A Reflective Review of a Practicum Placement with Regina Qu'Appelle Health Region

Risk Assessment: A Field Practicum Report

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Abstract

This report discusses the practicum experiences of a Master of Social Work student from the University of Regina. The practicum placement was a joint placement with the Regina Qu'Appelle Health Regions Risk Management department and Kaizen Promotion Office. The practicum I participated in the implementation of a risk assessment examining health care services provided by the region. This paper will conclude with a description of risk assessment process followed by a discussion of social work competencies.

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1. Introduction

My interest in patient safety stemmed from a volunteer experience at a rehabilitation centre several years ago. There I encountered a young man who, due to a medical error, had been rendered non-verbal and was paralyzed. I had the honour of getting to know him over his final five years and come to understand how incredibly brave and inspiration both he and his family were. But during that time I saw also the hardships both he his family, his friends, and his caregivers dealt with on a daily basis—financial, emotional, and physical—and the incredible toll that took on them. Despite the incredible care he received after his injury, the fact remained that his debilitation and ultimate passing all resulted from an error that could have been prevented. But in the midst of this tragedy, I was there to witness the incredible care he was provided, and what I learnt about compassion, perseverance, and unconditional love cannot be taught in a classroom.

The experience of getting to know this young man and those who surrounded him every day inspired, guided me during my social work studies to pursue an additional bachelors degree in Health Studies. In turn, I discovered that social work and health would provide me with the opportunity to have an impact on many of the issues I am passionate about. The knowledge and skills I gained during my Health Studies degree provided me with a thorough understanding how health is determined and how health systems are interconnected. It sparked an interest in holistic approaches to health which intermeshes perfectly with the interprofessional collaborations inherent to social work.[1]

[1] Incident did not occur in Saskatchewan.

Participating in the Regina Qu'Appelle Health Region's (RQHR) risk assessment process to improve patient safety provided an opportunity to actualize a connection between my life experiences and career aspirations. Patient safety and reducing medical errors is one of the top issues facing healthcare organizations today and research indicates that a large portion of medical errors and related injuries and deaths are preventable. There are many approaches being utilized to address these issues and my practicum experience provided me insight into an important strategy.

My practicum took place from September to December of 2013, within two separate, but connected, departments within the Regina Qu'Appelle Health Region (RQHR): the Kaizen Promotion Office (KPO) and the Patient Safety Department. During my practicum, under the supervision of the Executive Director of KPO and the Director of Risk Management, I participated in the implementation of a risk assessment program examining health care services provided by the region. The practicum consisted of 450 work hours where I continued work on their risk assessment process using a previously developed tool.[2] The foci for this process were Continuous Quality Improvement teams (CQI teams).

In this report I will provide a detailing of my practicum experience, beginning with a discussion of the learning goals devised to provide insight into effective interventions into healthcare-oriented risk assessment. I will then provide a discussion of the various agencies and tools developed and used to identify and mitigate harm to patients and staff, and how the RQHR sought to implement them. As part of this discussion, I provide research into the concept of patient safety and risk management, tying it to the social work values and principles that are critical for a successful generalist intervention. Included is information regarding the qualitative

[2] Due to the amount of work that needed to be completed for the assessment, I volunteered to remain with the office for an additional three weeks to complete the process with those units where work was already underway.

and quantitative methods employed in the risk assessment process, as well as the challenges I faced during. The guiding theoretical lens for this report—and my practicum in general—was systems theory, and I include a discussion of the school of thought and how it applied both to my practicum, and to health care in general. The latter sections of the report include discussions of other key social work competencies including an analysis of relevant relationships, values, and social positioning. I close by reviewing the skills developed throughout the course of the practicum, with particular attention paid to the various roles being performed at a variety of systemic levels.

1.1 Practicum learning goals and objectives

The following document is a reflective paper discussing my practicum experience with Kaizen Promotion Office (KPO) and the Patient Safety Department. This paper follows the Direct Practice Framework recommended for Integrative Practicum Reports as outlined by the University of Regina, Faculty of Social Work 2011 MSW Practicum Manual. The framework includes the following headings: Ideology, Theory, Values, Ethics, Relationships, Strategies, Skills and Vision.

Four learning goals for my practicum were created in consultation with my field practicum supervisors. The first was to critically review the risk assessment tool being implemented by RQHR. The second was to learn how Accreditation Canada standards drive quality improvement in the region and the implementation of best practices in a healthcare organization. The third goal was to learn more about healthcare generally, and RQHR, specifically. And finally, the fourth goal was to review literature regarding risk assessments and accreditation processes. The learning goals were achieved through meeting a number of objectives which involved working collectively with CQIs to conduct risk assessments and

facilitate the creation of risk mitigation plans to address patient safety concerns. I also utilized self-directed learning methods both online and in discussions with my practicum supervisors in order to learn about the various processes and institutions involved in risk assessment and patient safety.

Responsibilities and methods for risk assessment survey:

Accreditation Canada's risk-related standards and their resulting *Roadmaps* were used to construct RQHR's risk assessment tool. The assessment process employed TurningPoint, an interactive polling software that utilizes PowerPoints, to present a variety of options for participants to select. I began by organizing them and cross-referencing results[3] that had already been imported into the software with their respective risk results spreadsheets to ensure information was accurate and to identify any standards that were excluded or added. Twenty one CQI teams participated in the survey process, designed as a self-assessment tool to rate their adherence to standards, which in turn formed the basis of RQHR's risk assessment program. Each team answered a series of survey questions related to their respective field of practice. Results from the exercise helped to identify and prioritize those areas where teams perceived there to be a high risk for staff and patients. Part of my responsibilities included the creation of PowerPoint slides detailing the standards in question to be used during the survey process. During that process I operated TurningPoint and provided clarification on standards to CQI teams.

[3] At the time of my practicum 5 of the 21 CQI team assessments had been completed. However due to technical issues some of those results were lost and the process had to be completed anew.

I then created a risk mitigation template, inserting responses from the CQI teams.[4] Using RQHR's risk matrix (explained below), each of the Accreditation Canada standards used in the survey were prioritized based on how they were rated in both impact and frequency by the CQI Teams and inserted into the template. The results for each field were then presented back to the respective CQI team. Teams identified strategies for mitigating the risks, created a timeline for implementation, and an individual to spearhead the process.

1.2 Agency description

RQHR is the largest health care delivery system in southern Saskatchewan, covering more than 260,000 residents living in cities, towns, villages, rural municipalities, and First Nations communities across the region. They are responsible for a full range of services and institutions including: hospitals; rehabilitation; community and public health organizations; long-term care; and home care.

Kaizen Promotion Office

The KPO employs a number of staff from a variety of professional backgrounds including nurses, physicians, and unit managers. The KPO's role is in continuous improvement of the RQHR by promoting *lean* principles and tools and by supporting improvement activities (Regina Qu'Appelle Health Region, 2012). It is responsible for implementing *lean* initiatives within RQHR. *Kaizen* is a term associated with *lean* that refers to "continuous improvement" (Regina Qu'Appelle Health, Region, 2015). The goal of RQHR is to improve healthcare by building a patient and family-centred system (Regina Qu'Appelle Health Region, 2015). There are Kaizen Operation Teams (KOT) that work within the office to instruct managers, physicians, clinicians and staff regarding *lean* principles and initiatives (Regina Qu'Appelle Health Region,

[4] The document was so called because when results were presented back to team members they were asked to enter their mitigation plans for addressing the issue.

