Our Mission
To promote the adoption of best practices by Midwest healthcare organizations to improve the delivery of safe and quality care to all patients.

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TOP ISSUES FOR 2020

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As a patient safety professional, you know the opportunities for error and improvement are both numerous and varied. As you tackle the day-to-day challenges of improving care and patient outcomes, the Midwest Alliance for Patient Safety (MAPS) Patient Safety Organization (PSO) offers our Patient Safety Focus: Top 10 Issues for 2020 as a guidepost for the year ahead.

As your PSO, we strive to share new insights and strategies into ever-present patient safety concerns alongside issues that may be central to your efforts.

This year’s Top 10 builds on our first issue-focused white paper last year. Based in research, our Top 10 is also an extension of your commitment to reporting adverse events and engaging in your PSO throughout the year. This engagement is crucial to our shared goal of providing safer care for patients throughout the Midwest. The conversations we have with our MAPS members—whether it’s in person or over email—illuminate the challenges you face and provide the spark for needed programming and resources.

I encourage you to utilize our Patient Safety Focus: Top 10 Issues for 2020 to enhance the patient safety work you’re already doing. Constant concerns can benefit from new approaches, while emerging concerns require attention and action. Your work on these issues will benefit your organization, our MAPS PSO community and, importantly, patients and families across the Midwest.

Sincerely,

Helga Brake, PharmD, CPHQ, CPPS
President, Midwest Alliance for Patient Safety
Illinois Health and Hospital Association (IHA)
HOW WE IDENTIFIED THE TOP 10 ISSUES FOR 2020

This year’s top 10 patient safety issues emerged from over 140,000 submitted events, expert input and thought leadership, literature review, and shared learnings. We integrated information from:

- MAPS database
- MAPS staff research and analysis
- MAPS PSO Advisory Board
- Member research requests and discussions from root cause analyses (RCA)
- Learnings from the PSO community

Our top 10 list reflects urgent patient safety concerns—not necessarily the events that occurred most frequently or the most critical events—national and local concerns, and a few that may be long overdue for improvement. The issues that rose to the top highlight emerging risks, socio-economic challenges, patient/family communications and ongoing issues that require evidence-based ideas for improvement. Our goal is to provide insight into these issues, best-practice recommendations and resources for further exploration. With these tools, your organization can determine the best approaches to patient safety for your patient population.

Patient Safety Focus: Top 10 Issues for 2020

1. Care Transition Handoffs
2. *Clostridioides difficile* Infections
3. Discharge Against Medical Advice
4. ED Boarding of Behavioral Health Patients
5. Maternal Opioid Use
6. Medical Device-Related Pressure Injuries
7. Patient and Family Engagement
8. Post-Error Support for Clinicians
9. Social Determinants of Health Screening
10. Workplace Violence De-escalation
1 Begin discussions and prioritize improvement projects
Use the MAPS Top 10 as a starting point for patient safety discussions in your organization. This white paper can guide you in identifying and investigating patient safety issues, as well as prioritizing improvement projects.

2 Assess your organization’s patient safety events, including identification and response
Focus on events that have occurred, as well as potential events to identify prevention opportunities. Determine if teams within your organization face the same problems and evaluate processes to address them.

3 Develop solutions
Refer to the strategies and resources in this white paper for guidance on individual topics.

4 Incorporate solutions across the healthcare continuum
Consider organizational affiliates and settings when identifying patient safety issues and solutions that can apply across healthcare settings.

Please note: Throughout this white paper, text displayed in **bold and blue color** indicates clickable links to online resources.
Seamless handoffs that include all necessary patient information are an ongoing challenge in healthcare, especially along the care continuum. This real-time process of passing patient-specific information from one caregiver to another—or between teams of caregivers—is meant to ensure care continuity and patient safety. While it may sound simple, a successful handoff from a hospital to another healthcare facility requires careful attention and a systematic approach to reduce the risk of patient harm. Research shows that ineffective handoffs are linked to adverse events, as well as higher hospital readmission rates and costs.

