

Briefings On Accreditation and Quality

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Accreditation

Switching AOs: Kettering Health answers why they changed from Joint Commission to HFAP

A large health network's experience transitioning to a new AO



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Editor's note: This is the first in a new series on changing accrediting organizations (AO). We'll be talking to hospitals and healthcare organizations on why they changed accreditors, and lessons they learned during the process. If you'd like to share your facility's experience, please email us at bward@hcpro.com.

Kettering Health Network (KHN) is a non-profit network of eight hospitals, 10 emergency centers, and over 120 outpatient facilities in southwest Ohio. In 2016, the network reported more than 1 million outpatient visits, nearly 62,000 patient discharges, and about 315,000 emergency visits. KHN used to be accredited primarily by The Joint Commission, before deciding to switch all its facilities to HFAP in 2011.

Lisa Seitz, BSBA, CPHQ, CCMSCP, is network director of clinical decision support and accreditation & regulatory compliance at KHN, and **Brenda Kuhn, PhD, RN, FACHE, CPHQ**, is the network's chief

quality officer. They spoke with BOAQ about why they changed AOs, why they picked HFAP, and lessons they learned during the process. This Q&A has been lightly edited for clarity.

Q : Why did you decide to change accreditors? And why did you pick HFAP?

Kuhn: We've been developing as a network; we started as two hospitals, then those two joined two, and over time we've added three more. Some of our hospitals were HFAP-accredited and others were Joint Commission-accredited.

We have as one of our core strategies "alignment across the network," and another is "one best practice." These strategies primarily drive decisions. We decided that we needed to align our accrediting bodies so that work across the network was consistent. For example, if we are looking at the accreditation standards for our emergency departments, the leaders are all speaking the same language and focusing on the same standards. That is what drove us to look at changing accrediting bodies.

Why did we pick HFAP? Well, we have a very large osteopathic residency, and at the time, that residency had a requirement to be HFAP-certified. We contemplated whether we should ask our new hospitals to be both

HFAP- and Joint Commission-accredited, since most of our hospitals were already Joint Commission-accredited.

But as we started looking at the two organizations, we realized that the CMS standards are core. And our Grandview Hospital had a long history with HFAP and found it a very successful survey process, just as our other hospitals had with their Joint Commission survey process. However, we decided we would align with HFAP in support of the requirement for our residents.

Q : After the decision was made, how long did it take to completely switch over?

Seitz: Looking back, it took a little over a year. We began the process in August of 2010 when our board gave us the approval to proceed. The last transition survey was completed at the end of 2011, when we moved all facilities to HFAP.

Q : How did you sell leadership and stakeholders on switching?

Seitz: It was really the best option since two of our seven facilities would need to operate under two accrediting bodies. The American Osteopathic Association requires teaching facilities to have HFAP accreditation. Therefore, we felt that moving toward HFAP accreditation for all of our hospitals was the best option.

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BOAQ STAFF MEMBERS

Jay Kumar
Associate Product Manager
j कुमार@blr.com

Brian Ward
Associate Editor
bward@blr.com

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We had also already formed a centralized accreditation and regulatory compliance department, so it made the best sense for us operationally and financially to go that route.

Q : How do you prepare for this kind of change? Is there anything you wish you'd known beforehand?

Seitz: Since we already had two HFAP-accredited facilities, we used our facility leaders to mentor our other hospitals. We started a steering committee that included representatives of all our hospital campuses. We put a timeline in place to prepare our hospitals for their HFAP surveys. The timeline provided when to get the applications in to HFAP all the way through the actual survey.

We assigned chapter champions for each facility and began reviewing the chapters with all the department leaders and chapter champions. We started with mock surveys in 2011, and we put together a guidebook for all employees throughout the network highlighting the general standards they could be asked during a survey.

Kuhn: We had a benefit that other hospitals might not: Two of our hospitals had a long-standing history with HFAP, so we had internal experts for each chapter who could lead those chapter teams for us.

