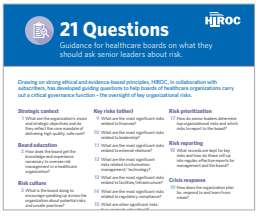
RISK WATCH

November 2018

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

LEADERSHIP/BOARDS



Questions healthcare boards should ask senior leaders about risk

Stevens P, Down A, Wilcox J. *Healthc Manage Forum*. 2018 (online September):1-7.
Article describing the challenges for healthcare boards and organizations on the governance of risk management, patient safety and quality improvement. Authors noted no guidance currently exists for healthcare boards regarding questions they should be asking about risk. A list of 21 questions and associated recommended practices across 11 themes was developed to empower board members across all healthcare sectors to ask probing questions of senior leaders about risks likely to occur in healthcare. The 11 themes include: strategic context, board education, risk culture, risk management program, key risks (patients and staff), key risks (other), risk management, risk prioritization, risk reporting, crisis response, and assurance and evaluation.
Editor's note: 21 Questions available here

MENTAL HEALTH/ON PREMISES SUICIDE

Incidence and method of suicide in hospitals in the United States

Williams S, Schmaltz S, Castro G, et al. *Jt Comm J Patient Saf*. 2018 (online September):1-8.
Study to estimate the rate of inpatient suicides, deemed never events, in hospitals in the US. Data from 2014-2015 in the National Violent Death Reporting System (NVDRS) and from 2010-2016 in The Joint Commission's Sentinel Events (SE) database were reviewed. Based on the NVDRS, the estimated rate of suicide for nonpsychiatric patients is 0.03 per 100,000 admissions and the rate for psychiatric patients is 3.2 per 100,000 admissions. The SE database showed of the 505 suicides reported during the seven-year period, 174 took place during inpatient treatment. Both databases showed the most common method of suicide was by hanging (70%). The most common location was the bathroom (51%) and the most commonly used ligature fixation point was a door, door handle, or door hinge (54%). Authors recommended mitigation efforts be focused on risks associated with hanging and on the immediate period following discharge.

ELECTRONIC HEALTH RECORD/CLINICAL DECISION SUPPORT

Choosing wisely clinical decision support adherence and associated inpatient outcomes

Heekin A, Kontor J, Sax H, et al. *Am J Manag Care*. 2018 (August):24(8):361-366
Study to explore whether utilization of clinical decision support (CDS) embedded in an electronic health record is correlated with improved patient clinical and financial outcomes. An observational study of provider adherence to CDS was conducted using 26,424 inpatient encounters spanning 3 years at a large US academic health system. The associations between alert adherence and the following four outcome measures were assessed: encounter length of stay, 30-day readmissions, complications of care, and total direct costs. Results showed the encounter cost increased 7.3% for non-adherent encounters to CDS versus adherent encounters. Length of stay increased 6.2% for non-adherent encounters. The odds ratio for readmission within 30 days increased by 1.13 for non-adherent encounters and for complications of care by 1.29 compared to adherent encounters. Authors concluded consistent improvements in measured outcomes were seen in the treatment group versus

the control group.

CARE/OPERATING ROOM

Minor flow disruptions, traffic-related factors and their effect on major flow disruptions in the operating room

Joseph A, Khoshkenar A, Taaffe K, et al. *BMJ Qual Saf*. 2018 (online August):1-8

Study to investigate the causes of minor and major flow disruptions (FDs) in the operating room (OR) as a result of staff involved, type of staff activities performed, and OR traffic and to describe contributing factors. Twenty-eight surgeries in three ORs in a large academic hospital system were video recorded and viewed. Of the 2,504 FDs identified, 658 (26%) were major disruptions and 1,846 (74%) were minor disruptions. Results showed the rate of major FDs increased linearly with increases in the rate of minor FDs, especially in the context of equipment-related FDs. Layout-related disruptions comprised more than half of all FDs. Thirty percent of major FDs occurred due to interruptions such as non-essential staff entering the OR, spilling or dropping of equipment, and searching activities because of missing items in the OR. Authors concluded room design and layout issues may create barriers to task performance, potentially contributing to the escalation of FDs in the OR.