Communication lies at the heart of the issue. An estimated 80% of serious medical errors involve miscommunication between providers during handoffs. Ineffective and potentially harmful handoffs can occur when communication is inaccurate, incomplete, untimely, misinterpreted, unnecessary or missing information.

Among hospital patients discharged to long-term care facilities, those with medication discrepancies in their health record have a higher rate (14.2%) of 30-day readmissions than patients without discrepancies (6.1%), leading to unnecessary harm and increased costs.

Because inadequate handoffs continue to occur so frequently, healthcare teams should consider this issue a high priority to fully address, standardize and improve patient care. This year’s look at care transition handoffs builds on the topic of clinician-to-clinician handoffs from our 2019 Top 10 white paper.

**Strategies to Improve Care Transition Handoffs:**

- **Standardize accompanying documents.** Determine which documents to send to the receiving facility to provide a complete picture of the patient’s care and condition. Incorporate those documents into a standardized transfer process.

- **Convene a workgroup to develop a transferring process.** Include members from receiving facilities and incorporate their feedback.

- **Provide information early.** Design a system in which the patient’s transfer information is provided to the receiving facility several hours before the patient arrives.

- **Standardize handoff training:** Include expectations and supporting education regarding care transition handoffs in orientation and annual trainings.

- **Leverage your electronic health record (EHR) and other technologies:** Incorporate your standardized handoff process into the EHR.

**Resources**

- *Pharmacy and Therapeutics: From the Hospital to Long-Term Care: Protecting Vulnerable Patients During Handoff.* 2016.
It’s the most common pathogen responsible for healthcare-associated infections (HAIs): Life-threatening and highly contagious *Clostridioides difficile* (*C. diff*). Formerly known as *Clostridium difficile*, these infections develop from the *C. diff* bacteria, typically as a side effect of antibiotic use. The Centers for Disease Control and Prevention (CDC) considers *C. diff* a major health threat, with recent data showing an estimated 223,900 cases in hospitalized patients and 12,800 deaths in the U.S. in 2017. Along with the cost to human lives—with estimated mortality rates as high as 22%—*C. diff* infections add up to $4.8 billion in excess healthcare costs every year in the U.S.

In Illinois, acute care hospitals reported a significant decrease in *C. diff* between 2017 and 2018, after a two-fold increase in *C. diff* discharges between 1999 and 2010. Still, of the 128 acute care hospitals with enough data to calculate a Standardized Infection Ratio (SIR)—the primary measure to track HAIs—23% had a SIR significantly worse than the national average.

*C. diff* infections continue to be a constant challenge for hospitals and providers along the healthcare continuum. To help prevent the transmission of *C. diff*, all healthcare facilities should follow the new *C. diff* guidelines published in 2018 (listed below) that include changes to initial treatment.

**Strategies to Reduce *C. diff* Infections:**

- **Work with physicians on avoiding unnecessary antibiotic use.** A narrow-spectrum antibacterial that specifically targets the *C. diff* bacteria should be prescribed.

- **Ensure clinicians practice good hand hygiene before and after treating patients.** Soap and warm water is more effective than hand sanitizer during a *C. diff* outbreak.

- **Provide patients with *C. diff* a private room or a room with another patient with *C. diff*:** Hospital staff and visitors must wear disposable gloves and isolation gowns while in the room.

- **Use a disinfectant with chlorine bleach to clean all surfaces.** *C. diff* spores are only destroyed by products with chlorine bleach and can last as long as five months on surfaces.

**Resources**

Centers for Disease Control and Prevention (CDC):
*Strategies to Prevent Clostridioides difficile Infection in Acute Care Facilities.* 2019.


Clinical Infectious Diseases: *Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA).* 2018.

Every year, 500,000 patients choose to leave hospitals across the U.S. despite their physician’s recommendation to continue care. While discharge against medical advice (AMA) represents a small fraction of total inpatient discharges, only 1-2%, the consequences of ending care early are profound. Among AMA patients, research shows:

- Risk of mortality 30 days after the patient leaves is as high as 10%.
- Readmission rates are 20-40% higher after 30 days compared with standard discharges.
- Healthcare costs are 56% higher than expected.

