

# Sentinel Event Newsletter

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

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## Coronavirus Update

Find the latest information about Maine’s response to the 2019 novel Coronavirus, or COVID—19, and resources for Maine people on the Maine CDC website.

<https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml>

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## What are Human Factors in Healthcare?

“Enhancing clinical performance through an understanding of the effects of teamwork, task, equipment, workspace, culture and organization on human behavior and abilities and application of that knowledge in clinical settings.” - [New England. NHS.UK](#)

The primary purpose of the NHS is to deliver high quality care to all, free at the point of need. High quality care encompasses care that is safe, clinically effective and results in as positive an experience for patients as possible.

However, delivering healthcare can place individuals, teams and organizations under pressure. Staff have to make difficult decisions in dynamic, often unpredictable circumstances. In such intense situation, decision making can be compromised, impacting the quality of care and clinical outcomes, and potentially causing harm to the patient. Poor performance also increases costs.



## Human Factors for RCA

Research indicates that Human Factor-related causes may account for up to 80 percent of problems within organizations. Understanding Human Factors that lead to Human Failure will lead to better solutions, more effective teams and improved outcomes.

At first glance the cause of a human error may seem obvious, followed then by the hasty conclusion that training or retraining can fix it. However, a complete human error root cause analysis investigation often reveals a much deeper issue is to blame.

In its white paper, “How to Reduce Human Error by Managing Human Factors,” the FDA indicates the “typical response to a human error is retraining. But studies have now shown that training—or lack thereof—is responsible for only about 10 percent of the human errors

that occur. Despite [an increased] awareness of human errors, companies still frequently fail to substantively and correctly address errors.”

George Bernstein, a root cause analysis expert with MAI Consulting ([www.consultmai.com](http://www.consultmai.com)) in North Carolina, indicates the most common root cause for a human error is not following procedure and the most common corrective action is retraining.

“While this may in fact be the root cause,” he cautions, “if the problem has been repeated numerous times within the past year or so with the same person, the problem may be ineffective training. If the problem is a repeat with a number of people, the problem may be inadequate instructions. Trending of deviations is essential to verify that the root cause was correctly identified.”

## Safe Ambulatory Care

The ECRI Institute, a nonprofit patient safety organization, released a report detailing the biggest risks patients face in ambulatory care, highlighting the areas clinicians should pay attention to.

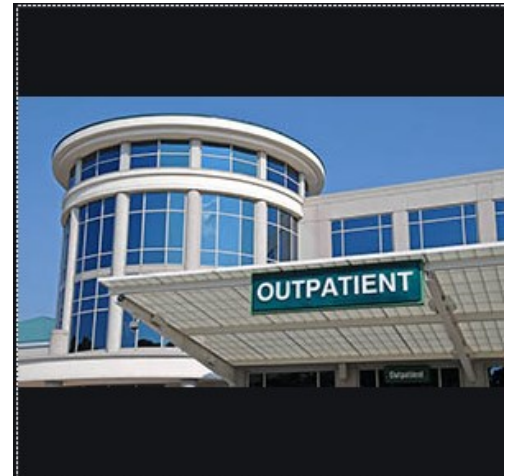
The ECRI Institute analyzed 4,355 adverse events reported by ambulatory care practices, physician practices and community health centers.

The organization found diagnostic testing errors were the most common adverse event, comprising half of the events studied. Specifically, nine out of 10 diagnostic errors were attributed to laboratory and imaging tests, including conducting excessive or unnecessary tests. ECRI Institute recommended providing decision support tools to providers to reduce testing errors.

Medication errors were the second most common errors for ambulatory patients. Adverse events involving medication include giving the patient the wrong drug, giving the patient too much of a drug or giving drugs to the wrong patient. Creating medication management procedures and determining how to handle safety events can help mitigate medication errors.

Falls, HIPAA violations and safety events, like disruptive patient behavior, were also adverse events the ECRI Institute analyzed. The majority of security and safety events involved verbal threats made by patients and visitors. The organization said training staff on what to do during a violent incident can help de-escalate the situation.

Read more [here](#).



"As healthcare delivery shifts from hospitals to ambulatory care settings, it can be challenging to coordinate care among various clinicians, systems, and facilities, raising the potential for errors that put patients at risk," said Marcus Schabacker, MD, PhD, president and CEO of ECRI Institute. "Reducing and eliminating adverse events in an outpatient environment will require an unprecedented commitment to collaboration and coordination."

# Leapfrog ASC Survey Results

Leapfrog Group released the results of its Inaugural ASC quality survey, as well as findings on hospital outpatient departments from its expanded hospital survey.

Through the two nationwide surveys, Leapfrog collected responses from 321 ASCs and 1,141 HOPDs that submitted information by Aug. 31.

Once Leapfrog collects several years of data, the organization will report facility-level performance data for ASCs and HOPDs.



Here are four insights from the quality surveys:

## 1. Concerning ASC ownership makeup:

- 38 percent of respondents owned a joint venture center between physician and management company
- 29 percent of respondents owned a center independent or with several physician owners
- 18 percent of respondents owned a joint venture center between a physician and a hospital
- 8 percent of respondents owned a three-way joint venture center with a physician, a management company and a health system partner
- 7 percent were categorized as another type of owner

2. ASCs and HOPDs had room for improvement with regards to ensuring medical, surgical and clinical staff members had appropriate education, training and certifications. While nearly all facilities in both the ASC and HOPD categories had an advanced cardiovascular life support-certified staff member present for adult patients, just 89 percent of ASCs and 96 percent of HOPDs always had a staff member present who was certified in advanced life support for pediatric patients.

3. Almost all ASCs and HOPDs made sure patients knew who to contact if a postsurgical complication arose after a procedure. However, only 78 percent of ASCs and 86 percent of HOPDs followed up with patients within 24 hours of discharge.

4. For patient selection, 97 percent of ASCs used a standardized screening tool to ensure procedures could be performed safely in their facility. Seventy-five percent of HOPDs used a similar tool.

Read the executive summary [here](#).



# News from the Sentinel Event Program

The 10th Annual Patient Safety Academy scheduled for **March 30, 2020** on the University of Southern Maine's Portland campus has been postponed. Stay tuned for more information.

This year's **Patient Safety Awareness Week** will be celebrated March 8-14. Consider assessing your employee culture using a patient safety culture survey that launches during Patient Safety Awareness Week. The additional campaign awareness can help achieve a strong response rate.

## Sentinel Event Team

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