

SENTINEL EVENT NEWSLETTER

DIVISION OF LICENSING AND REGULATORY SERVICES,
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ISSUE 7, DECEMBER, 2015

CONTENTS OF THIS ISSUE

Falls

Learning from Failure

Sentinel Event Team (SET) Updates

PATIENT FALLS

It is estimated that approximately 2% of hospital stays are complicated by a fall, with rates of falls in U.S. hospitals ranging from 3.3 – 11.5 falls per 1000 patient days (“Falls among Adult Patients Hospitalized in the United States; Prevalence and Trends”, *Journal of Patient Safety*, March, 2013). According to The Joint Commission (TJC), 30%-50% of these falls result in injuries (*TJC Sentinel Event Alert*, Issue 55, 9/28/15). 37 of the 196 sentinel events (18%) that have been reported to the SET in 2015 (through 12/17/15) were related to falls with serious injury. Patients who have a serious injury related to a fall during a hospital stay average 6-12 days of additional hospital time and incur, on average, \$13,316 more than comparison patients (*Journal of Patient Safety* – referenced above).

Effective October 1, 2008 the Center for Medicare and Medicaid Services (CMS) ceased paying for health care costs associated with falls that occurred during hospitalizations, deeming them events that should never occur during a hospitalization. For hospitals, falls are not only patient safety concerns; they can result in extended, uncompensated care.

TJC’s sentinel event database identifies the most common contributing factors to falls as pertaining to:

- Inadequate assessment;
- Communication failures;
- Lack of adherence to protocols and safety practices;
- Inadequate staffing orientation, supervision, staffing levels or skill mix;
- Deficiencies in the physical environment; and
- Lack of leadership.

In a study conducted over 27 months prior to the CMS implementation of non-payment for care related to injury from hospital falls, data from the National Database of Nursing Quality Indicators (NDNQI) was used to review the prevalence of falls in



PATIENT FALLS, CONTINUED

non-federal, short-term hospitals located in the United States. 315,817 falls occurred between July 1, 2006 and September 30, 2008. 26.1% resulted in an injury; 2% resulted in a fracture. Both total fall and injurious fall rates were highest in medical units and lowest in surgical units. There was no trend in fall or injurious fall rates by staffing level, and there was no trend in fall rates by hospital size. (“Falls among Adult Patients Hospitalized in the United States: Prevalence and Trends”, *Journal of Patient Safety*, March 2013).

In a September, 2015 issue of *Science Daily*, citing the American Association of Critical Care Nurses article, “Perceptions Related to Falls and Fall Prevention Among Hospitalized Adults”, it was noted that patient perceptions are a key element in preventing falls in hospitals. The inpatient study described in the article found that acutely ill patients’ intentions to engage in fall prevention behaviors during hospitalization decreased when they were not afraid of falling, when they did not anticipate adverse consequences if they fell, and had increased confidence that they could perform high-risk behaviors without help and without falling. Even though all of the 158 patients in the survey had been assessed by nurses as being at risk for falls, more than half reported that they were not at all likely or were slightly likely to fall during hospitalization, and were confident that they could get out of bed without help and without falling. 10% indicated that they would not call for help for any mobility-related activities, and approximately 80% of patients said they would reach for items on the bedside table without help and felt confident they could do so without falling. 69% of respondents felt that they would still

SENTINEL EVENT NEWSLETTER

DIVISION OF LICENSING AND REGULATORY SERVICES
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ISSUE 7, DECEMBER 2015

PATIENT FALLS, CONTINUED

Be able to cope alone if they fell. Although this is an admittedly small study, it points out the importance of patient's attitudes and beliefs in fall prevention efforts.

TJC Center for Transforming Healthcare launched its 7th project with 7 leading hospitals and health systems regarding fall prevention. Participating organizations used a systematic process improvement method called Robust Process Improvement (RPI) to identify targeted solutions. The new measurement systems and solutions from this project were able to reduce the rate of patient falls by 35% and the rate of patients injured in a fall by 62%. For a typical 200-bed hospital, this translates into a reduction in the number of patients injured in a fall from 117 to 45, saving approximately \$1 million annually. TJC accredited organizations can 'experience the same success' by utilizing the new Targeted Solutions Tool, now available. This is an online application that guides organizations in accurately measuring performance, identifying unique barriers and implementing proven solutions.

(<http://www.centerfortransforminghealthcare.org/tst.aspx>)

The Agency for Healthcare Research (AHRQ) has a toolkit for reducing falls during a patient's hospital stay.