This high-stakes issue has significantly impacted MAPS members, who have reported over 1,600 incidences of patients ending their care against medical advice. For example, a MAPS member reported that a patient complaining of chest pain and weakness refused to stay in the emergency department. He became belligerent, removed his telemetry monitor and walked out without signing the AMA form. Becoming an all-too-common scenario, the patient was lost to follow-up and the status of his condition unknown.

Research has identified common factors contributing to discharge AMA:

- Inadequate patient-provider communication of the risks of ending care early
- Insufficient access to community care centers
- Delays in care or discharge

Vulnerable populations are significantly more likely to refuse care and leave. They include individuals with psychiatric illness, substance use disorders and HIV, or those without insurance. Discharge AMA is recognized as a common and complicated problem, challenging providers to keep track of their patients, increasing healthcare costs and consuming staff time, and exacerbating risks associated with unresolved medical problems.

**Strategies to Reduce Discharges Against Medical Advice:**

- **Communicate** the reasons and importance of remaining for care.
- **Determine** if the patient is at risk of harming him/herself or others.
- **Appeal** to family members or friends who accompanied the patient.
- **Arrange** to follow up with the patient.
- **Do not blame** the patient for deciding to leave.
- **Document** all refusals to sign AMA forms.
- **Notify** risk management and the attending physician immediately.

**Resources**

Behavioral health-related disorders—from schizophrenia to alcohol abuse—account for over 5.4 million emergency department (ED) visits in the U.S. in a single year. These ED diagnoses are growing, even exceeding visits for open wounds.

EDs have become the de facto first line of care for behavioral health patients in crisis. Yet EDs are not well-equipped to provide the care needed. As a result, behavioral healthcare patients often must wait for hours or even days for an inpatient bed or a transfer to another facility. Known as “boarding,” the practice presents a significant challenge for hospitals and poses grave risk for patients. Research has overwhelmingly shown that boarding can result in serious patient safety issues and higher mortality rates. In addition, ED staff are increasingly susceptible to harm from high-risk, unstable behavioral health patients.

Consider the following statistics:

- ED diagnoses increased 52% for schizophrenia, mood, anxiety and other psychotic disorders along with substance- and alcohol-related disorders in a six-year period.
- Psychiatric ED visits require 42% more staff time and result in higher patient admissions (24% vs. 12%) and transfers (16% vs. 1%).

Strategies to Improve Care of Behavioral Health Patients During ED Boarding:

- **Treat patient agitation rapidly using an agitation rating scale.** The goal is to calm the patient, as a sedated patient may become agitated once awake.
- **Implement an algorithm or order set to initially treat psychiatric patients.** Work with Psychiatry and ED to create assessment and medication guidelines to stabilize patients.
- **Minimize the use of restraints and seclusion.** Both can be traumatic for patients and compromise trust in providers.
- **Evaluate medical comorbidities.** Absent a history of psychiatric illness, patients with psychiatric symptoms should evaluated for medical conditions contributing to the clinical presentation.
- **Add observation units.** Providing 24-hour observation and supervision can avert a behavioral health crisis and/or reduce acute symptoms of mental illness.
- **Improve care coordination.** Communication between ED and inpatient providers is critical to a successful handoff.

Resources

- The Joint Commission: Alleviating ED boarding of psychiatric patients. 2015.
The nation’s opioid epidemic has impacted countless lives—including pregnant women and their newborns. Opioid use during pregnancy has grown precipitously, just as it has in the general population.

**Among women:**
- Pregnancy-related deaths due to opioid poisoning increased tenfold in Illinois between 2008 and 2017.
- Overdose is now the primary cause of death among pregnant and postpartum women in Illinois.
- Opioid use disorder (OUD) is a life-threatening, urgent obstetric issue with life-saving treatment available.

**Among infants:**
- Neonatal Abstinence Syndrome (NAS) occurs among opioid-exposed infants shortly after birth and is associated with poor fetal growth and preterm birth.
- From 2011 to 2017, there was a 64% increase in the NAS incidence rate in Illinois.
- Newborns with NAS stay in the hospital 11 days longer, resulting in $40,000 more in birth-related hospitalization costs per patient.

