PARTNERING TO CREATE THE SAFEST HEALTHCARE SYSTEM

Integrated Risk Management in Healthcare

International Webinar Series, Webinar 46, CAHO & ISQua
1 October 2024

Disclosure

None

Objectives

By the end of this session, we will:

- Describe the fundamental purpose of Integrated Risk Management
- Explore a systems approach to safety and risk management
- Explore learning from harm
- Describe the importance of safety and risk management action

Healthcare Insurance Reciprocal of Canada (HIROC)

Our Mission

To provide insurance, risk management, and innovative solutions supporting safety and collaboration in healthcare.

Strategic Priorities

Patient Safety & Risk

Service Excellence

Innovation & Culture

Insurance landscape

- **HIROC Insurance**
- **HIROC** (95%) with 5% with the Commercial Marketplace
- Government Self-Insurance / Reciprocal
- Commercial Marketplace
- One of Two Regional Health Authorities

Enterprise = Integrated

Uncertainty

What if

Interconnection

Key updates

OPIOIDS | STIMULANTS

Reported in 2023 in Canada

8,049
Apparent opioid toxicity deaths [1] [2] [3]
(7% higher than the same period in 2022)

22
Deaths per day on average

6,312
Opioid-related poisoning hospitalizations [8]
(16% higher than the same period in 2022)

17
Hospitalizations per day on average

28,345
Opioid-related poisoning Emergency Department (ED) visits [9]
(17% higher than the same period in 2022)

78
ED visits per day on average

41,938
Emergency Medical Services (EMS) responses to suspected opioid-related overdoses
(18% higher than the same period in 2022)

115
EMS responses per day on average

Table 1
Number of deaths in fire-related incidents, seven jurisdictions, 2015 to 2021

Back to main article | CSV (1 KB)

Select columns

	2015	2016	2017	2018	2019	2020	2021	Total
	number of deaths	number of deaths	number of deaths	number of deaths	number of deaths	number of deaths	number of deaths	number of deaths
Total, including Canadian Armed Forces	**149**	**168**	**135**	**161**	**148**	**199**	**202**	**1,162**
Nova Scotia	10	7	6	18	14	7	15	77
New Brunswick	5	11	12	5	11	8	3	55
Ontario	97	104	78	93	70	114	117	673
Manitoba	13	20	12	16	19	14	5	99
British Columbia	23	25	26	26	28	54	59	241
Yukon	1	1	1	3	5	2	3	16
Total, excluding Canadian Armed Forces	**149**	**168**	**135**	**161**	**147**	**199**	**202**	**1,161**
Canadian Armed Forces	0	0	0	0	1	0	0	1

Note(s): There were seven jurisdictions in Canada that provided casualty data to the National Fire Information Database: Nova Scotia, New Brunswick, Ontario, Manitoba, British Columbia, Yukon and the Canadian Armed Forces.

Source(s): National Fire Information Database (5248).


Caution! Attention!
Dangerous cliff.
Escarpement dangereux.
Stay back from edge.
Eloignez-vous du bord.


ACHTUNG ATTENTION ATTENZIONE
Von hier aus begeben Sie sich in ein Gebiet mit alpinen Gefahren!
You are now entering an area where hazards inherent to mountain regions may occur!
A partir d'ici vous vous trouvez dans une région présentant des dangers inhérents à la montagne!
Da questo punto vi trovate in una regione di pericoli tipici della montagna!

Switzerland offers cash prize to get munitions out of lakes

17 August 2024

Share

Imogen Foulkes
BBC Geneva Correspondent

Munitions are dumped under Lake Brienz in the Swiss Alps

Key components of risk

- Attention to the identification of risk
- Assessment of the degree of risk
- Prevention, transfer and reduction of risk
  - Financing risk (insurance/reinsurance)

HIROC Resources

- Risk Note: risk identification
- Risk Note: risk assessment

Attention to the identification of risk – where risk may arise

- Intentional Tortious Conduct (e.g., battery, assault)
- Negligence
  - Duty of Care
  - Breach of Duty of Care
  - Resulting Loss or Damage
  - Caused by Breach
- Contributory Negligence
- Vicarious Liability (Liability for staff)
- Institutional Liability (Liability for itself)

Assessment of the degree of risk

- “Determining what to do”
- “Doing”