Q : How would you describe the transition process? Was there any impact on patient care or hospital finances during the transition?

Seitz: KHN already had a network team in place that supports our hospital campuses during surveys and provides constant survey readiness activities. We had already committed the resources year round. This dedicated focus has really had a positive impact on patient care. If a process or service is out of compliance, action plans are immediately going to be put in place.

Q : What was the most challenging part of the transition?

Seitz: I think the most challenging part was the staff who were very anxious about the transition. We had a lot of tenured staff that had conducted survey readiness within the individual campuses for years. They were gurus on the standards, and I believe they were

somewhat anxious during the transition.

But they soon found out that the CMS *Conditions of Participation (CoP)* are the foundation for all the AOs. So they were already familiar with the standards, and I think that helped them ease into the new process.

Kuhn: I think the other piece that was a challenge was making sure the timeline worked out. We wanted to make sure all the hospitals had their initial HFAP survey for accreditation before we discontinued the Joint Commission survey process. We wanted to make sure we timed it right so we didn't have a gap in accreditation coverage and we didn't have to go back through another Joint Commission survey in the transition process.

Q : What was the easiest part of the transition?

Kuhn: Once you realize that HFAP standards are mostly CMS' *CoPs*, the conversation changes from unknown requirements to aligning with CMS. We started working with our campuses that had been through HFAP surveys, and they started meeting with other campus leaders. And they realized they had a lot of familiarity even though it's a different AO. It went much smoother than I think we could have hoped for.

Q : What have the results been since joining HFAP?

Kuhn: When we're working with HFAP survey teams that come in to review the clinical standards and *Life Safety Code*[®], they really help to ensure we're providing a safe environment for our patients. We welcome their coaching and the recommendations that they provide during the survey.

We also do mock surveys, and when questions come up from our leaders, we reach out to the HFAP staff for clarification. They are a great resource on an ongoing basis. It really helps our surveys to always be in a survey readiness state, and we've had successful surveys.

We had that same experience with The Joint Commission, where we viewed the surveyors as partners with us. Their goal is to make sure we provide the best care to

the patients, which is also our goal. We aspire to be in the top decile nationally, and as a network we have been recognized as a top 15 health system multiple times.

We see this as an opportunity for someone to come in with a different set of eyes. The surveyors see a lot of organizations and can share with us the practices that they've seen that are stronger than ours or where we have a gap that we need to shore up. We have found both sets of accrediting bodies to be collaborative and helpful as we've gone through surveys.

I guess the other thing that Lisa [Seitz] said was that we believe “survey is every day, because patients come every day.” So with our ongoing mock surveys, we don't just have them when we're getting within a survey window; we do that on an ongoing basis.

Q : And an ongoing basis means every day, every week, every month?

Seitz: We have a mock survey team that goes out year round to our hospitals. We have eight hospitals and over 66 outpatient sites for which we're also responsible. So we're doing survey readiness activities daily.

Kuhn: Like Lisa [Seitz] said, we have a team of five people in the network whose responsibility is to help our leaders understand and meet the standards. And with

that number of facilities, on a regular basis you are either surveying an area or meeting with a group of leaders to make sure they are compliant with the standards.

Q : What practical advice would you give a facility thinking about switching AOs?

Seitz: I think communication about the transition throughout the whole organization. The survey process extends from your senior leaders, all the way down to your frontline staff. The more information communicated and repeatedly reviewed, the more confident everyone will be during the actual survey.

At the time, we were really trying to promote HFAP. We were using screensavers on our computers to review standards to really put that in the forefront and communicate what we're doing. It made everyone more confident during the actual survey, because we had communicated for an entire year before the survey process.

Q : Is there anything else you'd like to say?

Kuhn: I think this has been a great collaborative opportunity for our hospitals with the HFAP colleagues. They're tough but collaborative, they interact with the employees, and it's a very respectful process. We both have the same goal: great care for the patients and a safe environment for staff. 📧

HFAP

Longtime accrediting organization to keep its name, continue to expand

The Healthcare Facilities Accreditation Program—also commonly known as HFAP—will be keeping its name. The longtime accrediting organization had originally planned to take the name of the Accreditation Association for Hospitals/Health Systems (AAHHS), which acquired HFAP in 2015 from the American Osteopathic Association (AOA).

