RISK WATCH

December 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

QUALITY IMPROVEMENT/PRIMARY CARE

Ten tips for advancing a culture of improvement in primary care

Kiran T, Ramji N, Derocher M, et al. *BMJ Qual Saf*. 2018 (online October):1-6.

Article describing the experience of a large primary care practice in Ontario to transform the care being provided. Authors offer 10 tips and insights for advancing a culture of improvement learned over its seven-year journey: 1) commit time and resources; 2) appeal to intrinsic motivation; 3) measure and improve patient experience; 4) pick an early win; 5) adjust course as needed; 6) try, try and try again; 7) involve patients in improvement work; 8) welcome criticism and accept imperfection; 9) think ongoing improvement, not time-limited projects; 10) integrate improvement with management and operations. Authors noted success required deep engagement with both patients and clinicians, a long-term vision, and patience.

QUALITY IMPROVEMENT/HANDOVERS

Improving communication of patient issues on transfer out of intensive care

Roberts J, Johnston-Walker L, Parker K, et al. *BMJ Open Qual*. 2018 (October):1-7.

Article describing an improvement project to support care during handovers by better documentation of patient problems as they leave the ICU. The project was in an acute tertiary care hospital in New Zealand. Current problems were defined as any patient issues which require ongoing thought, management or follow up. The improvement project aimed to increase the numbers of items listed as current problems, as a way of improving quality of transfer communication and decreasing risk. Five Plan-Do-Study-Act cycles were completed. Results showed an improvement from 1.8 current problems as the baseline to 3.85 as the average current problems documented. The key improvements identified was the addition of a bedside problem list and discharge checklist for identifying ongoing patient issues. An example of the intensive care problem list form used for transitions or handovers is provided.

MEDICATION SAFETY

Community-acquired and hospital-acquired medication harm among older inpatients and impact of a state-wide medication management intervention

Pellegrin K, Lozano A, Miyamura J, et al. *BMJ Qual Saf*. 2018 (online October):1-8.

Study across six hospitals in the US to determine the origin of medication harm among older inpatients during a five-year period. Admission data for 13,795 patients 65 years old and above were reviewed, which found 16,225 medication adverse outcomes and 15% of patients experiencing two or more. Seventy percent of medication harm was community-acquired; the medication most frequently the cause of harm was anticoagulants. Among hospital-acquired adverse outcomes, antibiotics were most frequently cited. Additionally, it was found hospitals that had implemented a medication management intervention where patients at risk of medication problems were assigned a community pharmacist to coordinate their medications for one year post-discharge had a significantly lower rate of admissions with community-acquired medication harm.

DIAGNOSTIC ERRORS

Reducing treatment errors through point-of-care glucometer configuration

Estock J, Pham I, Curinga H, et al. *Jt Comm J Qual Patient Saf*. 2018 (November):44(11):683-694.
Study using human factors engineering approaches to test two display screen configurations for glucometers in the largest health system in the US. Sixty-six participants across two medical centers took part in simulation scenarios that asked them to interpret glucometer device readings and make treatment decisions for patients with subtle symptoms of hypoglycemia. One scenario displayed a numeric value with a pop up alarm while the other displayed a range abbreviation (e.g. "RR LO" or out of reportable range; low) with a pop up alarm. Results showed 11% of participants (7/66) in the range abbreviation scenario made a treatment error compared to none in the numeric value scenario. There was no difference in interpretation errors between the two scenarios; however, the numerical value group was able to recognize the error. Authors recommended system administrators configure glucometers to show numeric values. A table outlining each of the six possible configurations and the usability principles (e.g. language, memory load, terminology) they violate is provided.

COMPLAINTS/PATIENT VULNERABILITY

The nature of patient complaints: a resource for healthcare improvements

Raberus A, Holmstrom I, Galvin K, et al. *Int J Qual Health Care*. 2018 (online October):1-7.
Study to explore the nature, potential usefulness and meaning of complaints lodged by patients and their relatives. A systematic random sample of 170 out of 5689 patient complaints made to a Patient Advisory Committee (PAC) was reviewed. Authors stated PACs are legislated in Sweden, and are an independent, impartial body for each county/municipality. Results showed complaints reflected six themes which include: access to healthcare services, continuity and follow up, incidents and patient harm, communication, attitudes and approaches, and healthcare options pursued against patient's wishes. The study highlighted areas which commonly give rise to dissatisfaction; however authors noted the key findings point to the significance of patient exposure and vulnerability which could be reduced with a strong interpersonal focus.

"Patient complaints can assist in identifying problems and risks related to healthcare services" (p2).

CULTURE

Work-life balance behaviours cluster in work settings and relate to burnout and safety culture: a cross-sectional survey analysis

Schwartz S, Adair K, Bae J, et al. *BMJ Qual Saf*. 2018 (online, October): 1-9.
Study in the US to explore the difference in work-life integration (WLI) behaviours across healthcare settings and how these behaviours impact safety, teamwork and burnout. Survey responses of 10,627 workers across 440 large academic healthcare work settings were evaluated on how often they engage in negative WLI behaviours, such skipping breaks, to measure work-life balance. Results showed physicians report the poorest WLI behaviours among all specialties surveyed. Across all specialties, fewer than 6 months in the role, working the day shift and working an eight-hour shift were associated with better WLI behaviours. Engaging in positive or negative WLI behaviours was consistent across teams with team members more likely to engage in similar WLI behaviours. Authors noted an environment that encourages workers to engage in appropriate WLI behaviours could have a positive impact on patient safety, collaboration and decrease burnout.

Other Resources of Interest (all)

Chartbook on Patient Safety (October 2018) Agency for Healthcare Research and Quality (US) report on health system safety performance with a focus on adverse healthcare-associated conditions and harm from care.

Form 1 assessments under the Mental Health Act frequently asked questions (October 2018). Ontario Hospital Association and Borden Ladner Gervais LLP (CDN) resource clarifying various practices involving Form 1s.

Impaired driving and bodily fluid samples: what hospitals and health-care providers should know (November 2018). Borden Ladner Gervais LLP (CDN) article on the impact of legislative changes following legalization of cannabis.

Interventions for preventing falls in older people in care facilities and hospitals (September 2018). Cochrane (UK) review of 95 randomised controlled trials on effectiveness of interventions to reduce falls with older adults.

Managing transitions: a guidance document – second edition (October 2018). Ontario Hospital Association resource to support the standardization of policies and programs related to transitioning patients from hospital.

Measuring up 2018 (November 2018). Health Quality Ontario annual report on the performance of the province's health system based on key indicators such as wait times.

Police! Six concepts health leaders needs to know when interacting with police (October 2018). Kate Dewhirst LLP (CDN) article on contacting police, information sharing, and when safety trumps privacy.

Possible changes to long-term care home regulations regarding cannabis (November 2018). Borden Ladner Gervais LLP (CDN) article on preparing for the possible changes to legislation following legalization of cannabis.

The role of Community Treatment Plans in Community Treatment Orders (November 2018). Borden Ladner Gervais LLP (CDN) article on how a Community Treatment Order relates to a Community Treatment Plan for a person diagnosed with a serious mental disorder.