

# SENTINEL EVENT NEWSLETTER

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

ISSUE 5, JUNE, 2015

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### Risky business – healthcare after hours

Finding space in a hospital parking area Monday through Friday from 8 – 5 can be downright impossible, but wait until the weekend or a holiday, and there are parking spaces galore. What does parking space availability have to do with patient safety? Very little, in terms of a direct connection, but reflective of a reality that has significant impact on patient care. In short, hospitals run very differently on nights, weekends and holidays.

A recent article published in the British Medical Journal (BMJ), *Incidence of “never events” among weekend admissions versus weekday admissions to US hospitals: national analysis* (F. Attenalo, et al, April 15, 2015) reviewed the records of 351,170,803 patients admitted to hospitals between 2002 and 2010, with 19% of these admissions occurring on weekends. The study found that patients admitted on weekends were 20% more likely to sustain a hospital acquired condition (HAC) than those admitted on weekdays. The most common HACs were falls or trauma, pressure ulcers and catheter associated urinary tract infections.

A 2012 study published in the Emergency Medical Journal, *Emergency Medical Admissions, Deaths at Weekends and the Public Holiday Effect. Cohort Study* (Smith et al) concluded that patients admitted to hospitals on an emergency basis on public holidays were 48% more likely to die within 7 days of admission than those admitted on non-holidays.

Another BMJ study, *Time of birth and risk of neonatal death at term: retrospective cohort study* (Pasupathy, et al, 2010) reviewed 1,163,914 singleton births in Scotland between 1985-2004, and found that birth after hours (between 5 p.m. and 9 a.m. Monday through Friday and on weekends) was associated with a 45% increase in risk of neonatal death by anoxia than births occurring during the normal work week. The association was not explained by measured maternal, infant or obstetric characteristics and did not vary significantly over the study period in relation to hospital throughput or in relation to the onset of labor or the eventual mode of delivery.



In 2014, 30% of the sentinel events reported to the Sentinel events team (SET) occurred on weekends or holidays. In 2015, through May, 29% of sentinel event occurred on weekends or holidays.

Factors that may contribute to the increased risks to patients receiving hospital care outside of the regular work hours include, without limitation:

- Reduced staffing;
- Less experienced staff;
- Decreased availability of services;
- Unavailability or delayed availability of physicians and allied health professionals;
- Coverage by on-call physicians unfamiliar with patients;
- Impediments to care coordination;
- Lack of access to information from other providers;
- Communication delays; and
- Reduced management.

Developing interventions to reduce risk to patients receiving care ‘after hours’ will take an industry-wide culture shift. Management, staff and physicians who are used to working regular business hours will be resistant to changing their schedules. Hospitals may balk at the increased costs associated with bumping up staffing and making ancillary services available at all times. Even those hospitals willing to increase staffing levels and skill mix may have difficulty in recruiting experienced staff willing to work nights, holidays and weekends.

While there are significant challenges in addressing resource, knowledge and skill mix fluctuations, the consequences of ignoring the problem are significant. HACs have been associated with a 76% higher hospital charge (BMJ, 2015). Value based purchasing requirements withhold reimbursement for costs associated with HACs creating substantial financial burden for hospitals.

## HOW ARE YOU USING ROOT CAUSE ANALYSIS?

Conducting a thorough and credible root cause analysis (RCA) for sentinel events is a requirement of the Rules Governing the Reporting of Sentinel Events for covered providers. This regulatory imperative was initiated to improve the quality of healthcare and increase patient safety by requiring hospitals, ambulatory surgical centers, ICF/IIDs and ESRDs to examine, through a structured process, the underlying system breakdowns that resulted in patient harm.

Some facilities grudgingly comply with this regulatory requirement. Senior leaders, intentionally or unintentionally may be giving the message that 'sentinel events don't happen in this organization'. Conducting a thorough and credible RCA takes the time and attention of staff already stretched thin. Department managers may feel that RCAs are the purview of the Quality Department and discourage participation of front line staff. Staff members involved in a sentinel event may feel uncomfortable discussing the circumstances leading up to the event, and may fear that they will be blamed for it. The RCA becomes 'one more thing' to add to everyone's already full schedules.