AAHHS is a nonprofit organization focused on quality and safety in healthcare and has been acting in a management capacity for existing HFAP accreditation programs since the merger. According to HFAP media

representative **Mary Velan**, to avoid the alphabet soup of switching from AOA/HFAP to AAHHS/HFAP, they plan to simplify by going forward as HFAP.

“We had considered a name change, but HFAP has over 70 years of history behind its accreditation programs, and we want our current and future customers to know that the practical, educational approach that is what HFAP delivers remains unchanged,” she said.

Even though the name change is off, HFAP members shouldn't worry, said Velan. The new plan won't

affect any of the services provided by HFAP or its survey process.

“HFAP continues with its mission of advancing high-quality patient care and safety through objective application of recognized standards,” Velan said in an email.

She also added the accreditor is expanding its specialty care certification programs, including stroke, lithotripsy, wound care, joint arthroplasty, and compounding

pharmaceuticals. HFAP is also working on renewing its CMS deeming authority prior to 2019 expiration dates.

HFAP was established in 1945 to review osteopathic hospitals and was one of only two accrediting organizations deemed to review hospitals for eligibility to participate in Medicare when it was created in 1965. The other deemed accreditor was The Joint Commission. HFAP accredits both acute care and critical access hospitals, as well as other types of healthcare organizations. 

Patient safety

Joint Commission: Sentinel events declined again in 2017, but same problems top its annual list

Written by Matt Vensel

The Joint Commission recently released its final sentinel event statistics for 2017. The same medical miscues as last year top the list; however, it seems encouraging that the total number of reported sentinel events declined for a second consecutive year while the proportion of self-reported incidents continued to climb.

The Joint Commission reviewed 805 reports of sentinel events, which it defines as unexpected events that result in death or serious physical or psychological harm to patients. That total for 2017 was down slightly from two years ago, when it decreased from 934 in 2015 to 824 in 2016. But it was still more than in 2014, when the 763 sentinel events established the lowest mark of the past decade.

Steven A. MacArthur, a senior consultant with The Greeley Company in Danvers, Massachusetts, says there are a couple of ways to look at the decline in

sentinel events over the past two years.

“It’s really tough to say if there is a cause-and-effect consideration at work for this,” says MacArthur. “It could be that, on advice from legal counsel, folks are choosing not to report sentinel events beyond what is required. Or it could be that folks are working diligently to decrease the rate of incidence of these types of events.

“The optimist in me wants to lean towards the latter, but the person in me who’s worked in healthcare for almost 40 years thinks it may be more to the former.”

While there is no way of knowing just how many sentinel events go undiscovered by The Joint Commission, the statistics showed that a whopping 700 of the 805 sentinel events for 2017 were self-reported, which equates to the highest percentage (87%) since at least 2005. To compare, the self-reporting rate a decade prior, in 2007, was only 60%.

While accredited healthcare organizations are not required to report sentinel events to The Joint Commission, it is encouraged so the accreditor can work with organizations on addressing the cause; in addition, The Joint Commission feels that transparency and cooperation show the public that the industry is tackling a problem head on. However, if The Joint Commission is not satisfied by a healthcare organization’s response to a reviewable sentinel event, it could affect the organization’s accreditation status.

Top five

The five most frequently reported sentinel events in 2017, according to The Joint Commission:

1. Unintended retention of a foreign body (116)
2. Fall (114)
3. Wrong patient, site, or procedure (95)
4. Suicide (89)
5. Delay in treatment (66)

When The Joint Commission becomes aware of a sentinel event, whether self-reported or published in the media or some other source, the healthcare organization must prepare a root cause analysis and action plan within 45 days of becoming aware of the event and share it with The Joint Commission.

