

ECRI's *Strategic Insights for Ambulatory Care* newsletter is being offered to CAPIC insureds at no cost. If you are interested in visiting any of the links in this edition, please contact Brad Dunkin, Assistant Vice President, at BDunkin@CAPphysicians.com.

Patient Safety

Strategic Insights for Ambulatory Care



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Strategic Insights for Ambulatory Care is a biweekly service provided by ECRI and the Cooperative of American Physicians (CAP). We welcome your comments; please send them to AmbulatoryCareRM@ecri.org.



What's New?

- ECRI Blog: Could Natural Language Processing Help Close Gaps in Infection Prevention and Patient Safety Events? [read now](#)

Spotlight on Hand Hygiene

Each year, the first week of December is National Handwashing Awareness Week in the United States. "Some healthcare personnel may need to clean their hands as many as 100 times during a work shift. Keeping the skin on your hands healthy and clean is a challenge that requires all healthcare personnel to be knowledgeable about how to care for their hands and when hands should be cleaned," according to the [Centers for Disease Control and Prevention](#). Use



ECRI's resources to ensure your healthcare organization is meeting hand hygiene standards.

- [Hand Hygiene](#)
- [Hand Hygiene Training Program](#)
- [When to Use Alcohol-Based Handrub versus Handwashing](#)
- [Reality Check: Hand Hygiene in 20 Seconds?](#)
- [Sample Tool: Checklist for the Availability of Alcohol-Based Hand Rub and Clean Gloves](#)

Resource Collection: Infection Control

Patient Safety & Relations

Suicide Rates and Mechanisms among Adults Age 55 or Older

What's the news. Among adults age 55 and older, the highest rates of suicide were for men age 85 and older (55.7 deaths per 100,000 population) and women ages 55–64 (7.8) in 2021, according to a [November 2023 data brief](#) from the Centers for Disease Control and Prevention (CDC). For men age 55 and older, firearm-related suicide was the leading mechanism of suicide; for women age 55 and older, rates of firearm- and poisoning-related suicide were similar.

Why it matters. Suicide is a leading cause of mortality in the United States, and older adults tend to have higher rates of suicide due to factors including declines in physical and cognitive functioning, changes in mental health, and other factors often associated with getting older, like bereavement, loneliness, and lack of social connectedness, according to CDC.

How ECRI can help. The [Essentials: Behavioral Health](#) collection provides action recommendations and resources to help organizations identify and address risks of harm to patients and staff related to behavioral health.

Worker & Environmental Safety

Police and Security Perpetrate Harm in Healthcare Settings

What's the news. Analysis of 48 stories in US news media found that harms reported to have been perpetrated by healthcare-affiliated police and security personnel were identified within five domains: (1) patients shot by police or security personnel; (2) patients subject to excessive use of force; (3) patients arrested; (4) patients subject to sexual assault; and (5) hospital personnel or those considered collateral damage shot, injured, or arrested, according to a [study published November 13, 2023](#), in *JAMA Network Open*. Most survivors and victims were Black and had mental illness.

Why it matters. Healthcare organization reliance on police and security personnel can exert harm on patients and staff, with potential for disproportionate outcomes for racially marginalized people and those with mental illness, according to the study authors. Organizations can consider introducing accountability measures, de-escalation techniques, and removing arms from hospital security personnel to reduce harm.

How ECRI can help. The guidance article [Violence in Healthcare Facilities](#) discusses violence in healthcare perpetrated by individuals other than patients, covering risk factors, consequences, case examples, and strategies for prevention.

Legal & Regulatory

Over Half of US Physicians Have Been Sued in Medical Malpractice Lawsuits

What's the news. Fifty-five percent of US physicians have been defendants in a medical malpractice lawsuit, either alone or with others, and 49% of defendants have been sued two to five times in their career; the most frequently sued specialists were general surgeons, obstetrician gynecologists, orthopedists, plastic surgeons, and otolaryngologists, according to a [November 3, 2023, infographic from Medscape](#). For more information, see the [Medscape Physicians and Malpractice Report 2023](#).

