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Pressure Ulcers

Safety Culture, What Is It and Why Is It Important?

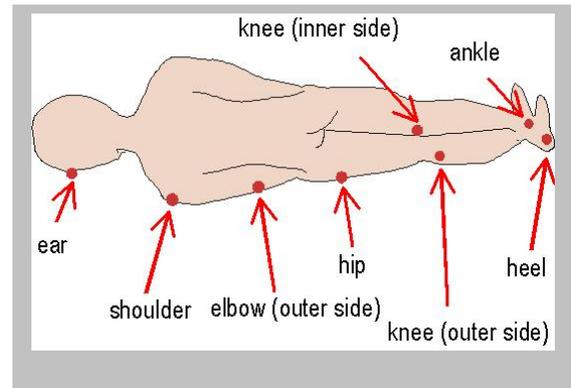
Updates from the Sentinel Events Team

PRESSURE ULCERS

The Agency for Healthcare Research and Quality (AHRQ) document, *Preventing Pressure Ulcers in Hospitals, A Toolkit for Improving Quality of Care* (AHRQ Toolkit), includes the following statistics:

- More than 2.5 million people in the United States develop pressure ulcers.
- Treatment of pressure ulcers in the United States is estimated to cost \$9.1 billion - \$11.6 billion per year.
- Cost of individual patient care ranges from \$20,900 - \$151,700 per pressure ulcer.
- More than 17,000 lawsuits are related to pressure ulcers annually – it is the second most common claim after wrongful death.
- Pressure ulcers may be associated with severe pain.
- About 60,000 patients die as a result of pressure ulcers each year.
- The Centers for Medicare & Medicaid (CMS) no longer provides additional reimbursement to hospitals to care for a patient who has acquired a pressure ulcer while under the hospital's care.

In 2013, Maine providers reported 40 sentinel events related to pressure ulcers (stage 3, 4 or unstageable); the most frequently reported sentinel event for that year. In 2014, through August, 27 pressure ulcer related sentinel events have been reported.



Based on this data, prevention and treatment of pressure ulcers should be a top priority for healthcare providers.

There are a number of sources available to assist facilities with developing a pressure ulcer prevention program. The AHRQ *Toolkit* was developed drawing on literature on best practices to assist hospitals in implementing effective pressure ulcer prevention programs

The National Pressure Ulcer Advisory Panel and the European Pressure Ulcer Advisory Panel developed *Quick Reference Guides* for both Pressure Ulcer Prevention and Pressure Ulcer Treatment. The Institute for Healthcare Improvement (IHI) also has a *How-To Guide* for preventing pressure ulcers. The National Quality Forum (NQF) has developed a pressure ulcer prevention and management framework for preventing and managing pressure ulcers at both the facility and practitioner levels across the continuum of care. The VA has developed a *VHA Handbook for Prevention of Pressure Ulcers*. There are also pressure ulcer prevention programs developed by healthcare facilities including Cynosure Health's *Implementation Guide to Prevention of Hospital Acquired Pressure Ulcers* (HAPU), and the James Cancer Hospital at Ohio State University Medical Center in Columbus *Pressure Ulcer Prevention*

PRESSURE ULCERS (CONTINUED)

Protocol Interventions (PUPPI). There are also vendors who provide training and tools related to pressure ulcer prevention and treatment.

Additional resources are listed on the CMS Partnership for Patients website:

http://partnershipforpatients.cms.gov/p4p_resources/sp-pressureulcers/toolpressureulcers.html

IHI has developed a mentor hospital registry – organizations who have volunteered to provide support, advice, clinical expertise and tips to hospitals seeking help with their implementation efforts. This registry provides demographic information that can be used to identify hospitals of similar size and location:

<http://www.ihl.org/Engage/Memberships/MentorHospitalRegistry/Pages/PressureUlcerPrevention.aspx>

Of assistance in conducting root cause analyses, the National Pressure Ulcer Advisory Panel has developed a template specifically for conducting root cause analyses for pressure ulcers:

<http://www.npuap.org/resources/educational-and-clinical-resources/pressure-ulcer-root-cause-analysis-rca-template/>

Welcome to our series on Patient Safety Culture. In this and following newsletters, SET will address elements of patient safety culture, why it is important, and how it can be achieved.

WHAT IS PATIENT SAFETY CULTURE?

The aviation industry has been credited with introducing a culture of safety to the United States after an aviation accident that killed 14 people in 1991. The National Transportation Safety Board identified failure in management to support and enforce approved safety procedures as the most probable cause of the crash. Since then, the concept has been adopted by other industries, including healthcare. (*Technical Report ARL-0203/FAA-02-2, prepared for Federal Aviation Administration. 2002*)

Maine facility action plans sent to SET regarding pressure ulcers included the following:

Equipment: explore options for current bed and mattress products; replace ICU specialty beds; replace failing air mattresses; identify updated products to use to elevate patients' feet.

Education: educate all licensed staff on completion of Braden scale and identifying high risk factors to the patient; educate staff on the added risks of pressure points with devices; develop "champions" on the day and night shift for skin care rounds; educate specialty staff to notify physician of skin issues as they arise, to allow for early intervention; utilize Wound Care nurse in orientation.

Human factors: ensure pharmacy reviews medications to see if there are contributing factors to patient restlessness; have Wound Care Nurse attend multidisciplinary rounds.