However, despite the threat of The Joint Commission finding out about a sentinel event on its own, MacArthur says responses to such events can vary among healthcare organizations because “the state and organizational reporting requirements can be different.”

“Generally, there would be some sort of investigation, perhaps followed by a root cause analysis—depending on the nature and severity of the event—and reporting within the organization and perhaps outside the organization,” he says. “The occurrence of sentinel events usually tests an organization’s ‘willingness’ to truly operate with transparency.”

According to The Joint Commission, the most common sentinel event in 2017—self-reported or otherwise—for at least the fourth year in a row was the unintended retention of a foreign body (116). Rounding out the five most common events were falls (114); errors due to wrong patient, site, or procedure (95); suicides (89); or delays in treatment (66).

There have been between 116 and 126 reported incidents of unintended retention of a foreign body in each of the past four years, so those numbers have been pretty consistent. Meanwhile, falls have increased each year since 2014, from

93 that year to 114 in 2017, while errors due to wrong patient, site, or procedure dropped from 121 to 95 from 2016 to 2017.

Still, based on the statistics released by The Joint Commission, the same five or six categories of sentinel events remain problematic for healthcare organizations from year to year.

“I’m sure folks are working to address the mechanics of why these things happened,” says MacArthur, who believes the frequency of sentinel events is probably a “pretty small” percentage of patient “activities” overall. “While everybody strives for 100% compliance, human condition tends to result in at least some aberrations from the expected outcomes. ... When any of these [sentinel events] happen, it impacts operations, sometimes costs money to fix, etc. Nobody wants these things to happen, and I am certain that folks work very diligently to reduce the risks.” 

EDITOR'S NOTE:

This issue of BOAQ is filled with stories on how to handle the top five sentinel events. Read on!

Resources

Check out some of our past articles to find out best practices and policies.

- [The cultural cure to sentinel events](#)
- [Sentinel Event Alert aimed at preventing falls](#)
- [Communication breakdown: Sentinel Event Alert calls out bad patient handoffs](#)
- [Newest Joint Commission Speak Up campaign targets identity verification](#)
- [New suicide risk expectations from Joint Commission in aftermath of sentinel events stats](#)

Patient safety

AORN guidelines on unintended retention of a foreign body focuses on counting and communication

Two years ago, The Joint Commission released a “Quick Safety” report on unintended retained foreign objects. That report was meant to build upon the info in The Joint Commission’s 2013 [Sentinel Event Alert 51](#), which also addressed retained surgical items (RSI).

Despite that, RSIs still topped The Joint Commission’s

2017 sentinel event statistics (see p. x). Patients continue to be stitched closed with surgical sponges, gloves, needles, electrodes, scalpels, wires, tweezers, forceps, scopes, masks, tubes, and scissors left inside them.

It’s estimated that around 1,500 surgeries each year end with an RSI. These patients often experience

frequent infections, pain, bowel blockage, and other complications—and to add insult to injury, patients then need to be operated on again to remove the RSI.

To combat the problem, the Association of periOperative Registered Nurses (AORN) released updates to its [Guideline for Prevention of Retained Surgical Items](#) back in 2016. Using a new evidence review model, the updated guidelines underscore the importance of clear communication and strong counting procedures to prevent the occurrence of RSI.

The most notable update to the guidelines is the inclusion of a new evidence rating model that is based on the Institute of Medicine's Standards for Developing Trustworthy Clinical Practice Guidelines. Each recommendation includes an assigned score based on an independent evaluation of all relevant research.

For example, recommendations assigned an appraisal score of "1" signify strong supporting evidence and a regulatory requirement. Those assigned a "5" have weaker evidence, or "benefits balanced with harms," according to AORN. It's an approach that is often used by other health organizations such as the CDC, which adds more weight to the updated recommendations, says Ramona Conner, MSN, RN, CNOR, editor in chief of the AORN guidelines.

