


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

MATERNAL NEONATE/QUALITY IMPROVEMENT

[Effect of a population-level performance dashboard intervention on maternal-newborn outcomes: an interrupted time series study](#)

Weiss D, Dunn S, Sprague A, et al. *BMJ Open Qual.* 2017 (online, November):1-12.

Study to assess the effect of a maternal newborn dashboard using data from the provincial birth registry for all hospital births in Ontario that targets six performance indicators. The dashboard uses an audit and feedback approach in which clinical performance is assessed and hospital-specific, near real-time feedback is provided to inform practice change. The six indicators were determined to have clinical importance to patient outcomes and included: 1) unsatisfactory newborn screening samples, 2) episiotomy, 3) formula supplementation, 4) elective repeat C-section prior to 39 weeks, 5) GBS screening, 6) postdates induction prior to 41 weeks. Results showed, almost three years after dashboard implementation, rates in four of the six indicators improved at the provincial level. Authors noted hospitals should set realistic expectations for how long practice change takes, especially when multiple issues are being targeted.



QUALITY IMPROVEMENT/LONG-TERM CARE

[London Transfer Project: improving handover documentation from long-term care homes to hospital emergency departments](#)

Carson J, Gottheil S, Gob A, et al. *BMJ Open Qual.* 2017 (online, November):1-7.

Quality improvement project among a Canadian teaching hospital and 10 long-term care (LTC) homes to improve the reporting of reasons for LTC residents' transfer to the emergency department (ED) and their baseline cognition status. A root cause analysis identified two reasons for the gaps: 1) the ED had not clearly communicated what information was needed, 2) transfer forms did not facilitate recording of baseline cognitive status. A standardized transfer package was developed for emergency transfers, which included the transfer/discharge report; one-page print out of the residents' most recent assessments; medication administration record; and advance directives. Results showed documentation of reason of transfer increased from 61% to 84% and baseline cognitive status increased from 4% to 56%.



ALWAYS EXPERIENCES/LONG-TERM CARE

[Operationalizing person-centered care practices in long-term care: recommendations from a "Resident for a Day" experience](#)

Johs-Artisensi J. *Patient Exp J.* 2017 (November);4(3):76-85.

Study using ethnography and an experiential learning approach over a three year period where long-term care administrators in training lived as a resident for 24 hours in 93 different US nursing homes. Following the experience, using Picker Institute's framework, each participant identified Always Experiences. Always Experiences are an optimal experience they believe should occur for every long-term care resident. A thematic analysis occurred and six action plans that identified operational practices and measures were developed in the following areas: admission, care, planning care, dining, activities, and responsiveness. Article provides specific information on the action plans including the Always Experiences, Always Events and suggested measures for the six areas.



MALPRACTICE CLAIMS/AMBULATORY

[A contemporary medicolegal analysis of outpatient medication management in chronic pain](#)

Abrecht C, Brovman E, Greenberg P, et al. *Anesth Analg*. 2017 (November);125(5):1761-1768.

Analysis of 37 closed claims files involving noninterventional pain management in outpatient settings in the US. Settlements were made in 27% of cases, with a median payment of \$72,500. Conditions related to the spine accounted for 73% of cases. The top two allegations were improper medication management (65%) and addiction and abandonment (11%). All patient deaths (49%) were associated with alleged improper opioid management. The top three contributing factors were patient behaviour (54%), clinical judgment (43%) and documentation (22%). Authors concluded chronic pain management claims are multifactorial and minimization of risk involves carefully selecting patients for medication therapy and evaluating compliance and improvement with treatment plans.



QUALITY IMPROVEMENT/ANTIMICROBIAL STEWARDSHIP

[Transition from a dedicated to a non-dedicated, ward-based pharmacist antimicrobial stewardship programme model in a non-academic hospital and its impact on length of stay of patients admitted with pneumonia: a prospective observational study](#)

DiDiodato G, McArthur L. *BMJ Open Qual*. 2017 (online, December):1-7.

Study to compare the length of stay (LOS) of patients admitted to an acute care, community based, Ontario hospital with community-acquired pneumonia (CAP) after the implementation of an antimicrobial stewardship program initially led by a dedicated infectious diseases trained pharmacist, and then transitioned to a ward based pharmacist. Daily audit and feedback occurred with recommendations to the attending physician by the infectious diseases team in phase 1 and ward pharmacists in phase 2. Over a three year period, 1,125 patients with CAP were entered into the hospital antimicrobial stewardship database with 518 and 247 patients receiving an antimicrobial stewardship audit and feedback in phases 1 and 2, respectively. Results showed an antimicrobial stewardship audit and feedback program reduced the median LOS in patients with CAP by approximately 0.5 days regardless of pharmacist model.



PATIENT SAFETY/HANDOVERS

[Improving cardiac operating room to intensive care unit handover using a standardised handover process](#)

Gleicher Y, Mosko J, McGhee I. *BMJ Open Qual*. 2017 (online, November):1-8

Quality improvement study with the goal to improve the effectiveness of information transfer during patient handover. The study was conducted at a Canadian tertiary care centre in the cardiovascular intensive care unit over a 4-month period. Authors identified weak handover processes have been recognized as contributing causes for adverse events and patient harm. A standardized handover protocol including a handover content checklist was utilized as well as a formal timeout environment to minimize distractions. The primary outcome measured was the quality of handovers determined by an overall score which comprised handover content, teamwork, and patient care planning indicators. Secondary outcomes included handover duration, adherence to protocol and team satisfaction. The study included 37 handovers. The mean handover score increased from 6.5 to 14 (maximum 18 points). Improvements included fewer handover interruptions and more frequent postoperative patient care planning. Average handover duration increased slightly from 2:40 to 2:57 minutes. Caregivers noted improvement in team work, content received and patient care planning. A copy of the transition note template is included.