Researchers have identified pregnancy as a critical opportunity to identify and treat women using opioids. Active engagement among providers and a strategic approach are needed to address maternal opioid use and its implications for women and infants.

### Strategies to Address Prenatal and Postpartum Maternal Opioid Use:
- Screen every pregnant patient for OUD with a validated screening tool
- Assess patient readiness for Medication-Assisted Treatment (MAT)
- Start MAT and link to recovery treatment programs prenatally or prior to discharge
- Provide Naloxone (Narcan) counseling and prescription prenatally or prior to discharge

### Strategies to Address Opioid-Exposed Newborns:
- Empower mothers through education to engage in non-pharmacological care (e.g., breastfeeding, rooming in) as the first line of treatment for opioid-exposed newborns
- Implement a standardized NAS signs-and-symptoms assessment tool (i.e., Eat, Sleep, Console; Modified Finnegan Neonatal Abstinence Scoring Tool)
- Partner with the care team, mother, family and community pediatrician to facilitate a coordinated discharge plan

Resources

- The Illinois Perinatal Quality Collaborative (ILPQC) has over 100 hospital members working to implement the American College of Obstetricians and Gynecologists and the Alliance for Innovation on Maternal Health guidelines. Visit ilpqc.org for additional resources and tools.
Medical Device-Related Pressure Injuries

Over 2.5 million Americans develop pressure injuries every year as a result of hospital care, making these painful yet preventable skin lesions a critical issue for patient safety professionals. Healthcare-associated pressure injuries increase risk for serious infection and clinical complications and can extend hospital stays, adding to healthcare costs.

Pressure injuries continue to occur despite numerous efforts by providers to eliminate them. To date, MAPS PSO members have reported over 1,900 pressure injury cases. In reviewing these events, MAPS experts identified medical device-related pressure injuries as the pressure injury that may be more easily overlooked and, therefore, require additional attention.

For example, a patient on a ventilator at a MAPS-member organization developed two pressure injuries, one on each cheek. The injuries were of mixed Stage 1 with non-blanchable redness and Stage 2 non-blanchable purple deep tissue injury. It was later determined that the ventilator’s thin non-padded nose pads and rigid nasal cannula contributed to the injuries.

Medical device-related pressure injuries account for 30% of all pressure injuries and have a potentially broad reach, as nearly all patients require at least one medical device for care. The ears and feet are most susceptible to injury, though lesions can occur on the chin and nose. Researchers have identified several device risk factors, including rigidness, difficulty securing or adjusting it to the body, and incorrect sizing for the patient.

**Strategies to Reduce Medical Device-Related Pressure Injuries:**

- Make sure the device is actually needed
- Avoid placing the device on skin prone to breakdown, e.g., a previous wound site
- Use the proper size and device type
- Secure the device to decrease movement
- Ensure padding is placed on the skin
- Monitor humidity and heat between the device and the skin
- Reduce moisture that can add to skin friction
- Remove the device regularly, such as every shift or every day, to assess the impacted skin

**Resources**


*Chronic Wound Care Management and Research*: Medical device-related pressure ulcers. Review. 2016.

Agency for Healthcare Research and Quality: Preventing Pressure Ulcers in Hospitals. 2014.

*Today’s Wound Clinic*: Adapting Pressure ‘Injury’ Preventing Programs for Use in the Outpatient Clinic. 2017.
Partnering with patients and their families has become an essential strategy in quality improvement, as growing evidence shows that Patient and Family Engagement (PFE) benefits patients, providers and healthcare organizations alike. In 2001, the Institute of Medicine’s *Crossing the Quality Chasm* cemented patient-centered care as a critical component of high-quality care. PFE is an effective tool in achieving it. In addition, CMS has prioritized PFE as a key component in its strategy to ensure healthcare organizations provide high-quality, safe and reliable care at a lower cost.

Healthcare organizations across the U.S. have adopted PFE over the past decade. Doing so in a meaningful way leads to:

- Better health outcomes
- Improvements in patient safety and quality
- Better patient experiences and satisfaction
- Increased satisfaction among healthcare professionals
- Lower healthcare costs and improved organizational financial performance

As PFE advisors, patients and family members can provide valuable input into practices, policies and needed changes, as well as a fuller view of the care experience. PFE advisors bring a fresh perspective and new ideas to enhancing patient engagement and outcomes.