"We've always included and discussed evidence in the literature, but we have a more formal way of doing that now," she says, noting that the guideline includes 222 supporting references. "There's quite a bit more information related to evidence that supports the recommendations in this new version."

The guidelines emphasize the importance of using a consistent counting process and minimizing distractions, noise, and interruptions during that process. Recommendations also hone in on the importance of a team-based approach to RSI prevention and the need for effective communication.

Verna Gibbs, MD, director of NoThing Left Behind®, a surgeon at San Francisco Veterans Affairs Medical Center, and a professor of surgery at the University of California San Francisco (UCSF) Medical Center, applauds the new recommendations, particularly the

emphasis on utilizing a sponge pocketing system that uses a blue-backed hanging sponge holder with clear plastic pockets. Several years ago, Gibbs developed and promoted a Sponge ACCOUNTing system that relies on this same approach.

"[AORN has] come to recognize that this old practice of counting sponges out of the kick bucket, or counting around the kick bucket, or putting [sponges] out on the floor, or doing these variable practices, is not reliable," she says. "The humans in our complex OR need some safer, simpler practices."

Using teamwork

Connor says that the basic principles of surgical counts "have not changed significantly over the years," so AORN has focused much of its attention on reducing the noise and distractions that can disrupt the counting process.

"What is very important is that the count method is consistent and it's used every time on every patient," she says.

AORN also recommends that OR team members participate in team training programs such as [TeamSTEPPS](#), an evidence-based program developed by the Agency for Healthcare Research and Quality (AHRQ) that emphasizes communication between healthcare professionals. Team members should be willing and able to speak up if there is a count discrepancy so that the whole surgical team can respond.

"Team training is really beneficial in helping improve processes," Connor says.

It's imperative that hospitals use the AORN updates to inform a multidisciplinary approach to RSI prevention, according to Gibbs. The guidelines are one cog in the wheel, and it's up to hospitals to determine the best way to integrate the recommendations in a way that involves every member of the team, including the surgeon and radiologists.

"The old established view of [RSI cases] 10 years ago was, it's all about nurses counting," she says. "One of the things [NoThing Left Behind] came out of the gates with really early was that it's not just the nurses, it's multi-stakeholder."

Device fragments

As surgical procedures have become complex, so have surgical instruments. As a result, the instruments can sometimes fragment or break, potentially causing harm to a patient.

“As the instruments and devices get smaller and more intricate, the potential for breakage is increasing,” Connor says. “When you have a small minimally invasive wound, it can go undetected in the wound itself.”

AORN says according to guidelines, the surgeon should weigh the risks of removing the device. But Gibbs recommends that hospitals require surgeons to report fragmented devices as an RSI. In her experience, that policy has prompted surgeons to remove fragments they might otherwise deem safe to leave in the patient.

“It’s been a common practice that surgeons have said, ‘I can’t remove that, and anyway it’ll be okay if I just leave it in the patient because the risk of removing it is greater than the risk of just leaving it there,’” she says. “Sometimes that’s not true.”

Eliminating human error

Developing, implementing, and adhering to a standardized methodology for tracking surgical items is critical in the OR setting. Ensuring that each team member is adhering to the same prescriptive process will eliminate potential mistakes.

“It’s very important that as you use the team approach that the methodology is standardized so you can eliminate, as much as possible, the potential for human error to occur,” Connor says. “Variability in process can be a real problem.”

However, Gibbs notes that the AORN guidelines appear to place a premium on communication. Although she acknowledges this is important, she does not subscribe to the notion that improving communication will prevent RSIs. Instead, Gibbs says practice and processes should be prioritized first, with a secondary emphasis on communication.

“The foundational problem with retained surgical sponges is more of a practice problem,” she says. “It’s not how we talk to each other about what we’re doing,

but what we do. If you focus on changing the practices of what the humans are doing, you will have greater success in eliminating retained sponges.”

For example, AORN emphasizes the need for nurses to speak up if they suspect a count discrepancy. However, Gibbs points to research showing that in more than 80% of cases where there has been a retained sponge, the nurse never recognized the sponge was missing and documented the count as correct.