Communication: skin assessments will be addressed at change of shift during bedside rounds; post turning schedule on patients' white boards; nutrition staff to attend daily rounding discussions; physicians to work with PT to establish a plan for therapy with immobile and mechanically ventilated patients; Wound Care Nurse receives wound staging report daily.

Documentation: optimize and standardize the drop down list under skin assessment; take pictures of pressure ulcers; consolidate wound documentation to improve communication and outcomes tracking; EHR will include trigger to identify high risk patients.

Process: link all wound consult orders to dietician assessments; daily manager rounding on all units to include identification of high risk patients; develop an order set within EMR specific to certain surgical patients and their limitations

Policy: standardize triggers for placing patients on specialty beds; hospital will send a skin integrity form and history of skin issues to nursing homes for patients returning to nursing homes; review and update current policies consistent with best practice; removed outdated manuals from units.

SENTINEL EVENT NEWSLETTER

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

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WHY IS SAFETY CULTURE IMPORTANT?

In 1999, the Institute of Medicine's report, *To Err is Human*, estimated that up to 98,000 patients died each year as a result of preventable adverse event. 14 years later, James Jones, PhD, in the *Journal of Patient Safety* (Vol. 9, September 2013) estimated that upwards of 440,000 premature deaths are associated with preventable harm. This makes patient death by preventable harm the third leading cause of death in the United States, after cancer and heart disease. With all of the patient safety initiatives that have been started by various agencies, such as CMS, AHRQ, The Joint Commission, the National Quality Forum, the Veterans Administration, and the Leapfrog Group, and all of the work that hospitals and other healthcare facilities have done in response to these initiatives, how is it possible that death by preventable harm remains so prevalent?

Some point to the underlying culture in healthcare as a key factor in the lack of progress in mitigating patient harm. For example, Dr. Peter Pronovost, a renowned patient safety expert, discussed the complexity of implementing a 5-step checklist to help lower the rate of bloodstream infections in Michigan hospitals (*Wall Street Journal*, 10/27/09). Even though there was evidence that use of the checklist could reduce bloodstream infections by 66%, it was not being utilized. Dr. Pronovost stated that implementing the checklist, which seems simple, was complicated due to the organizational culture. In this case, the nurses refused to ask doctors to follow the items on the checklist, and the doctors saw such an intervention as being second-guessed by nurses. Dr. Pronovost brought the doctors and nurses together to discuss use of the checklist as a way to decrease harm to patients, and was able to cut through the power/hierarchy that had been getting in the way of implementing a proven patient safety intervention.

Patient safety experts, Dr. Allan Frankel and Dr. Michael Leonard (AHRQ *web M&M*, July/August 2013) point to a correlation between high scores on patient safety culture surveys with improved patient safety. In one large integrated health system they studied, they found that "never events" occurred once every 38 months when more than 60% of surgical suite personnel perceived safety as good or excellent, versus once every 12 months in surgical areas with scores below 60%.

Drs. Frankel and Leonard also point out that healthcare happens in a complex technical environment, where skilled personnel in a variety of interrelated roles must work well together to safely and effectively care for patients. As they put it, "think of safety culture as the social glue that holds the care process together".

SAFETY CULTURE, CONTINUED

Although there is no standard definition for a culture of safety, there are pragmatic examples that illuminate conditions of work, and work practices, that must be managed if we are to achieve and maintain a healthy safety culture.

Drs. Leonard and Frankel define a culture of safety as a collaborative environment in which skilled clinicians treat each other with respect, leaders drive effective teamwork and promote psychological safety, teams learn from errors and near misses, caregivers are aware of the inherent limitations of human performance in complex systems, and there is a visible process of learning. (*The Essential Guide for Patient Safety Officers, 2nd Edition*, Joint Commission Resources, Institute of Healthcare Improvement, 2013)

AHRQ, in its *Patient Safety Primer*, defines key features of a culture of safety as follows: acknowledgement of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations; a blame free environment where individuals are able to report errors or near misses without fear of reprimand or punishment; collaboration across ranks and disciplines to seek solutions to patient safety problems, and organizational commitment of resources to address safety concerns.

The Institute for Healthcare Improvement (IHI) states that, in a culture of safety people are not merely encouraged to work toward change, they initiate action when it is needed. Inaction in the face of safety problems is not acceptable.

Duke University's website states that culture is comprised of overarching themes within an organization, and includes stories and unwritten rules governing behavior.

Frankel and Leonard make the point that culture is 'uniquely local' and determined at the unit level. Duke University also states that culture is not necessarily uniform within a single organization. Culture can vary by discipline (doctors, nurses, social workers, etc.) or by unit. This local nature of culture can support patient safety when teams are able to hold each other accountable through clear agreements as to the behaviors and cultural norms that create value for patients and caregivers.

SENTINEL EVENT NEWSLETTER

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

ISSUE 2, SEPTEMBER, 2014

SENTINEL EVENT TEAM (SET) UPDATES

Sentinel Event Rules – The public comment period for SE Rules has concluded. Comments have been reviewed and responses to the comments are in process.

Best Practices – SET has been in touch with several states regarding best practices in sentinel event reporting practices. We also sent out polling questions to members of the Association of Health Facility Survey Agencies, our national organization, regarding electronic reporting, sharing of data and best practices among reporting facilities, and confidentiality.

Collaborative Work Groups – SET is exploring appropriate means of working with facilities to review data, and share facilities' challenges and successes related to sentinel events. Please contact Joe Katchick if you are interested in participating in a workgroup.

SENTINEL EVENT TEAM

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Department of Health
and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

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