2009 Utah Sentinel Events Data Report

Identifying Opportunities for Improvement

A joint report from

HealthInsight

UTAH DEPARTMENT OF HEALTH

UHA Utah Hospitals & Health Systems Association

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About this report

The purpose of this report is to provide information on the sentinel event data collected from January-December 2009 by the Utah Department of Health. Facilities participating in the data collection include all Utah hospitals and ambulatory surgical centers.

Included in this report is a historical overview of the collection process, details of the data collection and the collaborative efforts underway to address issues identified in the data.

Overview of sentinel event reporting in Utah

In 2001 the Utah Department of Health (UDOH), in response to the publication "To Err is Human," initiated a patient safety program in partnership with the Utah Hospitals & Health Systems Association (UHA), Utah Medical Association (UMA), and HealthInsight, the Quality Improvement Organization for Utah. Quality and risk managers representing the healthcare sector collaborated as a learning group to better identify actual and potential events and to develop system-wide, sustainable safeguards to prevent these events in the future. The reporting system was deliberately designed to shift away from a traditional "focus of blame" and instead encourage a "just" culture for collaborative system improvement.

Sentinel events by their nature, are rare events. Although sentinel events are not always medical errors, they are indicators of system breakdown. Sentinel events can be devastating experiences to patients, their families, and their healthcare providers. Identification of these events across hospitals and ambulatory surgical centers provides opportunity for system-wide learning and the development of industry-based improvement strategies.

Between October 2001 and April 2007, sentinel events, defined as unanticipated deaths, wrong site surgeries, abductions, and loss of function that occur at a facility (hospital or ambulatory surgical center) directly related to any clinical service were required to be reported to the Utah Department of Health. During that time period there were eight general categories reported. On average, between 30 and 40 events a year were identified and reported.

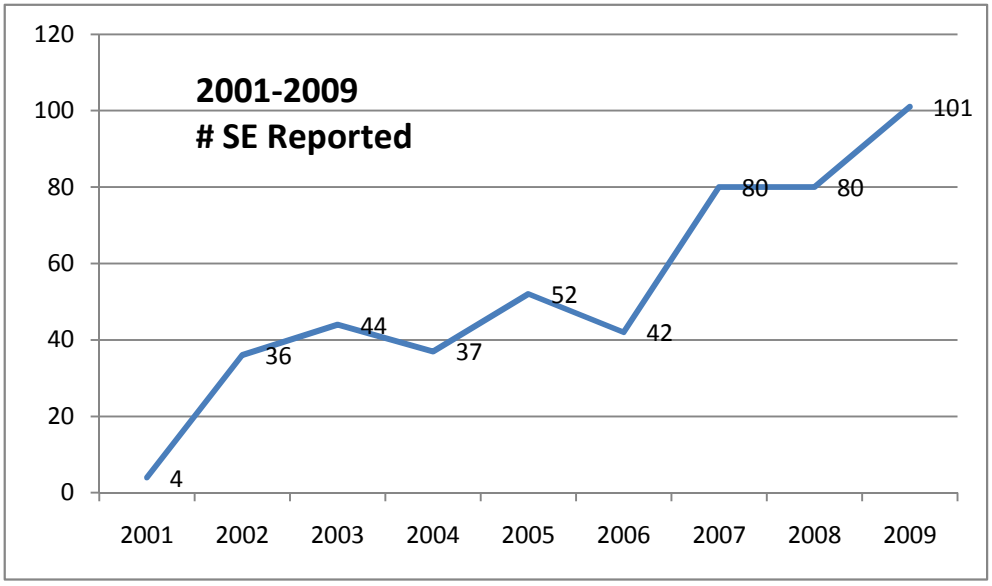
In an effort to improve reporting, the Sentinel Event Users Group (SEUG) now named the Patient Safety Work Group (PSWG), comprised of representatives from UHA, UMA, HealthInsight and UDOH, worked diligently to increase the types of events reported and the ease of reporting these events. Consequently, an administrative rule change was implemented mid-2007 to expand the type of events reported from eight general categories to 32 specific categories. The motivation for such a change was to be able to compare the Utah experience with national experiences and data. Additionally, in late 2008, the reporting process changed from a faxed document and manual data entry done by the UDOH Patient Safety Director to a secure, web-based reporting portal. This reporting change now supports individual facilities, offering the ability to download all of their reports and to conduct internal trend analyses.