“That means there is a problem with the practices they are using to count the sponges because they are calling the count correct,” she says.

Gibbs adds that in its quest to support recommendations with empirical evidence, AORN has missed some opportunities to highlight ways to combat human error. For instance, the AORN guidelines recommend “non-radio opaque dressings should be withheld from the field until the surgical wound is closed,” and that dressing sponges in custom packs should also remain sealed.

However, Gibbs recommends hospitals eliminate dressing sponges from the sterile field altogether, since they can be easily confused with radio-opaque sponges that are identifiable in an x-ray. Simply having dressing sponges available opens up the opportunity for a retained item. This type of experience-based recommendation relies on practical solutions to avoid human error.

“[AORN] give it lip service and speak to human errors, but I think in their quest to substantiate some of the recommendations they make, they should undergird it with an understanding of trying to prevent the humans that are doing the job from making a mistake,” she says. “What they speak to is trying to prevent a count discrepancy rather than trying to prevent patient harm from a retained sponge.” 



Questions Comments & Ideas

Contact me at ward@hcpro.com
or 781-639-1872, Ext. 3430.

– Brian Ward, Associate Editor

Patient safety

Case study: Reducing falls by engaging patients

Brigham and Women's 'Fall TIPS' tool offers tailored approach to falls prevention

The good news is that patient falls are largely preventable. Doing so can save patients undue pain and save a hospital around \$1 million a year.

The bad news: There are still between 700,000 and 1 million patient falls each year. Of that number, 30%–35% of falls lead to injuries such as internal bleeding, lacerations, and fractures. In addition, around 11,000 of those falls are fatal. Every fall adds an average of 6.3 days to a patient's hospital stay and \$14,056 to the cost of care—expenses CMS won't cover.

But there's at least room for improvement, which is a good start.

The Joint Commission reports that patient falls were the second most common sentinel event of 2017 (see p. x). The accreditor has been trying to curb this trend for years, even making it the topic of its [Sentinel Event Alert 55](#).

One hospital that has succeeded in curbing the trend is Brigham and Women's Hospital in Boston. When clinicians there walk into a patient's room, they only need a quick glance at a laminated, color-coded sheet of paper next to the bed to understand that patient's fall risks.

Brigham and Women's is a 793-bed teaching hospital affiliated with Harvard Medical School and is frequently ranked by U.S. News & World Report as one of America's best hospitals.

Over the course of several years, hospital leaders have refined their approach to fall prevention through the facility's "Fall TIPS ([Tailoring Interventions for Patient Safety](#))" program. In addition to fall risk screening and assessment protocols that allow clinicians to tailor fall prevention plans to the needs of the patient, the hospital has developed a color-coded sheet that quickly explains to the patient, family members, and clinicians the specific fall risks and personalized fall interventions of that patient.

Patricia C. Dykes, PhD, RN, FAAN, FACMI, senior nurse scientist and research program director at the Center

for Nursing Excellence at Brigham and Women's Hospital, explained the facility's program during a webcast hosted by the National Patient Safety Foundation (NPSF). During the webcast, she emphasized the importance of developing tailored interventions for each patient from evidence-based risk assessment tools, and taking time to explain the fall risks and interventions to the patient.

Brigham and Women's approach has been refined over the last several years. Based on previous research that showed falls were frequently linked to communication errors, in 2009 the hospital built a health IT application that produced tailored fall interventions based on a risk assessment filled out by a nurse. The application included posters that nurses could print out and attach near the bed, with icons to differentiate various risks and interventions.

"The idea of the bed poster is this will replace the generic 'high risk for falls' sign," Dykes said.

She published a study in the [Journal of the American Medical Association \(JAMA\)](#) that showed the interventions helped reduce the number of falls from 4.18 per 1,000 patient days to 3.15 per 1,000 patient days.

