Serious Reportable Events in Massachusetts Acute Care Hospitals:

January 1, 2009 – December 31, 2009

A report by the
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality

April 2010

Questions about this report should be directed to:
Elizabeth Daake, Director of Policy Development and Planning
Bureau of Health Care Safety and Quality
99 Chauncy Street
Boston, MA 02111
Elizabeth.Daake@state.ma.us

Executive Summary

This report presents patient safety data that Massachusetts hospitals reported to the Department of Public Health (the Department) from January 1, 2009 – December 31, 2009, pursuant to the Commonwealth's Health Care Quality and Cost Council recommendation that the Department provide an annual hospital-specific report.

Massachusetts acute care hospitals reported 383 serious reportable events (SREs) in 2009. Approximately 54 percent (207 events) were environmental events, with falls as the leading category (199 events). Seventy-eight care management events (20 percent of the total) and 75 surgical events (20 percent of the total) were reported. The remainder were criminal events (10 events, 3 percent of the total), product or device events (8 events, 2 percent of the total), and patient protection events (5 events, 1 percent of the total).

Non-acute care hospitals in Massachusetts reported 127 additional SREs, over 60 percent of which were falls. This report focuses on acute care hospital SREs. The systems at work in acute and non-acute hospitals are very different, as are the range of SREs that occur. Approximately 75% of the reported hospital SREs took place in acute-care hospital settings and the types of SREs were more diverse than those in non-acute settings. Non-acute care hospital SREs will be the subject of future reports.

When data is presented on the occurrence of SREs at individual Massachusetts hospitals, it is important to keep in mind that the purpose of public reporting is to influence and ultimately to improve quality of care. To that end, hospitals have been encouraged to share their programmatic responses to their SREs. Additionally, the Department provided the opportunity for hospitals to be interviewed about successes in the detection and prevention of SREs for potential inclusion in this report.

It is our hope that these shared responses and best practices will motivate continued improvement in patient care as we move toward the goal of reduction and eventual elimination of SREs in Massachusetts.

A. Introduction

In January of 2008, the Massachusetts Department of Public Health (the Department) implemented a new adverse event reporting system, based on the National Quality Forum's (NQF) list of twenty-eight (28) discrete adverse medical events, known as serious reportable events (SREs). All Massachusetts hospitals are required to report these events within 7 days of occurrence. Each of these 28 events can be placed in one of six categories:

- surgical,
- product or device related,
- patient protection related,
- care management related,
- environmental, and
- criminal

Since the Department presented its first annual report in April of 2009, hospitals have become more experienced with the reporting process and have also become more proficient at recognizing events as SREs. Hospitals have worked collaboratively with the Department to improve reporting and to clarify definitions and processes. Hospital risk management personnel continue to review every SRE that occurs at a facility, and the Department reviews all SRE reports.

There was a major SRE policy and reporting change in mid-2009. In June, new regulations were adopted by the Department that prohibit hospitals from seeking payment for care provided as a result of an SRE. The Department updated its incident reporting form and procedures to ensure compliance with the new regulations. Hospitals are now required to complete an initial report within 7 days of the detection of an SRE, and a follow-up report with a "preventability analysis" within 30 days of the first report. The follow-up report requires a facility to state whether or not it intends to seek payment for SRE-related care. Additionally, the regulations and reporting form include specific requirements for notification of the patient and the payers about the event.

The objectives underlying the Department's SRE reporting system are not focused on regulating these events or punishing hospitals. Rather, the goal is to gain a greater understanding of why events happen and how they can be prevented in the future. In that spirit, as part of this public reporting process, hospitals may share with the public additional information about their specific SREs and corrective steps taken as part of a document on the Department's website[1]. There is little question among the stakeholders that the imposition of consistently high levels of inquiry, accountability, and transparency will foster essential system-wide patient safety improvements.

[1] www.mass.gov/dph/dhcq . Scroll down to the Related Links section and click Serious Reportable Event.

B. Definition of Serious Reportable Events[2]

The Department's current definition of an SRE is based on the National Quality Forum's (NQF's) categorization of serious reportable events. NQF serious reportable events are adverse events that are of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable, and thus feasible to include in a reporting system; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility.[3]

Currently, Massachusetts' list of reportable SREs is identical to that of the NQF, but the state retains the right to add and remove events from the list as appropriate. NQF is currently reviewing its list with the intention of publishing a revised/expanded list in early 2011.[4] The 28 events listed below were required for reporting to Massachusetts in 2009.