2015). KOT uses *lean* tools to implement improvement work and track the impact of the changes (Regina Qu'Appelle Health, Region 2015).

Lean originated in the car manufacturing sector. It has now been applied to many other sectors and industries such as healthcare (Government of Saskatchewan, 2015). RQHR states that it is a patient-focused approach that puts the needs and values of patients and families first by focusing on better health, better care, better value, and better teams (Government of Saskatchewan, 2012). The goal of the *lean* strategies is to reduce waste by identifying and eliminating activities that do not add value. Lean empowers employees to create and implement value-added solutions to problems.

KOT was responsible for three service lines at the time of my practicum: surgical, medical, and mental health and addictions. For each service line there was a director to oversee the teams, with each identifying goals to work towards that would improve services and reduce waste, all the while making efforts to understand the patient's perspective. Kaizen specialists form KOT service lines include patients, family members, and frontline staff. The belief is that reducing waste and improving services will improve the management of risk and patient safety (Trillium Health Centre, 2010).

1.3 Risk Assessment

Advances in modern medicine have led to an increase in complex treatments and services, and as such, increased risks (Briner, 2010). Mistakes in healthcare will happen; the potential for human error will always be present. However, healthcare systems must work to improve people's safety by utilizing their employees and services appropriately. In Saskatchewan, healthcare is government funded. As such, errors result in increased costs to the healthcare system and thus, to the general public. Given the frequent debates regarding

healthcare funding, the general population is particularly sensitive to excess costs, but also does not want to pay more than is necessary to provide safe and efficient services. The public also expect to have access to services they can literally trust with their lives.

It is important to begin this discussion by understanding what exactly "patient safety" encompasses. However, during my practicum and research it became apparent that every organization and profession has their own definition of the concept. The discussion below highlights some of those complexities while providing us with a working definition.

Health practitioners in Canada have always been concerned with patient safety, however its improvement has become a priority both domestically and internationally over the last 20 years as a result of the publication of two instrumental documents: "To Err is Human: Building a Safer Health System" by Kohn et al. in 1999, and *Crossing the Quality Chasm: A New Health System for the 21st Century,* in 2001. In the wake of these publications, the Royal College of Physicians and Surgeons of Canada (RCPSC) formed the National Steering Committee on Patient Safety.

Five working groups were thus developed to identify key issues in a variety of areas: regulatory/legal; measurement/evaluation; educational/professional development; and information/communication (Davies, Hebert, & Hoffman, 2003). Using the report's findings, the RCPSC devised an integrated national strategy for patient safety resulting in Canada's first report on patient safety, released in 2002, *Building a Safer System: A national integrated strategy for improving patient safety in Canadian health care* (Davies et al., 2003).

With increased discussion appearing and work being conducted regarding patient safety, the RCPSC identified the need to develop a dictionary of patient safety terms that could be referenced for national strategies. Given the possibility of misinterpretations and

miscommunications resulting from the variety of professionals and organizations involved in healthcare, it is important to develop a common language. My research throughout my practicum experience and the writing of this paper brought with it my first realization of the importance of using consistent language when discussing patient safety. Individuals working in risk management and KPO affirmed that importance in their own work.

If terminology is not clearly defined, confusion may arise, especially if a word might generally have multiple meanings. In turn, this may lead to a lack of understanding and limit one's ability to understand problems or learn from them. It is suggested by RCPSC that without universalized definitions and terminology, healthcare studies are not readily transferable (Davies et al., 2003). Further, developing a comprehensive understanding of terminology is essential for improving patient safety; it is important to discuss definitions as disparate connotations may result in controversy (Davies et al., 2003).

The RCPSC's *Canadian Patient Safety Dictionary* is based on the belief that modern healthcare is provided in highly complex environments (Davies et al., 2003). Their recognition that patient outcomes generally result from a confluence of underlying illness(es) and interactions with a variety of factors, including treatment, the structure of the overall healthcare system, and social determinants of health such as socio-economic status, is an important starting point for examining patient safety (Davies et al., 2003). Because of how complex both the healthcare system and its delivery are, it was also important for them to define "systems." Their working definition for it is "'a grouping of inter-related components that act together in an environment to achieve a particular outcome'" (Davies et al., 2003).

In terms of patient safety, RCPSC began by explaining that defining it can be challenging (Davies et al., 2003). The Oxford English Dictionary definition of safety is a state of "being safe,

exemption from hurt or injury, freedom from danger" (Davies et al., 2003). However, as regards healthcare, "it is often defined negatively as the absence of hurt or injury, and as a result of unsafe acts" (Davies et al., 2003). They state that safety should encompass an expansive and positive definition as well, such as "abiding by practices and achieving outcomes that are compatible with striving for optimal patient outcomes and health-care indices" (Davies et al., 2003).

By adhering to such a definition, healthcare institutions are more easily seen as safe places where people receive the best healthcare available, and are not exposed to avoidable dangers (Davies et al., 2003).

The RCPSC presents a caveat to this, however, stating that:

> safety sometimes carries an implication that there will never be adverse outcomes. Human beings are generally accepted as fallible except if they provide health-care services, where perfection is routinely expected and rarely achieved. A move away from relying on the personal vigilance of health-care professionals and toward implementing a broader system perspective will facilitate the objective of improving patient safety. Our health-care system will never be 'safe' — 'safety' is a fleeting property of evolving complex systems. Safety is a goal to be striven for, not a conclusion that will ever be reached. (Davies et al, 2003)

So for the purposes of this paper, as recommended by the RCPSC, patient safety is defined as, "the reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes" (Davies et al., 2003).

Ensuring patient safety necessarily requires an assessment of risks, and the RCPSC uses the Canadian Council on Health Services Accreditation's definition to inform their policies: "... the chance or possibility of danger, loss, or injury. For health-services organizations this can relate to the health and well-being of clients, staff, and the public; property; reputation; environment; organizational functioning, financial stability, market share, and other things of

value." Risks are typically associated with adverse events, which are best understood using a multi-dimensional definition:

> 1. An unexpected and undesired incident directly associated with the care or services provided to the patient;
> 2. An incident that occurs during the process of providing health care and results in patient injury or death;
> 3. An adverse outcome for a patient, including an injury or complication. In view of the three different options, it is essential that the context be described whenever the term 'adverse event' is used. A preferable option would be to use an alternate term with a better defined meaning.

The state of patient safety in Canada

There is currently very little data available on adverse events occurring in Canadian hospitals (Baker et al., 2004). Baker's *Canadian Adverse Events Study* was the first Canadian study of adverse events, comparing Canadian estimates of adverse events with those of comparable hospitals in other countries. It is important to note that only adults in acute care hospitals were included, and hospital admissions information pertaining to obstetrics and psychiatric care was excluded from this study, as was the province of Quebec since at the time, they were not collecting discharge data (Baker et al., 2004). Baker reported that approximately 7.5% of people admitted to acute care in Canadian hospitals experienced one or more adverse events. Of the 7.5%, approximately 36.9% of the adverse events were deemed "highly preventable" (Baker et al., 2004).

