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Capitalizing on Social Work Expertise in Sentinel Events

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Overview

A sentinel event as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof during an episode of patients' care in the varied health care settings. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

JCAHO policy requires that all accredited health-related organizations be subject to review of sentinel event data. The policy also requires a root cause analysis and action plan that reflects JCAHO criteria. The recent mandate on using Sentinel Event Alert recommendations as the basis for scoring standards has created *ideal opportunities* for Social Work advocacy. Social Workers can leverage their professional strength and influence within their health care systems and state hospital associations in two important areas. First, Social Workers are an asset on the various Joint Performance Improvement Task Forces addressing type, frequency and action recommendations of Sentinel Event Alerts. Also and most importantly, Social Workers will use this broad knowledge at the institutional level as a participant on executive level committees where they will provide leadership for the prevention and mitigation of sentinel event occurrences.

Sentinel Events

Performance improvement measurements in one form or another are used by 17,000 ambulatory care, home care, hospital and network, assisted living, long term care, laboratory, office based surgical, and behavioral health organizations. These statistical streams of information enable organizations to validate their areas of excellence compared to benchmarks, as well as measure outcomes of any corrective actions. Voluntarily reported sentinel events statistics from these various health care locations track the type, setting, and percent of events. Root cause and outcome trends enable organizations to focus on reducing specific types of patient safety and health care errors.

The June 2004 JCAHO web site states 2552 total Sentinel Events have been reported since 1995. Adverse events that have been tracked since 1995 are: medication errors, inpatient suicide, patient delays, restraint death, wrong site surgery, out-patient/post op events, transfusion errors, infant abductions, patient assault, patient falls, home care fires, patient elopement, delays in treatment, and patient and maternal death. The majority of reported sentinel events are from the hospital setting, followed by psychiatric hospitals, and hospital inpatient behavioral health units as the third highest setting. As a pivotal member of the health care team, Social Work has an essential role in predicting and preventing the occurrences of

continued on page 2

Capitalizing on Social Work Expertise in Sentinel Events

continued from page 1

many of these types of costly and troubling sentinel events. The web site also depicts trends and root cause analysis for all sentinel events. Although Social Work has a relational role with many of the clinical sentinel events, five significant types of events fall directly within the sphere of Social Work influence: patient suicide, elopement, assault on patient, risk of falls and infant abduction.

Social Work Response to Sentinel Event Data

This data raises "red flags" for Social Workers who can respond with experience and expertise to improve outcomes. Root cause issues and variances in areas of patient assessment, communication (personnel and patient/family), staff orientation, and patient education, fall within the indirect or direct purview of social work. As key members of the care management team and clinical experts in patient family communication, assessment, and crisis management, Social Workers possess unique skills for identifying and alerting the health care team to these potential risks. Of greatest importance, professional Social Workers are capable of delivering well-honed, practical applications to *mediate many of the critical risk factors* that eventuate in health care error.

The critical indicators of clinical Social Work in a variety of health care settings (although for purposes of this discussion the focus is on inpatient acute and behavioral health) all emphasize the connections within the "red flag," the applicable Social Work function, the quality of practice, and measurement of its outcome. This is where Social Workers are capable of charging ahead and influencing the prevalence, volume, and quality and cost management of sentinel events within the scope of Social Work services.

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In today's health care institutions, Social Work functions are being carried under a variety of other titles such as clinical social worker, case manager, clinical care manager, outcomes coordinator, or discharge/transition planner. Regardless of these specific roles, a Social Worker prepared at the Master's level has the credentials and core competencies to bring to bear on the issues surrounding sentinel events: crises intervention, assessment of risk, patient family intervention, and continuity of care planning and community referrals. Focusing on the psychosocial strengths, needs and barriers, skilled Social Work professionals carefully craft *"the plan for the way"* in concert with the clinicians responsible for *"the plan for the day and stay"* and apply resources that enable a patient's smooth transition to the next environment.

Social Workers communicate patient and family assessments through formal and informal team collaboration and are bound both by the team's expectation and their own professional accountability to use knowledge to identify potential barriers. As the link to the patient and families' biopsychosocial status, Social Workers are a sculptor of the milieu that encourages their trust by bringing a well-developed knowledge of individual behavior and the impact of systems on the effective functioning of our patients. Social Workers are the voice for our disenfranchised and voiceless patients. For example, it is Social Work's responsibility to recognize the relationship between sentinel event data for inpatient suicide and elopement and the lack of parity for available mental health and financial resources in the community. And it is the Social Worker's obligation to use this knowledge to educate others on the healthcare team. Social Workers are trained to *"observe the actual and listen for the potential"*. (Kates, 2004)

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Organizations that utilize Social Workers in a leadership role on both the macro and micro practice levels benefit from the resulting ideas that help to establish corrective action plans that will reduce incidents of patient suicide, patient assault, elopement and infant abduction? With skills in team management and process improvement, coupled with the understanding of human dynamics, Social Workers can step forward to lead proactive performance improvement in the area of sentinel event prevention.

Taking Charge on the Macro Level

Some will say that Social Work has long been connected to the risk management process. Many Social Workers have completed incident reports and helped to prevent at-risk situations.

- However, how many of us can say that their institution *mandates* a social work consult for all patients threatening to leave against medical advice (AMA)?
- How many social workers are well-versed in workplace violence reduction and use that knowledge to regularly educate other personnel? How many trend this data and attach dollars to it?
- How many social workers *regularly* take responsibility for communicating appropriate risk reduction information at patient care conferences?
- How many *clinical pathways* have included evidence-based environmental elopement reduction prescriptives?

- How many Social Work Departments mandate family/caregiver contact within 24 hours of new admissions with key questions that screen for risk?
- How many Social Workers serve on and/or lead their sentinel event committees?
- How often are Social Workers facilitating family meetings to assist the delivery of physician information regarding the adverse effects of sentinel events?

To be an influence for change, Social Work must strategically drive and test corrective action plans with measurable performance objectives. Our organizations need to see these outcomes, benchmarked with JCAHO sentinel event data as well as other institutional report card criteria.

Summary

The collection, analysis, and application of sentinel event data and trends have reflected intense legal, legislature discussion, and lobbying efforts with relation to HIPAA. (Health Insurance Portability and Accountability Act), HCFA (Healthcare Financing Administration), and CMS (Centers for Medicare and Medicaid Services). It is vital that discussions regarding the sentinel event data trends continue. Social workers in relevant health care agencies must help their organizations prioritize the relationship between *data* and *changes in practice*. As an essential member of the care management team, Social Workers are the beacon to remind them of the importance of advocacy on key issues. Whether supporting NASW 2004 priorities or Society for Social Work Leadership in Healthcare or other professional membership and advocacy groups' goals to influence social health policy, social workers will positively impact the reduction of patient safety variances and health care errors. Therefore, Social Workers are encouraged to engage with their health agencies' executives to analyze root causes on an event-basis, and also support broader initiatives to decrease the crises that drive sentinel events.

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