(<http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html>) AHRQ focuses a great deal of the toolkit on successfully negotiating a change process, recognizing that high-quality prevention requires an organizational culture and operational practices that promote teamwork and communication, as well as individual expertise. To implement a successful initiative to improve falls prevention on a sustained basis, AHRQ states that an organization needs to address 6 questions:

- Are you ready for this change?
- How will you manage change?
- Which fall prevention practices do you want to use?
- How do you implement best practices in your organization?
- How do you measure fall rates and fall prevention practices?
- How do you sustain an effective fall prevention program?

The Veterans Administration (VA) also provides a Falls Toolkit (www.patientsafety.va.gov/professionals/onthejob/falls.asp).

The VA groups risk factors for falls into 2 categories: intrinsic (related to a patient's condition) and extrinsic (related to the environment or external to the patient) factors. Risks are also determined to be either anticipated (known) or unanticipated.

PATIENT FALLS, CONTINUED

A child falling during a hospital stay is a relatively rare occurrence. However, if a child does fall the consequences may be serious. Child Health Corporation of America (CHCA) conducted a retrospective multi-site study of inpatient pediatric falls to determine prevalence, fall characteristics and related injuries. 26 CHCA pediatric hospitals participated in the study. 782 pediatric falls were reported for a fall rate of 0.88/1000. 20% of falls involved infants (9 – 23 mos.); 25% involved toddlers (2 – 4 yrs.); 32% involved school aged children (5 – 12 yrs.) and 23% involved adolescents (13 – 18 yrs.). More falls occurred between noon and 6 pm. 59% occurred in patients' rooms (non-ICU). 75% were supervised by an adult during the fall. Of those who fell, 66.2% sustained no injury, and there were no serious injuries or deaths associated with falls. 86.6% of patients who fell were alert and 83.3% were oriented.

87.3% of pediatric patients were assessed using fall risk assessment tools:

- 11.8% GRAF-PIF
- 8.8% Humpty-Dumpty
- 5.3% CHAMP
- 74.0% Other tools

47.3% of patients assessed were identified at high risk, 50.3% were not at high risk. The study concluded that pediatric fall risk tools need further refinement in an effort to address pediatric falls. Falls occurred in all age groups but not at a significant level; therefore all children need to be assessed for fall risk.

GRAF- PIF: General Risk Assessment for Pediatric In-Patient Falls. Developed in 2005 at Lurie Children's Hospital by Elaine Graf, PhD, RN, NE-BC. Licensed screening tool.

(<https://www.luriechildrens.org/en-us/for-healthcare-professionals/patient-care-resources/Pages/pediatric-falls-assessment-tool.aspx>)

Humpty Dumpty Fall Risk Screening Tool: Developed at Miami Children's Hospital (now Nicklaus Children's Hospital). Licensed screening tool. (<https://www.nicklauschildrens.org/for-medical-professionals/humpty-dumpty-falls-prevention-program.aspx>)

CHAMPS: Changes in mental status or dizziness; History of previous falls at home or in the hospital; Age < 3 years; Mobility problems in walking or moving; Parental or primary care giver involvement in care; Safety actions in place. Developed by St. Francis Hospital. ("The Epidemiology of Falls in Hospitalized Children", *Pediatric Nursing*, Jan-Feb 2012)

SENTINEL EVENT NEWSLETTER

DIVISION OF LICENSING AND REGULATORY SERVICES,
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ISSUE 7, DECEMBER 2015

FALL PREVENTION ACTION PLANS FROM MAINE FACILITIES

The following represent some of the action items that were identified by facilities in the root cause analyses that were developed in response to a fall with a serious injury:

Education:

- Include other departments (PT/OT, etc.) and CNAs in fall prevention training;
- Develop fall prevention competencies;
- Include in orientation and annual reviews.

Process:

- Create a comprehensive fall prevention program;
- Create a falls focus group to review and revise Falls Protocol;
- Perform daily assessment of patient room – minimize clutter;
- Identify criteria for identifying patients who should be located close to nursing station.

Equipment:

- Purchase another mechanical lift;
- Gait belts will be in all patient rooms for easy access;
- All bed cords changed in facility;
- Capital request to phase in bed replacements with built in fall prevention/notification features.

Evaluation:

- Medical quality review committee to review falls and use reviews to increase staff awareness of seemingly independent patients;
- Refer cases to practice councils for quality research and clinical practice council for review of effectiveness of Conley Fall Risk Scale

Documentation/Communication:

- Utilize huddles to identify high risk patients and increase staff awareness of potential situations
- White board in rooms – room # circled in red to indicate fall risk;
- Assign experienced staff to float staff to ensure safe care;
- Quality member will monitor post fall documentation for compliance and learning opportunities;
- Record and template review to validate plan.