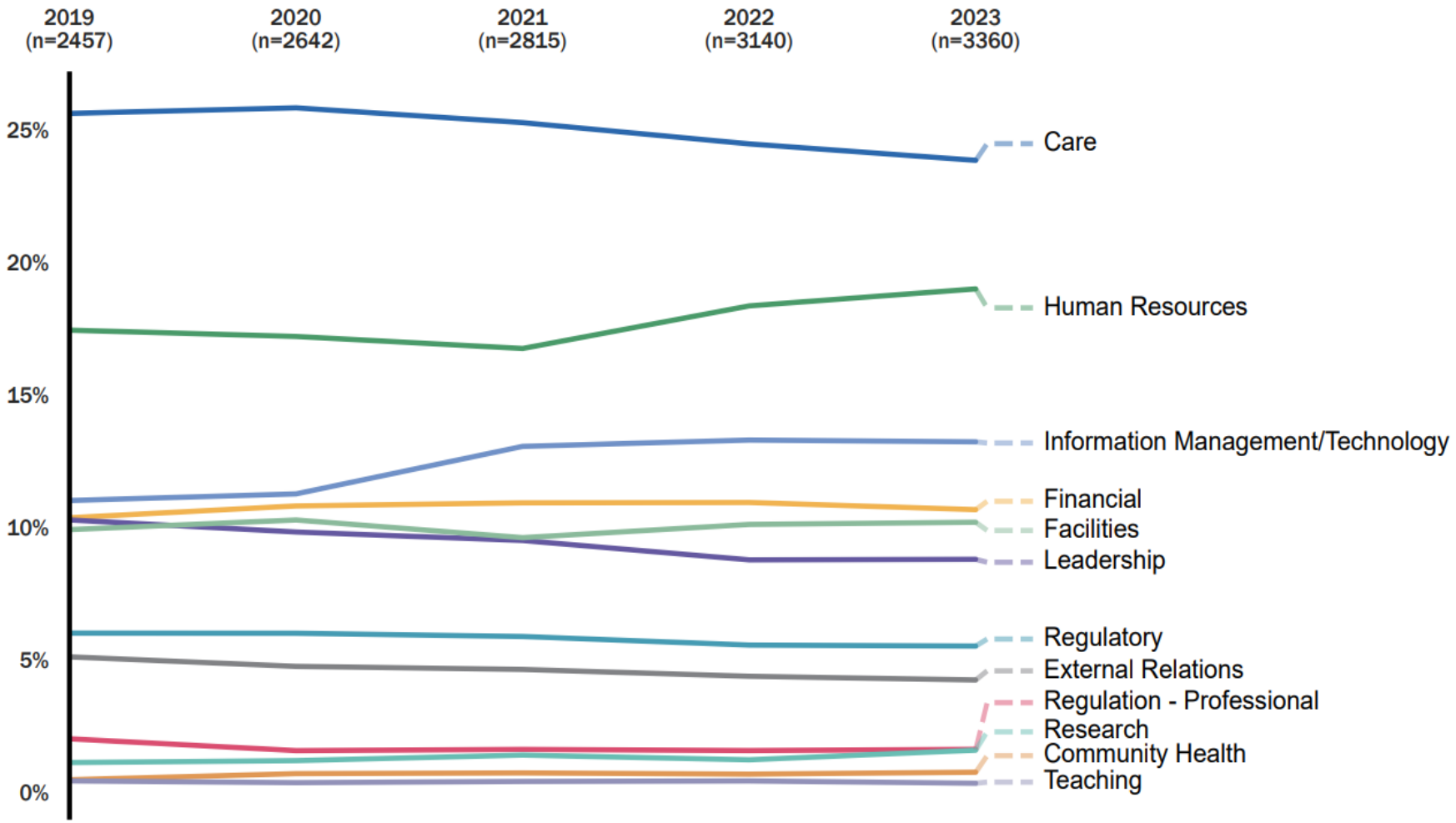
Assessment of the degree of risk

Healthcare Claims Experience

- Healthcare Professional Liability (78%)
- Bodily Injury (including personal injury) (13%)
- Errors and Omissions/Directors and Officers Liability (<1%)

Assessment of the degree of risk

Five year trend of Risk Register distribution tracked risks by *strategic objective risk category*

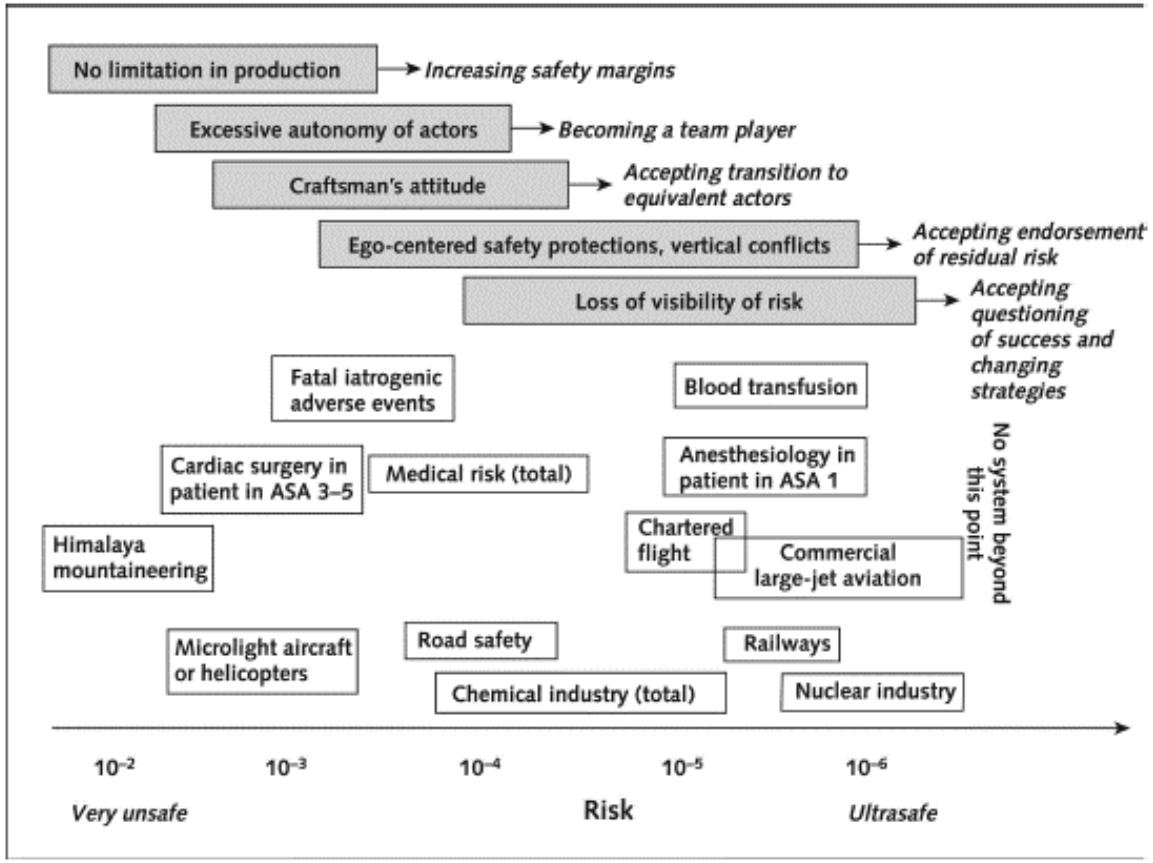


https://www.hiroc.com/system/files/resource/files/2024-08/HIROC%20Top%20Risk%20Report%202024.pdf

Integrated Risk Management in Healthcare

How safe is healthcare?

Figure 1. Average rate per exposure of catastrophes and associated deaths in various industries and human activities.



Amalberti R, Auroy Y, Berwick D, Barach P. Five system barriers to achieving ultrasafe health care. Annals of internal medicine. 2005 May 3;142(9):756-64.

How safe is healthcare?

Review

To Err is Human: Building a Safer Health System

Institute of Medicine (US) Committee on Quality of Health Care in America
Linda T. Kohn, Janet M. Corrigan, Molla S. Donaldson, editors.

Washington (DC): National Academies Press (US); 2000.

PMID: 25077248 Bookshelf ID: NBK225182 DOI: 10.17226/9728

Do we like to talk about our errors?

