

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.

EDITOR'S NOTE



This month's Risk Watch features a number of articles (many of them Canadian) on facilitating and sustaining improvement, integrated risk management, and safety culture. Liu et al. note several barriers to using patient complaints to drive improvement and suggest the key to meaningful improvement may be to systematically engage patients in clinical operations rather than developing solutions from analyzing complaints. Sangam reports findings from two incident reviews involving IV infiltration in infants, which mirror HIROC's claims experience of these cases, and which spurred the development of a unique IV securing method that addresses one of the main causes: the failure to detect and recognize the initial stages. Breckenridge et al. co-created a framework for sustaining improvement with leading change organizations. At the heart of it is the idea that with evidence of each successful change, intrinsic motivators are fundamentally transformed, making improvement self-proliferate within the organization. Finally, we would be remiss if we didn't reference the article co-authored by HIROC's own Polly Stevens along with Jordan Willcox (CAMH) and Lori Borovoy (HIROC). They provide background on a "by healthcare, for healthcare" integrated risk management program and present data from the first three years.

As always, we hope you find the articles interesting and insightful. If you have any feedback, please email me at schow@hiroc.com.

PATIENT COMPLAINTS/QUALITY IMPROVEMENT



Putting out fires: a qualitative study exploring the use of patient complaints to drive improvement at three academic hospitals

Liu J, Rotteau L, Bell C, et al. *BMJ Qual Saf.* 2019 (online, May):1-7.

Study at three academic hospitals in Canada to assess how the patient complaint process can offer solutions to frequent problems in healthcare and support hospital-wide improvement. Barriers to this process included: well-known issues that are difficult to address; ineffective change strategies; and complaints being handled at the unit level instead of the patient relations office. Including the patient voice in day-to-day operations of the hospital before a complaint occurs may be more beneficial.

DETERIORATION/PEDIATRICS



Quality improvement measures for early detection of severe intravenous infiltration in infants

Sangam S. *BMJ Open Qual.* 2019 (online, June):1-5.

Quality improvement (QI) review at a community hospital in the US to assess root causes and risk factors in two severe cases of intravenous (IV) infiltrates and to develop QI measures. Both cases involved: preterm infants; IV access >4 days; infrequent IV site documentation; IV pumps that failed to show pressure alerts. Interventions included an IV securing method to help identify early infiltration and mandatory frequent IV site assessments and documentation. No serious IV infiltration cases were reported in the six months post implementation.

CLINICAL TRIALS/PEDIATRICS

[Innovative approaches to investigator-initiated, multicenter paediatric clinical trials in Canada](#)

Kelly L, Richer L, Ali A, et al. *BMJ Open*. 2019 (online, June):1-5.

Article describing the design of four emergency room pediatric trials in six hospitals across four provinces, and operational considerations, including multisite contract development, centralized data monitoring, and patient engagement, for the development of pediatric clinical trials infrastructure in Canada. Authors described the legal and budgetary challenges and solutions in managing clinical trials in multiple jurisdictions.

QUALITY IMPROVEMENT/SUSTAINABILITY

[Motivating Change: a grounded theory of how to achieve large-scale, sustained change, co-created with improvement organisations across the UK](#)

Breckenridge J, Gray N, Toma M, et al. *BMJ Open Quality*. 2019 (online, June):1-12.

Study drawing on the collective expertise of 42 staff across three change organizations in the UK to develop a theory that describes ideal conditions for sustaining large-scale change, from the front-line perspective. Authors described the components of the framework which encompasses psychological, social, and structural factors in motivating change and aims to embed long-term improvement cultures within organizations.

END OF LIFE CARE

[Improving hospital-based communication and decision-making about scope of treatment using a standard documentation tool](#)

Kohen A, Nair R. *BMJ Open Quality*. 2019 (online, June):1-10.

Quality improvement project in a community hospital in Canada to improve communication and understanding around advanced care planning by implementing the medical order for scope of treatment (MOST). Implementation was associated with an increase in orders for life-sustaining treatment (33% vs 75%), a decrease in level of disagreement between healthcare providers and patients/families, and increased satisfaction with decision making regarding patient care plans.