The primary goal of the Utah Patient Safety Program is to create a robust surveillance system capturing the incidence of sentinel events occurring in hospitals and ambulatory care centers. This has been a work-in-progress and as the system has improved, the number of events reported has increased. When comparing Utah's voluntary program to Minnesota's mandated data collection process, both states are very comparable in terms of the number of incidents reported per population size. Working with a volunteer users group, building trust for safe reporting, streamlining the reporting process, and expanding the categories of reportable events are all factors contributing to the increase in events reported in 2009. Population growth, an increase in the number of available beds as well as the increase in ambulatory surgical centers operating in Utah may also play a role in increased reporting.

2009 sentinel event data for Utah

The following section provides information on the types and frequency of sentinel events (SE) reported by hospitals and ambulatory surgical centers for the period January-December 2009. In 2009, there were 101 sentinel events reported overall for the state of Utah. Fifty-four of these events were surgical or procedural events. For perspective, more than 152,000 hospital based outpatient surgeries were performed in Utah in 2008.[1] There were more than 262,000 hospital discharges in 2008, with surgeries comprising approximately one-quarter of all discharges.

The following table identifies the growth in sentinel event reporting as the process has become more streamlined and additional reporting categories were added with the 2007 rule change.



Utah's growth in reported sentinel events mirrors what is happening on a national basis as hospitals continue to work toward improved accountability. According to The Joint Commission, sentinel events rose in six of the 10 areas reported nationally in 2009.

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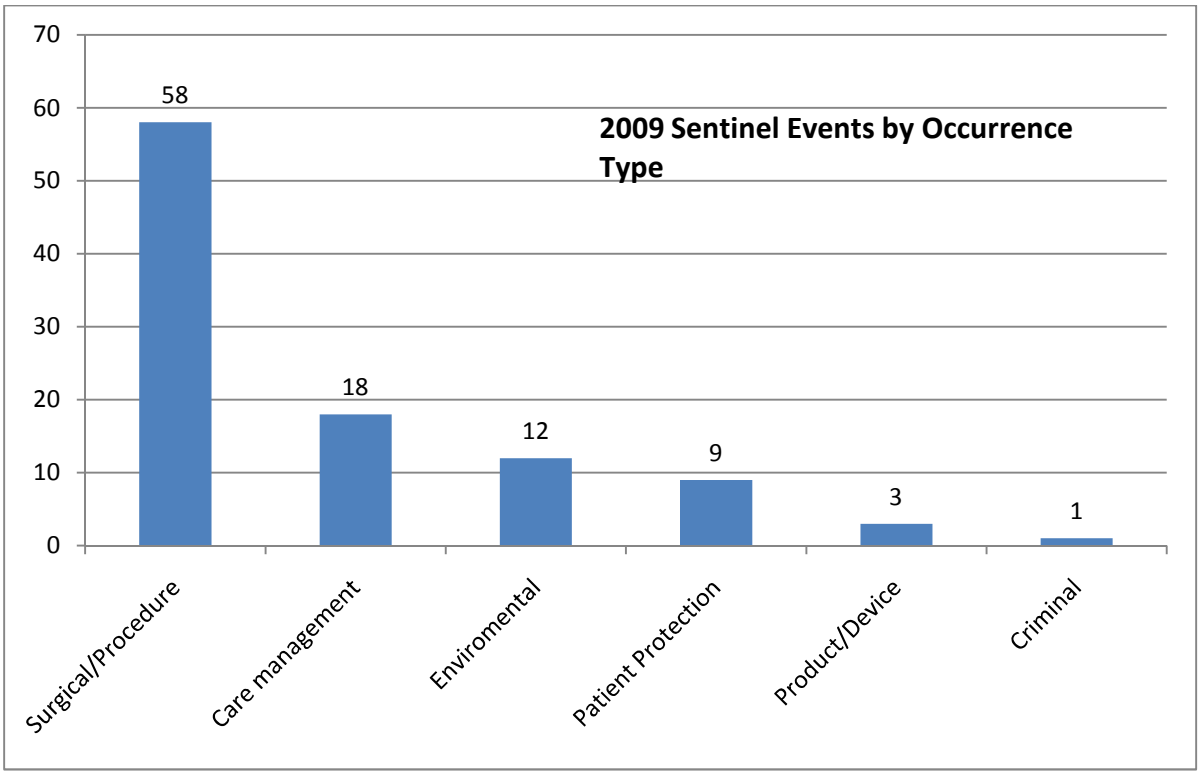
[1] AHA Hospital Statistics, 2008 edition.

