RISK WATCH

January 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 SAFETY/LIABILITY

Improved hospital safety performance and reduced medicolegal risk: an ecological study using 2 Canadian databases

Yang Q, Zhang C, Hines K, et al. *CMAJ Open*. 2018 (November);6(4):E561-E566.

Study exploring the link between in-hospital patient safety events and medicolegal cases involving physicians in Canada. Over 324,590 records from the national discharge database and 15,180 medicolegal cases for 15 patient safety indicators (e.g. pressure ulcers) from 2005-2015 were compared. Results showed a significant linear association between patient safety events and medicolegal cases; for every 10% decrease in patient safety events, there was an 11% decrease in medicolegal cases. Obstetrical and surgical matters were also analyzed. Every 10% decrease in obstetrical events showed to a 25% decrease in medicolegal cases; however, every 10% increase in events showed a 34% increase in medicolegal cases. For surgical events, a 9% decrease in cases was seen for every 10% decrease in events. Authors noted the results are consistent with studies that show improved safety and quality are associated with decreased medicolegal risk.

LIABILITY/TEST RESULTS

Content analysis of 50 clinical negligence claims involving test results management systems in general practice

Baylis D, Price J, Bowie P. *BMJ Open Qual*. 2018 (online, November):1-6.

Study in the UK reviewing 50 clinical negligence claims and system failures related to the management of laboratory test results in primary care settings. Results showed 28% of cases involved a delay in diagnosis or treatment of a patient with cancer, 30% of cases were judged to be "never events", 48% of the cases involved a failure to notify the patient of an abnormal test result, and 36% involved a test result not being actioned by a physician. The most frequently occurring contributory factors to why specific incidents happened were related to a range of local working conditions such as unclear professional responsibilities with regards to test result review, follow up, or lack of patient care continuity. Authors noted most claims involved preventable risks and that proactive test result management strategies were needed to reduce harm.

PATIENT SAFETY/SPEAKING UP

Every patient should be enabled to stop the line

Bell S, Martinez W. *BMJ Qual Saf*. 2018 (online, November):1-5.

Article describing development of systems that enable patients to speak up and stop care when patients do not feel safe. Patients and families were described as vigilant stakeholders who hold unique knowledge and can make important contributions to patient safety to identify problems in care, including ones missed by clinicians. Authors noted that creating environments which allow patients and families to effectively stop the line will require at least three related changes: 1) changing the research to focus on patient-centred outcomes, 2) change listening when patients speak up retrospectively after a safety event for better learning from existing patient feedback, and 3) changing the norms, creating the conditions in which patients feel comfortable bringing their voices into the healthcare system and clinicians have the resilience to listen and act.

PATIENT SAFETY/HANDOVERS

The impact of patient safety culture on handover in rural health facilities

Piper D, Lea J, Woods C, et al. *BMC Health Serv Res*. 2018 (online, November):1-13.
Study to explore the effect of handovers on patient safety across six Local Health Districts in Australia. Survey responses of 1587 workers across various healthcare settings such as district hospitals, community health facilities or tertiary referral hospitals were analyzed. Results showed, within rural health settings, effective handover is significantly related to patient safety perceptions. A strong teamwork culture and management support culture were found to enhance effective handover of patient information and personal responsibility. Authors noted despite the implementation of standardized communication tools and frameworks for handovers, patient safety is compromised by inadequate coordination, poor or absent documentation between departments or other healthcare agencies, and in transfer of care from acute facilities to primary/community care. A number of quotes from respondents are provided.

ALWAYS EVENTS/EMERGENCY DEPARTMENT

Testing of the 'Always Events' approach to improve the patient experience in the emergency department

Lowe D, Kay C, Taylor D, et al. *BMJ Open Qual*. 2018 (online, November):1-5.
Quality improvement project in the UK using always events to increase patient satisfaction in the emergency department (ED) for patients with minor injuries. Patients had identified communication and information provision as key improvement areas, and plan-do-study-act cycles were used to implement two interventions to increase patients' understanding of care provision in the ED: 1) informative posters were distributed throughout ED waiting areas, 2) a 2.5 minute video of the patient care journey through the ED. Results showed patient satisfaction regarding information provision increased from 80% to 88% after the poster intervention and to 92% after the video was implemented; understanding of how EDs function increased from 83% to 86% following the interventions. Samples of posters and a link to the video are provided.

QUALITY OF CARE/STROKE

Is length of time in a stroke unit associated with better outcomes for patients with stroke in Australia? An observational study

Busingye D, Kilkenny M, Purvis T, et al. *BMJ Open*. 2018 (online, November):1-9.
Study in Australia to determine whether patient outcomes differed between stroke patients who spent at least 90% of their admission in stroke units (SU) and those who spent less time. Admission data for 2,655 patients were analyzed; median age was 76 years and 55% were male. Results showed 64% of patients spent at least 90% of their admission in SU. Compared to patients who spent less than 90% of their admission in SU, patients who spent more time were more likely to have a brain scan within 24 hours, less likely to have severe complications, and median length of stay was shorter by two days. Authors noted early admission to the SU (within three hours of arrival to the emergency department) was independently associated with spending at least 90% of admission in the SU, and has also been associated with better recovery.