While there is no denying that healthcare organizations have significant financial and operational challenges, leadership in organizations that are truly committed to improving the quality and safety of patient care look at sentinel events as opportunities to learn. Identifying causal factors, and finding ways to remove or mitigate future harm is seen as not only the right thing to do, but 'good business practice'. The Center for Medicare and Medicaid Services (CMS) no longer pays hospitals for hospital-acquired conditions (HACs) and Value Based Purchasing is tying compensation to how well a hospital does in meeting various quality/safety indicators.

In an article in the September/October 2013 Patient Safety & Quality Healthcare magazine, Robert J. Latino's article, "Improving Reliability with Root Cause Analysis" describes another use for RCA. Latino supports using RCA as part of "Opportunity Analysis", in which process failures are identified, quantified and valued to identify financial losses associated with these failures with the following formula: frequency of failure/year x financial impact for each occurrence = total annual loss.

## HOW ARE YOU USING ROOT CAUSE ANALYSIS? CONT.

Latino outlines the following steps for Opportunity Analysis:

- 1) Map out a process flow diagram of the process chosen to analyze;
- 2) Define what a 'failure' is for the process;
- 3) Define 'assumptions' for the costs associated with each failure (i.e., labor, length of stay, supplies, etc.);
- 4) Obtain input (i.e., failure modes and frequencies) from those closest to the work in the chosen process;
- 5) Calculate the significant few; and
- 6) Conduct RCA on the significant few.

Latino states that the Opportunity Analysis makes a financial business case for why we should be conducting RCAs on events that have not passed through 'the regulatory threshold of pain.' Chronic failures and near misses, if left unchecked, pose additional risks in the future for contributing to sentinel events.

In the article, Latino gave an example of an Opportunity Analysis conducted at a 225 bed acute care facility for the blood drawing process. The significant few failures included the need to redraw because of blood culture contamination and hemolyzed blood in the ER. The frequency and cost of the redraws were 10,013/\$300 and 2,597/\$120 respectively. The total cost to the organization for these redraws was \$3,315,540 (10,013 x \$300 + 2,597 x \$120). While the redraws did not violate a regulatory requirement, use of RCA to identify causal factors for the redraws would result in better patient care and financial savings to the organization.

Latino believes that RCA has a negative connotation because of its use only in response to an adverse event. As such, organizations and executives do not understand its versatility and capability for practical applications. Latino states that utilizing RCA's proactive capabilities will create an environment where staff will be more accepting and knowledgeable of the RCA process.

Whether an organization chooses to utilize RCA for such proactive applications, or limits its use to sentinel events, it is essential for staff to have training in RCA. Training should include investigative technique, flowcharting, brainstorming and other tools, such as fishbone diagrams and Pareto charts.

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## LEADERSHIP'S ROLE IN PATIENT SAFETY, PART II

In its 2009 white paper, "Leadership in Healthcare Organizations", The Joint Commission (TJC) identifies three leadership groups in healthcare organizations: the governing body, the CEO/senior leaders, and the leaders of licensed independent practitioners. In hospitals, the third group comprises the leadership of the organized medical staff. This white paper goes on to state that, to fulfill its fiduciary responsibilities, leadership of an organization must engage collaboratively, in both strategic and management thinking to fulfill their fiduciary responsibilities, including the provision of safe patient care. Adopting a systems approach to creating patient safety is a primary goal of any healthcare organization, and requires that all three leadership groups work together.

TJC's Standard LD.01.03.01 for hospitals states that 'the governing body is ultimately accountable for the safety and quality of care, treatment and services' and 'the governing body's ultimate responsibility for safety and quality derive from its legal responsibility and operational authority for hospital performance'. Similarly the Center for Medicare and Medicaid Services (CMS) holds the hospital's governing body ultimately responsible for compliance with *all* Conditions of Participation. These accreditation standards and federal regulations create an enormous responsibility for members of governing boards, many of whom have little, if any, professional experience in healthcare. Therefore, governing bodies look to the CEO and senior leaders to manage the hospital and the medical staff to oversee the quality of patient care, treatment and services provided by the medical staff. This bifurcated division of responsibilities creates unique challenges for hospital leadership.

