RISK WATCH

HIROC

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Selected research, publications, and resources to promote evidence-informed safety and 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.

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EDITOR'S NOTE

In this month's Risk Watch, we feature a number of Canadian articles focusing on patient safety. Armutlu et al. share the development of a patient safety culture bundle for CEOs and senior leaders. Laeeque et al. describe the development of 15 never events for hospital care through collaborative work and national consensus. Kwok et al. explore the use of quality improvement methods to develop a standardized physician handover tool for the emergency department with the aim of increasing the number of adequate handoffs during the night shift.

If you have any comments about these articles or Risk Watch, please email me at lborovoy@hiroc.com. We look forward to hearing from you.

HOT OFF THE PRESS

PATIENT SAFETY/SENIOR LEADERS

🔓 **Patient safety culture bundle for CEOs and Senior Leaders**

Armutlu M, Davis D, Doucet A, et.al. *Healthc Q.* 2020 (online, February):22(SP):82-95.

Article from Canada to explore and develop a patient safety culture bundle for CEOs and senior healthcare leaders. Authors reviewed more than 60 resources and validated the safety culture bundle with thought leaders, both provincially and national. Authors stated, "Senior leaders themselves needed "education" that provided not only awareness but a standardized framework – not a patchwork of resources – that provided the knowledge, skills and attitudes they could easily follow to champion meaningful change. At the intersection of all of this would be a culture change, enabled by transformational leadership" (p.83).

PATIENT SAFETY/NEVER EVENTS

🔓 **Patient safety never events: cross-Canada checkup**

Laeeque H, Farlow B, Kossey S. *Healthc Q.* 2020 (online, February):22(SP):46-67.

Article from Canada which describes the development of 15 never events for hospital care through collaborative work and national consensus. A list of the 15 never events that cause harm and can be avoided with the appropriate mechanisms in place is provided, along with the status of reporting never events/critical incidents/serious patient safety events in each province. Authors noted, "We now have a call to action with pan-Canadian consensus on 15 never events for hospital care; now we need better information to act on and a public commitment to action" (p.50).

COMMUNICATION/DISCHARGE QUALITY

Measuring discharge quality based on elderly patients experiences with discharge conversation: a cross-sectional study

Boge R, Haugen A, Nilsen R, et al. *BMJ Open Qual*. 2019 (online, December):1-9.

Study in Norway to explore the association between discharge conversation and discharge quality assessed by measuring elderly patients' experiences. Results of the survey showed 74% of patients reported having discharge conversations; higher discharge care experience and patient experience scores were found for patients who reported having a discharge conversation compared to those who did not (15%) or were unsure (11%). Authors concluded the reported usefulness of the conversation had a significant association with discharge care quality.

COMMUNICATION/EMERGENCY DEPARTMENT

Development and implementation of a standardized emergency department intershift handover tool to improve physician communication

Kwok E, Clapham G, White S, et al. *BMJ Open Qual*. 2020 (online, February):1-11.

Study in Canada using quality improvement methods to develop a standardized physician handover tool for use in the emergency department with the aim of increasing the number of adequate handoffs during the night shift. Results show an increase in the amount of both verbal and written communication by physicians during handoff. Authors suggest including frontline staff in the development of the tool contributed to its success.

DIAGNOSTIC IMAGING/QUALITY IMPROVEMENT

Checklist for Head Injury Management Evaluation Study (CHIMES): a quality improvement initiative to reduce imaging utilization for head injuries in the emergency department

Masood S, Woolner V, Yoon J, et al. *BMJ Open Qual*. 2020 (online, February):1-9.

Study at an adult-only academic tertiary care centre in Canada aimed at reducing the rates of unnecessary imaging studies to diagnose minor head injuries in the emergency department. Using recommendations from the Choosing Wisely Canada campaign and quality improvement methodology, authors implemented strategies to tackle over-utilization. Results showed a decrease in CT scan rates over a 16 month period. Authors suggested the combination of patient-oriented and provider-oriented education positively impacted the success of the program.