Types of Occurrences

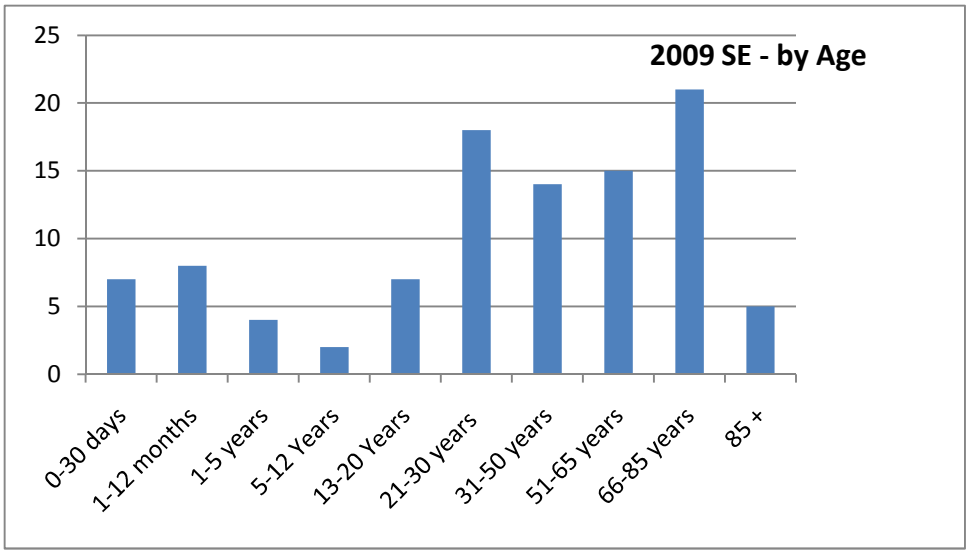
Utah again mirrors the national data reported to The Joint Commission regarding the type of occurrences and the number of reported events, with "surgical/procedure" events being the top concern. Events included in this category include "incorrect surgery or patient, wrong body part, retained foreign object, and interoperative deaths." Twenty-five of the 58 reported events in the Surgical/Procedure category were related to retained foreign objects, with many of these events occurring with obstetrical/gynecological patients.



Patient Age Distribution

The following table reflects the age distribution of those patients involved in sentinel events in 2009. As previously stated, 25 of the 58 reported events in the Surgical/Procedure category were related to retained foreign objects, with many of these events occurring with obstetrical/gynecological patients. The patient age distribution reflects those individuals of child-bearing age who may have experienced a retained foreign object sentinel event. The largest age group experiencing "surgical/procedure" sentinel events continues to be the 66-85 year old cohort. In 2008, seniors comprised more than 17% of all discharges for Utah residents.

The Patient Safety Work Group has identified Retained Foreign Objects as an area of primary concern, and will be offering best practices protocol to Utah hospitals to improve care in this area. More information is available in the *Utah Patient Safety Initiatives* portion of this report.



Utah Patient Safety Initiatives

Opportunities for improvement are abundant as a result of Utah's voluntary sentinel event reporting initiative. Efforts are underway to review the 2009 report, to drill down in a confidential manner to determine failure patterns and improvement opportunities, and to design statewide improvement efforts. The following is an overview of the work being done to address the results of the sentinel event data as well as other patient safety concerns.

Retained Foreign Objects--The top concern identified in the 2009 data is the issue of "retained foreign objects." Efforts are currently underway by the Patient Safety Work Group to publish a position paper based on current standards related to the unintended retention of a foreign body. Upon completion, this paper will be shared with all hospitals for systems improvement purposes. The group will also execute a "drill down" exercise to identify specific actions and best practices for reducing the number of these events among facilities.

C3 Initiative—The Utah C3 initiative is committed to assuring that the **correct** procedure is performed at the **correct** site on the **correct** patient. In 2005, the Utah Patient Safety Steering Committee adopted statewide guidelines for all hospitals and surgical centers to voluntary follow to reduce surgical errors. The guidelines include procedural recommendations for site marking, "time out" procedures and patient verification. To review these guidelines, go to http://www.uha-utah.org/patientsafety/patientsafety.htm.