Table 2: Comparison of Traditional and Learning Views of Desirable Employee Behaviors

When the employee faces:	"Ideal Employee" Behaviors	Employee Behaviors Conducive to Organizational Learning
Own errors and problems	Creates an impression of never making mistakes	Self-Aware Error-Maker: Lets manager and others know when they have made a mistake so that others can learn from their error. Communicates openness to hearing about their errors discovered by others

Tucker AL, Edmondson AC. Why hospitals don't learn from failures: Organizational and psychological dynamics that inhibit system change. California management review. 2003 Jan;45(2):55-72.

The need

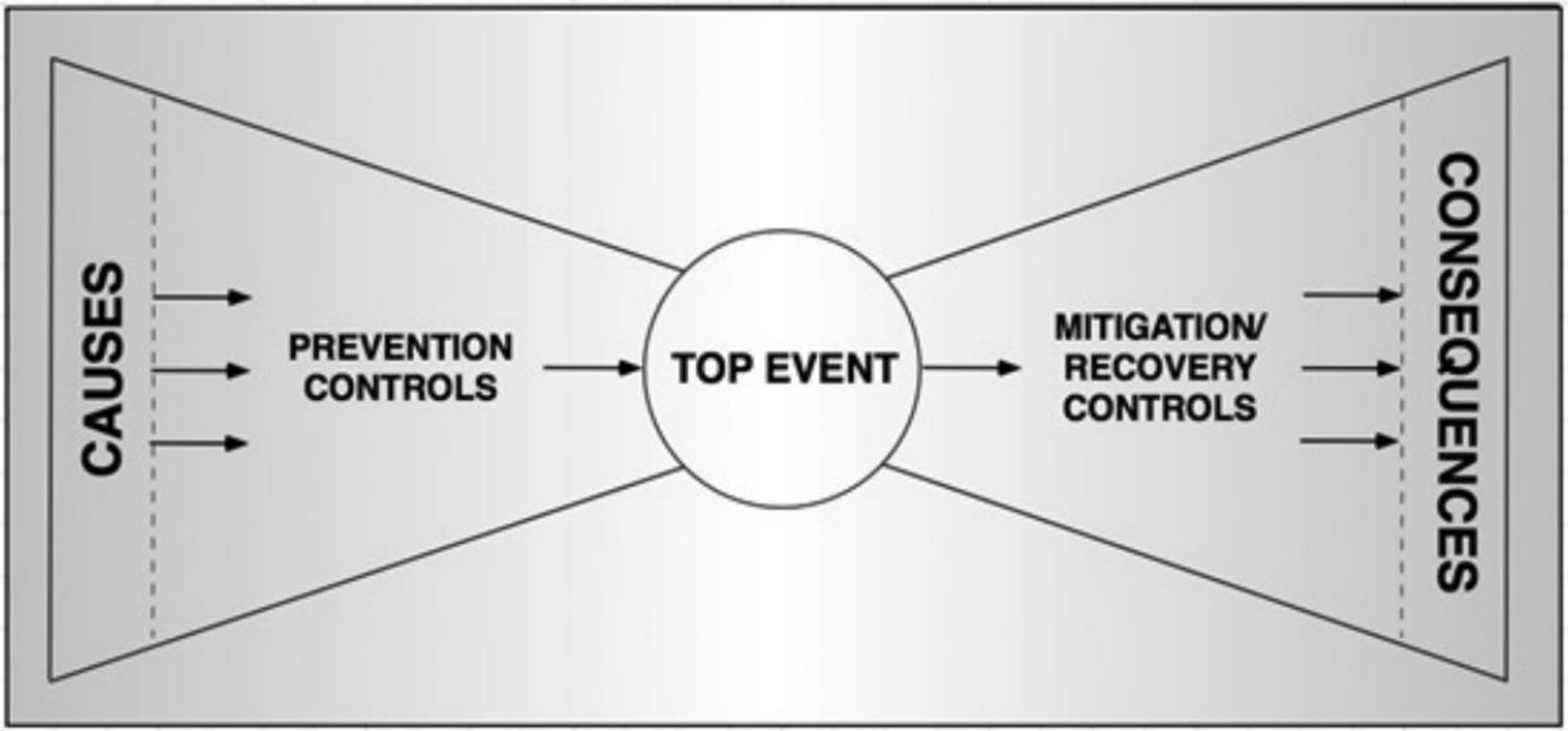
- The lack of patient safety continues to be one of the leading causes of preventable death globally
- Factors that influence risk outcomes in healthcare are largely unknown
- No prescriptions on how to design system safety to reduce top risks