HOME CARE/TELEHEALTH

[Partnering with patients: the Toronto Central LHIN Telehomecare experience](#)

Barbita J, Neves-Silva S. *Healthc Q.* 2017 (November);20(3):36-40.

Article describing the implementation of Telehomecare over a four-year period by a local health integration network in Ontario for 3,000 patients who have either chronic obstructive pulmonary disease or congestive heart failure. The service provided, at no cost to patients, six months of health status monitoring by a nurse and patient self-management education. Primary care providers received regular reports on each of their patients and nurses also provided coaching to patients by telephone. Results showed a reduction in emergency department visits and hospital admissions, improved patient confidence and self-management skills, and high patient satisfaction rates. Authors noted other patient groups (e.g. patients with chronic kidney disease, palliative care patients) are being considered for the program.



MENTAL HEALTH/PATIENT SAFETY

[Development and implementation of a universal suicide risk screening program in a safety-net hospital system](#)

Roaten K, Johnson C, Genzel R, et al. *Jt Comm J Qual Patient Saf.* 2018 (January); 44(1):4-11.

Quality improvement project to improve recognition of patients who may be at risk of committing suicide in a US safety-net hospital system. The Columbia-Suicide Severity Rating Scale, Clinical Practice Screener-Recent was utilized and incorporated into the electronic health record for screening. Of 328,064 adult encounters, results showed that six months after implementation, more than half of the screens were completed in outpatient clinics; more than 40% were completed in the emergency department (ED); and less than 5% were completed in inpatient units. In the ED, 6.3% of the screens were positive and the odds of having a positive screen were 4.29 times higher than the inpatient units and 3.13 times higher than the outpatient clinics. Lessons learned included the importance of strategic targeting of resources specific to varying severity of risk among patients identified by screening and the need to develop a tiered approach for prioritizing patients to expedite evaluation by a mental health provider.



MORTALITY REVIEW/PATIENT SAFETY

[Surveying care teams after in-hospital deaths to identify preventable harm and opportunities to improve advance care planning](#)

Lucier D, Folcarelli P, Totte C, et al. *Jt Comm J Qual Patient Saf.* 2017 (online, November):1-10.

Quality improvement project to explore how a postdeath care team survey might augment existing processes (chart review and interview) for learning from deaths at a US academic medical centre. Results showed, of the 82 deaths that occurred during the distribution period, a response rate of 72.3% and the identification of five patients who required further review. A review of free-text comments in all surveys identified themes related to advance care planning in extremely ill patients and the emotional and psychological stress of healthcare providers who care for patients who die. A copy of the mortality review survey is included.

“Postdeath care team surveys appears to have a role in augmenting other methods of learning from inpatient deaths, but their incremental benefit, particularly when balanced against the administrative burden of conducting them, may make it difficult for the majority of hospitals to adopt them” (p.9).



Other Resources of Interest (all)

Covers for hospital bed mattresses: learn how to keep them safe (November 2017). US Food & Drug Administration recommendations for hospital bed mattress and mattress cover inspections.

Experience-based co-design of health care services (November 2017). Institute for Healthcare Improvement (US) case study on an innovation showcasing experienced-based co-design in the National Health Service (free with log-in).

Health Law Monitor (December 2017). Borden Ladner Gervais LLP (CDN) inaugural newsletter on current legal and regulatory issues for the healthcare sector.

How the patient's voice advances safe care (December 2017). Canadian Medical Protective Association article on various ways that patient engagement may lead to safer care.

Individual clinician performance issues (November 2017). Agency for Healthcare Research and Quality (US) patient safety primer discussing the link between unprofessional behaviour and safety.

ISMP survey shows provider text messaging often runs afoul of patient safety (November 2017). Institute for Safe Medication Practices (US) newsletter advocating for not allowing texting of medication-specific orders until safety issues have been resolved.

Moral choices for today's physician (November 2017). Journal of the American Medical Association (US) opinion article by Dr. Don Berwick describing three moral choices physicians face: personal, organizational and societal.

More training won't reduce your cyber risk (November 2017). Harvard Business Review (US) article outlining six proposals for companies to proactively strengthen their approach to cyber security.

Patient safety in the office-based practice setting (November 2017). American College of Physicians position paper highlighting seven recommendations to address patient safety challenges in ambulatory environments.

Pressure injuries: care for patients in all settings (December 2017). Health Quality Ontario quality standard which includes guidance on optimal care for transitions between settings.

Quality surgery: improving surgical care in Ontario (November 2017). Health Quality Ontario report on performance of 29 hospitals involved in an international quality improvement program for surgery.

Two hospitals share their sepsis reduction programs (December 2017). Patient Safety & Quality Healthcare (US) article highlighting initiatives at two hospitals around reducing mortality from this condition.

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