There are many types of risks that could cause harm to individuals or staff, facility—operational, financial, or occupational. In the healthcare realm, risks may be present in areas such as communication, medication, or patient identification. There are similarly many different ways to define risk. The RCPSC began identifying risk by using the Oxford dictionary definition; a risk is a "hazard, endanger; to expose to the chance of injury or loss." Risks associated with healthcare organizations may involve: the health and well-being of clients, staff, and the public;

property; reputation; environment; organizational functioning; financial stability; or market share. For the purposes of this paper, risk is defined as "the probability of danger, loss or injury within the health-care system" (Davies et al., 2003). Risk management is the activity of working towards managing the uncertainty related to the threat or possibility of a negative event resulting from exposure to those risks (Davies et al., 2003). The field utilizes multiple strategies to do so, including risk assessment and risk mitigation. The goal of the risk assessment is to identify, assess, mitigate, monitor and control risks.

In healthcare we generally believe that the possible negative side effects of a procedure will be outweighed by its potential benefits. But risks always exist and as such, it is important for healthcare providers to discuss these risks prior to treatment or diagnostics (Davies et al., 2003).

Quality Performance Roadmap

Accreditation Canada provided RQHR with a *Quality Performance Roadmap* designed to assist the region in performing their own self-assessment to ultimately be used to remedy areas of weakness. Within that roadmap each risk-related standard assessed was assigned a coloured flag to assist in prioritization: green, yellow or red. Both yellow and red flags highlighted areas where significant improvement was required, and green identified strengths; the colours were assigned by Accreditation Canada (Accreditation Canada, 2012).

Each flag is also assigned a priority level of high or low. For the risk assessment during my practicum, we chose to focus on red flag-high priority, red flag-low priority, and yellow flag-high priority issues.

Dimension	Standard	Accreditation Canada Standard		Accreditation Canada Flag	RQHR Risk Flag
Effectiveness	Mental Health Services	MHS 11.5	Following transition or end of service, the team contacts clients, families or referral organizations to evaluate the effectiveness of transition, and uses this information to improve its transitions and end of service planning, as appropriate.	Yellow Flag High Priority	HIGH RISK

For illustrative purposes, in this paper I will use the Mental Health CQI team's survey experience as an example of the accreditation process as it relates to risk assessment. Accreditation Canada has two separate sets of standards it applies to mental health services and populations, both of which are designed to be used for the coordination and evaluation of mental health services (Accreditation Canada, 2015a). The Mental Health Services standards focus on care and treatment provided to the patient in acute or institutional settings. They cover the following areas:

- Investing in mental health services.
- Engaging competent and proactive staff.
- Providing safe and appropriate services.
- Maintaining accessible and efficient clinical information systems.
- Monitoring quality and achieving positive outcomes (Accreditation Canada, 2015b).

The Mental Health Populations standards focus on regions and organizations with a mandate to provide mental health services, and cover the following areas:

- Investing in mental health services.
- Partnering with the community.
- Integrating and coordinating services.
- Supporting clients to self-manage their condition.
- Basing decisions on research and evidence.
- Using information and information technology.
- Engaging competent and proactive staff.

- Providing safe and appropriate services.
- Monitoring quality and achieving positive outcomes (Accreditation Canada, 2015a).

All of these standards were covered in the survey questions presented to the mental health CQI team. For each of these standards I designed and created a PowerPoint slide outlining the relevant competencies to be presented during the survey. From each standard we derived two questions: one question pertaining to the frequency at which that standard was met, and one asking the respondents their perceived impact of a standard not being met. An example is presented below.

MHS 11.5 Following transition or end of service, the team contacts clients, families or referral organizations to evaluate the effectiveness of transition, and uses this information to improve its transitions and end of service planning, as appropriate.		
FREQUENCY		
Rank	Occurrence scale	Operational scale
1. Always	Every day	>1/100 ops hours
2. Frequently	Every week	>1/1,000 ops hours
3. Often	Every month	>1/10,000 ops hours
4. Sometimes	Every year	>1/100,000 ops hours
5. Rarely	Less than once/year	>1/1,000,000 ops hours

What is the impact if following transition or end of service, the team does not contact clients, families or referral organizations to evaluate the effectiveness of transition, and uses this information to improve its transitions and end of service planning, as appropriate?		
IMPACT		
Rank	Human scale	Financial scale
1. Negligible	Mild/No injury	No cost/loss
2. Minor	One injury	Max $10,000 cost/loss
3. Moderate	Multiple injury	$10,000 to $100,000 cost/loss
4. Major	One dead	$100,000 to $1,000,000 cost/loss
5. Severe	Multiple dead	>$1,000,000 cost/loss

Polling

Responses to survey questions were recorded in real-time using handheld polling devices that worked with TurningPoint software, which in turn was synced back to the PowerPoint presentations. The results were also calculated in real-time. Each individual in the CQI team voted on each question. The team was advised that their responses were anonymous.

The mental health CQI team's survey process had only been partially completed by March 2012, at which time staffing issues shelved the results. However, we rejoined them in December 2013 to complete the process. The CQI team was made up of one representative from each of the following mental health services lines:

- Adult mental health inpatient unit
- Adolescent inpatient unit
- Autism Services
- Adult Mental Health Clinic
- Child and Youth Services

My role during the time of the polling was to set up the computer, conduct the presentation, and observe and participate in subsequent discussions. The TurningPoint software then produced a report ranking the risks according to survey results, in accordance with the established RQHR Risk Matrix.

RQHR Risk Matrix

Risk is a measure of impact and frequency. A colour-coded risk matrix was developed by RQHR risk management to evaluate, identify, and prioritize risks. The colour indicates the risk level: red is Critical, orange is High, yellow is Moderate, and green is Low risk.

The matrix is based on two criterion:

1. The *frequency* or likelihood of a risk occurring.

2. The *impact* of the consequences of a risk and its severity, including both human and financial costs.

FREQUENCY		IMPACT				
		Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Always	(5)	Moderate Risk 5	Moderate Risk 10	High Risk 15	Critical Risk 20	Critical Risk 25
Frequently	(4)	Low Risk 4	Moderate Risk 8	High Risk 12	Critical Risk 16	Critical Risk 20
Often	(3)	Low Risk 3	Moderate Risk 6	Moderate Risk 9	High Risk 12	High Risk 15
Sometimes	(2)	Low Risk 2	Low Risk 4	Moderate Risk 6	Moderate Risk 8	Moderate Risk 10
Rarely	(1)	Low Risk 1	Low Risk 2	Low Risk 3	LowRisk 4	Moderate Risk 5

After each standard had been voted on for both frequency and impact, I inserted the results into the Excel document to calculate risk ratings. This rating was the result of the average frequency score multiplied by the average impact score for each risk. For example, if a risk had an average frequency score of 3.5 and average impact score of 4, then the risk rating would be 14. The range of risk ratings were classified as follows:

<5	Low Risk	
<12	Moderate Risk	5-11.999999999
<16	High Risk	12-15.99999999
>16	Critical Risk	16+

My role then was to enter the results into each CQI team's risk mitigation template (created in Excel) and present the information back to the CQI team lead. Teams were encouraged to discuss the results amongst themselves as well as refer back to the roadmap. At times the staff felt overwhelmed by the yellow and red flags, and so we encouraged them to review those standards for which they received green flags as a reminder of the positive progress they were making. In social work it is always important to assess and incorporate client strengths into the process (Kirst-Ashman & Hull, 2015). As such, this element of the process was particularly valuable. One team requested to receive copies of other CQI team results to see if they could learn from other teams; it was decided that this information could be provided.