Current approaches

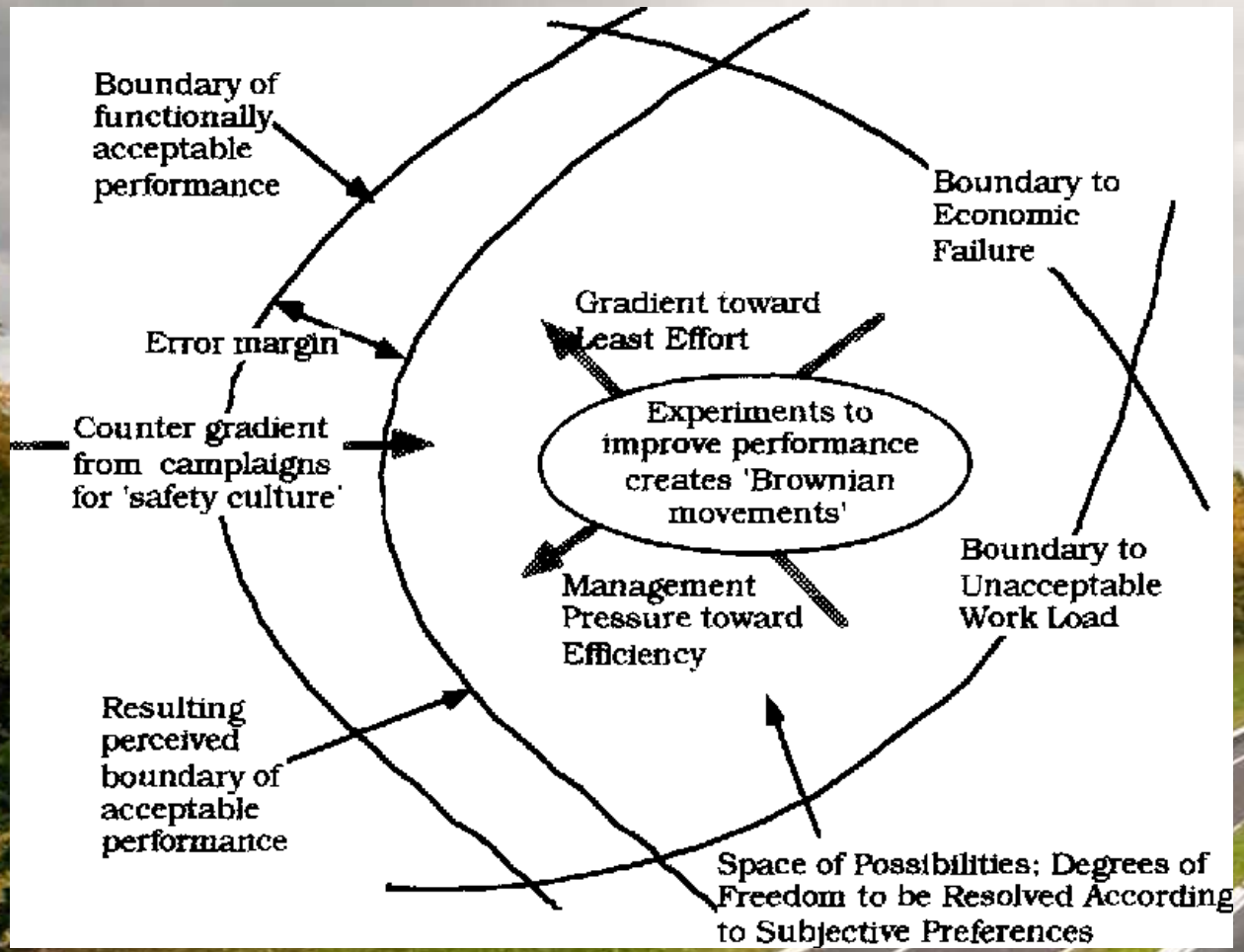
Characteristics

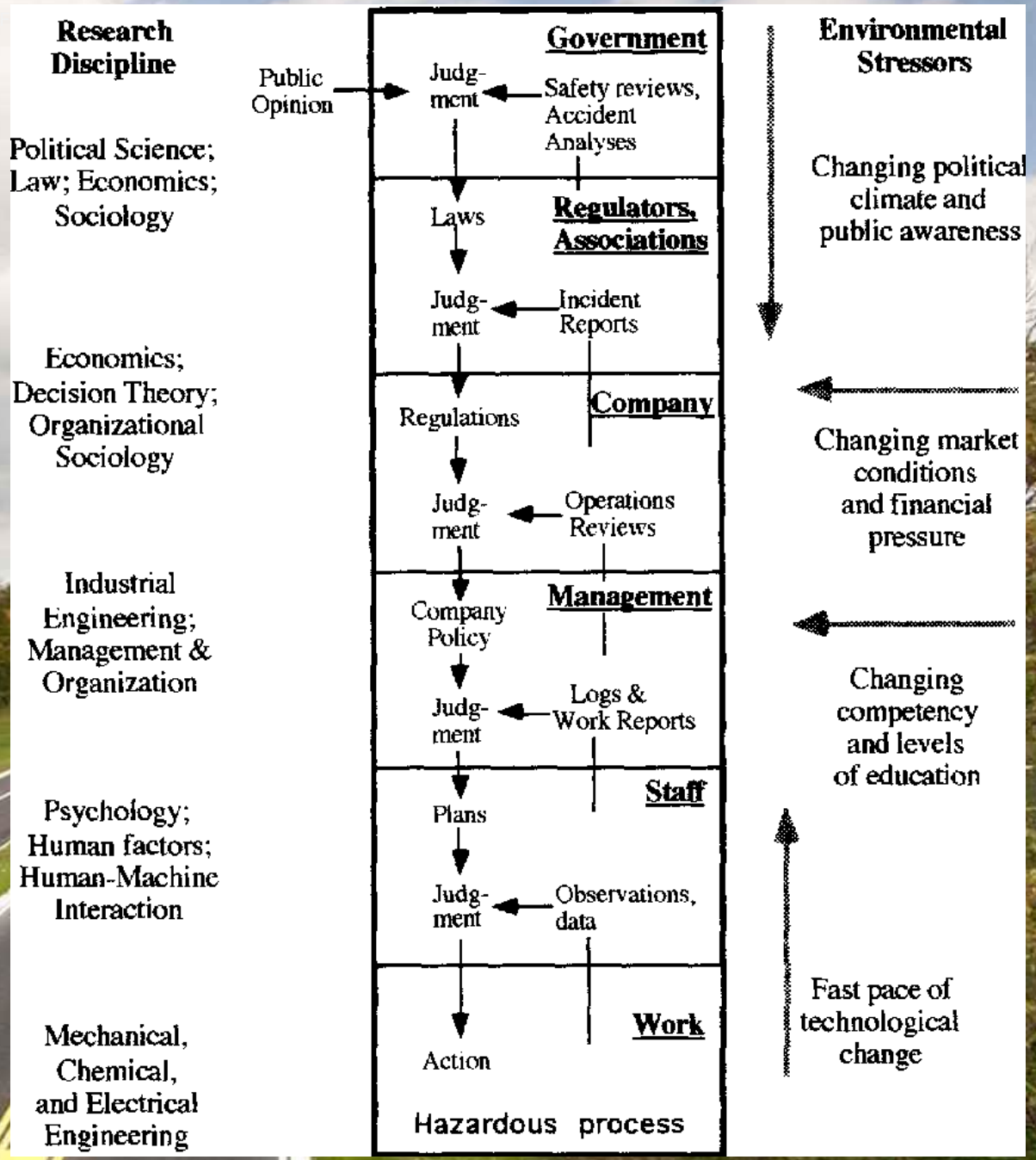
- Description of healthcare associated harm/patient safety incidents (i.e., cause and effect)
- Risks identified and prioritized by expert opinion (e.g., never events)
- Focused on patient safety on individual-level

Reductionist approach



Culwick MD, Merry AF, Clarke DM, Taraporewalla KJ, Gibbs NM. Bow-tie diagrams for risk management in anaesthesia. Anaesthesia and Intensive Care. 2016 Nov;44(6):712-8.





