Selected research, publications, and resources to promote evidence-informed 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.

Hot Off the Press

🔒 JUST CULTURE What is the role of individual accountability in patient safety? A multi-site ethnographic study
Aveling E, Parker M, Dixon-Woods M. Sociol Health Illn. 2015 (November online):1-17.

Study incorporating practice theory, political science, ethics, and data from five ethnographic case studies (UK and Africa) to determine the interdependence of systems and personal accountability. The collective nature of healthcare organizations is highlighted.

“An uncritically-applied ‘no blame’ approach may fail to recognise variations in the type and scope of opportunities for individuals to assert their moral responsibility, but a calculus-like logic seeking to promote ‘just culture’ that fails to recognise the limits of individual autonomy and the messiness of standards of practice may be equally misguided” (p.12).

🔒 INCIDENT ANALYSIS Patient safety’s missing link: using clinical expertise to recognize, respond to and reduce risks at a population level

Article outlining a framework for the surveillance of infrequent, serious risks across large (e.g. national) systems including: (1) system requirements (incident reporting, aggregation, support and surveillance, review and response, and dissemination of recommendations); (2) personnel requirements (non-hierarchical multidisciplinary team comprised of clinicians and subject-matter and human factors experts); and (3) the risk review/response process (searching of large incident and other databases for how and why things have gone wrong, narrative analysis by clinical experts, consultation with the health care sector, and development and pilot testing of corrective strategies). Criteria for determining which incidents require a population-level response are also included.

END-OF-LIFE The prevalence of medical error related to end-of-life communication in Canadian hospitals: results of a multicentre observational study

Canadian study quantifying the mismatch between patients’ and family members’ expressed preferences for end-of-life care and orders for life-sustaining treatments. Results showed that, among 16 Canadian hospitals, 37% of patients experienced a medical error (overtreatment or undertreatment). Of the patients who expressed a preference for cardiopulmonary resuscitation (CPR), 2% had CPR withheld in their medical orders. 35% of patients who did want CPR had orders to receive it. Variability in overtreatment rates ranged from 14-82%. Patients who were frail were less likely to be overtreated while those without a family member were more likely to be overtreated.

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“Medical errors related to communication about end-of-life treatments are very common in internal medicine wards across Canada, and many older patients in these wards are at risk of receiving inappropriate end-of-life care. There is striking variability in medical error rates across hospitals” (p. 8).

**LABORATORY SERVICES** Accountability through regulation in Ontario’s Medical Laboratory Sector
Gamble B, Bourne L, Deber R. *HC Policy* (Special Issue). Reprint 2015 (September); Original 2014 (September);10:67-78.

Case study examining approaches to accountability (i.e. financial incentives, regulation, information directed to potential users, and reliance on professionalism/stewardship) in the Ontario medical laboratory sector and their benefits and unintended consequences. The authors suggest that while much progress has been made in improving medical laboratory services in the analytical phase, continued improvement will require closer collaboration with providers who are responsible for ordering (pre-analytical phase) and interpreting results (post-analytical phase).

**CRITICAL INCIDENT ANALYSIS/MENTAL HEALTH** Root cause analyses of suicides of mental health clients: identifying systematic processes and service-level prevention strategies
Gillies D, Chicop D, O’Hallaran P. *Crisis*. 2015 (September);36(5):316-324.

Study to develop a standardized taxonomy for suicide-related root cause analyses (RCA), and to summarize service-related factors and prevention strategies associated with suicides. RCAs from 64 individuals who died by suicide and had been in contact with the mental health service in New South Wales, Australia within seven days prior to the suicide were reviewed. Themes included individual, situational (stresses and support) and care-related (risk assessment, medication, and follow-up) factors. Denying suicidality at the last assessment was the most common factor among clients and the median time from denial of suicidal ideation to the time of suicide was three days. Other factors identified were reliance on carers, recent changes in medication, and problems in communication, risk assessment and follow-up after in-patient discharge.

**INCIDENT ANALYSIS/COGNITIVE ABILITY** Incorporating metacognition into morbidity and mortality rounds: the next frontier in quality improvement

Canadian paper suggesting the need to incorporate metacognition into morbidity and mortality rounds (MMR) to enhance quality improvement. The authors suggest that systems reengineering is not able to solve all safety and quality problems where humans are involved. Illustrative case studies and recommendations for introducing ‘thinking about thinking’ into MMR are described.

