RISK WATCH

February 2019

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

PATIENT ENGAGEMENT

Supporting patient and family engagement for healthcare improvement: reflections on "engagement-capable environments" in pan-Canadian learning collaboratives

Fancott C, Baker G, Judd M, et al. *Healthc Q*. 2018 (December);21(SP):12-30.

Article describing the Canadian Foundation for Healthcare Improvement (CFHI) initiatives supporting Canadian healthcare organizations to meaningfully partner with patients, one of six levers CFHI has identified for accelerating healthcare improvement, in quality improvement and system redesign. Learning collaboratives included 51 teams from eight provinces and one territory. A model of engagement-capable environments emerged, referring to organizations that have enabled engagement through three pillars: 1) enlisting and preparing patients/families, 2) training staff for engagement, 3) ensuring leadership support of engagement activities. Authors explore each pillar and provide 10 insights from healthcare providers and leaders, and 10 lessons learned from patient and family advisors.

ANTIMICROBIAL STEWARDSHIP/LONG TERM CARE

Educational intervention to reduce treatment of asymptomatic bacteriuria in long-term care

Lee C, Phillips C, Vanstone J. *BMJ Open Qual*. 2018 (online, December):1-7.

Quality improvement project across seven long term care (LTC) facilities in Canada over a 12-week period to reduce inappropriate antibiotic treatment of LTC residents with asymptomatic bacteriuria (ASB). An educational intervention incorporating behaviour change techniques, including feedback and monitoring, shaping knowledge, natural consequences, and comparison of behaviour, was implemented. Clinical staff attended a 15-minute session to review the evidence around ASB treatment guidelines, preintervention findings, and diagnostic criteria for urinary tract infections, supplemented by wall posters and pocket cards. Results showed a significant decrease in the number of residents treated with antibiotics for ASB, from 90% at baseline to 63% postintervention, a 64% reduction in the cost of antibiotics for residents with ASB, and a 30% decrease in the cost of lab services. Authors noted continued efforts at the local level are needed to sustain the results.

PATIENT DETERIORATION

Emergency room safer transfer of patients (ER-STOP): a quality improvement initiative at a community-based hospital to improve the safety of emergency room patient handovers

Norman S, DeCicco F, Sampson J, et al. *BMJ Open*. 2018 (online, December):1-8.

Study in a Canadian community hospital to assess whether implementation of a locally adapted handover checklist tool containing an intentional pause and explicit management options would reduce unexpected critical care response team (CCRT) responses to patient deterioration on general medical surgical wards within 24 hours of admission from the emergency department (ED). Results indicated following deployment of the checklist, the monthly rate of unexpected CCRT significantly decreased from 3.8 to 1.0. ED wait times were unchanged. Authors concluded a simple intervention at ED admission improved outcomes by reducing high-risk unanticipated deterioration. A sample of the checklist is provided.

PATIENT SAFETY/COMMUNICATION

Patient safety after implementation of a coproduced family centered communication programme: multicenter before and after intervention study

Khan A, Spector N, Baird J, et al. *BMJ*. 2018 (online, December)1-17.

Study to assess the impact of an intervention to improve communication within family centered rounds on medical errors, experience of the family and the communication process. Parents, nurses and physicians from pediatric inpatient units in seven North American hospitals were involved in the development of the intervention to standardize communication during rounds. Following implementation of the intervention, harmful errors decreased by 38%, family understanding on rounds improved (63% vs 54%), family engagement improved (67% vs 56%), and family centered rounds happened more frequently (83% vs 72%). Findings suggest that implementing a standardized intervention to improve communication on rounds could improve patient safety and other outcomes.

COMMUNICATION/RESOLUTION

Lessons learned from implementing a principled approach to resolution following patient harm

Smith K, Smith L, Gentry J, et al. *J Patient Saf Risk Manage*. 2018 (online, December 2018):1-7.

Article describing the lessons learned following implementation of the resolution phase of the Communication and Optimal Resolution program at a large community health system in the US. Evaluation of the program generated seven strategies aimed at supporting the resolution phase: 1) support patients and family immediately following event, 2) hold and waive bills when preventable harm occurs, 3) conduct investigations immediately following event, 4) acknowledge the definition of legally defensible is changing, 5) include multiple stakeholders such as legal, patient safety and risk management in the process to develop a legal community for the common aim of a swift and principled resolution to harm, 6) prepare to accept sacrifices within the resolution phase, 7) evaluate potential challenges when cases involve open medical staff. Authors suggest the resolution phase is complex and while their program is in the initial implementation stage, early trends suggest the program has improved transparency within the organization.

HOSPITAL READMISSIONS/PATIENT PERSPECTIVE

Patient vs provider perspectives of 30-day hospital readmissions

Smeraglio A, Heidenreich P, Krishnan G, et al. *BMJ Open Qual*. 2019 (online, January):1-8.