Rasmussen, J. (1997). Risk management in a dynamic society: a modelling problem. *Safety science*, *27*(2-3), 183-213.

Systems thinking

"Complex systems cannot be understood by studying parts in isolation. The very essence of the system lies in the interactions between its parts and the overall behavior that emerges from the interactions. The system must be analyzed as a whole."

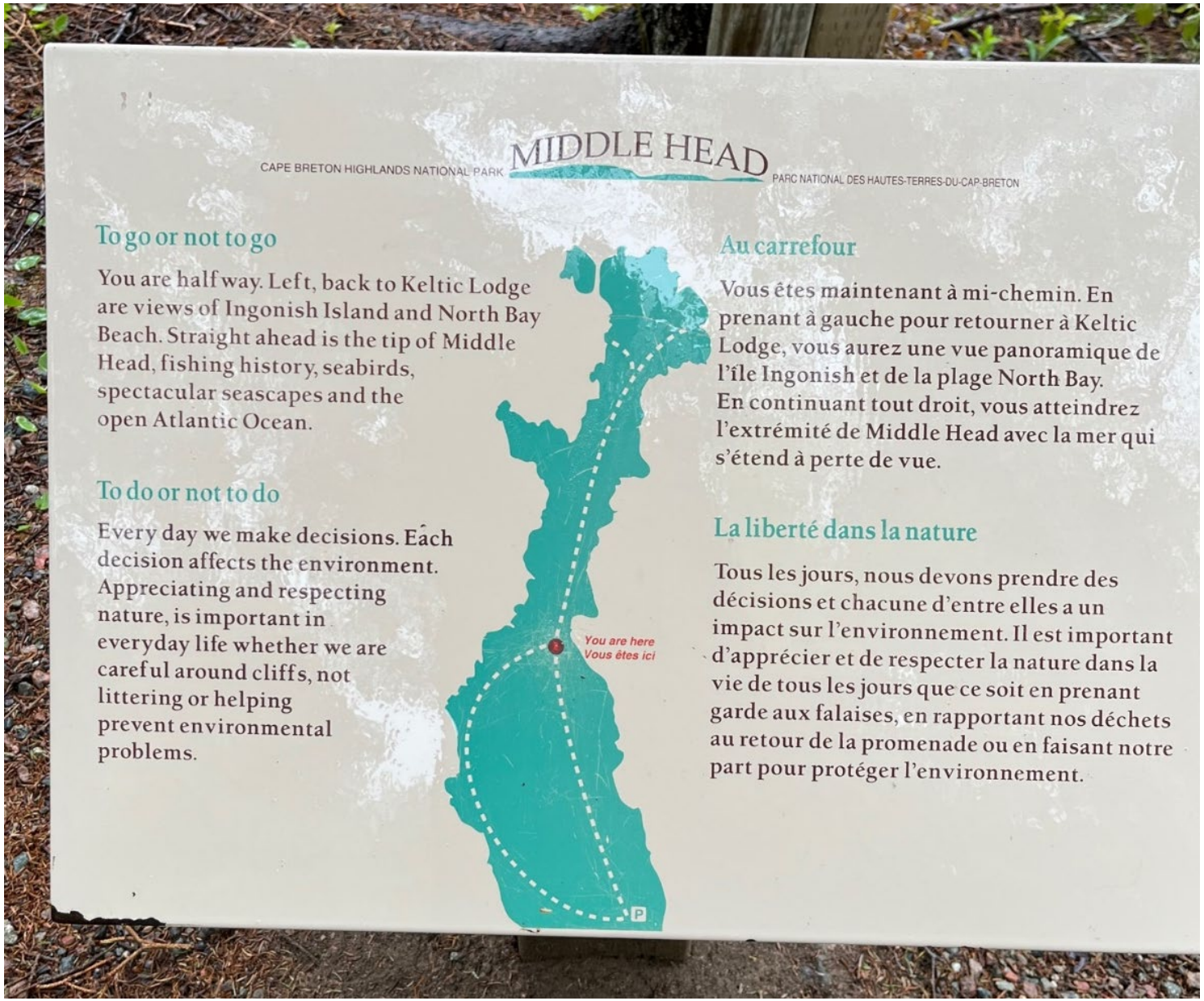
Ottino, J. M. (2003). Complex systems. American Institute of Chemical Engineers. AIChE Journal, 49(2), 292.