With these calculations complete, a risk registry was created in Excel logging the comprehensive list of the 1240 standards from all the CQI teams involved. Mitigation plans were also documented in the registry. The registry is an important tool not only for the CQI teams involved in its creation so that they can reduce risks in their units, but it's important for the accreditation process as a whole as it assists in evaluating existing services and helps identify those requiring the allocation of services and funding. They will also be used for the next accreditation cycle to show the agency that the CQI teams had identified their own risks, as well as created and then implemented mitigation plans.

1.4 Challenges

Social work utilizes theories, knowledge, and skills to identify, assess and work with individuals, groups and organizations to create change. Challenges are unavoidable, and we tend to view them negatively. But they provide us with opportunities to grow and learn. Since healthcare systems are large and complex with many microsystems affecting the whole organization, these challenges may also be complex. And so assessing, understanding, and mitigating them to create a positive outcome requires continuous learning on the part of those involved. It is also important to identify where successes occur at both the micro and macrosystem level.

Healthcare professionals such as doctors, nurses, and social workers deal daily with challenges and the need to problem-solve to provide care and services to the public. They also function in complex and continuously evolving systems, requiring them to continuously update their knowledge and skills.

During my time at RQHR I gained knowledge regarding standards and how they affect patient care and safety, as well as the day-to-day operations of hospital professionals, and the

organization as a whole. In my role facilitating the risk assessment process and generating results, I did, however, encounter a number of challenges, many of which were associated with technological failures.

- Frequent software and computer crashes resulted in many delays in the processing of results and subsequently, the creation of a risk registry.
  - Files and survey results were corrupted or lost altogether.
  - Large periods of time were required during days, evenings, and weekends to re-enter lost data and create new spreadsheets and slides.
  - There was a lack of IT support for the TurningPoint software, nor was it compatible with, or transferrable to, all RQHR computers.
- I encountered significant difficulties in coordinating the schedules of multiple staff members for the assessment process.
- Because of the lengthiness of the process, CQI team members were not constant throughout the survey period. For example, given that the Mental Health CQI team had only partially completed the process in March of 2012, the year and a half lag meant that during that time staff had changed, resulting in a lack of continuity for the process and potential impacts on the results.
- In large part due to technical considerations, the scope of the project ran beyond that which could be completed in the timeframe allotted for my practicum.
- As I had been assigned to deal primarily with the risk assessment process, there were few opportunities for discussions related social work theories, principles, and standards of practice as they relate to healthcare and risk management. The polling process using TurningPoint was challenging; the computer or software would freeze or take extra time reloading. TurningPoint twice froze completely, requiring facilitators to verbally review the polling slides and for me to record results by hand.

2. Image of client

Generalist social work practice identifies a "client" as any individual, family, group, organization or community that will benefit from social intervention (Kirst-Ashman & Hull, 2015, 9). A macro client system might include any large number of clients, such as a family, or any other group sharing similar characteristics or qualifications for accessing resources or services. It might also include an agency or community that might benefit from a macro-intervention process, which was particularly relevant to my practicum (Kirst-Ashman & Hull 2015, 9). Macro-level change is designed to benefit a larger group of people. My practicum involved macro practice, where the "client" consisted of the professionals that made up the CQI

teams. There were 23 CQI teams involved in the process, however due to time constraints I worked with just 11 of them. The CQI teams were made up of registered nurses, psychiatric nurses, doctors, unit managers, pharmacists, and EMTs. They varied in age, experience and educational background.

2.1 Beliefs about client worker status

RQHR is committed to delivering health care services that take into account the patient's perspective. Their vision of a health region encompasses a holistic approach: "healthy people, families and communities" (Regina Qu'Appelle Health Region, 2013). They have also expressed a commitment to developing a culture of "Patient First…Safety Always" and to deliver safe care at all times to all people: "Our commitment guides us continuously to improve the safety of the care we provide" (Regina Qu'Appelle Health Region, 2013).

During my practicum I observed interactions between my supervisors and CQI teams. In order to improve healthcare and patient safety, RQHR values the input of frontline staff as well as managers and senior leadership. The supervisors made clear to CQI teams their important role in identifying and addressing systemic barriers to the timely delivery of quality services. And as they facilitated the survey sessions, they explained to the teams that while RQHR could create policies and strategies on paper, in order to actually improve healthcare engagement and collaboration with frontline staff, patients, families, and stakeholders is critical to increase transparency, accountability, and quality of care. This level of engagement was a new concept to many. When my practicum supervisors first began the process of creating CQI teams for the purposes of self-assessment, the focus was on developing relationships, familiarizing oneself with the areas in need of improvement, and communicating openly with one another to talk about risks and the development of mitigation plans.

3. Theory

Theoretical approaches are lenses used to understand and explain human behaviour and interactions. They are also used as a starting point for addressing issues. Social workers, like all professionals, encounter challenges in the workplace, and using a particular theoretical perspective can help social workers to both identify and address them in positive ways. When working with organizations, theoretical lenses are particularly important in order to evaluate issues and implement change. Management/organizational theories and conceptual frameworks assist us in understanding how organizations operate and break down the various interactions that form its totality (Kirst-Ashman & Hull, 2015).

Many of the relevant theories borrow from business and management literature. In that literature two key concepts are identified that must form the basis for any theoretical approach: organizational behaviour and management. Organizational behaviour is the study of human behaviour in the workplace (Kirst-Ashman & Hull, 2015). The goals of studying organizational behaviour are to explain, predict and control behaviour. Management refers to attaining organizational goals in an effective and efficient manner through planning, organizing, leading, and controlling organizational resources: "The focus is on examining the interactions between managers, those in power, and the workers directly involved in accomplishing the organizations goals" (Kirst-Ashman & Hull, 2015). Kirst-Ashman and Hull state there is a significant overlap between the two fields of study, both approaches "focus on what is the best structure of the organization, beliefs about employees, and how to best lead the organization in pursuit of its goals" (2015).

Theories tend to rise and fall in popularity and so choosing the most appropriate theory depends on the specific context of the organization being examined. Organizations operate in

highly uncertain environments and go through transitions; so too do organizational theories shift and their viability change (Kirst-Ashman & Hull, 2015). Taking into consideration the structure of both the clients and the organizations I was involved with during my practicum, *systems theory* stood out as the most appropriate theoretical lens to examine the risk assessment process as it relates to patient safety in the healthcare setting.

3.1 Systems theory

According to Kirst-Ashman and Hull, "a system is a set of elements that are orderly and interconnected to a functional whole" (2015). Systems may be either micro, mezzo or macro. A microsystem might include individuals, a mezzo system to small groups, and macrosystems include larger units, such as organizations and communities. Systems theory, then, is used to develop a thorough understanding of individuals existing within these various systems and how they influence, and interact with, one another. Systems theory can also be used to identify locations for intervention, recognizing that when a single microsystem is strengthened or improved, it affects the broader system it is interacting within. (Kirst-Ashman & Hull, 2015). Systems theory is particularly important to generalist practice as it allows social workers to focus on a system of any size.

