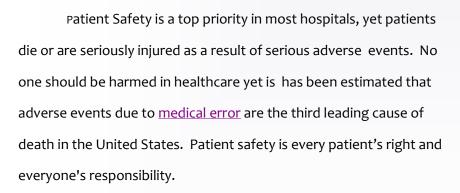# Sentinel Event Newsletter

Division of Licensing and Certification

Maine Department of Health and Human Services

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Patient Safety is a top priority in most hospitals, yet patients die or are seriously injured as a result of serious adverse events. No one should be harmed in healthcare yet is has been estimated that adverse events due to medical error are the third leading cause of death in the United States. Patient safety is every patient's right and everyone's responsibility.

In this edition of the Sentinel Event Newsletter, we discuss the importance of communication in healthcare, best practice in order to sustain improvements, The National Academy of Medicine's recent release of "Taking Action against Clinical Burnout", and Suicide Prevention.

Communication in Healthcare

Communication in healthcare is key in providing effective and safe patient centered care. In addition to technical competence, health care providers must master the   ability to communicate in a precise, clear, and effective manner 100% of the time to successfully provide safe care. Effective communication is not just the ability to speak clearly and send a message. Hundreds, if not thousands, of root cause analyses done over the years have proven that a breakdown in communication can be the root cause of serious safety events. When communication is ineffective, incorrect, or not planned and thoroughly detailed, it often results with negative impacts on our patients that we are working so hard to help. There is no doubt that effective communication is a key to success in highly reliable organizations. In fact, research indicates that ineffective communication among healthcare professionals is one of the leading causes of medical errors and patient harm. An analysis of 421 communication events in the operating room found communication failures in approximately 30 percent of team exchanges; one-third of these jeopardized patient safety by increasing cognitive load, interrupting routine and increasing tension in the OR setting.   In a study of 2000 health care professionals, the   Institute for Safe Medication Practices (ISMP) found intimidation as a root cause of medication error; half the respondents reported feeling pressured into giving a medication, for which they had questioned the safety but felt intimidated and unable to effectively communicate their concerns. Speaking up for patient safety is extremely important. Speak Up™ , The Joint Commission's patient safety program aspires to help patients and their advocates become active in their care. The Joint Commission launched Speak Up™ in 2002. By 2017, the program had reached people in more than 70 countries. The World Health Organization has   recognized patient safety as a global health priority and on September 17, 2019 launched a global campaign to create awareness of patient safety and urge people to show their commitment to making healthcare safer. No one should be harmed in health care. And yet, every day, thousands of patients suffer avoidable harm while receiving care. If you are a doctor, nurse, pharmacist or health worker, engage patients as partners in their care. Work with the patient to create an open and transparent patient safety culture. Encourage blame-free reporting and learning from errors. Speak up for patient safety!

"Our lives begin to end the day we become silent about things that matter."   *- Martin Luther King, Jr.*

Per section 4.2 of the Rules Governing the Reporting of Sentinel Events, a healthcare facility is required to submit to the Sentinel Event Team (SET) a thorough and credible root cause analysis (RCA) no later than 45 days after notification of the sentinel event. This RCA must be credible and thorough and where improvement actions are planned, include identification of who is responsible for the implementation, when the action will be implemented and how the effectiveness of the action will be evaluated. This final step in an RCA, evaluating the effectiveness of the actions, is an essential component in helping an organization understand if their actions were effective.

Sustaining Improvements

As part of a developing a thorough RCA, the measurement plan should evaluate whether the action plan was implemented as intended and resulted in changes in practice to the system, or to a process of care. The measurement plan should not be limited to just measuring the completion of the actions. It should measure that the new process is occurring and is effective, not simply that staff have been trained on the new process or that the new process has been communicated. Essentially, measurements should provide answers to the following three questions:

1. Were the recommended corrective actions accomplished?

2. Are staff complying with the recommended changes?

3. Have the implemented changes made a difference?

Evaluating whether the actions have been successful should include:

- Measures of success were monitored over time.