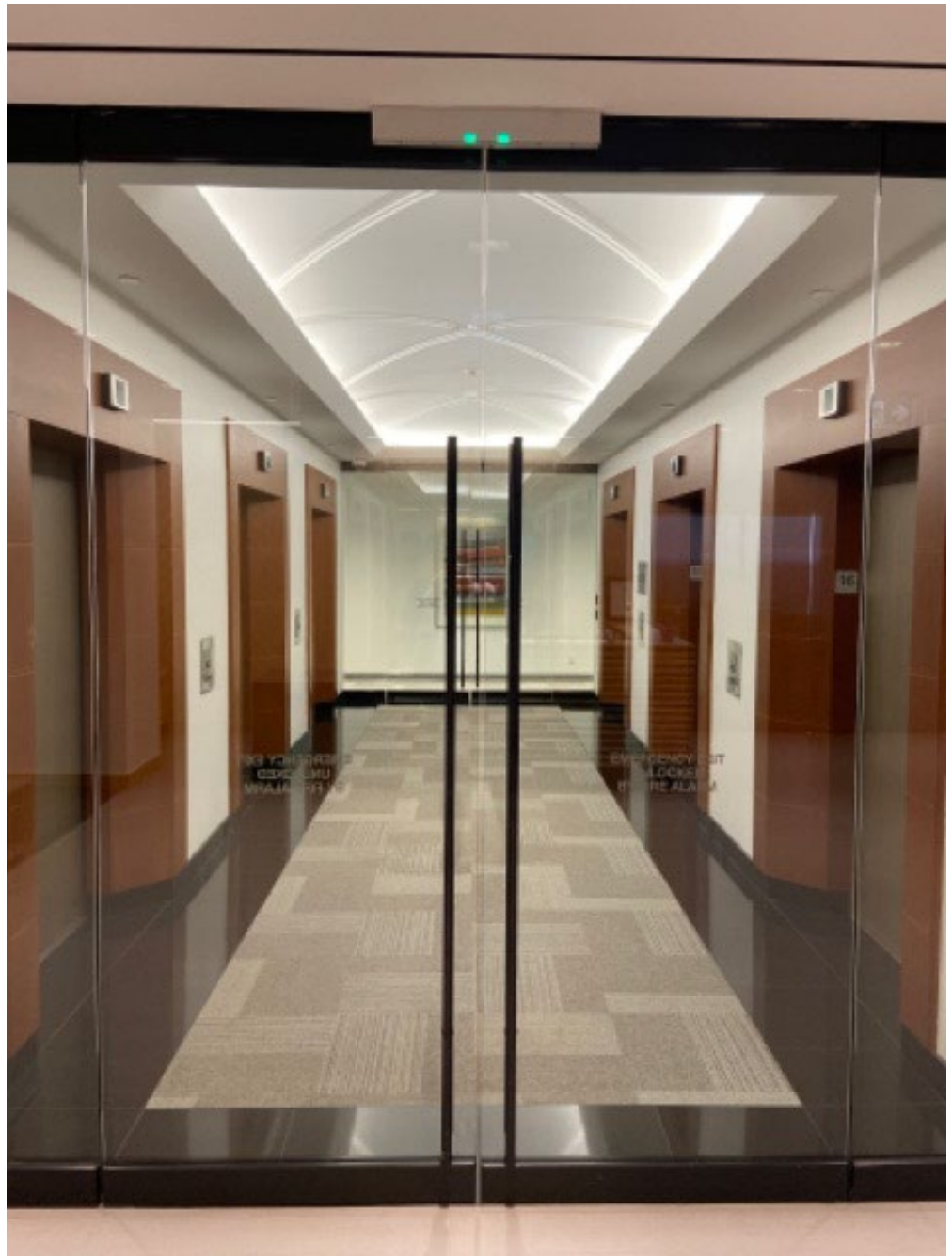
Systems thinking frameworks – examples

Systems Engineering Initiative for Patient Safety (SEIPS)	Functional Resonance Analysis Method (FRAM)	Systems Theoretic Accident Model and Processes (STAMP)
Framework for understanding outcomes within complex sociotechnical systems SEIPS work system: • Tools/technology • Tasks • Person • External environment • Organization • Internal environment	FRAM seeks function/process variability to understand everyday work. FRAM examines everyday work as described by six aspects of the function: • Input • Output • Precondition • Resource • Control • Time	Engineer a sociotechnical system in which responsibilities and controls are designed to allow the entire systems and its individual parts achieve their objectives. Safety control structures: • Design supervision • Process oversight • Social controls
Carayon	Hollnagel	Leveson

