical Center Outpatient Clinic Areas, Common Areas, and Hospital Grounds

Rajendran S, Mills PD, Watts BV, Gunnar W. J Patient Saf. 2022 Jan 1;18(1):33-39. doi: 10.1097/PTS.0000000000000796. PMID: 33273398.

US study analyzing suicide deaths and attempts occurring outside inpatient units on other hospital locations. The researchers aimed to quantify and analyze suicide deaths and attempts occurring on Department of Veterans Affairs grounds to determine whether a relationship with access to mental health care exists and to elucidate potential mitigation strategies. The study concluded that clinical changes, including environmental assessments and interventions, policy changes toward improving contraband search techniques, a medications risk assessment, and timely access to care may be effective mitigation strategies toward preventing suicides of this nature.

Measuring implementation climate: psychometric properties of the Implementation Climate Scale (ICS) in Norwegian mental health care services

Peters N, Borge RH, Skar AMS, Egeland KM. BMC Health Serv Res. 2022 Jan 4;22(1):23. doi: 10.1186/s12913-021-07441-w. PMID: 34983526.

Norwegian study investigating organizational climate for implementation of new methods. Three measures were used for the purpose of this study; the Implementation Climate Scale (ICS), the Implementation Climate Measure (ICM), and the Measure of Innovation-Specific Implementation Intentions (MISII). All three instruments were translated into Norwegian. Overall, the results supported the psychometric properties of the total ICS scale.

PATIENT DETERIORATION

Failure to Rescue Deteriorating Patients: A Systematic Review of Root Causes and Improvement Strategies

Burke JR, Downey C, Almoudaris AM. J Patient Saf. 2022 Jan 1;18(1):e140-e155. doi: 10.1097/PTS.0000000000000720. PMID: 32453105.

UK study identifying root causes of "failure to rescue" (FTR) events to explore the salient factors that led to failure to recognize evolving or established complications, with the aim understanding of what underlies the variability in outcomes. The systematic review covered a number of electronic databases over 2006-2018. The authors proposed the framework of "The 3 Rs of Failure to Rescue" of recognize, relay, and react, and their findings showed that complications occurred consistently within healthcare organizations, representing a huge burden on patients, clinicians, and healthcare systems.

Implementation of a structured emergency nursing framework results in significant cost benefit

Curtis K, Sivabalan P, Bedford DS, Considine J, D'Amato A, Shepherd N, Fry M, Munroe B, Shaban RZ. BMC Health Serv Res. 2021 Dec 9;21(1):1318. doi: 10.1186/s12913-021-07326-y. PMID: 34886873; PMCID: PMC8655998.

Australian study investigating any net financial benefits arising from the implementation of the History, Identify Red flags, Assessment, Interventions, Diagnostics, communication and reassessment (HIRAID) emergency nursing framework. This retrospective cohort study was conducted between March 2018 and February 2019 across two hospitals in regional Australia. The study found that the HIRAID-equivalent savings per annum exceeded the costs of implementation under all scenarios (Conservative, Expected and Optimistic), with reduced costs associated with resources consumed from patient deterioration episodes.

Regulatory Investigations of Adverse Events That Caused Patient Death: A Process Evaluation Part 1 – Part 2

Wiig S, Haraldseid-Driftland C, Tvete Zachrisen R, Hannisdal E, Schibevaag L. Next of Kin Involvement in Regulatory Investigations of Adverse Events That Caused Patient Death: A Process Evaluation.

- (Part I - The Next of Kin's Perspective). J Patient Saf. 2021 Dec 1;17(8):e1713-e1718. doi: 10.1097/PTS.0000000000000630. PMID: 31651540; PMCID: PMC8612916.
- (Part II: The Inspectors' Perspective). J Patient Saf. 2021 Dec 1;17(8):e1707-e1712. doi: 10.1097/PTS.0000000000000634. PMID: 31651541; PMCID: PMC8612908.

Norwegian study exploring various perspectives of a new method in the regulatory investigation process of adverse events causing patient death. Qualitative data was collected by interviewing 29 next of kin involved in the cases. Part 1 explored the involvement of next of kin, using data from qualitative data from interviews from while Part 2 explored the investigator's perspective in those interviews. Next-of-kin involvement informed the investigations by revealing new information about the adverse events. Inspectors considered next of kin as a key source of information that contributed to improve the quality of the investigation. The authors concluded that involvement of next of kin in regulatory investigation contributed to a better understanding of work as done in clinical practice and to strengthen the learning potential in resilience.

OTHER RESOURCES OF INTEREST

Filling a gap in safety metrics: development of a patient-centred framework to identify and categorise patient-reported breakdowns related to the diagnostic process in ambulatory care *(Bell SK. et al. BMJ Qual Saf. 2021 Oct 16:bmjqs-2021-013672. doi: 10.1136/bmjqs-2021-013672. Epub ahead of print. PMID: 34656982).* Study testing the use of patient-reported diagnostic process-related breakdowns (PRDBs) to inform organizational learning. Researchers found that the framework could readily identify and categorize PDRBs including some that are invisible to clinicians; guide interventions to engage patients and families as diagnostic partners; and inform whole organizational learning.

Champlain Maternal Newborn Regional Program: Induction of Labour Toolkit *(CMNRP, 2022).* This toolkit was developed by the regional interprofessional Induction of Labour Workgroup, to standardize care provided to pregnant patients across the region. The contents of the toolkit are designed for health care providers, patients and family members and organizations.

Top 10 Health Technology Hazards for 2022 Executive Brief *(ECRI, 2022).* ECRI's Top 10 Health Technology Hazards list identifies the potential sources of danger that warrant the attention for 2022 and offers practical recommendations for reducing the risks.

National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event *(Morton CH. et al. J Obstet Gynecol Neonatal Nurs. 2021 Jan;50(1):88-101. doi: 10.1016/j.jogn.2020.09.160. Epub 2020 Nov 19. PMID: 33220179).* The National Partnership for Maternal Safety, under the guidance of the Council on Patient Safety in Women's Health Care, has developed interprofessional work groups to create safety bundles on diverse topics. This article provides structure and evidence-based resources for women, families, and maternity care providers after a severe maternal event.

Inclusion, diversity, equity, and accessibility: From organizational responsibility to leadership competency *(Mullin AE, et al. Healthc Manage Forum. 2021 Nov;34(6):311-315. doi: 10.1177/08404704211038232. Epub 2021 Sep 17. PMID: 34535064; PMCID: PMC8727822).* Article on IDEA-informed (inclusion, diversity, equity and accessibility) leadership, to support the reader's understanding of what it means to embed IDEA within traditional leadership competencies. As well it seeks to propose opportunities to achieve durable change by rethinking governance, mentorship, and performance management through an IDEA lens.

Sentinel Event Alert 64: Addressing health care disparities by improving quality and safety *(The Joint Commission November 2021).* This document summarizes strategies for health care and human services organizations in all settings as they begin to address health care disparities; it also provides examples of successful initiatives for organizations that are well on their way.