LEARNING COMMUNITIES/INNOVATION

Using learning communities to support adoption of health care innovations

Carpenter D, Hassell S, Mardon R, et al. *Jt Comm J Patient Saf*. 2018 (October):44(10):566-573.

Article describing the establishment of three learning communities through the Agency for Healthcare Research and Quality (US) focused on adopting innovations in the three high-priority areas of advancing the practice of patient and family-centred care in hospitals, promoting medication therapy management for at risk populations, and reducing non-urgent emergency services. Results for each learning community are described within the article. Lessons were identified related to learning community startup, learning community operations (engagement, collaborative decision-making and sustainability) and innovation implementation (changing care delivery processes and/or policies). Authors concluded the findings from the learning community model can serve as an effective method to support dissemination and implementation of innovations, and to achieve outcomes at a local level.

QUALITY IMPROVEMENT/CARE

Redesigning care: adapting new improvement methods to achieve person-centred care

Bhattacharyya O, Blumenthal D, Stoddard R, et al. *BMJ Qual Saf*. 2018 (online September):1-7.

Article describing how traditional and newer improvement methods can contribute to improved healthcare delivery. Authors noted creating new services has a distinct set of challenges from improving existing services. Service development methods were grouped into three approaches: process focused, solution focused, and problem or need focused. Specific organizational examples are provided for each approach. The process approach example provided describes improving responsiveness at a US primary care clinic in which “patient satisfaction with phone access went from 40% to 85%, and incoming calls went down by 50,000 each year because calls were more often answered the first time” (p.3). A solution focused approach example by a Canadian hospital is described for creating virtual care.

Other Resources of Interest (all)

5 Innovation Challenges and Tips for Overcoming Them (September 2018). Institute for Healthcare Improvement (US) summary report on how to create an innovation system.

2019 top 10 health technology hazards (October 2018). ECRI Institute (US) list of safety issues healthcare leaders should prioritize and plan for (free with registration).

Lessons learned from recent cases: the importance of documenting maintenance activities (September 2018). Borden Ladner Gervais LLP (CDN) summary of a trip and fall case on the grounds of a healthcare facility.

People, processes, health IT and accurate patient identification (October 2018). The Joint Commission (US) quick safety bulletin with actions to consider for achieving accurate patient identification.

Q: The journey so far: Connecting improvements across the UK – insights and progress three years in (September 2018). The Health Foundation (UK) report on the design and delivery of the Q initiative.

Sentinel event statistics released for first half of 2018 (September 2018). The Joint Commission (US) report on the most frequently reported types of sentinel events; top two were falls and retained surgical items.

The operating room emergency checklist implementation toolkit (October 2018). Ariadne Labs and Stanford School of Medicine (US) online tool to help surgical teams implement checklists for emergencies.

The role of the patient in patient safety: what can we learn from healthcare's history? (August 2018). Journal of Patient Safety and Risk Management (US) editorial on lessons on how to engage patients in patient safety.

The spread challenge: how to support the successful uptake of innovations and improvements in health care (September 2018). The Health Foundation (UK) report on successful factors in implementing interventions.

Transitions in care: what we heard (September 2018). Health Quality Ontario summary report highlighting experiences of patients, caregivers, and families with the transition from hospital to home.

Who is fit to drive? Amended legislation expands and clarifies medical reporting requirements under the Highway Traffic Act (September 2018). Borden Ladner Gervais LLP (CDN) article highlighting notable changes.

HIROC Healthcare Risk Management

HIROC Monthly Risk Management Webinars – 2018 Upcoming Topics – Save the dates!		
Nov 22	Risk Assessment Checklists: Experiences from the Post Acute Care Sector	**REGISTER HERE!**