Sentinel Event Newsletter

Division of Licensing and Certification
Maine Department of Health and Human Services

Issue 31, March 2022

In This Issue

Becker's: Top three patient safety concerns right now, per Leapfrog CEO

More than two years into the pandemic, a lot of problems have been compounded from previous surges. Amid the Omicron surge, one expert has identified three patient safety and infection control issues that are top of mind.

Leah Binder, president and CEO of The Leapfrog Group, shared the three most concerning trends she is currently seeing:

- Hospitals bringing in underqualified physicians because of staffing shortages
- Significant rise in bacterial and fungal infections
- Practicing proper hand-hygiene monitoring

Read full article here

AHRQ Report: “Strategies to Improve Patient Safety”

As required by the Patient Safety Act of 2005, the US Department of Health and Human Services, in consultation with AHRQ, has delivered a final report to Congress.

Several strategies to accelerate progress in improving patient safety were outlined, including:

- Using analytic approaches in patient safety research, measurement, and practice improvement to monitor risk.
- Implementing evidence-based practices into real-world settings through clinically useful tools and infrastructure.
- Encouraging the development of learning health systems that integrate continuous learning and improvement in day-to-day operations.
- Encouraging the use of patient safety strategies outlined in the *National Action Plan by the National Steering Committee for Patient Safety*.

Download AHRQ’s report here

By the Numbers: Events associated with facility suicides and suicide attempts and suicides within 48 hours of discharge

The SET looked at suicides and suicide attempts in the hospital and suicides within 48 hours of discharge reported for the last five years.

The breakdown of cases reported showed:

Total cases reported = 40

Near Miss = 2

Nonreportable = 2

Sentinel Event = 36

A recent article in AHRQ looked at missed opportunities for suicide risk assessments in the emergency room and primary care settings.

Read article here

From the Sentinel Event Team Office

A while back we had posted questions to ask yourself when thinking about a culture of safety:

- Can you openly talk about difficult things with your supervisor and others in the organization?
- Is there a no-blame culture that supports reporting and analysis of adverse and near miss events
- Is leadership accountable for implementing the required changes?

Fast forward two years into a pandemic which has totally altered normal operating procedures. Everyone has been impacted including patients, families, staff, providers, administrators, transport services, placement options, inpatient and outpatient settings, and regulatory oversight. The SET recognizes and ***thanks you*** for the continued effort being put forward in providing patient care at your facilities. Please be aware of attempts to help you maintain your well being and mental health during this crisis. Utilize the support services available at your facility as needed.

Reminder: Feel free to reach out to the SET at any time for technical assistance, consultation, interpretive guidance, possible extensions on due dates, or any other support we may be able to provide.

Sentinel Event Team
Jessica Levesque, Social Services Program Specialist II, Sentinel Event Program

Joseph Katchick, RN, Health Services Consultant II, Sentinel Event Program

Maine Department of Health and Human Services, *Jeanne Lambrew, Commissioner*
Division of Licensing and Certification
41 Anthony Avenue, Augusta, Maine 04333-0011 | 207-287-9300 | fax 207-287-3251 | https://www.maine.gov/dhhs/dlc