Utah CheckPoint—Found at http://utcheckpoint.org/, this website provides reliable data on 14 interventions that medical experts agree should be taken to treat heart attacks, heart failure and pneumonia. CheckPoint is designed to help Utah citizens learn more about health care and makes evidence-based health information publicly available and understandable. Additionally, CheckPoint assists hospitals in continuously improving their performance, and, thereby, improving the overall quality of care provided to Utah citizens. Utah CheckPoint is a joint effort between UHA, Utah Hospitals & Health Systems Association and HealthInsight, the quality improvement organization (QIO) for Utah.

Healthcare Associated Infections—Nosocomial infections, also known as Healthcare-Associated Infections (HAIs) pose a significant burden on patients and their care within the healthcare system. Many patients enter a hospital with decreased immunity and are undergoing complex and invasive procedures introducing different routes of possible infection. The Healthcare-Associated Infection Work Group (HAIWG) was established to provide recommendations for the surveillance and prevention of these HAIs in Utah hospitals. This workgroup has utilized the FMEA process to ascertain process improvements used to reduce infections related to central line associated bloodstream infections. For more information on this project, go to http://www.uha-utah.org/patientsafety/patientsafety.htm

"Never Events" Policy Guidelines—In 2008, UHA's board of trustees adopted guidelines related to the non-payment for certain conditions caused by medical error. Utah hospitals agreed not to seek payment for costs associated with the occurrence of a serious event if an investigation by the hospital determines that the event was reasonably preventable and was within the

control of the hospital. The list included in these guidelines details the serious events for which a hospital will not seek payment if the hospital determines them to be preventable and within the hospital's control. The guidelines were distributed to all hospital members for inclusion in their individual hospital's policy.

Standardized Patient Wristband Initiative—In 2008, UHA members worked together to reach consensus on standard colors for patient wristbands in our state. This standardization will alleviate confusion for staff working at multiple facilities. The color "red" has been standardized to serve as an "allergy" alert; "yellow" indicates a fall risk, and "purple" indicates "Do Not Resuscitate."

Failure Mode Effects Analysis (FMEA)—Three different workgroups have utilized the "Failure Mode Effects Analysis" technique to determine approaches to reduce the risk of error in inpatient settings. Two of the analyses took place under the guidance of the Medication Safety Workgroup. The third analysis was undertaken by members of the Healthcare Associated Infection work group. More information on this project can be found at http://www.uha-utah.org/patientsafety/patientsafety.htm

Utah PricePoint—Found at http://utpricepoint.org/ , this Web site allows health care consumers to receive basic information about inpatient services and charges at Utah's hospitals. Utah PricePoint is a joint effort between UHA, Utah Hospitals & Health Systems Association and the Utah Dept. of Health.

MedCard Initiative—The MedCard initiative is designed to help patients and their families create and maintain a list of medications currently being used. This is an important first step in the event of an admission to a hospital, helping in the medication reconciliation process and thereby reducing the possibility of adverse drug interactions. This initiative, developed and supported by the Medication Safety Workgroup, offers the MedCard in various forms and is available for download at http://www.uha-utah.org/patientsafety/medication/MedRec.htm

Safe Patient Lifting Practices—In 2006 UHA convened a workgroup to review and develop state standards for the transport and lifting of patients. The workgroup explored various options and after several months of work developed voluntary guidelines for safe patient lifting practices for the protection of healthcare workers and patients alike.

Healthcare Information Technology—UHA, UMA and other members of the healthcare community are heavily involved in several projects with the Utah Health Information Network (UHIN). One of the biggest projects is the **cHIE**, or Clinical Health Information Exchange initiative. When completed, this project will allow the transfer of clinical data between providers, improving the quality of care and alleviating duplication of clinical tests. Another major effort, **ARCHES**, will attempt to improve the statewide infrastructure for the transfer of clinical information between facilities.

This report was prepared in cooperation with the Utah Department of Health, HealthInsight and UHA, Utah Hospitals & Health Systems Association.

For more information on Utah's Patient Safety Initiatives, go to http://health.utah.gov/psi/.