

Patient Safety Review Committee 2013-2014 Annual Report

Office of the Chief Coroner
Province of Ontario

November 2015



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Message from the Chair



This Patient Safety Review Committee Report of the Office of the Chief Coroner for Ontario is reflective of cases that were reviewed in 2013 and 2014.

Over the past two years, the committee completed 13 death reviews, nine in 2013 and four in 2014, in which systemic issues related to medical care were identified. From the cases reviewed, the committee made a total of 68 recommendations, 48 in 2013 and 20 in 2014, aimed at preventing deaths in similar circumstances. Two cases from 2014 were deferred for review and completion in 2015 and will be included in the next annual report.

The recommendations were categorized into seven issue/theme groups, of which the most common in 2013 and 2014 were: communication/documentation; education/training and research; and policy/procedures. Some cases and recommendations involved more than one theme; hence the total number of themes identified is greater than the number of cases and greater than the total number of recommendations.

The primary themes/issues identified in the cases that were reviewed in 2013 included: communication and documentation; education, training and research; and policy and procedures. In 2014 the most common themes/issues identified were: communication and documentation; policy and procedures; and resources.

Special recognition must be made to Dr. Dan Cass, who chaired the committee for several years. His guidance and leadership was valued by all members of the committee. His tenure as Chair came to an end in October 2014. Dr. Craig Muir was Chair of the committee for the remainder of 2014. Both were dedicated and committed to the principles of patient safety and their guidance was appreciated by all who worked with them. All the committee members, past and current, must also be thanked for their hours of dedicated and caring guidance with the goal of increasing patient safety throughout the Province.

On behalf of the committee, thank you for your interest in patient safety, and in the work of the Patient Safety Review Committee.

Reuven Jhirad MD MPH CCFP FCFP, for Dr. Cass & Dr. Muir
Deputy Chief Coroner
Chair, Patient Safety Review Committee

Committee Membership

Dr. Dan Cass

Committee Chair 2013-Oct. 2014
Deputy Chief Coroner - Investigations

Dr. Craig Muir

Committee Chair Oct. – Dec. 2014
Regional Supervising Coroner, Kingston

Dr. Glenn Brown

Family Physician and Head
Department of Family Medicine
Queen's University

Ms. Patti Cochrane

Vice-President, Patient Services, Quality and
Practice and Chief Nursing Executive
Trillium Health Partners, Mississauga

Dr. Kris Cunningham

Forensic Pathologist
Provincial Forensic Pathology Unit, Toronto
(Formerly Medical Director, Kingston
Regional Forensic Pathology Unit)
Ontario Forensic Pathology Service

Dr. Jonathan Dreyer

Emergency Physician and Research Director
Division of Emergency Medicine
University of Western Ontario

Ms. Julie Greenall

Interim Operations Leader
Institute for Safe Medication Practices
(ISMP) Canada

Dr. Ian Herrick

Anesthesiologist
Director, Quality Assurance and Continuing
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Western University
London Health Sciences Centre and St.
Joseph's Health Care London

Dr. Madelyn Law

Assistant Professor
Dept. of Community Health Sciences
Brock University

Dr. Ann Matlow

Vice-President, Education
Women's College Hospital
Associate Director, Centre for Patient Safety
University of Toronto

Dr. David Musson

Academic Leader
Centre for Simulation-Based Learning
McMaster University

Dr. Michael Szul

Medical Advisor, Associate Registrar
College of Physicians and Surgeons of
Ontario
(Ex-Officio)

Mr. David U

President and CEO
Institute for Safe Medication Practices
(ISMP) Canada

Ms. Kathy Kerr (2013)

Ms. Tara McCord (2014)

Executive Lead
Office of the Chief Coroner

History

Historically, issues or concerns relating to patient safety that were identified during a coroner's investigation may have led to individual recommendations being generated by the investigating coroner, or to a public review of the circumstances surrounding the death through a coroner's inquest. The complexity of cases involving patient safety issues, however, often requires specialized knowledge and expertise in order to fully understand the intricacies of the circumstances of the death. Inquests may take place several years after a death and it may be challenging for a jury comprised of members of the public to fully grasp the complex medical details in order to make practical recommendations aimed at preventing similar deaths.

The Patient Safety Review Committee (PSRC) was established in 2005 in order to address the need for specialized knowledge and expertise and to help expedite the review of coroners' cases with actual or perceived systemic patient safety implications, and where possible, to make recommendations to prevent similar deaths.

