Sentinel Event Newsletter

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

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Coronavirus Update

On April 24, Governor Mills signed an Executive Order extending the 45-day reporting requirement to 120 days for filing an RCA following a Sentinel Event set forth in 22 M.R.S. **This order remains in effect.**

Find the latest information about Maine's response to COVID–19 and resources for Maine people on the Maine CDC website:

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

Inside this issue

What is Patient Safety?

According to the World Health Organization (WHO) patient safety is the, "absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum." Millions of patients annually suffer or die due to medical errors and mishaps. Adverse events due to unsafe care are one of the 10 leading causes of death and disability in the world. It is estimated that one in 10 patients is harmed while receiving hospital care. Nearly half of the errors are preventable. World-wide four in 10 patients are harmed in health care facilities. Most errors are related to diagnosis, prescriptions, and the use of medication. The WHO lists the following errors as "those that present the most concern" :

1. **Medication errors** The cost associated with medication errors is estimated at $42 billion annually)
2. **Health care associated infections**
3. **Unsafe surgical care procedures** (Experienced by nearly 7 million patients per year)
4. **Unsafe injection practices**
5. **Diagnostic errors** (Diagnostic errors contribute to an estimated 10 percent of patient deaths)
6. **Unsafe transfusion practices**
7. **Radiation errors** (Wrong patient or wrong site)
8. **Sepsis** (Estimated 31 million patients worldwide; 5 million deaths per year)
9. **Venous Thromboembolism** (blood clots)

Decreasing patient harm will result in better patient outcomes, as well as financial savings. Traditionally, errors have been attributed to the health care worker who made the mistake, and blame would be attributed to human error. More recently, the focus has started to shift to improving systems that support the provision of quality health care.

World Health Organization , Patient Safety, 13 September 2019, www.who.int

AHRQ, Volume 4: Issue 2 Challenges and opportunities from the AHRQ research summit on improv-

National Action Plan to Advance Patient Safety

There have been substantial gains in improving patient safety and reducing harm related to health care delivery over the past twenty years. Improvements across delivery systems have included creating a culture of safety in hospitals and outpatient health care facilities; checks and balances in the provision of care and service; increased competency of workers; and improved communication with patients and families.

According to the report, *Safer Together: a National Action plan to Advance Patient Safety*, "total system safety requires a shift from reactive, piecemeal interventions to a proactive strategy in which risks are anticipated and system-wide safety processes are established and applied across the entire health care continuum to address them."

The *National Action Plan*, developed with input and feedback from 27 organizations, focuses on four areas essential to support safety. Recommendations include:

Culture, Leadership, and Governance

Establish a safety culture.

Commit resources.

Promote transparency.

Support competency-based leadership.

Patient and Family Engagement

Establish competencies for health care workers.

Include patients, families, and caregivers in safety improvement initiatives.

Promote a culture of trust and respect.

Workforce Safety

Create a systems approach to safety.

Be accountable for safety and the work environment.

Prioritize programs that foster workforce safety.

Learning System

Support and encourage organizational learning.

Develop the best safety learning systems.

Share goals for safety throughout the continuum of care.

The goal of the plan is to "ensure that health care is safe, reliable, and free from harm " by providing clear suggestions and recommendations to advance patient safety.

National Steering Committee for Patient Safety, Safer Together: A National Action Plan to Advance Patient Safety. Boston, Massachusetts: IHI; 2020. www.ihi.org/SafetyActionPlan

Preventing Medication Errors During Surges in Care

According to the Institute for Safe Medication Practices, rapid increases in the volume of patients receiving medical care can lead to an increase in medication errors. The WHO estimates that the cost associated with medication errors is approximately $42 billion annually.

Here are 10 tips on how to address medication errors:

1. Anticipate that medication errors may occur during surges due to altered workflow and challenged work settings.
2. Implement confidential, easy to use systems for reporting incidents and near misses.
3. Institute a non-punitive system to maintain trust and minimize fear of punishment.
4. Provide rapid and beneficial feedback to clinicians in a timely manner.
5. Standardize to a single concentration or dose rate of appropriate IV infusion when possible.
6. Use premixed solutions for common infusions that are visually distinct from one another.
7. Label infusions when dispensing a nonstandard concentration or paralyzing agent.
8. Implement safety huddles and conduct double checks before administering infusions.
9. Use open communication and support staff.
10. Establish expectations with staff that "blaming and shaming" are unacceptable after a medication error.

Www.beckershospitalreview/patient-safety-outcomes

Www.who.int/news-room/fact-sheets/detail/patient-safety

Medical errors increase nearly 20% around daylight savings

Fall back, spring forward. Daylight savings changes many things. According to a study published in the *Journal of General Internal Medicine,* medical errors increased nearly 20% in the days following the time change. A voluntary study conducted at the Mayo Clinic studied incidents occurring seven days before and after the spring and fall time changes. Patient incidents studied included defective systems, equipment failure, and human error. The study didn't reveal significant change in errors overall in the time before or after the change. However, *human errors* increased by 18.7 percent in the spring. Most errors involved medications; administration of the wrong drug or the wrong dose were most common.

Journal of General Internal Medicine, September 2020.

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