- The goal was attained (process changes were made and sustained, no recurrent events).

- You are confident that the change is permanent.

According to the VA National Center for Patient Safety, the basic requirements include:

Numerator: What specific group/event/cause/outcome is being measured/monitored/changed for improvement?

Denominator: Out of what population/total group is the numerator being sampled?

Threshold: What is the realistic expected level of compliance (percent) / result of the numerator?

Date/Timeframe: How long it will be measured?

Example:

N = number of collected specimens with proper labeling

D = Total number of specimens collected on the nursing unit

Threshold = 98 percent of the specimens will have the proper labeling

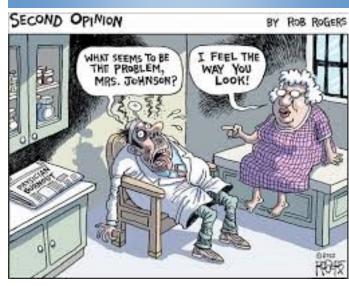*Date = the collection will be monitored for three months*

Resources:

> *Minnesota Adverse Health Events Measurement Guide* (Minnesota Department of Health, 2010).

> VA National Center for Patient Safety RCA Tools REV.02.26.2015 (https://www.patientsafety.va.gov)

Burnout—The Hot Top in Medicine

It has been twenty years since the Institute of Medicine responded to a crisis in patient safety by releasing two significant reports.   This led to significant reform and improvements in quality and patient safety. Today the crisis is clinical burnout. The National Academy of Medicine released a report called, "Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being," The report was prepared by the Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being. The recommendations target changes in workplace culture, debt and financial stress along with policies, practices and technologies that detract from patient care. "While many health care stakeholders are initiating important actions to address the burnout problem, there is little research indicating how effective they are in reducing burnout (and even less concerning their effectiveness in improving well-being or patient care)," according to the report's summary. "

The panel found that healthcare organizations need guidelines for designing, implementing, and sustaining professional well-being systems to mitigate the multitude of factors contributing to burnout. There are a number of gaps in the existing research literature, the committee found.

To address these concerns, the committee made six recommendations:

Create positive work environments: Transform healthcare work systems by creating positive work environments that prevent and reduce burnout, foster professional well-being, and support quality care.

Create positive learning environments: Transform health professions education and training to optimize learning environments that prevent and reduce burnout and foster professional well-being.

Reduce administrative burden: Prevent and reduce the negative consequences on clinicians' professional well-being that result from laws, regulations, policies, and standards promulgated by healthcare policy, regulatory, and standards-setting entities, including government agencies (federal, state, and local), professional organizations, and accreditors.

Enable technology solutions: Optimize the use of health information technologies to support clinicians in providing high-quality patient care.

Provide support to clinicians and learners: Reduce the stigma and eliminate the barriers associated with obtaining the support and services needed to prevent and alleviate burnout symptoms, facilitate recovery from burnout, and foster professional well-being among learners and practicing clinicians.

Invest in research: Provide dedicated funding for research on clinician professional well-being.

The full report is available on line. To access the report, click here.

Suicide Prevention

Suicide is a common cause of death that impacts Patient Safety in Emergency Departments and medical hospitals across the United States. It is one of the Joint Commission's National Patient safety goals (NPSG.15.01.01 – reduce the risk for suicide) and is included in the National Quality Forum's (NQF) list of serious reportable events. Patient suicide, attempted suicide or self-harm resulting in a serious injury, while being cared for in a healthcare setting must be reported to the State of Maine's Sentinel Event Team (SET).   The Patient Safety Network (PSNet) released a spotlight case on the topic of Missed Opportunities for suicide Risk Assessment. This case study seeks to recognize the types of distractors that may prevent suicide risk assessments from being completed.   It compares differences between suicide screening and suicide risk assessment and discusses evidence-based suicide prevention strategies. To read, click here.

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