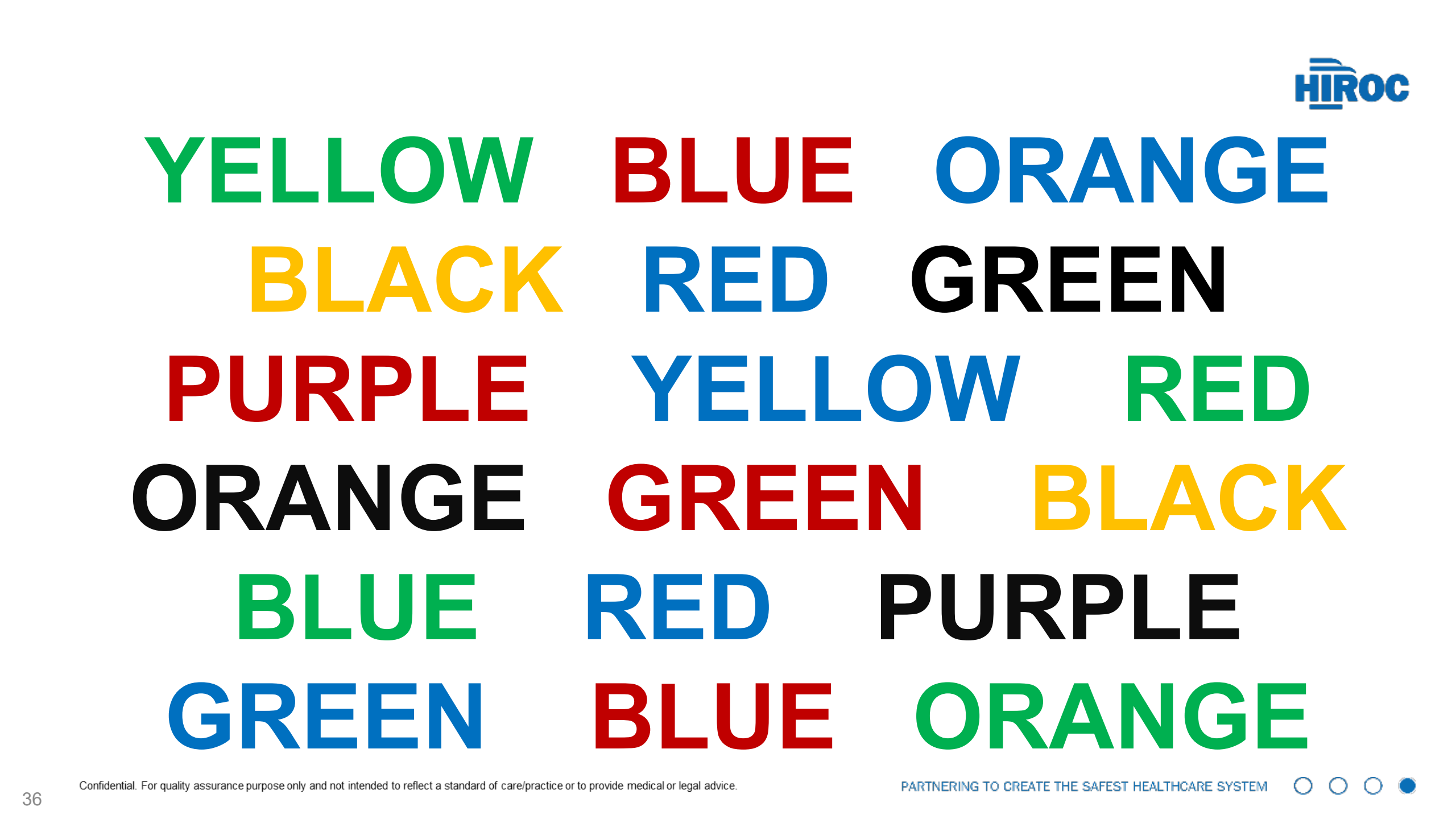
Learning from ~~error~~ harm

The concept of human error

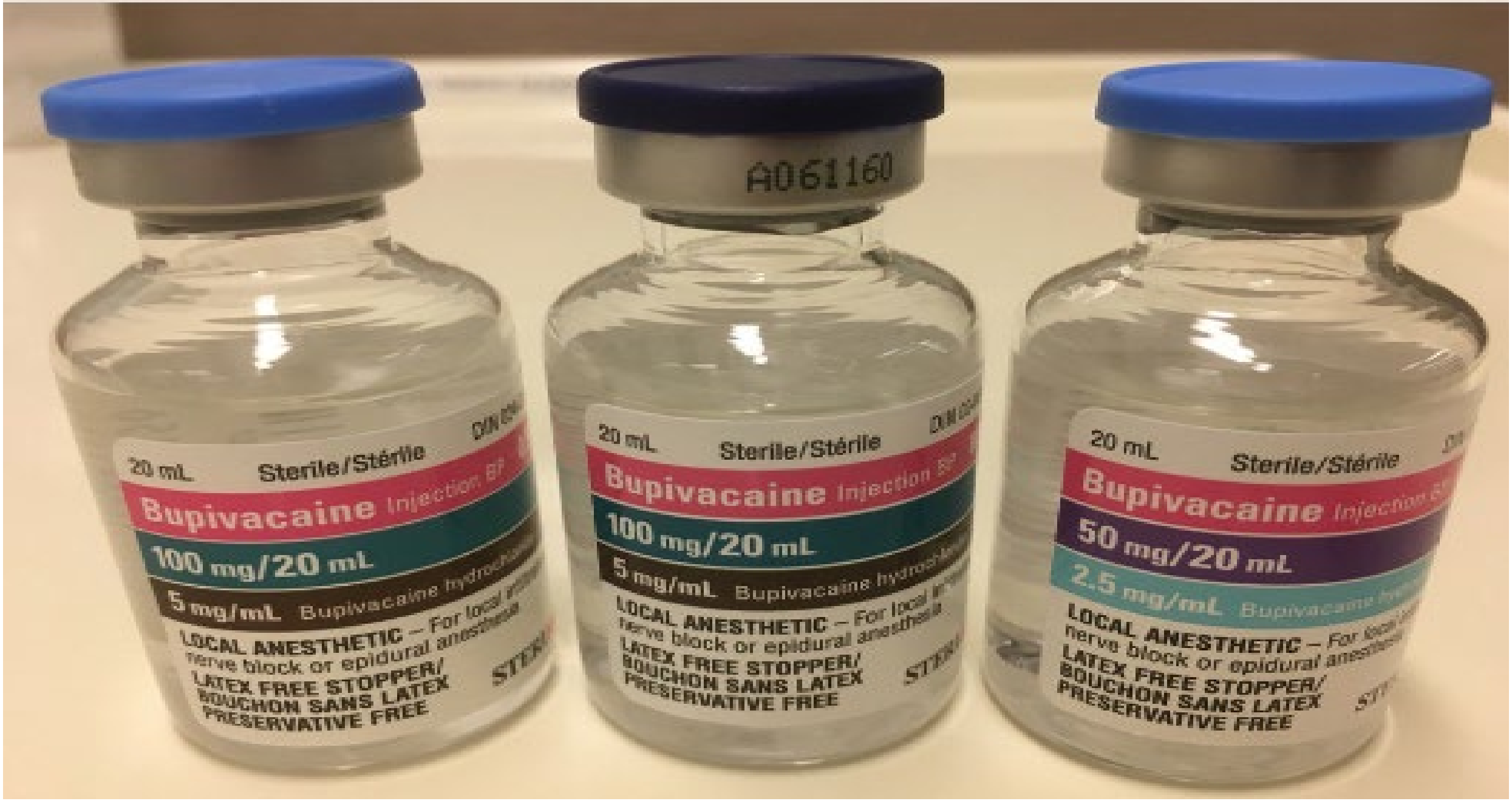




https://99percentinvisible.org/article/norman-doors-dont-know-whether-push-pull-blame-design/



Aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoetnt tihng is taht the frist and lsat ltteer be at the rghit pclae. The rset can be a toatl mses and you can sitll raed it wouthit porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe.


20 mL
Sterile/Stérile
Bupivacaine
100 mg/20 mL
5 mg/mL
LOCAL ANESTHETIC – For local
nerve block or epidural anesthesia
LATEX FREE STOPPER/
BOUCHON SANS LATEX
PRESERVATIVE FREE
A061160
20 mL
Sterile/Stérile
Bupivacaine
100 mg/20 mL
5 mg/mL
LOCAL ANESTHETIC – For local
nerve block or epidural anesthesia
LATEX FREE STOPPER/
BOUCHON SANS LATEX
PRESERVATIVE FREE
20 mL
Sterile/Stérile
Bupivacaine
50 mg/20 mL
2.5 mg/mL
LOCAL ANESTHETIC – For local
nerve block or epidural anesthesia
LATEX FREE STOPPER/
BOUCHON SANS LATEX
PRESERVATIVE FREE

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Only 1 left and in 1 basket

CA$44.48+

Propofol/Midazolam/Ketamine Label Autumn Scents Candle | Soy and Coconut Wax | Medic Gift | Anaesthetics | 180g | 6 oz

✓ Arrives soon! Get it by 08-15 Apr if you order today

✓ Returns accepted

Scent *

Select an option

Drug Name *

Select an option

Add to basket

Star Seller. This seller consistently earned 5-star reviews, dispatched on time, and replied quickly to any messages they received.