Policy:

- Develop post fall protocol;
- Review rapid response team policy for possible extension for use for falls;
- Review fall policy for provider documentation and intention.

Training:

- Mandatory training for all staff regarding bed alarms;
- Staff training on use of voice command function for chair alarms.

Environment/Barriers:

- Short staffing during storms – evaluate accommodations for staff during inclement weather;
- Improvement plan to address removing grommets, fill holes and replace flooring.

LEARNING FROM FAILURE

In a 2011 *Harvard Business Review* article called, “Strategies for Learning from Failure”, Harvard Professor of Leadership and Management, Amy Edmondson reviews the importance of organizational learning from failure. Dr. Edmondson acknowledges that sometimes organization failure, rather than being a bad outcome, can be inevitable or even good. There is a spectrum of reasons for failure, from the obviously blameworthy deliberate deviance from safe practice to process failures due to system complexities. Executives interviewed by Dr. Edmondson admitted that very few failures in their organizations were truly blameworthy (2% - 5%), but also admitted that a high percentage were treated as blameworthy (70%-90%).

When staff members believe that they will be blamed for an error or mistake, they will be hesitant to report the incident, thereby preventing the learning that can come from exploring how the event occurred. Dr. Edmondson emphasizes the importance of leadership in building a learning culture, “Only leaders can create and reinforce a culture that counteracts the blame game and makes people feel both comfortable with and responsible for surfacing and learning from failures. They should insist that their organizations develop a clear understanding of what happened – not of ‘who did it’ when things go wrong. This requires consistently reporting failures, small and large; systematically analyzing them; and proactively searching for opportunities to experiment.”

Individual learning from failures can be variable. In an April, 2014 *Harvard Business School Working Paper*, “My Bad! How Internal Attribution and Ambiguity of Responsibility Affect Learning from Failure”, Myers, et al explore the question of why some people learn from failures and others do not. Learning from failure is a complex process that involves not only the objective failure or success of an individual’s effort but also his or her own interpretation of that effort. “Failure reveals gaps in knowledge, encouraging learning, yet it also presents threatening uncertainty that constricts these search and information process efforts.”

The authors state that “underlying every failure is an individual’s own attribution of responsibility – namely, taking personal ownership for the outcome or blaming it on external circumstances.” They further state that internal attribution (taking personal responsibility) is necessary for motivating learning and behavioral change – a failure leads to learning and improved performance only when an individual internally attributes the failure. However, when an individual’s responsibility for failure is ambiguous, for example, an error made in a complex surgical case, s/he may point to external attribution for the failure. This ‘ambiguity of responsibility’ greatly influences whether an individual learns from failure or not. The more ambiguous the situation, the more likely it is for failure to be externally attributed, and less learning to occur. Decreasing ambiguity can be very difficult, but an organization that embraces failures as learning opportunities will encourage transparency, and individuals will be more willing to examine their own role in the failure and learn from it.

SENTINEL EVENT NEWSLETTER

DIVISION OF LICENSING AND REGULATORY SERVICES,
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ISSUE 7, DECEMBER 2015

UPDATES FROM THE SENTINEL EVENT TEAM

Staffing changes – Jennene Murphy has left the Division of Licensing and Regulatory Services. We appreciate Jennene’s time with the SET. We are currently recruiting to replace this position.

On-site reviews – The SET has conducted three on-site reviews to determine if facilities are in compliance with the SE Rules and Statute. All three reviews went very well, and the SET identified some best practices, including routine use of root causes analyses for adverse events event when they do not rise to the level of a sentinel event, multi-disciplinary rounding in the ICU and a comprehensive pressure ulcer prevention program. We appreciate these facilities’ cooperation and helpfulness during the reviews.

Pressure Ulcer Collaborative – the first SE Collaborative was held at the Maine Hospital Association on December 9. Twenty hospitals were represented, with over 40 attendees. Presentations were made by Maine Medical Center, The Aroostook Medical Center, Bridgton/Rumford Hospitals, Southern Maine Medical Center and St. Mary’s Hospital. The SET reviewed aggregated data, and presented information regarding action plans that were submitted with pressure ulcer root cause analyses.

Annual Report – the SET will be working on the 2015 Annual Report, which will highlight sentinel event data and SET activities for the past year.

SENTINEL EVENT TEAM

Joseph Katchick, R.N

Sentinel Event Team Manager



Department of Health
and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor Mary C. Mayhew, Commissioner