With PFE an important tool in quality improvement, many hospitals and health systems across Illinois have created Patient and Family Advisory Councils (PFACs) and/or incorporated PFE principles in other ways. See IHA’s virtual gallery of posters to learn about the work of 24 hospitals and health systems.

**Strategies to Engage Patients and Families as Partners:**

- **Identify a staff liaison** to implement needed infrastructure changes; prepare staff and clinicians; and recruit, train and support PFE advisors.

- **Identify opportunities to involve PFE advisors:** Involvement can range from short-term projects to a formal PFAC to participation on quality and safety committees.

- **Prepare hospital leadership, clinicians and staff** to work with advisors.

- **Recruit, select and train PFE advisors:** Appropriate training is important to their success.

- **Implement and coordinate advisor activities:** Coach and mentor PFE advisors, track their accomplishments and communicate their results.

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**Resources**

Illinois Health and Hospital Association (IHA): [Resources and Toolkits](#). 2019.


The floor nurse at a MAPS-member organization was so busy that she forgot to start an urgently needed bolus on a patient. Within a few hours of admission, the patient was transferred to the intensive care unit (ICU) in critical condition, leaving the floor nurse distraught that the delay in treatment had worsened the patient’s condition.

The focus of clinician error is rightly on the patient who is harmed. But too little attention is given to the significant impact of causing a patient harm. These events linger with the staff and contribute to emotional distress, much like with the nurse in the above reported event.

Considering the following statistics:

- Among ICU nurses, 24% tested positive for symptoms of post-traumatic stress disorder.
- Almost 40% of physicians experience depression and 400 commit suicide every year.
- In a 2018 survey, 62% respondents said their organization does not have a post-error support program.

Studies show that clinicians experience a range of emotions—guilt, shame, fear, loneliness, frustration and decreased job satisfaction—after an error. Trouble sleeping, fatigue and hypertension can also occur, along with reduced job performance. These effects can last weeks, months or even indefinitely.

A strong culture of safety supports clinicians by letting them focus on providing the best patient care possible. The MAPS team considers care for the clinician a perennial issue organizations must prioritize. Programs that support clinicians after an error can strengthen safety culture while reducing stigma and biases.

**Strategies to Address Post-Error Trauma Among Clinicians:**

- **Provide meaningful support for staff experiencing trauma:** Encourage constructive coping and choose a trauma-sensitive approach that promotes healing.
- **Ensure communication is professional and person-centered:** Practice empathic listening, be supportive and conduct a debriefing with all involved staff.
- **Lead with intention:** Address staff conflict appropriately and enhance work environments to better prevent error.
- **Implement practices that support safety and collaboration:** Strengthen staff skills through training and support organizational resilience before events occur.

**Resources**


Does a lack of transportation keep your patients from their appointments? Do your patients have the means to buy enough food? Is violence a threat or reality in your patients’ lives? Through sensitive and thoughtful questioning, healthcare professionals can get to the heart of what’s impacting patient health. Research shows that only 10% of health outcomes is linked to access to quality care, while up to 90% is related to social determinants of health.

Transportation, food insecurity and experience with interpersonal violence are examples of social determinants of health, which the World Health Organization defines as “the conditions in which people are born, live, work and age.” Mounting evidence suggests that physician- and hospital-led interventions to address social needs can improve health outcomes, reduce healthcare costs, alleviate emergency department overcrowding and curb readmissions.

With value-based care models putting greater emphasis on population health, screening for social needs can be a powerful tool to:

• Enhance patient and family engagement
• Identify unmet needs and barriers, both current and expected
• Empower patients to share what’s most important to them
• Allow providers and communities to work together to address population needs

Yet a cross-sectional study showed that only 24% of hospitals and 16% of physician practices reported screening for social needs. Many providers are missing valuable opportunities to find and address potential sources of serious health conditions among patients. Identifying patients with unmet social needs is a necessary first step to addressing them. Adopting effective screening practices represents an opportunity for healthcare professionals, who are deeply invested in patient outcomes.