The appeal of systems theory also comes from my positioning within the First Nations community. We believe that what happens to an individual is connected to, and affects, the family, community, and nation we belong to. Modern medical practices and interventions tend to focus solely only on specific body parts—disassociating it from body as a whole. But we believe that body, mind, and spirit are not separate; they are all part of a greater system. First Nations cultures believe that we are made up of four components that are interconnected: the physical,

emotional, mental, and spiritual (Verniest, 2009). Thus, an illness or injury not only affects the individual system, but also families and communities.

To achieve balance within ourselves, it is important to understand how each element of our system is connected to the other. Unfortunately, holistic approaches to medicine are not currently the norm. However, there is evidence suggesting that such approaches are vital to ensuring overall health (Verniest, 2009). Just as continuous improvement is required by healthcare, continuous self-reflection and self-improvement by individuals is needed to obtain and maintain a healthy lifestyle.

My practicum experience enhanced my understanding of systems theory by observing how microsystems (patients) are linked to mezzo systems (hospitals and care delivery centers), which in turn interact with the entire macrosystem (RQHR). Interactions at every level must run smoothly in order for the whole system to run efficiently. I observed exactly the types of ripple effects between subsystems that systems theory describes.

A hypothetical example to illustrate the impact health subsystems have on patient safety might be the use of patient identifiers provided during admission, which are invaluable for patient transfer and medication administration. If any given unit does not observe or apply the use of patient identifiers, the results can affect every system level. The most obvious example is incorrect administration of medication. At the micro level results can vary from little to no effect, all the way to a fatality. This would cause irreparable damage to the family unit at the mezzo level. At minimum, within the health region it could create additional work for other professionals such as pharmacists, administrative staff, managers, nurses, and doctors. At its extreme it could affect other mezzo-level systems such as the emergency department or the morgue. At the macro level the patient death could affect the entire organization, resulting in a

review of agency practices and policies as well as potential legal action. It may also involve media attention which could affect the ways in which society views the healthcare system as a whole.

On the flipside, the multi-system impact of a single event also highlights the ability of microsystem changes to positively affect broader systems. It is important for social workers to recognize that clients are a part of multiple, overlapping systems—that micro and macro–level social work practice is interconnected: "the focus of social work practice is on the interactions between people and systems in the social environment" (Kirst-Ashman & Hull, 2015). Thus it is important to identify areas where changes are needed in order to make the systems more responsive to the needs of the population and increase patient safety. In addressing these changes it's important to collaborate with other units or professions in order to understand an issue from all perspectives. The goal of utilizing systems theory is to restore the "balance or equilibrium within immediate social systems where there has been a disruption" (Zapf, 2011).

Specific to generalist social work practice there are four key identifiable systems: "the client system; the change agent system; the target system; and the action system" (Kirst-Ashman & Hull 2015, 21). The client system refers to those people who will benefit from particular changes, and in my practicum these were the CQI teams; together our goal was to improve patient safety by improving services. The change agent system in macro practice is the individual who initiates the macro-level changes (Kirst-Ashman & Hull 2015, 21). However, KPO and risk management work together with a variety of systems with the common goal to improve patient safety. In this practicum the people who will directly benefit from the changes are the people utilizing services, stakeholders, employees, and society as a whole. Improving patient care will lead to improved services and, ultimately, to healthier population.

The target system is that which must change or be influenced in order to accomplish the goals that will result in client benefits (Kirst-Ashman & Hull, 2015). In macro practice, the target system is an organization or community (Kirst-Ashman & Hull, 2015). During my practicum the system being influenced was risk identification mechanism for ensuring patient safety. The action system includes those people who work collaboratively to achieve the proposed macro change (Kirst-Ashman & Hull, 2015), which, in my practicum, was everyone involved in the risk assessment process.

In this practicum, I witnessed how systems theory contributes to understanding relationship development, inter-professional problem solving, and networking. Observing the interactions of multiple systems allowed me to see how senior leadership, nurses, doctors, unit managers could work together to learn more about their units' strengths and weaknesses, and develop and implement mitigation plans to address problems.

Healthcare organizations are complex and adaptive systems. Their complexity is only increasing and as a result they face a variety of challenges in providing safe care while maintaining financial viability. And as Johnson et al. suggest, it is typically the systems within healthcare organizations that are the root cause of patient safety problems. Macrosystems made up of microsystems work collaboratively to provide care. Microsystems change over time as they respond to the needs of patients, providers, and external pressures such as accreditation requirements (Mohr et al., 2004). All the microsystems within a healthcare organization, such as a hospital, share the common goal of providing care or a service. But, "what differs across microsystems is the ability of individual caregivers to recognize their efforts as part of a microsystem as well as the microsystems level of functioning" (Mohr et al., 2004, ii34).

It is important that interventions to create change are assessed and implemented at a microsystem level. To assist in creating change within an organization at any level, collaborative relationships are key: "Comprehending the assembly of the system as a whole can inform the work of those who are trying to create successful, interdependent systems. Learning to see interrelationships, rather than linear cause-and-effect chains, and grasping the phenomenon of change as a process, rather than as a snapshot, are essential for understanding systems" (Johnson, 2010). Microsystems can assist in developing resilience into communication, work processes and healthcare environments. Medical errors occur on a microsystems level; microsystems can stop, prevent and mitigate errors that cause harm to people. There are many methods for assessing systems; it is important to assess an entire system and not just a root cause of a problem. Assessing microsystems is important when focusing on patient safety interventions (Zapf, 2011). From a social work perspective, these types of interventions fall under generalist practice.

Generalist practice and intervention models

Kirst-Ashman and Hull define generalist practice with organizations and/or communities "as the application of various knowledge, professional values, ethics and wide range of skills required to assist organizations and communities to create change" (2015, 2). Social workers utilize a variety of skills to assist people to affect change on individual and organization levels. Generalist practice uses a flexible seven-step method for making change, referred to as the "Generalist Intervention Model" which includes: engagement, assessment, planning, implementation, evaluation, termination and follow-up. The model acknowledges that problems may include individuals, families, groups, organizations and communities, and uses a systems-based approach to assess and manage them.

In the context of the risk assessment process which took place during my practicum, the model can be seen to have been applied as follows:

- Engagement began when RQHR began the risk assessment process with the goal of improving patient safety (this began before my involvement).
- Assessment took place when it was decided what subsystems would be involved in the survey and risk mitigation process.
- Planning involved addressing the logistical elements of conducting the assessment and survey processes.
- Implementation occurred at the micro level with the participation of individual CQI teams.
- Evaluation included the development and implementation of risk mitigation plans in response to survey results (I was not involved in this part of the intervention).
- It is assumed that the termination of the intervention would accompany RQHR's accreditation, however I have not been apprised of whether or not this has taken place.

Throughout all phases of intervention, it is important to keep in mind three key values for generalist practice, as identified by Kirst-Ashman and Hull: empowerment, strengths and resiliency (2015). "Empowerment is the process of increasing personal, interpersonal or political power so that individuals can take action to make improvements" (5). One of social work's main goals is to "empower clients' right to make their own choices and participate in decision making process when it comes to their own circumstances" (Kirst-Ashman & Hull, 2015). Social workers must be able to identify address potential barriers that impede client empowerment. In the context of my practicum, the risk assessment and survey tools provided CQI teams with a method of identifying those barriers using their unique perspectives and creating mitigation plans to address the areas requiring improvements. It is a bottom-up rather than top-down approach, precisely the kind of recognition of expertise that social work values.