But Dykes and her colleagues also knew 90% of falls were preventable, and they continued to tinker with the Fall TIPS toolkit in the following years, specifically the bedside poster, which they saw as the key to ensuring clinicians were consistently implementing each patient's fall plan. Additionally, they saw an opportunity to involve the patient in the risk assessment and the fall plan, which would provide a level of investment and engagement that didn't exist when nurses simply labeled patients a fall risk without explaining the process to them.

Following the JAMA study, the hospital sought input from patients regarding the effectiveness of the icons used to differentiate various fall risks and interventions. Using that feedback, the hospital partnered with Northeastern University's engineering program to redesign the icons and incorporate them into a color-coded sheet so patients,

family members, and clinicians could easily link specific fall risks to correlating fall interventions.

Common fall factors

The Joint Commission identified the following as the most common factors contributing to falls, based on its analysis of falls with injuries in the Sentinel Event Database:

- Lack of adequate assessment
- Failure to communicate effectively
- Inconsistent use of protocols and failure to follow pertinent safety practices
- Staffing issues, including failure to provide adequate orientation for staff, lack of staff supervision, inappropriate skill mix, and low staffing levels
- Factors in the physical environment, such as loose handrails in corridors or slippery floors
- Leadership issues

After a nurse conducts a fall risk assessment, he or she reviews the color-coded sheet with the patient and then posts it next to the bed so that any other clinician who walks into the room can quickly determine whether that patient needs assistance because of an unsteady gait, requires a walker, or is on medication that increases the risk of falling.

The hospital also integrated those icons into several electronic formats, including the hospital's Patient Portal, which is accessible through several mobile devices. Each icon is also prominently displayed on the screensaver on the desktop computer in each patient room.

Based on follow-up surveys, both patients and nurses felt the tools were much more user-friendly and well-integrated into the system.

"It's a good reminder for anyone that walks into the room why the patient is at risk and what is their plan," Dykes said. "This way, everyone knows what their role is in preventing the fall." 

Suicide prevention

Check(list) your ER for suicide risks

Written by A.J. Plunkett

With the renewed focus on ligature and self-harm, facilities need to undergo a complete reassessment of the physical environment where patients with behavioral or mental health problems are cared for. That goes especially for emergency departments. Annually, [460,000](#) emergency department visits occur following cases of self-harm, and those patients are six times more likely to make another suicide attempt in the future.

To prevent patients from further harming themselves, staff should start each shift by reviewing emergency department rooms designated for treatment of behavioral health patients to remove any items patients could use in a suicide attempt.

For example, there's a case where a World War II POW committed suicide by hitting himself in the head with an empty metal canteen after days without water. While that happened in the hold of a Japanese prison

boat, not a hospital, it highlights how resourceful a suicidal person can be when it comes to finding ways to self-harm. In a hospital setting, [earbud cords](#), compact mirrors, trash bags, bed frames, IV tubing, socks, and much more can be used to attempt suicide.

You may want to use a checklist (see p. x.) to ensure no items are overlooked. In rooms that can't be completely cleared of ligatures or other instruments for self-harm, facilities should have trained one-on-one observers available to keep patients safe.

"As healthcare organizations and accrediting bodies intensify efforts to make the healthcare environment safer, it is critical to use available data and expert opinion to have clear guidelines on what constitutes serious environmental hazards that must be corrected and what mitigation strategies are acceptable in those situations when all potential hazards cannot be removed," wrote The Joint Commission in a [special report](#) on suicide prevention.

Boarded patients a concern

When evaluating physical risks in emergency departments, remember that behavioral health patients awaiting transfer to a psychiatric unit or facility may be in the ER for hours, if not days, says Ernest E. Allen, a former Joint Commission life safety surveyor and current patient safety account executive with The Doctors Company in Columbus, Ohio. The company is a medical malpractice insurer.

Minimizing self-harm opportunities in the physical environment is not only a patient safety issue, but also vital to the hospital's bottom line, says Allen, who presented an HCPro [webinar](#) last November on evaluating the environment of care for suicide risk.