Purpose

The purpose of the PSRC is to assist the Office of the Chief Coroner in the investigation and review of healthcare-related deaths where system-based errors or issues appear to be a major factor. The PSRC develops recommendations aimed at preventing similar deaths, which are sent to relevant agencies and organizations by the Chief Coroner for Ontario. The patient and public safety mandate of the Office of the Chief Coroner is derived from the *Coroners Act*:

Chief Coroner and duties

4. (1) The Lieutenant Governor in Council may appoint a coroner to be Chief Coroner for Ontario who shall,

- (d) Bring the findings and recommendations of coroners' investigations and coroners' juries to the attention of appropriate persons, agencies and ministries of government;

Disclosure to the public

18. (3) The Chief Coroner shall bring the findings and recommendations of a coroner's investigation, which may include personal information as defined in the *Freedom of Information and Protection of Privacy Act*, to the attention of the public, or any segment of the public, if the Chief Coroner reasonably believes that it is necessary in the interests of public safety to do so. 2009, c. 15, s. 10.

In the context of the PSRC, the use of the word "error" does not imply blame or responsibility on the part of any individual or organization. For the purposes of this committee, "error" is defined as a system design characteristic that either permits unintended adverse events to occur (latent error) or does not detect deviations from the

intended path of care (active error). System design would include not only the design of care processes, but also access to care management (such as delays in receiving care). The presence of such errors does not mean that an individual or organization should be assigned blame or responsibility for an unintended outcome. The mandate of the PSRC, like that of the Office of the Chief Coroner, is one of fact-finding, not fault-finding.

The aims and objectives of the PSRC during this time were:

1. To provide expert opinion about the cause and manner of death in healthcare-related cases where systems-based errors appear to be a major factor.
2. To assist coroners to improve the investigation of deaths within, or arising from, the health care system in which systems-based errors appear to have occurred.
3. To stimulate educational activities for professionals through identification of systemic problems, referral to appropriate agencies for action, collaboration with professional regulatory bodies and the dissemination of an annual report. Emphasis will be placed on speedy dissemination of information.
4. To provide expert evidence at inquests on request.
5. To conduct or promote research, where appropriate.
6. To undertake random or directed reviews when requested by the chairperson.
7. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.

Structure and Size

The committee membership consists of respected practitioners from various disciplines related to health care. The membership is balanced to reflect wide and practicable geographical representation and representation from all levels of institutions, including teaching centres, to the extent possible. Other individuals with specialized knowledge or expertise are invited to participate in committee reviews when required and at the discretion of the chairperson.

In 2013 and 2014, the PSRC was comprised of a diverse membership, including the chairperson and executive lead, of healthcare professionals with significant experience in patient safety. The committee membership, and its balance, is reviewed regularly by the chairperson and by the Chief Coroner, as requested.

Limitations

The PSRC is advisory in nature and makes recommendations through the chairperson. While the committee's consensus report is limited by the data provided, efforts are made to obtain all available, relevant information. It is not within the mandate of the committee to re-open other investigations (e.g. criminal proceedings) that may have already occurred.

Information collected and examined by the PSRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to section 15(4) of the *Coroners Act*, R.S.O. 1990 Chapter c.37, as amended.

All information obtained as a result of coroners' investigations and provided to the PSRC is subject to confidentiality and privacy limitations imposed by the *Coroners Act* of Ontario and the *Freedom of Information and Protection of Privacy Act*. Unless and until an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Accordingly, individual reports, review meetings, and any other documents or reports produced by the PSRC, are private and will not be released publicly.

Each committee member has entered into, and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

Members of the committee do not give opinions outside the coroners' system about cases reviewed. In particular, members do not act as experts at civil trials for cases that the PSRC has reviewed.

Members do not participate in discussions or prepare reports of clinical cases where they have (or may have) a conflict of interest, or perceived conflict of interest, whether personal or professional.

Medical records, draft and consensus reports and the minutes of committee meetings are confidential documents.

Summary of Cases Reviewed in 2013 and 2014

Nine cases were reviewed by the PSRC in 2013 and in 2014, four cases were reviewed. Two cases referred to the committee in 2014 were deferred to the following year and were not included in the 2014 case review count. In 2013, 48 recommendations were made in response to the cases reviewed and in 2014, there were 20 recommendations made. The recommendations were categorized by the following theme/issues:

- Communication and Documentation
- Education, Training and Research
- Legislation
- Policy and Procedures
- Quality of Care Review
- Resources
- Miscellaneous / Other

The majority of themes / issues identified in cases reviewed in 2013 were communication and documentation, education, training and research and policy and procedures. The most prevalent themes / issues identified in cases reviewed in 2014 were communication and documentation, policy and procedures and resources. A summary of the 2013 and 2014 case recommendations has been included in Appendix A.

