



Patient safety, risk management and quality improvement *Are they at odds?*

By Eleanor Morton and Margaret Colquhoun

The recent focus on patient safety in Canadian healthcare is very exciting. Notably, the Canadian Patient Safety Institute (CPSI) was established to oversee and coordinate Canadian patient safety efforts and research work. The results of the Canadian adverse event study (Baker & Norton) published in May 2004 are a wake-up call for additional work to implement initiatives to ensure patients are safe while under our care. Patient safety initiatives are emerging and expanding throughout the Canadian health system.

Although quality improvement and risk management are frequently linked, with our new focus on patient safety there is sometimes a tendency to isolate it, as though patient safety is completely different, or stands on its own. Managing a health care organization's risk, however, incorporates many activities including, but certainly not limited to, infection control, occupational health and safety, patient relations, credentialing and quality improvement, all of which are intended to promote patient safety. Risk management encourages self-assessment, disclosure, data sharing, excellence in communications and patient involvement – in the same way as the patient safety movement does. Rather than being considered as exposing a health care organization's weaknesses or inefficiencies, it is now understood that organi-



zational and individual efforts to improve systems and make patients and workers safer, lead to culture change and in fact, reduce organizational risk. The safeguards that result when we look upon adverse events or errors as opportunities to identify and implement change, not only make our patients safer and allow us to make better overall use of our resources, they protect the hospital from litigation and financial loss.

Processes such as root cause analyses of sentinel events or important near misses have for some time been a focus of risk managers, and are now a focus of patient safety as well. Instead of considering their risk managing processes as separate and distinct activities, health-care organizations should describe and link their envelope of initiatives to enhance patient care and reduce risk to the organization.

In discussing risk management or patient safety, it is worth taking note of the warning cited in a recent Institute for Healthcare Improvement (IHI) newsletter, and given by Bob Lloyd, PhD, IHI's new Executive Director of Process Improvement. While Dr. Lloyd issued his warning in the "quality improvement" context, his warning is equally applicable if you replace the word "quality" with "risk" or "safety". He cautioned that "Quality is not a program or a project; it isn't the responsibility of one individual or even those assigned to the quality department. Your organization will only make meaningful and sustainable quality improvements when people at every level feel a shared desire to make processes and outcomes better every day."

While it is true that in a few instances an adverse event or error may lead to a legal action, fear of a lawsuit should never be an excuse for withholding information from a patient, or for our failure to learn from our errors and improve the way we practice. Having said this, however, health care organizations need to be cognizant of potential legal implications as they develop their policies relating to the "Reporting of Sentinel Events (Serious Adverse Events)", "Disclosure" and "Investigation following an Adverse Event". It is important that the organization's risk

manager be notified as soon as possible following the event, and most certainly prior to the commencement of any investigation. The risk manager is in the best position to coordinate any follow-up and act as a resource to those who may be involved in disclosure to the patient or in a subsequent investigation. It is important to remember, too, that disclosure is not a one-time process. Only as an investigation proceeds, do all the facts become known. Where circumstances point to the possibility or probability of litigation, the risk manager will notify the organization's insurer and lawyer, and double check to make sure all records (as well as any other potential evidence) has been secured for safe-keeping.

When patient safety, risk management and quality improvement work together as one, their mutual goal of improving patient safety will naturally lead toward a culture of safety, where learning from adverse events and errors, improving what we do, and sharing our learning with others, becomes a way of life.

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Researchers find antidepressants not linked to increased non-Hodgkin's lymphoma risk

By Karen Ramlall

A new study from Cancer Care Ontario has found no association between long-term use of antidepressants and risk for non-Hodgkin's lymphoma.

Previous animal and observational studies have shown that there may be an association

between non-Hodgkin's lymphoma and antidepressants. Based on these findings and together with the increase in rates of non-Hodgkin's lymphoma and the use of antidepressants, Cancer Care Ontario (CCO) researchers investigated this relationship using a population-based case-control approach. They found no asso-

ciation between the use of antidepressants and non-Hodgkin's lymphoma.

"While our study found no association, future studies may consider investigating individual antidepressants, especially those in the selective serotonin reuptake inhibitor (SSRI) class," said Saira Bahl, a researcher with Cancer Care Ontario's division of preventive oncology. "SSRIs have now been on the market for more than 10 years and researchers will have a larger pool of people exposed to this class than was available in our study."

Cancer Care Ontario (CCO) researchers investigated the effect of antidepressant medication by comparing 638 Ontarians diagnosed with non-Hodgkin's lymphoma (cases) to 1,930 individuals randomly selected from the Ontario population (controls). Participants completed a self-administered questionnaire that asked about

use of anti-depressants and other potential cancer risk factors.

While the CCO researchers found no association between antidepressant use and non-Hodgkin's lymphoma, they found the case subjects were more likely to consume high levels of dietary fat, were more likely to be previous smokers and less likely to be current smokers. Consistent with other studies, the researchers also found that chemical exposures are associated with increased risk for non-Hodgkin's lymphoma. However, this can only explain some of the overall rise in this disease.

To date, research into some of the risk factors – including dietary fat, vegetable and fruit intake, alcohol consumption and smoking – has shown weak or inconsistent associations with this cancer. Viruses, such as Epstein-Barr and HIV, and immunosuppression related to

organ transplantation explain only small proportions of the increase in this cancer.

"The changes in non-Hodgkin's lymphoma over the past few decades are perplexing, in that, this cancer went from a relatively rare disease to one of the most common cancers in Ontario with little to no risk factor information to explain the dramatic change," Bahl said. As a result, researchers feel that attention must be directed toward other potential risk factors.

In Ontario, non-Hodgkin's lymphoma represents the fifth most common cancer diagnosed in men and the sixth most common in women. Very little is known about the causes of this disease.

This study is published in the current issue of the American Journal of Epidemiology.

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