Suicides were the third most common sentinel event of 2015, with 95 reported cases in 2015’s Sentinel Event Statistics. The total number of patient suicides reported to The Joint Commission is now up to 1,184 since the start of the decade.

That said, only 2% of sentinel events are reported to The Joint Commission, and the cases reported are only the ones that occurred inside a healthcare facility or within 72 hours of discharge. Nationally, suicide is the 10th leading cause of death, with 9.3 million adults having suicidal thoughts, 1.3 million attempting suicide, and 41,149 deaths in 2013. In addition to the loss of life, suicides cost $51 billion in combined medical and work costs annually.

In February, The Joint Commission released Sentinel Event Alert 56 (www.jointcommission.org/sea_issue_56) to highlight the detection and treatment of suicidal patients. The accreditor found that 21.4% of accredited behavioral health organizations and 5.14% of accredited hospitals are noncompliant with National Patient Safety Goal 15.01.01, which focuses on suicide prevention. The alert calls on healthcare facilities to improve suicide prevention compliance by establishing suicide screening programs (SSP) to identify at-risk patients.

Universal screening

Many hospitals fall short in screening for suicidal ideation, if they screen at all, says Julie Goldstein, PhD, director of health and behavioral health initiatives at the Suicide Prevention Resource Center (SPRC) for the past three years. She also leads the organization’s Zero Suicide Initiative.

Industry attitudes toward suicide screening have changed, Goldstein says.

“Up until recently, the U.S. Preventive Services Task Force [USPSTF] only recommended screening in the event that there were services available to support the screening results,” she says. “So they said you should...”
Q&A: What 2015’s sentinel event stats mean to hospitals

The Joint Commission released its 2015 Sentinel Event Statistics in March; based on 936 reported events, the accreditor found the most common sentinel events were unintended retention of a foreign body (116), wrong-site/wrong-side/wrong-procedure surgery (111), falls resulting in death or permanent loss of function (95), and patient suicides (95). The most common root causes for these events were human factors (999), leadership failures (849), communication failures (744), patient assessment (545), and physical environment (202).

Joe Kiani, founder of the Patient Safety Movement Foundation and chair and CEO of the Masimo Corporation, discusses what the statistics mean for patient health and the steps facilities should take in response.

BOAQ: What is the big takeaway from The Joint Commission’s sentinel event statistics for 2015?

Kiani: Surprising and disturbing! It is truly amazing that the sentinel event list is topped by “retained foreign body” and “wrong-patient/side procedure.” This is on the same level as forgetting to lower the flaps before takeoff in an MD-80 [commercial jet], which has happened twice—both times with fatal results. [The] aviation [industry] responded with procedures that should prevent that event from ever happening again—yet we are still leaving sponges in the abdomen and operating on the wrong side with apparent regularity. I know of a case where a patient had a malignant tumor in one kidney and the other kidney was normal. Surgeons removed the wrong kidney—the normal one. The fact that fires even made the list [10th most reported event in 2015 with 23] is also disturbing.

BOAQ: What are the top steps that facilities can take to tackle the issue of retained surgical objects?

Kiani: That is the question, and here comes the broken record: Use a checklist! Very much like taking off and landing an airplane, each required step is on the list. The team (either the flight crew or the operating room staff) reads the checklist out loud and verifies that each step is done. “Sponge count: number on table before surgery = number on table before closure.” It’s not rocket science, but it has to be a bit obsessive-compulsive.

BOAQ: What are the top steps that facilities can take to tackle the issue of wrong-site/wrong-side surgery?

Kiani: Same answer as above. In this case, the true test must involve multiple sources, not just the patient consent form, which is sometimes wrong. Before making the incision to start surgery, most hospitals now use a “timeout” procedure, during which a checklist is read and each step is confirmed. This should be rigorously observed and enforced.

BOAQ: What resources should an accreditation professional look to when trying to improve compliance on these issues, aside from accreditation standards?

Kiani: These professionals should examine the specific tools being used to prevent each of these sentinel events; that is, look at the actual checklists and review exactly how, when, and where they are used, and actually observe their use in the appropriate site, including the operating room. They need to also connect themselves with the Patient Safety Movement Foundation. We have, through collaboration with some of the best clinicians and hospital administrators around the world, identified top problems—and continue to do so at our midyear meetings—and provided actionable patient safety solutions.