Figure 1: 2013 PSRC Recommendations based on theme / issue

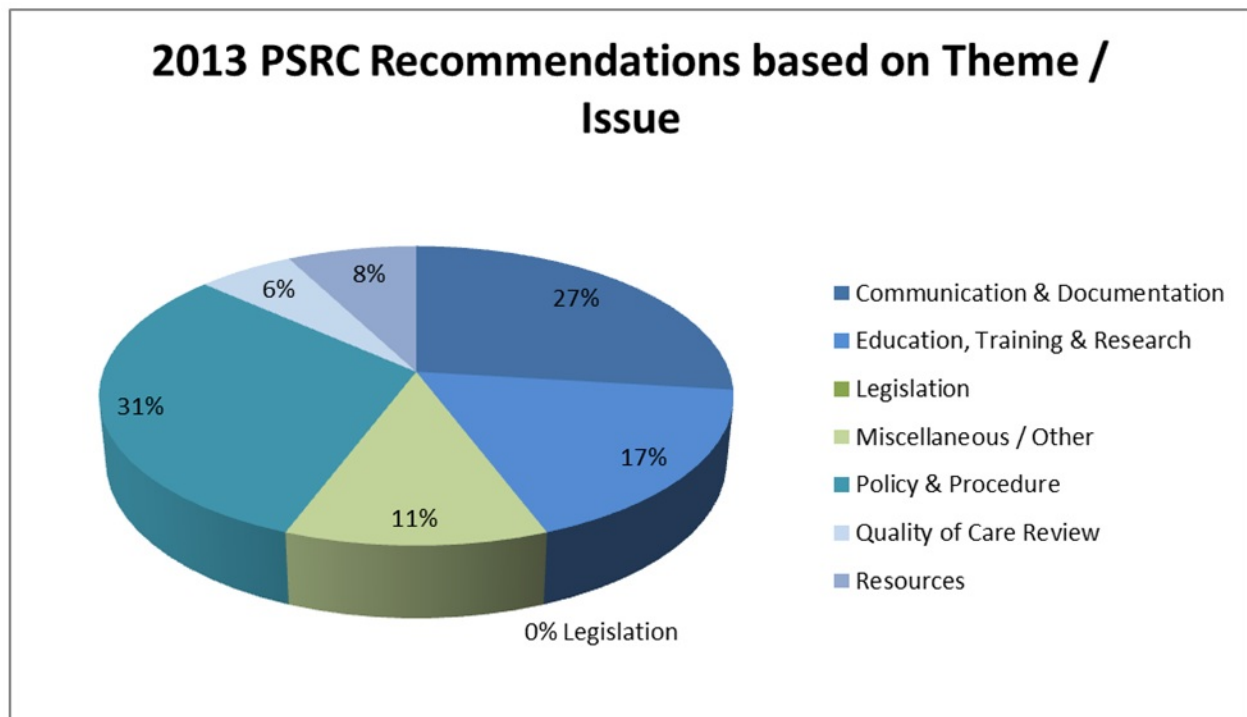


Figure 1 demonstrates the distribution of themes / issues derived from the recommendations of patient safety related cases reviewed by the PSRC in 2013. Policy and procedure was identified most often, (31%), followed by communication and documentation (27%), education, training and research (17%), miscellaneous / other (11%), resources (8%) and quality of care review (3%). There were no themes / issues related to legislation. Note that some recommendations had more than one theme / issue identified.

