RISK WATCH

October 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/INFECTION CONTROL

A pre and post intervention study to reduce unnecessary urinary catheter use on general medicine wards of a large academic health science center

Wooller K, Backman C, Gupta S, et al. *BMC Health Serv Res*. 2018 (online August):1-9.

Quality improvement project using the SafetyLEAP program to reduce the prevalence of urinary catheters on two general medicine wards at a large academic hospital in Canada. The program components consist of: 1) Leadership and Engagement, 2) Audit and feedback (prospective surveillance), 3) Planned quality improvement intervention which in this study was a standardized order set, modified by plan-do-study-act cycles. Results showed the program was 97% implemented on both wards. Catheter prevalence decreased from 22% to 13%, and was sustained for two years. Although catheter associated urinary tract infections were unchanged, authors stated the overall rate was low. Authors noted keys to the success of the program included relevant and timely local data, leadership support, and engaged physicians and nursing staff who volunteered on work on the project as opposed to being assigned.

SAFETY/SPEAKING UP

Speaking up about care concerns in the ICU: patient and family experiences, attitudes and perceived barriers

Bell S, Roche S, Mueller A, et al. *BMJ Qual Saf*. 2018 (online July):1-9.

Study in the US to determine patients' and families' comfort with voicing concerns in the ICU. Over 1,100 patients in the ICU and family members were surveyed on speaking up around eight common ICU topics (e.g. medications, plan of care). Results showed around 50% of patients and families had some reluctance to speak up, with the highest level of comfort around medications (70%) and lowest around hand hygiene (42%). Barriers to speaking up included: fear of "troublemaker" label (34%), team is too busy (32%), and didn't know how (32%). Given the high stakes of the ICU, authors noted strategies to encourage patients and families to voice concerns should come with clear steps and a genuine invitation, as well as preparing clinicians to respond meaningfully.

MENTAL HEALTH/SPEAKING UP

Service user and carer involvement in mental health care safety: raising concerns and improving the safety of services

Berzins K, Louch G, Brown M, et al. *BMC Health Serv Res*. 2018 (online August):1-8.

Study to explore experiences of mental health service users' and carers' in the UK in raising concerns about safety. Survey responses of 77 service users, 18 carers and 90 health professionals were analyzed. Results showed 77% of service users and carers found it difficult to raise concerns for various reasons: services do not listen (27%), concerns about repercussions (19%), process for raising concerns was challenging (16%), difficulty raising concerns while experiencing mental ill health (14%). All health professionals and 90% of service users and carers supported service user/carer involvement in safety interventions, primarily due to their expertise from experience. Authors noted that by not routinely gathering feedback, it could be a missed opportunity for organizational learning.

RISK ASSESSEMENT/PRESSURE ULCERS

Value of hospital resources for effective pressure injury prevention: a cost-effectiveness analysis

Padula W, Pronovost P, Makic MB, et al. *BMJ Qual Saf*. 2018 (online, August):1-10.
Study to explore the cost-utility of performing repeated risk assessment for hospital acquired pressure-injury prevention in all patients or only in select high-risk groups based on the Braden Scale for Predicting Pressure Ulcer Risk. Patient-level longitudinal data on 34,787 encounters from a US academic hospital electronic record over 3 years, had met inclusion criteria to create a matrix for illustrating the probability of moving between pressure ulcer risk levels during each day of hospitalization. Results showed prevention for all patients would be a cost-effective strategy for most Western societies since prevention for all was the most costly but also the most effective strategy. Authors noted hospitals should invest in nursing compliance with international pressure ulcer prevention guidelines.

ACCESS/COMMUNITY CARE

Improving access to services through a collaborative learning system at East London NHS Foundation Trust

Shah A, Chitewe A, Binley E, et al. *BMJ Open Qual*. 2018 (online, July):1-9.
Quality improvement project to improve access to community-based services in the UK. A collaborative learning system was formed with 15 teams that were diverse in both nature and geography, consisting of community teams from adult mental health, child and adolescent mental health, secondary care psychological therapy services, memory services, musculoskeletal physiotherapy service and a sickle cell service. Results showed over the course of the 2 year project, waiting time from referral to the first face-to face appointment reduced 23% from an average of 60.6 days to 46.7 days. Nonattendance at the first face-to-face appointment reduced from an average of 31.7% to an average of 20.5% while referral volume increased by 25%. Quality improvement tools including a driver diagram which identified the change ideas are provided.