AGING POPULATION

Coping with more people with more illness. Part 1: the nature of the challenge and the implications for safety and quality

Amalberti R, Vincent C, Nicklin W, et al. *Int J Qual Health Care*. 2018 (online, November):1-5.
Article outlining the potential impact of the aging population on quality and safety initiatives in healthcare. Authors suggested health systems will need to shift the focus from primarily acute care and diagnostic healthcare to preventative, integrated community healthcare services, including the home care setting. A panel of 50 world leaders at the 2017 ISQua London conference were asked to prioritize potential initiatives to guide this change. The panel suggested two broad categories of priorities: 1) keeping people healthy in the home setting for as long as possible while anticipating the changes needed to the healthcare system, and 2) the need for driving change in the governance structure for the evolving social and healthcare systems.

"The central aim of health and social care will shift towards preventing disease and illness and extending the quality of life of people over the long term rather than resolving short-term acute crises" (p.4). [See Part 2 here.]

PATIENT SAFETY/CHANGE MANAGEMENT

Two decades since To Err Is Human: an assessment of progress and emerging priorities in patient safety

Bates D, Singh H. *Health Aff (Millwood).* 2018 (online November):1736-1743.
Article summarizing the progress of patient safety initiatives since To Err is Human was published two decades ago. Authors noted that improvements have been made, however, patient harm still occurs as uptake of patient safety initiatives has not been consistent across healthcare organizations. It is suggested that contextual factors such as leadership support or human cognition impact the effectiveness of these interventions aimed at reducing harm. Significant improvements in patient safety have not occurred as organizations cannot take on new initiatives while they are still struggling to implement the current interventions. Authors suggested organizations can improve uptake by publicly reporting harm rates, implementing penalties for certain patient safety events, and using frontline staff experience to develop future interventions.

SECOND VICTIM/ADVERSE EVENTS

Implementation of a second victim program in the neonatal intensive care unit: an interim analysis of employee satisfaction

Merandi J, Winning A, Liao N, et al. *J Pat Saf*. 2018 (online November):1-8.
Study to assess the use of and satisfaction with a second victim support program in the US. More than 460 participants from seven neonatal intensive care units (NICU) within a large pediatric hospital were surveyed. Results showed 37% of participants witnessed or were directly involved in an adverse event while only 14% of those involved sought support from colleagues in the NICU and 16% contacted a peer supporter following the event. Three quarters (73%) of participants who accessed the program reported some benefit from peer support. However, 88% of participants had not utilized the program. Participants suggested ways to encourage use of the program, including improving access and education about the program (13%), encouraging management/supervisor involvement (5%), and increasing the number of peer supporters (4%). Authors noted peer support programs can be effective, however, in order to promote these programs, second victims need to feel safe and not stigmatized when accessing resources.

Other Resources of Interest (all)

2 MSO programs show value of safety position (November 2018). Article highlighting the ways in which two health systems in the US have expanded upon the role of medication safety officers in patient safety.

C-section rate rises globally as "cost intervention" replaces "natural process" (November 2018). CMAJ News (CDN) article highlighting some factors related to the global trend.

Cyber pulse: the state of cybersecurity in healthcare (November 2018). Kaspersky Lab (US) report on survey results of healthcare organizations in Canada and the US.

Cybersecurity breaches will soon reverberate all the way up to the board level (December 2018). Globe and Mail (CDN) article with specific steps organizations can take to protect against cyberattacks.

Developing a reporting culture: learning from close calls and hazardous conditions (December 2018). The Joint Commission (US) sentinel event alert (and infographic) with suggested actions to increase incident reporting.

Disclosure of personal information to law enforcement (November 2018) Information and Privacy Commissioner of Ontario fact sheet on disclosure of personal information to a law enforcement agency.

ERs can be loud, hectic and even dangerous for the elderly. Here's how hospitals are trying to fix that (December 2018) Washington Post (US) article on strategies for the challenges the elderly have in ERs.

FDA: duodenoscopes are contaminated at a higher rate than previously assumed (December 2018). ECRI Institute (US) news brief of an ongoing assessment of duodenoscope reprocessing and recommendations.

Framework on palliative care in Canada (December 2018). Government of Canada framework providing an overview of palliate care requirements in Canada.

Five steps to compliance with privacy consent guidelines (December 2018) Borden Ladner Gervais LLP (CDN) article on compliance with the Privacy Commissioner of Canada guidelines for obtaining meaningful consent.

Hospital-acquired infections are declining (December 2018). New York Times (US) article on the reduced risk of certain hospital-acquired infections in the US.

Marginalized Canadians may lack information about end-of-life options (November 2018). CMAJ News (CDN) article summarizing insights from the recent Family Medicine Forum on medical assistance in dying in Canada.

New study on hospital readmittance (December 2018). International Hospitals & Healthcare Review (UK) article summarizing a study led by two Canadian hospitals on sleep disturbances in hospital and readmission rates.

Opioid use disorder (OUD) tool (December 2018). Centre for Effective Practice (CDN) tool to guide primary care providers through screening, diagnosing, treating, and communicating with patients who have OUD.

Uterotonics for the prevention of postpartum haemorrhage (December 2018). World Health Organization (CH) guideline to inform clinical protocol and health policy development related to postpartum haemorrhage.