Figure 2: 2014 PSRC Recommendations based on theme / issue

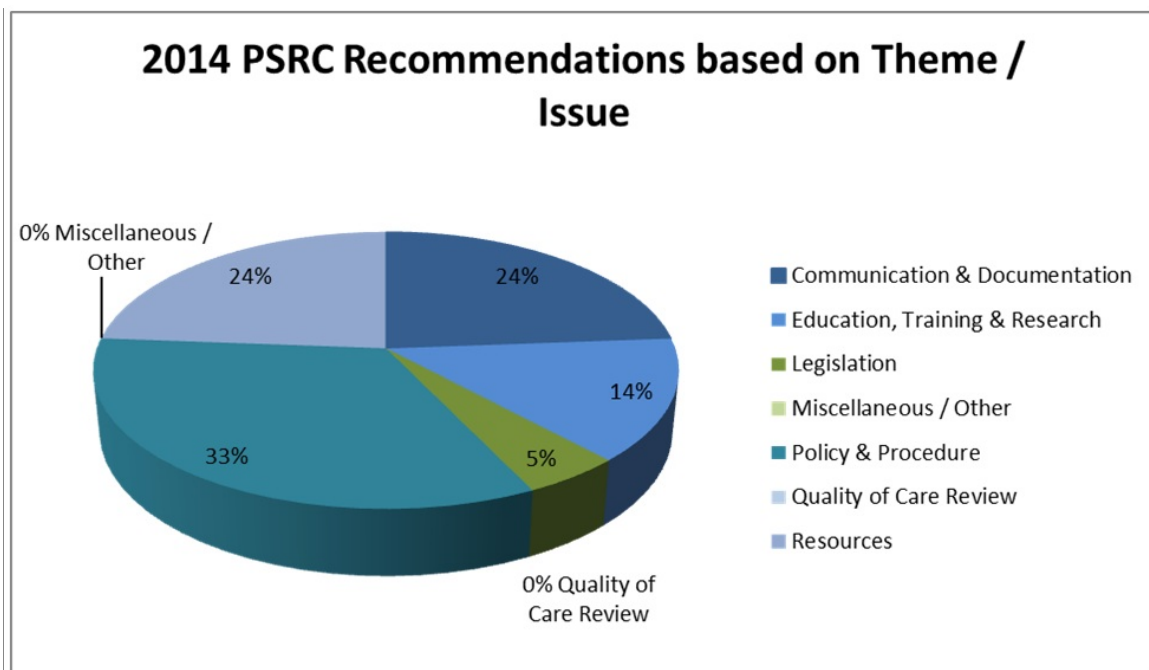


Figure 2 demonstrates the distribution of themes / issues derived from the recommendations of patient safety related cases reviewed by the PSRC in 2014. Policy and procedure was identified most often, (33%), followed by communication and documentation (24%), resources (24%) education, training and research (14%) and legislation (5%). There were no themes / issues related to quality of care review or miscellaneous / other. Note that some recommendations had more than one theme / issue identified.

Appendix A

2013 PSRC Recommendations

PSRC File Number	Recommendations
2013-01	<ol style="list-style-type: none"> <li data-bbox="414 520 1393 693">1. To Hospital A, the Ontario Hospital Association, and the Ontario Medical Association: Venous thromboembolism (VTE) prophylaxis should be initiated as soon as possible after presentation to hospital for any patient in whom it is indicated. Theme: Quality of Care Review <li data-bbox="414 730 1393 976">2. To Hospital A, the Ontario Hospital Association, and the Ontario Medical Association: Greater consideration be given to the possibility that sudden and unexplained hypoxia and tachycardia could be the result of a pulmonary embolus in any patient who has been immobilized for a period of time, even if conventional anticoagulant therapy to prevent venous thromboembolic disease has been part of the treatment regimen. Theme: Education, Training & Research <li data-bbox="414 1014 1393 1260">3. To Hospital A, the Ontario Hospital Association, and the Ontario Medical Association: Hospitals should review the antidotes they stock on a regular basis, and at least annually. If a given antidote is not stocked by a hospital, a plan should be in place and readily available to staff in order to ensure that this antidote can be obtained rapidly from another institution or source, on a 24/7 basis. Theme: Resources <li data-bbox="414 1297 1393 1585">4. To Hospital A, the Ontario Hospital Association, and the Ontario Medical Association: Alcohol withdrawal should be considered in any patient admitted to hospital within the last five days who demonstrates signs or symptoms such as tachycardia, hypertension, tremor or confusion / disorientation / hallucinations. If alcohol withdrawal is suspected, this should be assessed and managed using accepted protocols, such as the CIWA-Ar score and symptom-triggered therapy with benzodiazepines. Theme: Education, Training & Research
2013-02	<ol style="list-style-type: none"> <li data-bbox="414 1623 1393 1795">1. To Hospital A: The hospital should consider and respond to the additional questions posed by the PSRC reviewer in this case, and in addition, should report back to the PSRC on the actions taken as a result of their internal review. Theme: Quality of Care Review

PSRC File Number	Recommendations
	<p>2. To the Ontario Hospital Association: Consider automation (e.g., automated dispensing cabinets, bar code verification of medication administration) as a priority for critical care areas given the extensive use of floor stock in these care areas. Theme: Resources</p> <p>3. To the Institute for Safe Medication Practices (ISMP) Canada: ISMP Canada should identify medications which may be fatal if administered via intravenous (IV) push, and make recommendations to manufacturers and pharmacies regarding labelling or other markings to minimize the likelihood that such medications will be administered by IV push in error. Theme: Miscellaneous / Other</p> <p>4. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: Ensure that processes, such as critical incident debriefing and employee assistance programs, are in place to provide psychological support for staff involved in incidents. Theme: Miscellaneous / Other and Policy & Procedures</p>
2013-03	<p>1. To the Ontario Hospital Association (OHA), the Ontario Nurses Association, and the Canadian Society of Hospital Pharmacists, Ontario Division: Use smart pumps with hard stops for the administration of infusions of high alert medications such as propofol. In the absence of smart pump technology, ensure that independent checks include verification of pump programming. Theme: Policy & Procedures</p> <p>2. To the Ontario Hospital Association (OHA), the Ontario Nurses Association, and the Canadian Society of Hospital Pharmacists, Ontario Division: Ensure that programming of smart pumps is consistent in all areas of the hospital and give priority for technology to support wireless updates so that all pumps can be updated simultaneously. Theme: Policy & Procedures</p> <p>3. To the Ontario Hospital Association (OHA), the Ontario Nurses Association, and the Canadian Society of Hospital Pharmacists, Ontario Division: Develop order sets to guide administration of high alert medications such as propofol. Theme: Policy & Procedures</p>