**Strategies to Screen Patients for Social Needs:**

• **Co-design the screening process** to incorporate input from providers, patients and community stakeholders.

• **Create the conditions for screening**, which include locations, modes of communication and points of contact throughout the patient encounter.

• **Identify the right care team members** to conduct the screenings.

• **Document what you learn**, as screening results should be regularly documented in patients’ electronic health records and included in treatment plans.

**Resources**

- Illinois Health and Hospital Association: [Enhancing Partnerships to Address Social Determinants of Health](https://www.aha.org/). 2019.
A MAPS-member organization reported a conversation between a physician, two nurses and a patient that took a chilling turn when the patient threatened to stab the three clinicians. Long considered “part of the job,” aggressive behavior in healthcare has become increasingly common. Faced with the stabbing threat, the clinicians attempted to calm down the patient but his anger grew. Thankfully, the incident finally ended with only frayed nerves, not physical harm.

With lives at risk, workplace violence is a significant safety issue for providers and patients. De-escalation techniques are a must-have skill for healthcare professionals as:

- 50% of emergency physicians report being physically assaulted at work.
- 70% of emergency nurses have been hit or kicked on the job.
- 80% of emergency physicians say violence in the emergency department (ED) harms patient care.

Outside the ED, 25% of nurses report being assaulted by patients or their family members. Clinicians and staff in mental healthcare settings can be subjected to aggressive behavior on a daily basis. In addition to the lives impacted, workplace violence increases healthcare costs. Hospitals across the U.S. take on $852 million in unreimbursed medical care for victims every year and spend $429 million related to violence against their employees. De-escalation techniques—such as communication, assessment and safety maintenance—can reduce the potential for harm.

**Strategies to Prevent and De-escalate Violence by Patients:**

- **Communicate clearly and calmly**, avoiding healthcare terms or abbreviations.
- **Use non-threatening body language** when approaching patients.
- **Treat patients with respect**, being supportive of their issues and problems.
- **Build trust with patients** by responding to their expressed problems or conditions.
- **Set clear limits** for patients to follow.
- **Practice and discuss** de-escalation techniques in an educational format.
- **Use risk assessment tools** for early detection and intervention.
- **Implement environmental controls**, such as dimming lights and reducing noise and loud conversations.

**Resources**


Occupational Safety and Health Administration: *Preventing Workplace Violence in Healthcare*. Webpage resources.


We encourage you to explore these additional references as you plan and implement the strategies presented in this white paper.

Agency for Healthcare Research and Quality (AHRQ): Preventing Pressure Ulcers in Hospitals

AHRQ: Patient and Family Engagement: Information to Help Hospitals Get Started


American Nurse: Evidence-based practice: Medical device-related pressure injury prevention


Centers for Disease Control and Prevention (CDC): Clostridioides difficile Infection


Heart: Advancing the science of discharges against medical advice: taking a deeper dive. 2018.

Illinois Department of Public Health: Neonatal Abstinence Syndrome

Institute for Safe Medication Practices: From the Hospital to Long-Term Care: Protecting Vulnerable Patients During Handoff. 2013.

International Journal of Obstetric Anesthesia: Care of the clinician after an adverse event. 2014.

Iowa Health Collaborative: Social Determinants of Health Toolkit

Next-Level Emergency Medicine: Leaving the ED Against Medical Advice: Consequences and Considerations. 2019.


Seminars in Perinatology: Opioids in pregnancy and neonatal abstinence syndrome. 2015.


The Joint Commission: Transitions of Care: The need for a more effective approach to continuing patient care
The Midwest Alliance for Patient Safety is a federally certified Patient Safety Organization and a wholly owned subsidiary of the Illinois Health and Hospital Association. Founded in 2010, we are a non-profit organization with 93-member organizations across the Midwest.

Our program provides full privileges and confidentiality, secure adverse event data-collection solutions, peer networking and learning, and educational tools to improve patient care.

Contact us at MAPSHelp@team-iha.org or 630-276-5657. Visit our website at www.alliance4ptsafety.org. We offer numerous ways for you to get involved in collaborative efforts and education.