3.2 Macro Practice

Macro practice involves the application of generalist practice skills to organizational, institutional or community systems. This type of practice was particularly relevant to my

practicum as the changes being implemented affect a broad range of individuals including those accessing services, employees, stakeholders, and the community at large.

In order to understand how the change process works at the macro level of an organization (like RQHR), it is important to understand the microsystems that operate within. Organizations are social entities made up of people (microsystems) with strengths and weaknesses. Organizations are goal directed with a specific purpose, and as such it is important for them to identify and understand those goals and to continuously assess whether those goals are benefitting clients. All organizations have structures which include policies on how organizations should run, hierarchies of supervision, and multiple subsystems that operate interconnectedly (Kirst-Ashman & Hull, 2015). Their structure determines how we behave and identifies our roles, resulting in patterns of behaviour being developed through our participation in them.

These organizations then themselves function within a larger macro environment. Kirst-Ashman and Hull (2015) identify three environmental dimensions that affect an organization's operations: available resources, legitimation, and clients. All organizations require resources for salaries, building maintenance and associated costs, technology services, etc., as well as for developing and implementing new programs and services. Resources become a factor in deciding whether macro changes are possible as costs can be the deciding factor. Legitimation is the granting of status or authority by an external entity to perform specific functions or pursue agency goals. Legitimacy is granted provided the agencies abide by the rules set out (Kirst-Ashman & Hull, 2015). When they fail to do so, they lose their legitimacy.

4. Values

Values include those principles, qualities, and practices that we deemed most desirable (Kirst-Ashman & Hull, 2015). Our life experiences shape our values; they are a central part of who we are as they guide us in what we perceive to be right and wrong behaviour (Kirst-Ashman & Hull, 2015). Social work practice is guided by the interweaving of our knowledge, skills and values. Throughout my social work education we were required to examine our personal values, and our beliefs and ethical perspectives as they directly affect our professional behaviour. I have found that my personal values are congruent with the values of social work as a profession which include self-determination, the promotion of social justice, being caring and helpful toward others, truthfulness (honesty), and respect. This system of values and beliefs form the basis for my professional ideology. As social workers we must act in accordance with these values, but also recognize how and when they may conflict with a diverse client base. Organizational cultures may not always support social work values; politics may undermine professional values. But social workers can use an understanding of organizational politics to help create positive change (Kirst-Ashman & Hull, 2015).

Social work values directly inform our ethical standards of practice. The Canadian Association of Social Workers' *Code of Ethics* provides basic guidelines pertaining to research: "Social workers who engage in research minimize risks to participants, ensure informed consent, maintain confidentiality and accurately report the results of their studies" (2005). In my capacity administering the risk assessment surveys these considerations were not explicitly a concern for me as I was not involved in the study design. However I was guided by the *Code* in my participation as it provides a set of values, principles, and standards to guide decision making

and conduct when ethical issues arise, as "ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional."

As social workers, we are committed to working with individuals, families, groups, communities, and organizations in order to improve their health and well-being. We advocate for the needs, decisions, and rights of our clients. As it relates to the healthcare system and my practicum, social work advocacy includes addressing clinical and policy issues at micro, mezzo, and macro levels by improving patient safety in the delivery of healthcare. By engaging in the RQHR risk assessment process, I was able to participate in a project designed to maintain ethical standards of service delivery. From a research perspective, there were concerns regarding the sample size of the assessment process, which I did raise to my supervisors. However again, as I was not involved in study design, this was not an issue I was in a position to resolve. This was the first time RQHR implemented a risk assessment using this method, therefore it was a learning opportunity going forward.

4.1 My value base and social location

There are a variety of factors that make up our social location, affecting our development and outlook on life. Reflecting on our social location helps us to understand who we are as people and how we relate to, react to, and interpret situations, people, and life around us. Our social location may have both positive and negative effects on us personally and professionally. Self-awareness and self-reflection help us to identify our social location. Just as healthcare organizations are complex, we, as individuals, groups and communities, are complex as well. Our own internal microsystems interact, shaping what we think, how we feel, and how we behave in response to external relationships and experiences. It is impossible for us to completely separate our thoughts, feelings, and behaviours from our professional selves.

However, it is important for as social workers to be aware of those values, beliefs, and biases which might influence our practice.

Factors such as our ethnicity, gender, family, religion, education, class, beliefs and attitudes make up our social location. Our life experiences, and subsequently our values and beliefs, all influence our professional path. My life experiences have taught me the value of helping others. Through self-reflection throughout my social work education, I have gained an understanding how being self-aware affects how I work with clients and how benefits both myself and them. In particular, "social workers are obligated to prevent our personal values from conflicting with our professional values" (Kirst-Ashman & Hull, 2015, 14).

As a result of my formal education, my personal and professional experiences, and being First Nations, I have come to value a holistic approach to understanding the inherent dignity of all people, and the importance of self-determination. My work and volunteer experiences have heightened my ability to understand people's contexts and view their situations from their individual, unique perspectives. From our life experiences we are able to draw from our own feelings and experiences to develop empathy and understanding for clients and their situations.

4.2 Regina Qu'Appelle Health Region values

RQHR's vision, mission, values, and beliefs provide direction for the organization as a whole, and for employees. Their vision identifies a clear set of values designed to provide a "quality experience" for patients, clients, residents, and anyone who interacts with the health system. It is important that all employees integrate RQHR's values into their practices as it is through their behaviours that their mandate can be met.

RQHR developed a document entitled *Living Our Values*, designed to guide and support employees. The document outlines the organization's philosophies and beliefs, providing clear ideological guidelines on appropriate behaviours and identifying supportive policies:

> • Compassion: Our caring approach to people, families and communities.
> • Respect: Honesty, trust and valuing diversity, as well as similarity, which will guide all relationships, decisions and actions.
> • Collaboration: Relationships built upon a shared vision, open communication, involvement and genuine recognition for the contributions of people and partners.
> • Knowledge: Continuous improvement and effective decision-making based on the pursuit of knowledge, evidence, standards of practice and sound ethics.
> • Stewardship: Accountability for the people and resources entrusted to us, and the courage to do what is right (Regina Qu'Appelle Health Region, 2013, 3).

The RQHR states that their vision is to create "Healthy people, families, and communities." With this vision in mind, they hope to inspire, energizes, and help to create a mental picture of the best possible outcome for our communities. This vision is said to inform their mission, and thus, their mission statement: "The Regina Qu'Appelle Health Region is a provincial and community provider of a full range of safe, quality health services, education and research that inspires public confidence. We achieve success in meeting the diverse health needs of our communities through the strength of our people, partnerships and personal responsibility for health" (Regina Qu'Appelle Health Region, 2013).

4.3 Potential value clashes

As previously stated, healthcare organizations are complex systems with many microsystems that are interconnected and affect the whole. Conflict occurs on micro, mezzo, and macro levels. Conflict is normal and can be used to in positives ways to help people identify common ground. *The Canadian Association of Social Workers' (CASW) Code of Ethics* identifies values and principles that guide social workers' professional behaviour (Canadian Association of Social Workers, 2005). However, the *Code* does not provide guidelines for how

social workers should act in every situation. As such, it is essential for social workers to be aware of potential conflicts between their personal and professional values and approach conflict resolution professionally and respectfully: "Although different value orientations may produce conflict, the differences also can catalyze successful collaboration between the two professions, which ultimately will benefit patients who receive care" (Roberts, 1989).

