

FACILITATOR GUIDE FOR CASE DISCUSSION DOMAIN 4: MANAGING SAFETY RISKS

“In health care, as in as other high-risk endeavours (e.g., aviation and the nuclear industry), it is recognized that things can and will go wrong. Therefore, **it is necessary to design the health care work system**, and to **train** individual health care professionals, in a manner that **anticipates and recognizes** this potential and that **facilitates** the effective management of situations that place individuals and groups at risk.” (Safety Competencies, Domain 4, CPSI/ RCPSC 2008).

Key Competencies

Health care professionals are able to:

1. *Recognize routine situations and settings in which safety problems may arise*
2. *Systematically identify, implement, and evaluate context-specific safety solutions*
3. *Anticipate, identify and manage high-risk situations*

1. Do you think this resident demonstrates situational awareness? Yes or no: explain.

- a. *Yes.*
- b. *He is aware of the noise and chaos in the nursing station. He knows this is not an ideal environment in which to give handover as there is the potential for distraction from the task at hand. It would be much better if he had a quiet room, a so-called “sterile cockpit”; instead he has found a quietish corner in which to conduct handover.*
- c. *He is sensitive to not unnecessarily bothering those dealing with urgent issues.*
- d. *Despite the above, he understands the importance of the checklist, particularly in situations where there is distraction. Memory alone is unreliable.*
- e. *In keeping with situational awareness, when he asks himself “what should I do?”, he should to take one more look himself, or approach someone who doesn’t seem essential for the management of the trauma victims and ask where the checklists are kept.*

2. What practices to reduce the incidence of adverse events (AEs) are demonstrated in this case.

- a. *Availability of a transfer checklist. Handovers or transitions in care are very vulnerable times for communication lapses that may lead to AEs*
- b. *Jay’s commitment to finding a checklist and not cutting corners. There may be a policy around use of the checklist, or merely the culture of safety alone in the institution that motivates Jay to do as he should.*
- c. *Hand hygiene on exiting the patient’s room.*

- d. *Private room on the ward with enhanced precautions to prevent the transmission of influenza.*
- e. *Use of O negative blood.*

3. Reflective Exercise:

Think of an unintended adverse event you were involved with or heard about. What happened? Why do you think it happened? Were there any changes made as a result of the event? What were they? Sometimes changes in a process lead to their own unanticipated negative outcomes (eg shorter work hours result in more handovers which can increase the risk for more adverse events). Were there any unintended consequences in your story? Did any policy change result?

ENABLING COMPETENCIES COVERED BY THIS CASE INCLUDE:

- 1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences
- 2.1 Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state
- 2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention
- 2.6. Adjust policies and procedures to reflect established guidelines, if applicable
- 3.1. Recognize health care settings that may lead to high-risk situations
- 3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making