ELECTRONIC HEALTH RECORDS/CLAIMS

[Electronic health record-related events in medical malpractice claims](#)

Graber M, Siegal D, Riah H, et al. *J Patient Saf*. 2019 (June);15(2):77-85.

Study in the US reviewing 248 closed medical malpractice claims that involved health information technology to identify types of errors. The majority of claims (59%) were from ambulatory settings, with hybrid record systems cited as the leading contributing factor. Medication, treatment, and diagnostic errors were the top allegation types. Solutions which address the following could improve safety: routing problems (getting the right data to the right provider), pre-populated fields, and intrinsic cross-checking (e.g. detecting decimal point errors).

INTEGRATED RISK MANAGEMENT

[Integrated \(enterprise\) risk management in Canadian healthcare organizations; common barriers and a shared solution for effective and efficient implementation in Canada](#)

Stevens P, Willcox J, Borovoy L. *Healthc Q*. 2019 (April);22(1):48-53.

Article outlining a Canadian, sector-wide initiative to spread at scale an effective, evidence-based program for integrated risk management. National results from the first three years of implementation are provided. Authors discussed the development of a common taxonomy of risks which related to key strategic objectives, and a top five risk ranking by frequency and impact.

JUST CULTURE CREATION

[Creating a just culture; The Ottawa Hospital's experience](#)

Forster A, Hamilton S, Hayes T, et.al. *Healthc Manage Forum*. 2019 (online, June):1-6.

Article from an academic hospital in Canada to describe how, following two events that called into question the hospital's safety culture, the hospital adopted a methodical organizational change to create a Just Culture. Impacts of the change included renewed energy of serious and critical events investigations with reviews by a senior executive within 48 hours and completing critical events investigations within 4 weeks, and improved relationships with unions and staff. Authors discussed the impact on objective measures of safety.

OBSERVERS/NON-CLINICAL STAFF

[So that is how it works? How observing a clinical process improved the management perspectives of non-clinical staff](#)

Heenan M, Lukich A, Myers D, et.al. *Healthc Manage Forum*. 2019 (online, June):1-5.

Study at a community hospital in Canada to improve operations through exploring patient flow using 14 non-clinical staff to observe the journey of 32 patients from point of emergency presentation to inpatient admission to discharge. Authors described what non-clinical staff learned from observing the patient journey, how their understanding of clinical workflow changed, and discussions on learning opportunities outside of traditional venues and reducing barriers to collaboration between clinical and non-clinical staff.

Other Resources of Interest (all)

[A healthy Ontario: building a sustainable health care system](#) (June 2019). Ontario Premier's Council on Improving Healthcare and Ending Hallway Medicine second report with 10 recommendations to improve healthcare.

[All eyes on hospitals: mandatory drug and medical device adverse event reporting](#) (June 2019). Borden Ladner Gervais LLP (CND) article outlining considerations for frontline staff education and training.

[Emergency department risks: through the lens of liability claims](#) (June 2019). Coverys (US) report with insights from 1,362 closed medical malpractice claims to identify root causes of emergency department claims.

[Medication safety in key action areas](#) (June 2019). World Health Organization (CH) set of three technical reports to facilitate priority planning and action in transitions of care, high-risk situations, and polypharmacy.

[Preventing, containing and managing cyber breaches: where to begin?](#) (May 2019). Borden Ladner Gervais LLP (CDN) article describing strategies to safeguard electronic information and respond to cybersecurity incidents.

[Take your patient partnering to the next level](#) (June 2019). Health Quality Ontario guide to overcoming common challenges in partnering with patients in quality improvement efforts.

[Protect against phishing](#) (August 2019). Information and Privacy Commissioner of Ontario fact sheet on phishing, how to recognize and protect against phishing attacks, and how to respond to incidents.

[The Consent and Capacity Board's jurisdiction to make section 41.1 orders](#) (June 2019). Borden Ladner Gervais LLP (CND) article outlining the Board's authority over long-term involuntary detainees.

[The financial and human cost of medical error](#) (June 2019). Betsy Lehman Center for Patient Safety (US) report on key risks to patient safety, impacts of medical error, and proposes a coordinated response to reduce errors.

[The pitfalls of AI in healthcare: bias and faulty anonymization](#) (June 2019). HealthManagement (CY) article summarizing discussions around the key challenges, which took place at a Harvard Medical School conference.