“Discussions centered on a physician’s raw thinking ability have become a “third rail,” even though clinical reasoning lies at the core of patient safety... However, the fields of cognitive psychology and medical decision making have clearly established that cognitive errors occur predictably and often, especially at times of high cognitive load (e.g., when many high stakes complex decisions need to be made in a short period of time)” (p.2).
CRITICAL INCIDENT ANALYSIS  How is the effectiveness of root cause analysis measured in healthcare?

Article discussing processes involved in critical incident analysis, and challenges in communicating results and demonstrating value to organizational leaders. Included are: a technical comparison of three common analytical processes (5-whys, fishbone diagram, logic tree); and potential metrics to track and measure the effectiveness of analyses (e.g. % of recommendations made in previous analyses, #/% of repeat analyses).

“Human decision making can be greatly improved by RCA via participation on the RCA teams and by proper dissemination of RCA results through an RCA knowledge management system” (p.29).

PATIENT SAFETY/PSYCHOLOGY  Making health care safer: what is the contribution of health psychology?

Editorial discussing the need for health psychologists to engage more closely with patient safety and quality improvement initiatives given their knowledge and understanding of human behaviour. Areas of intervention could include: behaviour change, teamwork, communication after medical error, diagnosis and decision making, organisational culture, and improving compliance with rules and standards.

“Briefings, checklists, and other approaches tend to be treated as techniques which can be implemented in any setting and with any team. Psychological studies have shown that they are not a panacea and, according to how they are used, can be either a positive or negative influence on team performance. If used badly, they can disrupt positive communications, reinforce professional divisions, create tension, and perpetuate problematic cultures” (p.683).

DISCLOSURE/DIAGNOSTIC ERRORS  Primary care physicians’ willingness to disclose oncology errors involving multiple providers to patients

Cross-sectional survey of almost 300 primary care physicians from three integrated health systems in the US using two hypothetical vignettes: (1) delayed diagnosis of breast cancer, and (2) care coordination breakdown causing a delayed response to patient symptoms. Results showed: 77% and 58% of physicians for the two cases respectively, would offer no information or make vague references to miscommunication; more than half of physicians in both cases would not offer an apology or would offer vague expression of regret; and the greatest predictors of disclosure were perceived personal responsibility, perceived seriousness of the event and perceived value of patient-centred communications.

“Physicians are likely to find discussion of delays in diagnosis especially challenging, in part due to uncertainty about whether the delay affected the patient’s outcome. Compounding this is the additional challenge of communicating this uncertainty to the patient. Because such cases are so difficult, they should prompt disclosure coaches to provide extra support and attention in the planning and execution of these discussions” (p.7).
Other Resources of Interest (all 🗝️)

2013 annual hospital-acquired condition rate and estimates of cost savings and deaths averted from 2010 to 2013 (October 2015). AHRQ (US) report on annual and cumulative changes in hospital-acquired conditions. Results show a 17% decline from 2010 to 2013.


Continuous improvement of patient safety: the case for change in the NHS (November 2015). Health Foundation (UK) report on changing the approach to patient safety at the team, leadership and system levels.

Critical analysis of the evidence for resident safety practices in nursing home settings (October 2015). AHRQ (US) draft technical brief on safety in nursing homes.

Key vulnerabilities in the surgical environment: container mix-ups and syringe swaps (November 2015). ISMP (US) medication safety alert and recommendations for ORs.

Preventing medication errors by empowering patients (September 2015). American Nurse Today (US) article on factors that contribute to medication errors and the patient’s role in preventing them.

Toolkit for reducing CAUTI in hospitals (November 2015). AHRQ (US) website with tools and resources for reducing CAUTI, based on Comprehensive Unit-based Safety Program (CUSP) concepts.

Top 10 health technology hazards for 2016 (November 2015). Abridged version of ECRI (US) annual list of medical device and systems hazards (registration required).


HIROC Healthcare Risk Management

HIROC Monthly Risk Management Webinars – 2015/16 Upcoming Topics – Save the dates!
- December 10 A Critical Incident Has Occurred – Now What? Click here to register!
- January 21, 2016 The Risk Assessment Checklists Program – What’s New for Cycle Two
- February 18 HIROC’s Claims Reports – Everything You Ever Wanted to Know
- March 3 Understanding the Coverages Available Through HIROC’s Brokerage
- March 31 Privacy Issues in Long-Term Care
- April 21 Focus on Children’s Issues
- May 19 Directors’ and Officers’ Liability Insurance
- June 16 Agency Agreements – Is Your Organization Protected?

For an up-to-date list of HIROC webinars please click here.