PSRC File Number	Recommendations
	<p>4. To the Ontario Hospital Association: Develop processes to support the provision of safe care to admitted patients in the Emergency Department when there are no intensive care beds available. Such processes may include, but are not limited to: protocols to support rapid transfer to ICU; bringing ICU nurses to provide care to ICU patients in the ED, and; use of smart pumps and other technological solutions in order to mitigate risk when high alert medication infusions are used in the ED setting. Theme: Policy & Procedures</p> <p>5. To the institute for Safe Medication Practices (ISMP) Canada: ISMP Canada should review the labeling and packaging issue related to this product (i.e., product label not designed to support reading upside down). Theme: Miscellaneous / Other</p> <p>6. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: Ensure that processes, such as critical incident debriefing and employee assistance programs, are in place to provide psychological support for staff involved in incidents. Theme: Policy & Procedures</p>
2013-04	<p>1. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association and the College of Nurses of Ontario: Review the medication administration processes to identify and address barriers to taking the MAR to the bedside for medication administration. Theme: Policy & Procedures</p> <p>2. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association and the College of Nurses of Ontario: Ensure consistent use of two patient identifiers at all steps in the medication use process. Theme: Policy & Procedures</p> <p>3. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: If the clinical status of a patient changes suddenly, consider medication error in the differential diagnosis. Theme: Education, Training & Research</p> <p>4. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: Routinely check blood glucose levels when a patient experiences a sudden altered level of consciousness. Theme: Education, Training & Research</p>

PSRC File Number	Recommendations
	<p>5. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: Assess current staff identification practices and remind staff to wear identification tags in a way that makes them visible to patients and family members; work to create a culture of healthcare workers introducing themselves to patients and family members. Theme: Communication & Documentation</p> <p>6. To the Ontario Hospital Association, the Ontario Nurses Association, the College of Nurses of Ontario, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario: Ensure that processes, such as critical incident debriefing and employee assistance programs, are in place to provide psychological support for staff involved in incidents Theme: Policy & Procedures</p> <p>7. To the Ontario Association of Chiefs of Police: Police investigators who are conducting interviews in a healthcare setting should be mindful of the potential negative impact of overly-aggressive lines of inquiry on staff and their willingness to participate in both the current investigation, and subsequent incident reporting of medical errors. Theme: Communication & Documentation</p> <p>8. To the Ontario Association of Chiefs of Police: When police are investigating a death (whether under the aegis of the coroner, or as part of a criminal investigation), consideration should be given to enlisting the assistance of health care providers who might educate and guide the police in some of the relevant medical issues and lines of inquiry, so as to allow police to focus their inquiry more effectively. Theme: Communication & Documentation</p>
2013-05	<p>1. Hospital A should undertake a review of the care provided in this case, including but not limited to:</p> <ul style="list-style-type: none"> a. Determining whether there was a delay in timely access to past health records and if so, whether the circumstances that gave rise to such delay are the result of a remediable issue. If possible, processes to facilitate timely access to past health records should be instituted. b. Whether due consideration was given to the possibility that the decedent's dramatic decline may have been prompted by an acute change in his coagulation status and seek to identify the cause for this. This would be done with a view to identifying protocols / best practices for the management of similar patients in future. <p>Theme: Quality of Care Review</p>