That's because patient suicides can not only result in investigations by CMS and your accrediting organization, but also a visit from your local or state department of health and possible fines. Lawsuits from family members can draw unwanted media attention.

Incidents of self-harm by patients also create poor morale among staff, notes Allen. He recommends you consider designating a room or rooms in your ER area to specifically house psychiatric patients if necessary.

Design features can help

Those rooms should have many of the features CMS and The Joint Commission now expect in behavioral health units or facilities: rooms without drop-down ceilings, ligature-resistant plumbing features and door handles, no clothes hooks or hooks that break away, and only paper trash can liners.

If you are renovating or designing new exam rooms, consider installing a roll-down door in the room behind which dangerous items can be easily and quickly locked away, says Allen.

For rooms that cannot be modified, The Joint Commission will allow one-on-one observation, says Allen. Sometimes items considered dangerous, such as intravenous poles and tubing, a sharps container, portable equipment with tubing or electrical cords, or other supplies, may be necessary.

“If the patient also has medical issues, sometimes some of those items are needed,” he says, “but a sitter should be with the patient.”

Train your sitter

While the task sounds simple, it's essential that your observer is trained and understands hospital policies. Just last year, CMS put one hospital under immediate jeopardy (IJ) after learning that a one-on-one observer left her post to take a break after deciding the patient was asleep.

Another hospital faced IJ, which threatens a hospital's ability to bill Medicare, after a patient was brought into a hospital by law enforcement, who warned staff that the patient was suicidal. As the patient awaited triage, family members called to tell the hospital of specific problems with this patient, but the nursing assistant who took the call refused to take the information, citing erroneously that HIPAA privacy regulations prevented it.

In the 20 or so minutes before the patient was seen—also a violation of hospital policy, which stated that ER patients were to be triaged within 15 minutes of arrival—the patient used a belt to hang himself. The belt was not taken from the patient because hospital staff was unsure if it was legal to do so. That also was apparently in violation of hospital policy, which said the belt should've been taken away.

Extensive education and retraining of staff was required before the IJ rulings were removed from both hospitals, according to CMS inspection reports found on [HospitalInspections.org](#), maintained by the Association of Health Care Journalists.

Safe environment checklist for suicidal patients

The following checklist is used at the beginning of every shift when reviewing exam rooms for at-risk patients at a hospital in Georgia. The checklist is part of an effort to revamp the hospital's policies and procedures around minimizing suicide risk, says Susie Jester, MSN, RN, director of clinical practice.

Reviewed by Allen, the checklist should mainly be used in non-psychiatric areas, such as emergency rooms, since many of the items, such as sharps containers, would not be found on a psychiatric unit. In the event that not all items can be removed, Allen recommends having a one-on-one patient observer also be available. 

Checklist

To be completed at the beginning of every shift:

- Remove all detachable/removable hanging risk items, if possible and unless medically necessary, including:
 - Suction tubing
 - Electric cords/telephone cords/bed cords (if detachable)
 - Oxygen tubing/flowmeter (unless required for continuous use)
 - Excess IV tubing
 - Cords attached to mounted equipment not in use
- Remove IV poles and other portable equipment not in use, such as oxygen cylinders
- Remove plastic trash bags
- Remove glass, plastic, or metal objects that can be broken and used for harm, such as lab specimen tubes
- Remove gloves, tourniquets
- Remove hand sanitizer
- Remove any unsecured items not in use
- Lock supply cabinets/carts in the room
- Remove extra linen (sheets, towels, pillowcases)
- Sharps container no more than half-full
- Remove any items that would be dangerous if ingested
- In addition, when patient is in the room:
 - Door remains open (unless care is being provided)
 - If curtain in room cannot be removed, it is to remain pulled back
- Patient should be in paper scrubs (not wearing any personal items except wedding band)
- No personal belongings, including, but not limited to:
 - Ribbons
 - Pins
 - Socks
 - Scarves
 - Jewelry
 - Nail polish/remover
 - Toiletry items
 - Earbuds
 - Compacts with mirrors

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