In his article, *Hospital-Medical Staff Culture Clash: Is it inevitable or preventable?* (Healthcare Trustees of New York, May 2005), Martin D. Merry, M.D. discusses some of the challenges of bringing healthcare administrators and medical staff leaders together in a collaborative relationship. Dr. Merry describes a 'deep personal and professional cultural divide' that separates some physician leaders from hospital administration and vice versa. The origins of this divide are multifactorial, and of long standing.

Dr. Merry states, "The combined effects of isolated professional enculturation and structural isolation of physicians and managers in their daily work have created a situation unsustainable at any cost. As they face the very real necessity of massive health system redesign, each group needs the other. In sum, the time has arrived in which these two groups must work more collaboratively to design and implement new health systems."

## LEADERSHIP'S ROLE IN PATIENT SAFETY, PART II, CONT.

TJC's 2009 white paper has a similar perspective, "conflicts among leadership groups with regard to accountabilities, policies, practices and procedures that are not managed effectively have the potential to threaten the safety and quality of patient care. Therefore, hospitals need to manage these conflicts so that the safety and quality of care are protected."

With regard to patient safety, it is essential that all three leadership groups are committed to the provision of safe patient care, above all other competing organizational imperatives. There are a number of resources available regarding the important role healthcare leaders have in promoting patient safety. For governing boards, a first step might be to conduct a self- assessment of the members' knowledge and support of patient safety. A self-assessment tool is available through the Institute for Healthcare Improvement (IHI):

<http://www.ihl.org/resources/Pages/Tools/StrategiesforLeadershipHospitalExecutivesandTheirRoleinPatientSafety.aspx>

The Institute for Healthcare Improvement (IHI) has a white paper, *Engaging Physicians in a Shared Quality Agenda*. This paper provides a framework for engaging physicians in quality and safety:

<http://www.ihl.org/resources/Pages/IHIWhitePapers/EngagingPhysiciansWhitePaper.aspx>

There is also a need to provide physicians with the education and training necessary to become effective leaders. The National Health Service (NHS) Leadership Academy has developed a model for medical leadership, *Medical Leadership Competency Framework, Enhancing Engagement in Medical Leadership* that identifies 5 domains related to the provision of quality services: demonstrating personal qualities, working with others, managing services, improving services and setting directions. This can be accessed at:

<http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf>

The NHS also provides a self- assessment tool for the 5 domains. The self- assessment can be accessed at:

<http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Framework-LeadershipFrameworkSelfAssessmentTool.pdf>

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## UPDATES FROM THE SENTINEL EVENT TEAM

Sentinel Event Annual Report – the 2014 Annual Report was released in April, and may be accessed at:

<http://www.maine.gov/dhhs/reports/2015/Sentinel-Events-2014-Annual-Report.pdf>

Upcoming Events – the 6<sup>th</sup> annual Patient Safety Academy will be held September 23, 2015 at the University of Southern Maine, Abromson Center on the Portland campus. Keynote speaker will be Dr. J. Bryan Sexton, Director of the Duke University Patient Safety Center. Dr. Sexton's presentation will be: "Thriving and Surviving During Times of Change: The Science of Enhancing Resilience." The SET will be conducting a break-out session, as well.

Audits – the SET will begin its audit of covered providers this summer, in accordance with the Sentinel Event Rules and statutes. Facilities will be notified one week prior to the audit. The SET will be reviewing policies and procedures, notification and reporting systems, staff education, and will be reviewing a sample of medical records. A report of audit findings will be provided to the facility, with recommendations for enhanced compliance.

## SENTINEL EVENT TEAM

Joseph Katchick, R.N.

Sentinel Event Team Manager

Jennene Murphy, R.N.

Health Services Consultant



*Department of Health  
and Human Services*

*Maine People Living  
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*Paul R. LePage, Governor    Mary C. Mayhew, Commissioner*