PATIENT SAFETY/PAEDIATRIC

Paediatric intensive care and neonatal intensive care airway management in the United Kingdom: the PIC-NIC survey

Foy K, Mew E, Cook T, et al. *Anaesthesia*. 2018 (online first, August):1-8.
Article describing airway complications in adult intensive care units in the UK and recommended practices of: preparation for airway difficulty, immediate availability of difficult airway equipment and routine use of waveform capnography monitoring. Through a telephone survey, authors investigated if the recommendations for adult ICUs had been embedded into paediatric and neonatal intensive care practice. Results showed a difficult airway policy existed in 67% of paediatric intensive care units (PICU) and 42% of neonatal intensive care units (NICU); a pre-intubation checklist was used in 70% of PICUs and in 42% of NICUs; a difficult intubation trolley was present in 96% of PICUs and in 50% of NICUs; a video laryngoscope was available in 55% of PICUs and in 29% of NICUs; capnography was “available” in 100% of PICUs and in 46% of NICUs, and “always available” in 100% of PICUs and in 18% of NICUs. Death or serious harm occurring secondary to complications of airway management in the last five years was reported in 19% of PICUs and in 26% of NICUs. Authors concluded major gaps in optimal airway management provision exist and wider implementation of waveform capnography is necessary, particularly within NICUs.

PATIENT SAFETY/AVOIDABLE DEATHS

Rate of avoidable deaths in a Norwegian hospital trust as judged by retrospective chart review

Rogne T, Nordseth T, Marhaug G, et al. *BMJ Qual Saf*. 2018 (online, July):1-7.
Study to estimate the rate of and mechanisms behind avoidable deaths in an unselected population of 1000 consecutive non-psychiatric deaths of one hospital trust. More than 65,300 patients were admitted during the study period, of whom 1000 died and whose health records were included in a chart review. Results showed 4.2% of the evaluated deaths were at least probably avoidable. The surgical department had the greatest proportion of such deaths. Authors concluded avoidable hospital deaths occur less frequently than estimated by the national monitoring tool, and much more frequently than reported through mandatory reporting systems. Retrospective chart review of an unselected sample of all hospital deaths would likely provide a better estimate of the proportion of avoidable deaths than the current methods. Reductions in avoidable deaths can be achieved by improving training, education and supervision.

PATIENT SAFETY/PEDIATRICS

Adverse events in hospitalized pediatric patients

Stockwell D, Landrigan C, Toomey S, et al. *Pediatrics.* 2018 (online first, July);142(2):1-14.
Study to measure temporal trends in adverse events (AEs) rates among hospitalized children across the US. The Global Assessment of Pediatric Patient Safety (GAPPS) Trigger Tool was applied to 3,790 medical records of patients discharged between January 2007 and December 2012 in 16 teaching and nonteaching hospitals. Results showed AEs due to medical care were common among hospitalized children, and AE rates did not appear to be decreasing. Of the 414 AEs identified, 210 (50.7%) were preventable (9.5 AEs per 1000 patient days). AEs were more common in patients with increased complexity; AE rates were substantially higher in teaching hospitals than nonteaching hospitals (26.2 vs. 5.1 AEs per 1000 patient days). Authors identified the need for additional efforts to achieve improvements in the safety of all care for hospitalized children.

QUALITY IMPROVEMENT/CLINICAL DECISION MAKING

Implementation of an evidence-based care program within a multihospital health care system

Guth R, Herring A, Merz L. *Am J Med Qual.* 2018 (online, July):1-8.
Article describing the effectiveness of an onsite evidence-based care (EBC) program within a US health care system consisting of 15 hospitals to rapidly respond to urgent issues, synthesize evidence for policy making, and perform technology assessments. Over a five-year period, 377 rapid reviews were completed. Findings showed using rapid review methodology can successfully deliver timely and relevant evidence for quality of care decision making in a health care system. Nearly 90% of the review requestors indicated that EBC's review informed their project or final decision, and more than 90% expressed satisfaction with the reviews and likely would request a review in the future.

Other Resources of Interest (all)

Combating clinician burnout with community-building (July 2018). New England Journal of Medicine Catalyst (US) article on utilizing peer support to increase morale, address burnout and a description of the outcomes.

Data governance: driving value in healthcare (July 2018). KPMG LLP (UK) article highlighting their framework to effectively manage enterprise data assets; includes roles and responsibilities, key data management capabilities and critical success factors.

Healthier physicians: an investment in safe medical care (August 218). Canadian Medical Protective Association booklet for physicians with resources to promote wellness.

High-alert medication survey results lead to several changes for 2018 (August 2018). Institute for Safe Medication Practices (US) newsletter on changes to the list of high-alert medications in acute care settings.

How can health systems advance patient-reported outcome measurement? (August 2018). The Joint Commission (US) editorial on the expansion of patient-reported outcomes into clinical practice.

I-PASS handoff program: use of a campaign to effect transformational change (July 2018). Pediatric Quality & Safety (US) article describing the organizational transformation techniques that fostered widespread adoption.

Loss of legal privilege over cyberattack investigation report (August 2018). Borden Ladner Gervais LLP (CDN) cybersecurity bulletin on a 2018 Ontario Superior Court decision illustrating loss of privilege.

Work-Life balance, burnout, and the electronic health record (August 2018). The American Journal of Medicine article on attributes of physician burnout relating to electronic health record with some strategies provided.

Understanding the patient experience of health care-associated infection: a qualitative systematic review (August 2018). American Journal of Infection Control systematic review describing the similarities and distinctions in the experience recounted by patients.

HIROC Healthcare Risk Management

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