Item details

Handmade

Report this item to Etsy

https://www.ismp.org/resources/be-wary-controlled-and-non-controlled-medication-replicas-sold-online

Case study – drug diversion

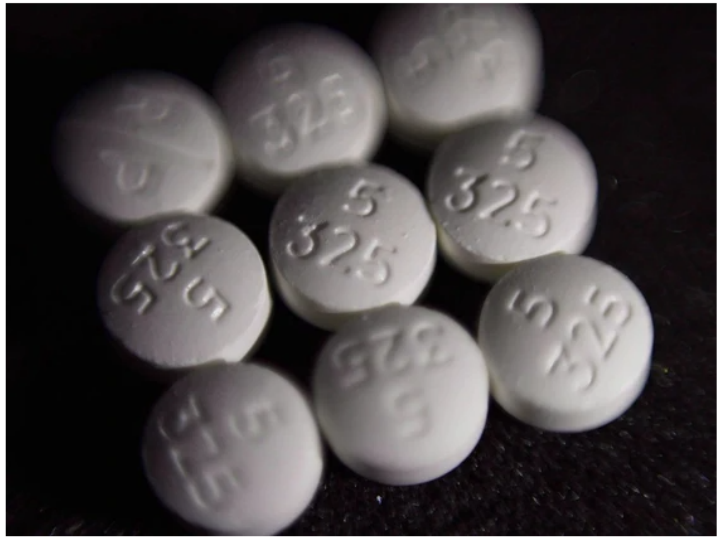
Local News

'Drug diversion' a growing problem in Canada's health-care system

Andrew Duffy

Published Oct 09, 2018 • Last updated Oct 09, 2018 • 4 minute read

Join the conversation



file photo PHOTO BY PATRICK SISON /THE ASSOCIATED PRESS

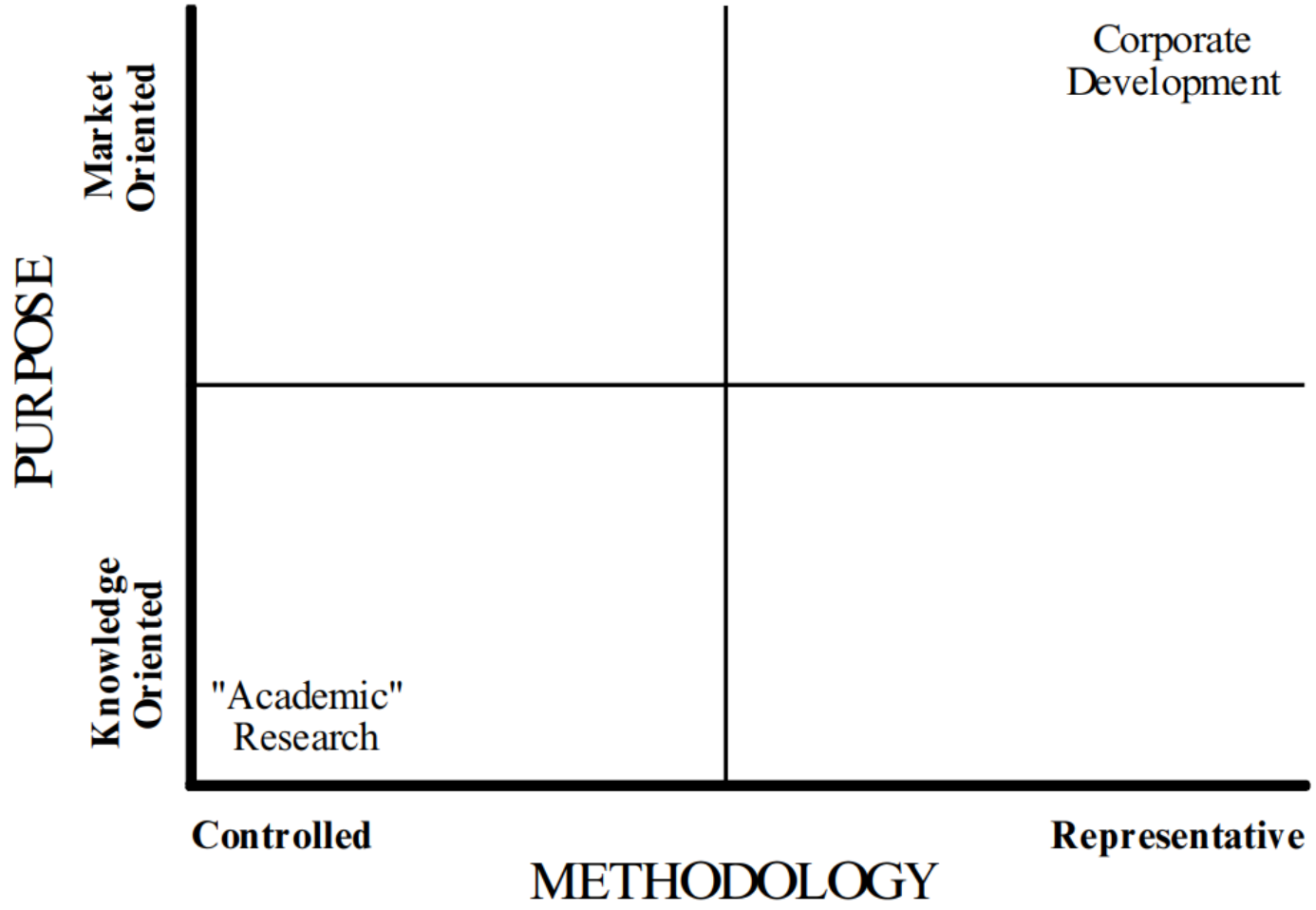
On June 8, 2016, Kitchener nurse Leigh Wardlaw was assigned a homecare shift: Her job was to care for a 13-year-old boy dying of brain cancer and to administer him morphine every two hours.

Seven hours into the shift, the boy's parents became concerned about the state of the nurse: Wardlaw was falling asleep and unsteady on her feet.

- https://www.ismp-canada.org/download/JHospMed.pdf
- Pan-Canadian Drug Diversion Tool Kit: https://mssa2.ismp-canada.org/cdn-diversion

Creating (and sustaining) action

Intentional design of research to inform practice



Vicente, K. J. (2000). Toward Jeffersonian research programmes in ergonomics science. *Theoretical Issues in Ergonomics Science*, *1*(2), 93-112.

https://www.hiroc.com/resources

- Top Healthcare Risks Report
- Risk Reference Sheets
- Risk Note:
  - Link between Risk Management, Patient Safety and Quality Improvement
  - Risk Management
  - Just Culture
- Applied toolkits
  - Allegations of Sexual Assault: Incident Response Toolkit

Is care safe today, how about tomorrow?

- Error is inescapable
- Human error is a symptom not a cause
- Safety and integrated risk management is a system problem
- Action

Thank you

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