BOAQ: Was there anything you were surprised to see in the statistics this year? Something that wasn’t a
The cultural cure to sentinel events

In 1998, The Joint Commission made wrong-site surgery the topic of Sentinel Event Alert 6. The alert said that every facility must conduct a comprehensive systematic analysis when a wrong-site surgery occurs and proposed several solutions to the problem. But the issue persists in healthcare. In 2015, almost two decades after the alert was retired, an Iowa health system had four wrong-site surgeries in under 40 days. Then in March 2016, a Connecticut patient sued her surgeon for removing the wrong rib, lying about it, then charging her double after removing the correct rib.

Despite numerous resources, training courses, webinars, standards, and regulations, certain sentinel events continue to happen with alarming frequency. In the 2015 Sentinel Event Statistics (see related story on p. 5), several of the top 10 reported events, including unintended retention of a foreign body, patient suicide, medication errors, and wrong-site/wrong-side/wrong-procedure surgery, were classified as “never events”—things that should never occur.

Kenneth Rothfield, MD, MBA, CPE, CPPS, system vice president and chief medical and quality officer at St. Vincent’s Healthcare of Ascension Health in Jacksonville, Florida, says the same major categories of patient harm have continued to top the sentinel event list year after year.

“Things like retained surgical instruments and fires, those are all problems that I think healthcare professionals thought would be fixable early on,” he says. “I like to call these the never events that never stopped occurring.”

Rothfield says that after years of trying to eliminate these issues, the healthcare industry’s problem isn’t a lack of solutions.

“The reality is that we’re dealing with a social problem with these patient injuries, not so much a technical problem,” he adds. “Without a culture that will support the technical solutions, the technical solutions don’t work.”

As an example, he points to a 2009 U.S. study showing morbidity and mortality rates go down when checklists are used. However, even in facilities that have adopted preoperative checklists, wrong-site surgeries still continue to be relatively common.

“We had a lot [of people] say this [preop checklist] was going to be our salvation,” Rothfield says. “But when we have wrong-site surgeries, what we find, frequently, is that the surgeon isn’t engaged with the process. This is something done by the rest of the teammates, without involving the surgeon. You have a tendency to do that in healthcare. You have a lot of ancillary support so the doctors can spend their time doing that critical, technical thing that only they can do, and we delegate a lot of patient safety functions to other people.”

He points out that when the same checklist study was conducted in Canadian hospitals and facilities, the study found the checklist had no impact on morbidity and mortality rates. If the tool itself were the only thing needed to improve safety and quality, he argues, then it wouldn’t matter where it’s used or who uses it.

“In the Canadian study, I think the healthcare professionals involved viewed this as something given to them by the people in the C-suite, and they [checklists] were not adopted with enthusiasm,” says Rothfield. “They didn’t have leadership support.”

The key lesson from the checklist studies and the sentinel event statistics is that culture is everything, he says. On the 2015 sentinel event list, the top three root causes of sentinel events were human factors (e.g., staff supervision), leadership (e.g., organizational planning), and communication failures with either patients or administration. These three categories accounted for 2,592 of the 3,713 root causes identified by the statistics. In other words, there was a 70% chance that a sentinel event in 2015 was caused by poor staff interaction, organization, communication, or guidance.

“The Joint Commission points out that leadership is the No. 1 or No. 2 cause leading to these sentinel events,” Rothfield says. “When I talk about leadership, I particularly like to emphasize physician leadership. This is a great opportunity for physicians to get in the game and be leaders. That means understanding more deeply what it means to interact with a team, what it means to support other team members, flatten hierarchy, and encourage open communication.”
The cultural cure to sentinel events (cont.)

Rothfield says the first step in quality care is critically assessing and confronting your culture. He compares today’s healthcare industry to the airline industry in the 1970s. Airlines of that era abdicated a lot of their authority to their pilots, he says, allowing them to run their planes as they wished. Notably, commercial airline crashes were much more common at the time.

“I don’t think twice about my personal safety when I get out of that Southwest jet because commercial aviation has really achieved high reliability,” Rothfield says. “There were a lot of high-profile commercial airline crashes, and that was because back in the ‘70s they had a very pilot-centric culture, where the pilots truly were the captains of the ship. They [were] allowed much more latitude in terms of autonomy and entitlement, and the results were a lot of safety events. Because what we’ve learned is that when there’s a lot of variability, the results are usually not very good.”

In 1977, the airline industry was spurred to change after a plane crash on the island of Tenerife killed 583 people. Nearly 22 years later, the Institute of Medicine report *To Err Is Human* caused an uproar among the medical community when it found that 100,000 patients die each year because of preventable medical harm. Most agreed that the real number was actually much higher, Rothfield says.

“The real number was somewhere between 250,000 and 440,000 patients [per year],” he says. “So I think that was the beginning of the wake-up call for the industry, and we’ve certainly had lots and lots of high-profile deaths. But I don’t think it’s going to be one event that will become the tipping point for the industry. I think we’ve already had our wake-up call, but the industry is just moving way too slow.”