INFECTION CONTROL/SURGICAL

Increasing the documentation of 48-hour antimicrobial reviews

Sahota R, Rajan K, Comont J, et al. *BMJ Open Qual*. 2020 (online, February):1-6.

Study on two surgical wards in the UK to reduce the negative consequences of inappropriate antibiotic use by improving staff engagement with completing antimicrobial reviews. Authors noted the most successful interventions were those that were not resource intensive and required minimal input after initial rollout, such as providing presentations and displaying posters on wards.

ALARM FATIGUE/PEDIATRICS

Time series evaluation of improvement interventions to reduce alarm notifications in a paediatric hospital

Pater C, Sosa T, Boyer, et al. *BMJ Qual Saf*. 2020 (online, January):1-10.

Quality improvement project in the cardiology unit of a large paediatric acute care center in the US that reduced alarm notifications by 68% over 3 years. Interventions included integrating new technology, customizing alarm logic, and implementing process changes. Improvements were sustained for more than 18 months and authors noted strategies that addressed human, organizational, and technical factors were key to success.

DIAGNOSTIC ERROR/AMBULATORY

Patient safety culture, health information technology implementation, and medical office problems that could lead to diagnostic error

Campione J, Mardon R, McDonald K. *J Patient Saf*. 2019 (December);15(4):267-273.

Study using safety culture survey results from 925 medical offices across the US to understand the relationship between safety culture, health information technology (IT) implementation, and diagnostic error in outpatient care. The problems most frequently cited as occurring daily or weekly were missing test results (15%) and patient records not available when needed (10%). Authors noted implementation of new or upgraded technology is a particularly risky time that can negatively impact office processes and increase the possibility of unintended harm. Assessment frameworks and toolkits for implementing health IT can help mitigate some risks by ensuring critical processes are working as they should.

PATIENT DETERIORATION/SEPSIS

Validation of automated sepsis surveillance based on the Sepsis-3 clinical criteria against physician record review in a general hospital population: observational study using electronic health records data

Valik J, Ward L, Tanushi H, et al. *BMJ Qual Saf*. 2020 (online, February):1-11.

Study in Sweden to develop and validate an automated sepsis surveillance system using electronic health record data. An algorithm was developed based on clinical criteria for sepsis: cultures taken, at least two doses of antimicrobials administered, and increase in organ failure assessment scores. Compared to physician review, the algorithm performed well, achieving sensitivity 0.887, specificity 0.985, positive predictive value 0.881, and negative predictive value 0.986. Authors discussed the strengths of this algorithm compared to other methods of monitoring sepsis, including medical coding and a different algorithm developed to facilitate automated sepsis surveillance.

Other Resources of Interest (all)

Embedding relationship and interpersonal skills in the surgical setting (January 2020). BC Patient Safety & Quality Council webinar on the benefits of human relational skills training in healthcare.

Employer strategies for managing novel coronavirus risks in the workplace (March 2020). Borden Ladner Gervais LLP (CDN) article with steps for employers to prepare contingency plans to manage COVID-19.

Health privacy update: new class action certified in Ontario after privacy breach at a hospital (February 2020). Kate Dewhirst Health Law (CDN) article on whether fleeting views of health records constitute a privacy breach.

***Healthcare* Quarterly volume 22 special issue patient safety** (February 2020). Longwoods (CDN) publication focusing on patient safety with overview of some key initiatives across Canada.

Ontario Health Teams: personal health information sharing, client privacy and PHIPA compliance (February 2020). Borden Ladner Gervais LLP (CDN) article with considerations for handling legislative and operational issues.

Recent amendments to the controlled act of psychotherapy for nursing (February 2020). Borden Ladner Gervais LLP (CDN) article highlighting changes to regulations affecting psychotherapy treatment for nurses.

Subscriber Alert: Citrix vulnerabilities, the COVID-19 social engineering attack, and an update on the LifeLabs breach (February 2020). This Subscriber Alert is intended for healthcare organizations and professionals to raise awareness of cyber threats that may impact information security and privacy.

Understanding your legal accountabilities: a guide for Ontario hospitals (January 2020). Ontario Hospital Association toolkit outlining statutory obligations of healthcare organizations in order to assist with risk management and compliance functions.