Study to explore the factors contributing to avoidable 30-day hospital readmissions by comparing patients' and providers' views. Interviews of 178 readmitted patients occurred at a single tertiary care academic hospital in the US. The factors patients believed contributed to their prehospitalization was compared with their discharging physicians' in addition to a chart review by an RN case manager. Results showed 58% of patients believed a modifiable system issue contributed to readmission compared to providers where only 2% of the time a system issue was a contributor. The RN case manager's review determined in 48% of cases the system had some contribution to a patient's readmission. Authors noted the gap between providers' and patients' perspective of discharge as a potential contributing root cause to preventable readmissions and recommended more patient engagement into the discharge process. A table comparing responses of patients, providers, and the RN case manager to the question, is there anything could be done differently for preventable admission, is provided.

CAREGIVER BURNOUT

Neurocognitive disorders: what are the prioritized caregiver needs? A consensus obtained by the Delphi method

Novais T, Mouchoux C, Kossovsky M, et al. *BMC Health Serv Res*. 2018 (online December 2018):1-9.
Study in France using the Delphi method to understand and prioritize the needs of informal caregivers looking after patients with neurocognitive disorders (NCD). The expert panel involved 68 informal caregivers of individuals with NCD living in the home setting. In the first round of questions, the need for information about the individual's disease and the ability to provide affective support were ranked the highest concerns. In the second round, information about the disease and effective coping skills were cited as the most important needs. Authors suggest the perspective of informal caregivers is important to consider when designing interventions and to guide policy development in order to better support caregivers.

PATIENT SAFETY/MEDICAL ERROR VICTIMS

The domino effect of medical errors

Ellahham S. *Am J Med Qual.* 2018 (online December):1-2.
Article outlining the ill effects of medical errors which are not limited to patients, families and the healthcare provider. Author noted that the other stakeholders of the healthcare system are often neglected, and thus increasing the chances of future medical errors. Support and help to be extended to all vulnerable members of the team, and not be limited to just the first and second victims of the patient/family and the healthcare provider, is suggested. Other victims of a medical error include healthcare support staff, the healthcare organization, and the community. A multicomponent intervention to reduce medical errors is outlined including a positive safety approach, effective communication, timely monitoring and documentation, extending support and knowledge sharing.

HANDOFFS/EMERGENCY DEPARTMENT

Developing standardized "receiver-driven" handoffs between referring providers and the emergency department: results of a multidisciplinary needs assessment

Huth K, Stack A, Chi G, et al. *Jt Comm J Qual Patient Saf.* 2018 (December);44(12):719-730.
Study in a tertiary care pediatric hospital in the US to explore stakeholder perceptions of the handoff process from referring providers to the emergency department (ED), as well as key handoff elements and strategies to optimize patient care on transfer. Authors noted communication failures are among the most frequently identified contributors to sentinel events and many involve patient handoffs at transitions of care. Participants included 129 providers who participated in a survey and some focus groups. Survey results showed 42% described the quality of the handoff process between referring providers and the ED as very good or excellent and 43% reported miscommunication occurring sometimes or frequently. Responses showed three themes related to the handoff process: information flow via a central handoff receiver, standard process, and closed loop communication. Three themes emerged for handoff content: key information needed, complex cases, and miscommunication and perceived harm. Ten key elements to obtain a receiver-driven handoff process to optimize care on transfer is provided, with clinical stability most important.

"Notably, there is a shared perception of variability in handoff communication, leading to delays in care, unnecessary testing, and sometimes patient safety risks" (p.725).

Other Resources of Interest (all)

Achieving true partnership: three case studies of patient- and family-centred care in Ontario (January 2019). The Change Foundation (CDN) report featuring the work of three sites advancing patient-centred pediatric care.

Annual priorities for the 2019/20 Quality Improvement Plans (December 2018). Health Quality Ontario letter outlining planned changes to the Quality Improvement Plan program.

Blueprint for complex care (January 2019). National Center for Complex Health and Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement (US) joint plan to improve complex care.

Critical order set change and critical limb ischemia (January 2019). Agency for Healthcare Research and Quality (US) web M&M case of medication under-dosing due to order set revisions in the electronic medical record.

CRTC issues guidance for avoiding indirect liability for CASL violations (December 2018). Borden Ladner Gervais LLP (CDN) bulletin describing a stricter approach in interpreting the provisions that impose liability.

Framework for effective board governance of health system quality (December 2018). Institute for Healthcare Improvement (US) white paper with a framework, assessment tool and support guides (free with login).

Get your priorities straight: tips for using safety huddles (January 2019). Institute for Healthcare Improvement (US) blog article with strategies on how to use huddles, including keeping them to 10 minutes or less.

How to get started in quality improvement (January 2019). BMJ (UK) article outlining the skills, knowledge and support needed to get started in quality improvement and deliver effective interventions.

Perspectives on safety - maternal safety (January 2019). Agency for Healthcare Research and Quality (US) article highlighting increasing rates of maternal morbidity and mortality and spreading maternal safety practices.

Unscrambling digital laws and cybersecurity (January 2019). Borden Ladner Gervais LLP (CDN) article on cybersecurity and the evolving landscape, how hacks happen, consequences and how to better protect data.