Rothfield points out that the airline industry solved its safety problem by creating a culture that flattened hierarchy and allowed for more open communication among airline personnel without fear of reprisal. This permitted safety issues and concerns to be voiced by crew and staff before the issues became life threatening.

“Healthcare organizations have started to adopt that [management style], but it hasn’t become a deeply embedded part of our culture,” he says. “Until we get to a culture where everybody finds it easy to speak up without fear of retaliation, we’re going to continue to have things like wrong-site surgeries or retained foreign bodies. Because usually in a lot of these events, somebody knows that something is wrong, but feels very intimidated about speaking up about it.”

St. Vincent’s has the surgeon perform the final readthrough of the preop checklist aloud to his or her team, thus making sure everyone is on the same page and nothing has been missed. Making surgeons the final quality control check gets them actively engaged in the process, Rothfield says, and spurs the rest of the team to ensure everything goes as planned.

“The reason why it’s so important to get the active engagement of leadership of surgeons and proceduralists is that anybody can load the gun in a wrong-site procedure, but it’s always the surgeon pulling the trigger,” he says. “After the patient, surgeons have the most to lose in a wrong-site surgery procedure, so it doesn’t make sense to delegate the preop checklist to other people.”

Rothfield suggests that hospitals trying to improve their quality and safety compliance look into the ECRI Institute’s Patient Safety Center website and the Patient Safety Movement’s Actionable Patient Safety Solution document. He cites Virginia Mason Hospital and the University of Vermont Medical Center as facilities with great cultures and leadership, as well as a constant focus on quality and safety.

“Einstein defined insanity as doing the same thing repeatedly and expecting a different outcome,” he says. “We’ve kind of done that in healthcare in our approach to these problems. We fool ourselves into thinking that if we just try harder, we’re going to fix things. Trying harder is the strategy that’s prevented the Avis car rental company from ever being No. 1—they’re No. 2 in trying harder. I think the answer is to be like Apple and think different.”
Avoid infectious outbreaks with strong device reprocessing policies

Reusable medical devices carry a special risk of infection if they aren’t properly reprocessed and sterilized. This fact was clarified in recent months when scores of infection outbreaks and dozens of deaths were linked to defective endoscopes. Many of these outbreaks involved drug-resistant superbugs and sparked a national conversation on medical device safety.

How can a healthcare facility design the best reprocessing policies and stay compliant with infection prevention regulations?

The key lies in the device manufacturer’s instructions, says Peggy Prinz Luebbert, MS, CIC, CHSP, CBSPD, co-owner and president of Healthcare Interventions, Inc., who also spent nine years as an infection prevention specialist at Nebraska Orthopedic Hospital. There’s a lot going on in the world of infection prevention, she says, and hospitals are now recognizing the importance of double-checking manufacturers’ reprocessing instructions against what people are actually doing.

“When I do rounds, I will pick a piece of equipment and ask a user if they’ve used it,” Luebbert says. “If they say yes, then [I say], ‘Tell me how you reprocessed it. How you clean it. How you disinfect it.’ Then [I say], ‘Show me the manufacturers’ instructions; I’d like to see if they match what you’ve been doing.’ It’s amazing to me how many times you’ll find discrepancies between the two.”

When developing reprocessing policies, don’t assume anything, she says. Working with the individuals actually doing the reprocessing is key to knowing whether they are following manufacturers’ instructions or cutting corners.

“Typically, you will see basic instructions for general environmental cleaning to be quite good,” Luebbert says. “But it’s that piece of equipment that they rarely use or the piece that they use all the time where shortcuts tend to happen. For example, vaginal probes in an OB-GYN clinic or laryngoscope blades in an operating room are equipment that staff gets so used to that they start taking shortcuts.”

Part of the renewed focus on proper reprocessing, she notes, is due to updated guidelines for device management and a growing awareness of the potential risks associated with improper sterilization and cleaning. One of the issues that brought reprocessing procedures to the forefront was the discovery that duodenoscopes from three manufacturers had a design flaw that prevented them from being properly sterilized, even when the proper instructions were followed.

The scope issue made infection preventionists realize they needed to look deeper into the protocols surrounding other scopes and probes, Luebbert says. In the long run, she adds, it made them focus more time and effort on protocols that are effective for any type of scope or probe, as well as any technique that involves instrumentation.

“Most [infection preventionists] and most of the users thought what they were doing was effective based upon the knowledge we had from both the manufacturer and regulatory [agencies],” she says. “There were people who