Social workers are involved in conflict resolution on daily basis. Conflicts cannot always be avoided. To deal with them, we must utilize a combination critical thinking skills, positivity, and constructive conflict management skills appropriate for the issue at hand. Poor conflict management can lead to increased personal and professional stress and affect relationships negatively. It is crucial that social workers be aware of their professional boundaries and potential conflicts of interest that may be problematic. We have to approach conflict as an opportunity to assist in developing or enhancing our resolution skills. In doing so we can provide opportunity for clients to engage in self-reflection and improve self-awareness, thus leading to greater understanding about themselves, the issues at hand, and their own beliefs and values.

Communication skills, active listening, empathy, and assertiveness are a few key skills required in effective conflict resolution. We must also recognize that not everyone in an organization may like, or agree with, change. It is also important for social workers to understand the impact change may have on multiple systems within an organization. RQHR's risk assessment process sought to address these issues by having senior leadership work with the frontline employees that formed the basis for the CQI teams. It was important to recognize that the clients (CQI teams) may have differing educational and work experiences that have shaped their values, ethics, and beliefs. And so a clash could potentially arise when developing mitigation plans to address the risks highlighted by the process.

4.4 Potential value clashes between self and client

Given the above-cited importance of self-reflection and self-awareness on the part of the social worker, I made every effort to ensure that I remained cognizant of the potential for clashes with the CQI teams. However, given that my individual interaction with CQI team members was largely associated with facilitation of the survey and polling process, the likelihood of such conflicts was low. My practicum did, however, provided me with a unique experience to witness how teams that are made up of different disciplines can work collaboratively to identify and address concerns. Without prompting, teams praised each other for their successes, highlighting the efforts that were being put into patient care, and discussed the many positive benchmarks being achieved.

4.5 Potential value clashes between client and society

There were a number of potential loci for value clashes between the client and society given the politicized nature of healthcare. Society at large may have different opinions regarding healthcare funding and spending, and the direction they think healthcare should take may differ greatly from those of frontline workers. However given that the risk assessment was a closed process, no such conflicts were observed.

4.6 Potential value clashes between client and agency

This was the one area of the process in which a number of value clashes were observed. All the CQI teams (client) involved in the risk assessment process appeared to be genuinely interested in it and enthusiastic about their role in identifying and mitigating risks. RQHR used

the information provided in Accreditation Canada's *Roadmap* to identify areas of concern. However during some of the discussions during polling, many team members did not agree with the results from Accreditation Canada. In an effort to resolve those conflicts, RQHR remained open to identifying areas of improvement from the perspective of the CQI teams.

In particular, during my practicum there was one conflict with a CQI team which stood out. We were scheduled to meet with a particular CQI team to conduct the survey and upon arriving, were surprised to find the team lead was the only person present. He informed us he didn't agree with the risk assessment process and would not allow his team to participate. The team lead instead informed us of how he wanted the risk assessment conducted with his team. My supervisor engaged in active listening to the team leads concerns and suggestions on how the assessment should proceed.

During this discussion, my supervisor was professional in his explanation of the purpose of the risk assessment and the process being used. He explained that the process was mandatory for RQHR's accreditation process, as the mitigation plans would be used to address areas Accreditation Canada had identified as requiring improvement. Further, he underscored that this process was specifically designed to gain input from CQI teams so that they could play a greater role in mitigation planning. The meeting ended with everyone agreeing to meet at a later date to discuss possible solutions.

4.7 Success of Intervention

As my practicum ended prior to the completion of the risk assessment process, I am unable to assess the success of the intervention. The process will continue through 2016 and its ultimate success will be determined both by the ability of RQHR to implement the mitigation plans outlined in the results, and if Accreditation Canada grants accreditation.

5. Relationships

Relationships are dynamic, interpersonal connections between two or more people (systems). They reflect how we think, feel about, and behave towards one another (Kirst-Ashman & Hull, 2015). During my practicum, my interactions were both formal and informal in nature, and were oriented towards completing the risk assessment. I did not observe the client's (CQI teams) relationships with RQHR being maintained over a period of time, but do not preclude that possibility.

In observing the physical locations of the various offices, I found it interesting that one of RQHR's goals is to "break down the silos." My practicum largely fell under the hospices of KPO and Risk Management. Risk Management was located down one hallway, I was in the middle, client representatives were on the other side of me, and KPO was down the hall and around the corner. In order to get to KPO, you had to walk down the hallway past client representatives. But while geographically linked, the lack of real integration between the departments meant that the silos remained very much intact. While staff from respective departments were respectful of one another, little interaction between them was observable.

My engagement with staff from KPO and Risk Management was limited. My risk assessment responsibilities were separate from the *lean* activities being conducted by KPO. I did attend KPO's Monday morning meetings, however only as an observer. As I was unfamiliar with the work and methods being discussed, I engaged in self-directed learning on Kaizen and *lean*. Unfortunately being a student I was not invited to attend the one-day employee workshop that provides education on *lean* principles. Further, because I largely worked independently (except

during the risk assessment survey administration) the collaborative work I engaged in was with individuals not connected to the profession. For this reason I cannot speak to a worker relationships with the social work profession, as in this setting one did not appear to exist.

6. Strategies

The RQHR has expressed a vision aimed at creating a culture of safety where both patients and staff are free from harm within facilities. During my practicum I was introduced to a number of strategies designed to address patient safety concerns within the region.

Risk Management

Just as humans cannot be eliminated from patient care, neither can risk. It is for this reason that risk management plays a vital role in enhancing patient safety (Briner et al., 2010). It is critical for agencies to assess, develop, implement, and monitor risk management strategies with the goal of minimizing staff and patient exposure: "Effective risk management requires an informed understanding of relevant risks, an assessment of their relative priority and a rigorous approach to monitoring and controlling them" (Silver, 2015). Clinical risk management is a specific form of risk management that focuses on clinical processes that directly or indirectly affect the patient. One of the roles of hospital risk management is to identify, contain, and manage risks related to patient safety (Briner et al., 2010).

Risk management operates as one system within the larger system of an organization. Its role will differ according to circumstances. More generally risk management can be defined as a "process of minimizing risk to an organization by developing systems to identify and analyze potential hazards to prevent accidents, injuries, and other adverse occurrences, and by attempting to handle events and incidents which do occur in such a manner that their effect and cost are minimised" (Davies, et al., 2003). Specific to healthcare it refers to those "organizational

activities designed to prevent patient injury or moderate the actual financial losses following an adverse outcome." RQHR does not have a publicly expressed risk management policy regarding patient safety.

The specific role and goals of RQHR's risk management department are not public knowledge, however given the nature of the risk assessment process I was involved in, it is clear that their perception of the practice mirrors more general developments in the field. In the past, risk management primarily focused on issues such as medical malpractice, employee risks, general liability, workers' compensation, and reducing exposures to risk. However, as referenced earlier, advances in technology and changes to the structure and funding of healthcare have seen risk management expand to also include a host of other issues not limited to, but including, healthcare reform, electronic medical records, population health, the determinants of health, workplace violence, and, most relevant to my practicum, patient and employee safety (Department of Health, 2002). The survey and polling process I participated in during my practicum is an important tool for managing risk, as it both identifies the areas in need of attention, and works towards mitigating those risks through concrete action and monitoring strategies.