PSRC File Number	Recommendations
	<p>2. To the Office of the Chief Coroner: The PSRC recommends that the Office of the Chief Coroner approach the Canadian Health Information Management Association (CHIMA) to seek collaborative opportunities to develop a standardized approach to the organization of health records transmitted in electronic format specifically with the intention of supporting clinical review processes directed at quality and safety in healthcare.</p> <p>Theme: Policy & Procedures and Communication & Documentation</p>
2013-06	<p>1. To the Ontario Hospital Association (OHA): Hospital boards should ensure that appropriate consultation is obtained (including, but not limited to Medical Advisory Committees) when implementing policies impacting the delivery of patient care.</p> <p>Theme: Communication & Documentation</p> <p>2. To the Ontario Hospital Association (OHA): All hospitals should develop clear policies and protocols which delineate the role of hospital Code teams and local EMS resources for medical emergencies which occur outside of the walls of the hospital. Such protocols should include processes to ensure that EMS responders are provided with accurate information and assistance to facilitate their timely access to the patient.</p> <p>Theme: Policy & Procedures</p> <p>3. To the Ontario Hospital Association (OHA): Hospitals should perform mock exercises to test and improve upon their response to medical emergencies in atypical locations as part of their ongoing quality improvement and emergency response processes.</p> <p>Theme: Education, Training & Research</p>
2013-07	<p>1. The Minister of Health and Social Services for the Northwest Territories should establish a working group to set standards for physicians and nurse practitioners on the prescribing of opioids and benzodiazepines. The Canadian Guideline needs to be adapted to the NWT setting, where short-term locums provide much of the care and the patient population has a high prevalence of substance use disorders.</p> <p>Theme: Policy & Procedures</p> <p>2. The Ministry of Health and Social Services for the NWT should review the NWT Ministry of Health's eligibility criteria for Suboxone coverage, to ensure that all patients who need it are able to receive it.</p> <p>Theme: Miscellaneous / Other</p>

PSRC File Number	Recommendations
	<ol style="list-style-type: none"> <li data-bbox="412 306 1365 474">3. The Ministry of Health and Social Services for the NWT should establish a working group to set guidelines and standards for the medical management of opioid dependence. Current guidelines on Suboxone prescribing and dispensing need to be adapted for the NWT setting. Theme: Policy & Procedures <li data-bbox="412 516 1344 621">4. In setting up addiction services, the eight NWT Regional Health Authorities must work closely with First Nations communities and their band councils. Theme: Communication & Documentation <li data-bbox="412 663 1360 873">5. The Ministry of Health and Social Services for the Northwest Territories should provide training for physicians and nurse practitioners on opioid and benzodiazepine prescribing and on the identification and management of opioid misuse and addiction. The training could be offered through telemedicine. Theme: Education, Training & Research <li data-bbox="412 915 1377 1052">6. The Ministry of Health and Social Services for the NWT should provide physicians and nurses with access to a long distance clinical support network to assist them in the management of opioid prescribing and opioid addiction. Theme: Communication & Documentation <li data-bbox="412 1094 1373 1262">7. The Ministry of Health and Social Services for the Northwest Territories should arrange for one or more physicians and nurse practitioners to receive more intensive training in Suboxone prescribing, structured opioid therapy, and benzodiazepine tapering. Theme: Education, Training & Research
2013-08	<ol style="list-style-type: none"> <li data-bbox="412 1304 1373 1545">1. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: Where a continuous infusion rate has been ordered, include this information on pharmacy-generated Medication Administration Records (MARs) to support pump programming. Theme: Communication & Documentation <li data-bbox="412 1587 1349 1829">2. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: When using a Patient Controlled Analgesia (PCA) flow sheet or equivalent document, include the medication order on the flow sheet (transcribed via a double check process) for reference. Theme: Communication & Documentation

PSRC File Number	Recommendations
	<p>3. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: Institute independent double check practices for programming of infusion pumps for opioid infusions (and other high-alert medications). Theme: Policy & Procedures</p> <p>4. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: Create a process at shift change whereby infusion or fluid orders are reviewed and confirmed against the original order or independently checked MAR. Theme: Communication & Documentation</p> <p>5. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: Ensure that the 24 hour check process includes comparison of the original order to both handwritten and pharmacy-generated MARs, including drug, dose, concentration, rate, frequency, breakthrough parameters, etc. Theme: Communication & Documentation</p> <p>6. To Hospital A, the Ontario Hospital Association, the Ontario Nurses Association, the Registered Nurses Association of Ontario, and the Ontario Branch of the Canadian Society of Hospital Pharmacists: Require a clinical review of opioid infusion orders by a pharmacist that includes assessment of prior opioid use. Theme: Communication & Documentation</p> <p>7. To Hospital A, the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, and the College of Pharmacists of Ontario: Educate clinicians on the definition of opioid tolerance, and review the patient conditions and comorbidities that may suggest the need for a reduced dose of opioid. In addition to ongoing educational efforts, this information may be included as part of a palliative care pathway or protocol. Theme: Education, Training & Research</p>