Why it matters. Medical malpractice claims can lead to financial costs and reputational damage. Identifying the characteristics of malpractice claims may help organizations develop safety initiatives to prevent future harm.

How ECRI can help. The [Essentials: Litigation and Claims Management](#) collection provides action recommendations and resources to help organizations implement effective systems to manage potential claims, complaints, and litigation.

Proposed Rule Establishes Disincentives for Information Blocking

What's the news. The U.S. Department of Health and Human Services (HHS) proposes to establish disincentives for healthcare providers who commit information blocking—actions that interfere with the access, exchange, or use of electronic health information, according to a [proposed rule published November 2023](#) in the *Federal Register*.

Why it matters. These disincentives would advance HHS priorities for deterring information blocking and encourage appropriate sharing of electronic health information by providers to support safer, more coordinated patient care, according to the proposed rule.

How ECRI can help. The article [The Information Blocking Rule](#) summarizes the primary requirements of the rule.

Incomplete Communication of Lab Results Leads to \$1.5M Settlement

A case in which a patient was diagnosed with metastatic colon cancer after a gastroenterologist did not inform the patient of abnormal lab results settled for \$1.5 million, according to the September 2023 *Medical Malpractice Verdicts, Settlements & Experts*.

A patient with a clinical history of ulcerative colitis and a family history of colon cancer received regular colonoscopies in 2013 and 2014 with documentation of pseudopolyps. In 2016, a coloscopy yielded eight samples which were sent for biopsy. The results noted that seven out of eight were benign; the last was "indefinite for dysplasia." The gastroenterologist communicated to the patient in writing that all the results were normal, omitting the one with dysplasia.

In 2018, an office visit progress note indicated a diagnosis of "ulcerative colitis, unspecified, doing well in remission," with a recommendation for a colonoscopy in a year. There was no mention of the potential dysplasia from 2016. A form letter notifying the patient that it was time to schedule the colonoscopy was sent in August 2019, but the procedure was never scheduled.

In 2021, the patient was hospitalized with abdominal pain and vomiting. A CT scan identified possible malignancy. Metastatic colon cancer was found when an open total colectomy and ileostomy were performed.

The parties settled the case for \$1.5 million.

ECRI Resources:

- [Resource Collection: Diagnosis: Test, Referral, and Hospitalization Tracking](#)

- **[Test Tracking and Follow-Up](#)**

ECRI Commentary: Providers who order tests are generally responsible for ensuring that test results are communicated appropriately. Risk managers should ensure that their organizations, including outpatient settings and affiliated physician practices, have policies that clearly state where responsibility lies. The **[Partnership for Health IT Patient Safety](#)** evaluated the problem of missed or incorrect diagnoses and the impact that health information technology (IT) could have on limiting diagnostic errors. In **[Health IT Safe Practices for Closing the Loop](#)**, the Partnership discussed the importance of ensuring that "all patient data and information that may require an action are delivered and communicated to the right individuals, at the right time, through the right mode to allow interpretation, critical review, reconciliation, initiation of action, acknowledgment, and appropriate documentation." In the **[White Paper: Implementing Closing the Loop Safe Practices for Diagnostic Results](#)**, the Partnership further noted that "one insidious diagnostic error is based on the failure to respond in an appropriate manner to new, actionable information about the patient's condition. Regardless of the means of communication, tracking of test results and referrals has long been a challenge in all practice settings."

This abstract is a summary of a recent court decision, verdict, settlement, or other action affecting healthcare organizations and their risk management programs. When reviewing this abstract, keep in mind that laws and court decisions vary among jurisdictions and that decisions of lower courts may be overturned on appeal. For specific legal guidance regarding the significance or applicability of this decision, contact legal counsel.



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