Accreditation

Every health region in Canada must be accredited through an accreditation body. Saskatchewan Health requires Health Regions to seek accreditation from the national agency responsible for ensuring standardization of healthcare as it relates to quality, safety, and efficiency. There are four steps involved in the accreditation process. Steps 1-3 take approximately 17 months. The entire process took place over a three-year period. My involvement with the risk assessment took place during step 3.

1. Accreditation Canada conducts a Readiness Assessment with the RQHRs accreditation team.
2. Accreditation Canada provides training on accreditation.
3. RQHR staff completes a self-assessment and patient safety survey. Accreditation Canada provides the RQHR with a Quality Performance Roadmap.
4. An on-site survey is completed by Accreditation Canada and the RQHR provides follow up information until the next accreditation process begins. At that point the cycle starts over.

While I was not involved in the accreditation per se, its standards and roadmap form the foundation for that process and as such it formed an important part of the patient safety strategies I was exposed to.

Incident Reporting

Incident reporting is another important strategy employed by RQHR. It is a strategy many hospitals have adapted from aviation industry. Incident reporting is viewed as a possible method to promote learning from incidents (Briner et al., 2010). Lessons regarding the nature of risks and safety practices are brought to bear on healthcare safety. Learning from aviation provides healthcare with many opportunities to learn about safety measures such as adopting active approaches to healthcare risks rather than reactive approaches to adverse events that have occurred (Kapur, Parand, Soukup, Reader, & Sevdalis, 2016). This includes adopting methods for assessing systems as opposed to focussing on individuals (Kapur et al., 2016). Checklists and briefings before and after a surgery are similar practices to those used by pilots prior to flight (Kapur et al, 2016). The limitations of my practicum meant I was not privy to firsthand incident reporting, but the risk management director frequently referenced its importance.

Stop the Line

"Stop the line" is a principle that originated in the Toyota Production System, designed to empower employees who encounter a potentially harmful situation to literally stop any processes underway in order to immediately report the problem. The "line" does not restart until whatever

element of the process that led to the problem is identified, and a solution developed. By utilizing this strategy, RQHR identifies concrete performance measures and targets areas to improve patient safety (Regina Qu'Appelle Health Region, 2015b). Their *Stop the Line* system involves:

• A protocol to ensure that any serious event is reported to a senior manager who will resolve the problem within a set timeframe.

• The cessation of all related functions in cases involving to the most serious patient safety concerns, until staff and leaders are able to convene to address the problem and find a solution.

• Empowering individuals to stop the line as soon as a problem is identified, with the intention of avoiding harm "down the line" (Regina Qu'Appelle Health Region, 2015b).

7. Skills

My practicum experience afforded me greater understanding of the accreditation process generally, and risk assessment and patient safety, specifically. Observing the real-time application of systems theory-related practices and how they can inform micro and macro-level policy was invaluable. In particular, my engagement with this project led me to better understand the importance of active listening, the development of frontline relationships and their dynamic interactions with all system levels, conflict resolution, working collaboratively.

Additionally, having the opportunity to see what patient safety as a concept actually means in terms of practical application helped to highlight the importance of putting people first in our interventions. The *Roadmap* used in the risk assessment process was one thing to read on paper. However once we began working with the CQI teams we were able to observe the very tangible impacts those standards have on frontline workers and patients. This further underscored the need to utilize team members' strengths in order to affect change and move the process

forward. By empowering the employees, we increased the likelihood of success during the implementation of mitigation plans.

Another important skill I developed during my practicum was a greater understanding of the importance of roles in organizational structures and understanding their place in social work practice. Generalist social practice identifies role as "expected behaviour pattern for a person having a specific status or being involved in a designed social relationships" (Kirst-Ashman & Hull, 2015, 40). Generalist practice identifies 10 main roles which include; enabler, mediator, manager, educator, analyst/evaluator, broker, facilitator, initiator, negotiator, mobilizer and advocate (Kirst-Ashman & Hull, 2015). Of these roles, several in particular stood out and were readily observable throughout my practicum.

An "enabler" is one who provides support, encouragement, identification of strengths, and assistance in problem solving (Kirst-Ashman & Hull, 2015). During my practicum I witnessed my supervisors taking on this role on a daily basis with their staff during both the staff meetings and the CQI team risk assessment process. These skills were also exemplified by the Executive Director as he identified stressful situations and provided assistance for those feeling anxiety over planned changes. For example, when one staff member was experiencing a heightened level of anxiety and stress related to the process, work was stopped, the team was brought together to provide support, discuss feelings and coping strategies, and to identify ways to support one another. This is precisely the kind of intervention that will help to inform my future social work endeavours.

The role of "mediator" is defined as one who resolves disagreements and conflicts (Kirst-Ashman & Hull, 2015). Obviously the above cited issue with a CQI team lead unwilling to participate in the risk assessment process is a prime example of the importance of this role.

However there were also many other examples of disagreements during the survey process which, while minor, still had to be reconciled. My practicum supervisors remained neutral and helped others to recognize the important context related to each issue spawning disagreement, and to acknowledge everyone's perspective. Team members were encouraged to talk through their interpretation of the standards and risks involved, and by doing so, the teams were able to arrive at a consensus and continue the process.

The initiator role is defined as the person or persons who first identify the presence of an issue (Kirst-Ashman & Hull, 2015). While I was not present at the initiation of the risk assessment process, patient safety—as a concept related to risk management—also effectively acted as an initiator. Often the outcomes of a medical error or adverse event are what serve to identify a problem, rather than an individual. In those cases where in impact is felt by individuals using the services, patients, families, and staff all play important roles identifying concerns. As such, both those outcomes and those individuals have acted as initiators in this intervention.

Finally, and most importantly, in generalist practice the role of the advocate is considered the most important role in social work. By addressing the issue of patient safety, those involved in the risk assessment and mitigation process have all taken on a role advocating for patient safety. I witnessed how staff at all levels, stakeholders, individuals, all took on advocacy roles in their respective mezzo systems to ensure that the safety needs of patients and front linestaff are all met.

7. Conclusion

Social work is practice-based, and as such, practicums form a vital part of our education. No matter whether that experience is positive or negative, it provides us the opportunity to critically assess whether the systems in place are functioning as they should, and how

interventions can work to improve engagement and enhance well-being. The expansion of my knowledge of how systems theory applies to generalist interventions has greatly assisted me in understanding organizational functions and behaviours that guide assessments and interventions within macro practice organizations.

My practicum's focus on applying qualitative and quantitative research to the problem of improving patient safety served to highlight that while risks in any field—though particularly in healthcare—can never be fully eliminated, agencies must continually evaluate their services and standards to mitigate and reduce those risks whenever possible. And just as RQHR must continue their processes of self-assessment and adaptation, I need to do the same in my development as a social worker. This experience has renewed my commitment to ongoing self-reflection and skill development, and I look forward to using these skills to address client needs in institutional settings such as hospitals and group homes.

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