

WELCOME TO OUR FIRST NEWSLETTER

The Sentinel Event Team would like to welcome you to the first issue of our Sentinel Event newsletter. We plan to send this out to the facilities we serve on a quarterly basis. Included in each newsletter will be trends that we have noted from reported sentinel events throughout Maine; trends in adverse/sentinel events nationally; topics of interest; and other related information that we hope you will find beneficial.

As this is a work in progress, please feel free to share any ideas that you have; information you would like to see; or other comments.

We would like to include one item from the field and will be soliciting your input regarding challenges you may be facing, best practices, or questions that you would like others to weigh in on. All material will be de-identified prior to posting.

SENTINEL EVENT ANNUAL REPORT

The 2013 Sentinel Event Annual Report has been posted on the DHHS website. Highlights of the report include that: 256 events were reported in 2013. Of these, 40 events did not meet the criteria of a sentinel event and an additional 39 were considered 'near misses', bringing the total number of actual sentinel events to 177.

The most frequently reported categories of events were Stage 3 or 4 and unstageable pressure ulcers (23% of events), fall with serious injury (15%) and unanticipated transfer (12%).

In 2013, general hospitals accounted for 70% of reported sentinel events, 26% of events came from Critical Access Hospitals, 2% came from psychiatric hospitals and 2% came from some other type of facility.



The following categories were identified as contributing to the sentinel events, as identified through root cause analyses performed by the facilities: communication, education, environmental, policies/procedures, documentation, equipment, human factors and process/system.

REMINDERS

The DLRS website has been updated to include forms associated with the reporting of sentinel events. Please complete as much information as possible when filling out these forms. We are specifically interested in times and dates of events, so that we can start looking at trends related to shifts, weekends and holidays.

The Sentinel Event Team encourages phone calls from facilities to discuss cases, particularly if there is a question whether or not an event meets criteria for reporting as a sentinel event.

We are available to provide technical assistance and on-site education regarding sentinel event reporting and root cause analysis.

ELECTRONIC HEALTH RECORDS

In its 2012 report, *Health IT and Patient Safety*, the Institute of Medicine acknowledged that while some components of Health IT have contributed to improving patient safety, concerns about harm from the use of Health IT have emerged. As many Maine healthcare facilities have implemented or are in the process of implementing electronic health records, the Sentinel Event Team wanted to share some data and information.

The ECRI institute analyzed electronic health record (EHR) issues in 2011 and identified these common EHR related adverse events:

- Delay/failure of entering the physician order;
- Discrepancy between the EMR and the paper chart;
- Delay/failure to act on charted order;
- Wrong order entered/order entered in error;
- Discrepancy among EHR views, or EMR and linked systems; and
- Wrong patient/patient identification problem.

The Pennsylvania Patient Safety Authority analyzed 300 event reports related to EHR software default systems, and found that 3% were found to result in unsafe conditions or prolonged hospitalization for patients. The default- values were related to preset medication, medication doses and deliveries. The three most common reported error types were: wrong time errors (200); wrong dose errors (71); and inappropriate use of an automated stop function (28). While default values are often used to add standardization and efficiency, be aware of the unintended consequences.



HEALTH IT RESOURCES

Looking for some resources to assist your organization with its EHR implementation? The Agency for Healthcare Research and Quality (AHRQ) has a number of tools and resources available at:

<http://healthit.ahrq.gov/health-it-tools-and-resources>

Tools include: workflow assessment for HIT; HIT evaluation measures; HIT evaluation toolkit; HIT human factors design guide; and more.

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

ISSUE 1, JUNE, 2014

TRENDS

Suicide (including attempted suicide/self-harm) was the top category in Maine's near miss data analysis in 2013. There were 11 cases of suicide in 2013, up from 4 in 2012. According to a U.S. CDC document, *Facts at a Glance*, published in 2012:

- In 2010 suicide was the 3rd leading cause of death among persons aged 15 – 24 years, the second among persons 25 – 34 years, the 4th among persons aged 35 – 54 years, and the 8th among persons 55 – 64 years.
- In 2010, there were 38,364 suicides, or an average of 105 each day.
- Among adults aged 18 or older, an estimated 1 Million adults reported making a suicide attempt in the last year.
- There is one suicide for every 25 attempted suicides
- In 2011, 487,700 people were treated in emergency departments for self-inflicted injuries.

INPATIENT SUICIDE

The Agency for Healthcare Research and Quality's report, *Identifying Patients at Risk for Suicide: Brief Review* points out that suicide is difficult to predict even in populations with multiple risk factors and high relative risk. This holds true for both outpatients and inpatients. A personal history of suicidal behavior has been consistently associated with suicide completions.

Schizophrenia and mood disorders (especially depression) are leading psychiatric diagnoses.

Medical and surgical patients have different risk factors and a different profile from psychiatric patients, typically by lacking a strong personal history of suicide attempts, psychiatric diagnoses and substance abuse. Common medical diagnoses are cancer, cardiovascular and pulmonary disease.

SUICIDE PREVENTION IN HOSPITAL SETTINGS

In a May 2012 *Psychiatric Times* article, *Inpatient Suicide: Identifying Vulnerability in the Hospital Setting* it was noted that approximately 6% of all suicides happen in an inpatient setting. The Joint Commission (TJC) issued a Sentinel Event Alert in 1998 on preventing inpatient suicides, and followed it with a 2010 Sentinel Event Alert with a focus on prevention of suicide in general hospitals (medical/surgical units, and EDs).

In psychiatric hospitals, the most frequent method of suicide is hanging and 75% of inpatient suicides occur in the patient's bathroom, bedroom or closet. Psychiatric hospitals can address environmental risk factors such as ligature attachment points that pose a hanging risk from a sitting or kneeling position. Support bars in showers and bathrooms are potentially dangerous. Additionally, psychiatric hospitals should avoid 15 minute checks in seriously suicidal patients – it only takes 4 – 5 minutes of adequate pressure on the carotid arteries to produce death by oxygen deprivation.

General hospitals have greater challenges in managing environmental risks, due to open (unlocked) wards, and access to means easily available. These include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing. Additionally, general hospital patients who are suicidal attempt suicide after admission more rapidly and with fewer threats or warnings than suicidal psychiatric patients.

TJC recommends education and training for general hospital staff about the risk factors for suicide, including environmental risk factors. TJC identified Mental Health First Aid as an international public health intervention that is intended to provide mental health skills for non-mental health providers.

www.MentalHealthFirstAid.org/cs/

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The Department of Licensing and Regulatory Services, welcomes Sarah Taylor, MBA, FACMPE as the new Assistant Director Medical Facilities Unit, overseeing licensing and certification, Sentinel Events and Health Care Oversight. Sarah has an extensive background in healthcare administration and consultation, with a special interest in patient safety. Sarah is very happy to support Joe and Rhea in their work with Maine providers related to Sentinel Events. She may be contacted directly at sarah.taylor@maine.gov.

SENTINEL EVENT TEAM

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*Department of Health
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*Maine People Living
Safe, Healthy and Productive Lives*

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