PSRC File Number	Recommendations
2013-09	<ol style="list-style-type: none"> <li data-bbox="412 306 1365 512">1. To Hospital A: Transfer of care policies and procedures for patients awaiting transfer should be reviewed. The patient’s condition, as well as information regarding the urgency, mode and reason for the transfer should be communicated to the attending physician if the admitting/transferring physician is not on site. It must be clear at all times who is the Most Responsible Physician (MRP) for the patient. Theme: Policy & Procedures and Communication & Documentation <li data-bbox="412 590 1365 722">2. To the Ontario Hospital Association, Criticall, all Local Health Integration Networks (LHINs), and the Ministry of Health and Long-Term Care: Access to urgent/emergent care for patients with morbid obesity should be better coordinated and facilitated. Theme: Resources <li data-bbox="412 837 1365 970">3. To the Ontario Hospital Association, Criticall, all Local Health Integration Networks (LHINs), and the Ministry of Health and Long-Term Care: Timely access to ICU beds must be ensured for patients with life-threatening conditions. Theme: Resources <li data-bbox="412 1050 1365 1226">4. To the Ontario Hospital Association and the Ontario Medical Association Sections on General and Family Practice and Emergency Medicine: Develop and/or enhance existing processes to ensure that appropriate primary care follow-up is arranged following emergency department (ED) visits, particularly for patients with repeat ED visits for the same problem. Theme: Policy & Procedures <li data-bbox="412 1304 1365 1436">5. To the College of Physicians and Surgeons of Ontario and the Ontario Medical Association: Physicians should be reminded of the challenges in clinical assessment of morbidly obese patients which may lead to a risk of under-appreciation of the severity of their condition. Theme: Education, Training & Research

PSRC File Number	Recommendations
2013-10	<p>1. To Hospital A: It is understood that Hospital A has undertaken an extensive review subsequent to this man's death and has addressed a number of issues identified in the review process. As the results of that process were not available to the PSRC, recommendations regarding issues identified by the PSRC for review and follow-up by the hospital are as follows:</p> <ul style="list-style-type: none"> a. Nursing documentation and follow-up, including notification of the attending physician, when abnormal conditions arise. b. Clinical assessments during the night shift including suitable documentation that patients are assessed regularly. c. Ensure that a policy exists that promotes the documentation of allergic reactions for each allergy identified or clearly documents when this information is deficient and a plan to address. d. Review airway management during the resuscitation and remedy any identified impediments to timely intubation, if they exist. <p>Theme: Communication & Documentation and Miscellaneous / Other</p> <p>2. To the Regional Supervising Coroner: In view of the finding of cardiomegaly of unknown etiology at post-mortem examination, first-degree relatives should be advised to be assessed by a cardiologist with a view to providing advice regarding risk and follow-up, as appropriate.</p> <p>Theme: Policy & Procedures</p>

2014 PSRC Recommendations

PSRC File Number	Recommendations
2014-01	<i>Case deferred to following review year</i>
2014-02	<p>1. To Hospital A, Ontario Hospital Association: It is recommended that access to critical Diagnostic Imaging investigations, particularly Computerized Tomography, be available 24/7 for urgent indications as assessed by specialist services.</p> <p>Theme: Resources</p> <p>2. To Hospital A, Ontario Hospital Association: All hospitals utilizing the services of trainee physicians should establish, or review, policies requiring prompt notification of staff specialists when patients have potentially serious diagnoses.</p> <p>Theme: Policy & Procedure</p>

PSRC File Number	Recommendations
	<p>3. To Hospital A, Ontario Hospital Association: Hospitals should continue efforts to reduce or eliminate situations of ambulance offload delay. If offload delay does occur, hospitals should ensure that, whenever possible, urgent patient assessments (including laboratory investigations and physical examinations) are initiated promptly, even if these assessments occur on the ambulance stretcher.</p> <p>Theme: Resources</p>
2014-03	<p>1. To Hospital A, the Ontario Association of Radiologists, and the Ontario Hospital Association (OHA): Hospitals should ensure that x-rays and other forms of imaging are labelled (on the image itself) with the time and date the image was acquired in a clear and unambiguous way. Ideally, annotation should be made on the image in an automated way that does not depend on human intervention.</p> <p>Theme: Communication & Documentation</p> <p>2. To Hospital A, the Ontario Association of Radiologists, and the Ontario Hospital Association (OHA): Electronic imaging (PACS) systems should clearly indicate when images have been ordered and/or acquired but not yet displayed, in order to minimize the likelihood of image confusion.</p> <p>Theme: Communication & Documentation</p> <p>3. To Hospital A, the Ontario Association of Radiologists, and the Ontario Hospital Association (OHA): Hospitals should ensure that processes exist to ensure that critical findings (including, but not limited to, mal-placed feeding tubes) on diagnostic images are communicated immediately and directly to the responsible clinical staff by the reading radiologist as soon as they are identified.</p> <p>Theme: Policy & Procedure</p> <p>4. To Hospital A, the OHA and the College of Physicians and Surgeons of Ontario: Procedure notes should be written for all invasive procedures. Such documentation should include:</p> <ul style="list-style-type: none"> • the name and position (e.g., medical student; third-year resident; staff physician) of the person performing the procedure, and the person who is providing supervision (if any); • risks explained and how/from whom consent was obtained • any complications • name and position of person confirming placement of device (feeding tube; central line, etc.) as applicable. <p>Theme: Communication & Documentation, Policy & Procedure</p>

PSRC File Number	Recommendations
	<p>5. To Hospital A and the OHA: Hospitals should develop (or review existing) policies for the use of patient care assistants, with a specific aim of ensuring that patient needs are identified and addressed across transitions of care (i.e., changes in service; transfers within or between institutions).</p> <p>Theme: Policy & Procedure</p>
2014-04	<p>1. To Hospital A, Hospital B, and the Ontario Hospital Association: All hospitals in which negative pressure wound therapy (NPWT) devices are used should develop (or adapt existing) policies, procedures and clinical tools (such as standard order sets, transfer of care documents, etc.) to support clinicians using these devices. Such documents should provide clinicians with information including, but not limited to:</p> <ul style="list-style-type: none"> a. Appropriate use of NPWT devices, b. Indications and contraindications (relative and absolute), c. Troubleshooting d. Emergencies, such as bleeding. Such policies, procedures and clinical tools should support, but not replace, appropriate education and training for clinicians using these devices. <p>Theme: Policy & Procedure</p> <p>2. To Hospital A, Hospital B, and the Ontario Hospital Association: The use of negative pressure wound therapy (NPWT) devices over infected graft sites should be discussed with the patient’s full health care team, with documentation of discussion of bleeding risk and emergency measures to be taken if bleeding occurs. This should include education of patients with respect to signs to watch for and the need to urgently alert clinical staff should signs of bleeding occur. This information should be explicitly communicated as part of every transition of care.</p> <p>Theme: Communication & Documentation</p> <p>3. To Hospital B: This case should be reported to Health Canada as a serious adverse event associated with a medical device, if this has not already occurred.</p> <p>Theme: Communication & Documentation</p> <p>4. To Health Canada: A safety alert should be issued by Health Canada regarding the risk of bleeding associated with negative pressure wound therapy (NPWT) devices in certain clinical scenarios.</p> <p>Theme: Legislation</p>
2014-05	<i>Case deferred to following review year</i>

PSRC File Number	Recommendations
2014-06	<ol style="list-style-type: none"> <li data-bbox="423 302 1365 474">1. Re: the Nursing Station: Point of Care blood testing could be made available to enhance the level of care that can be rendered in remote locations. (To include: CBC, INR, electrolytes, urea, creatinine, glucose, liver function tests, albumin, calcium, amylase, CK and troponin). Theme: Resources <li data-bbox="423 516 1341 617">2. Re: the Nursing Station: Functional suction devices must be available at all times at nursing stations. Theme: Resources <li data-bbox="423 695 1373 831">3. Re: the Nursing Station: Medical and nursing staff who deal with patients with chronic alcoholism should be made aware of the increased potential for acetaminophen toxicity in these patients. Theme: Education, Training & Research <li data-bbox="423 873 1382 1045">4. Re: the Nursing Station: A review should be conducted of the policies and procedures for transfer of patients from nursing stations to regional / tertiary care centres. This review should include the indications for transfer (including the need for timely investigations not available at the nursing stations). Theme: Policy & Procedure <li data-bbox="423 1087 1377 1224">5. Re: Aeromedical Transport: Transport teams should perform a daily equipment check based on a pre-established list of required items (e.g. blood tubing). Theme: Policy & Procedure <li data-bbox="423 1266 1349 1402">6. Re: Aeromedical Transport: Monitoring equipment must be capable of assessing BP, Pulse and O2 saturation at all times despite aircraft noise and vibration. Theme: Resources <li data-bbox="423 1444 1325 1581">7. Re: Aeromedical Transport: Crews should receive in-service education to ensure they are completely familiar with equipment they carry, including blood transfusion tubing and oxygen connections for their ventilator. Theme: Education, Training & Research <li data-bbox="423 1623 1377 1829">8. Re: Transport Physicians: Physicians who are providing on-scene or on-line advice to paramedics, need to be aware of guidelines for airway management in critically ill patients, including the need for airway protection in patients with decreased levels of consciousness, and controlled ventilation in shock states in which there is poor tissue perfusion and oxygenation. Theme: Education, Training & Research

Questions or comments pertaining to this report may be directed to:

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