Serious Reportable Events:

1. Surgical Events
   - A. Surgery performed on the wrong body part
   - B. Surgery performed on the wrong patient
   - C. Wrong surgical procedure performed on a patient
   - D. Unintended retention of a foreign object in a patient after surgery or other procedure
   - E. Intraoperative or immediately postoperative death in an ASA Class I patient

2. Product or Device Events
   - A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
   - B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
   - C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

3. Patient Protection Events
   - A. Infant discharged to the wrong person
   - B. Patient death or serious disability associated with patient elopement (disappearance)
   - C. Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility

4. Care Management Events
   - A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   - B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
   - C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
   - D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
   - E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates

---

[2] National Quality Forum. *Serious Reportable Events in Healthcare-2006 Update.* Washington, D.C: National Quality Forum; 2007

[3] NQF website: http://www.qualityforum.org/projects/completed/sre/

[4] To learn more about this project, including discussions to date and upcoming meetings, please visit the NQF website at: http://www.qualityforum.org/projects/hacs_and_sres.aspx

F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
G. Patient death or serious disability due to spinal manipulative therapy
H. Artificial insemination with the wrong donor sperm or wrong egg

5. Environmental Events

A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
D. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

6. Criminal Events

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
B. Abduction of a patient of any age
C. Sexual assault on a patient within or on the grounds of a healthcare facility
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

C. The Massachusetts Experience: 2009

Non-Payment for SREs

In June 2008, Massachusetts announced uniform non-payment policies for costs associated with 28 serious reportable health care events. The state's Office of Medicaid (MassHealth), Health Safety Net, Commonwealth Connector, Group Insurance Commission and Department of Correction adopted a single set of guidelines to reduce preventable medical errors and advance patient safety. Collectively, these five agencies insure or purchase care for more than 1.6 million people in Massachusetts.

Shortly thereafter, the Massachusetts legislature enacted Chapter 305 of the Acts of 2008, prohibiting all hospitals from seeking payment for SRE-incurred care and mandating that the Department adopt regulations to implement the law.

In June of 2009, new DPH regulations were put in place to prohibit health care facilities from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. According to the legislation, a health care facility may not charge or seek reimbursement for a serious reportable event that the facility has determined, through a documented review process, and pursuant to Department regulations was preventable, within the hospital's control, and unambiguously the result of a system failure based on the hospital's policies and procedures[5]. The non-payment provisions of these regulations do not apply to Medicare and other federal insurance providers, as dictated by federal guidance. Medicare has its own non-payment rules for events known as Hospital-Acquired Conditions (HACs), some of which overlap with SREs.

The SRE non-payment regulations were accompanied by changes in the reporting process, which was updated in June of 2009. Hospitals are now required to complete a 30-day update form in addition to the initial 7-day incident report. The update form must include the patient's insurance information, as well as the hospital's declaration of whether or not the hospital intends to seek payment for care related to the SRE. Copies of both forms must be provided to any third-party payer, if one exists. Hospitals must also provide the patient with a copy of the 30-day form.

The complete set of materials including reporting forms, guidelines, criteria and definitions provided by the Department to hospitals may be found on the Department's website.[6]

Ambulatory Surgery Centers (ASCs)

Ambulatory Surgery Centers (ASCs) are now required to begin reporting serious reportable events to the Department, due to regulations implementing a section of Chapter 305 of the Acts of 2008. The regulations require ASCs to be licensed as clinics by the Department of Public Health, and therefore to report SREs to the Department. As the deadline for applying for licensure was at the end of the reporting period, the current report does not include ASCs. In 2010, ASCs will be responsible for reporting events for the entire year and the Department anticipates including them in the next report. However, the total numbers are not expected to be high, as one of the challenges with the current list of SREs is that they do not apply as readily to ASCs.

Reporting Process

To improve consistency of reporting, each quarter a list of the most current quarter's SREs is sent to hospitals to ensure that the captured incidents reflect the hospitals' understanding of what they have reported. Hospitals then have the opportunity to raise any questions about the information they have received. If a hospital does not believe an incident to be an SRE, the Department works with the hospital to

[5] M.G.L. C. 111, Section 51H (d)

[6] SRE materials can be found at www.mass.gov/dph/dhcq. Scroll down to the Related Links section and click Serious Reportable Event.

make a determination.

Massachusetts Data 2009

As reported in the following figure, in 2009 Massachusetts acute care hospitals reported 383 serious reportable events to the Department. Falls were by far the most common event reported representing 52% of the total (199 events). The next three most common events comprised an additional 34% of the total: stage 3 or 4 pressure ulcers (17%), retained foreign objects (11%), and wrong site surgeries (6%).

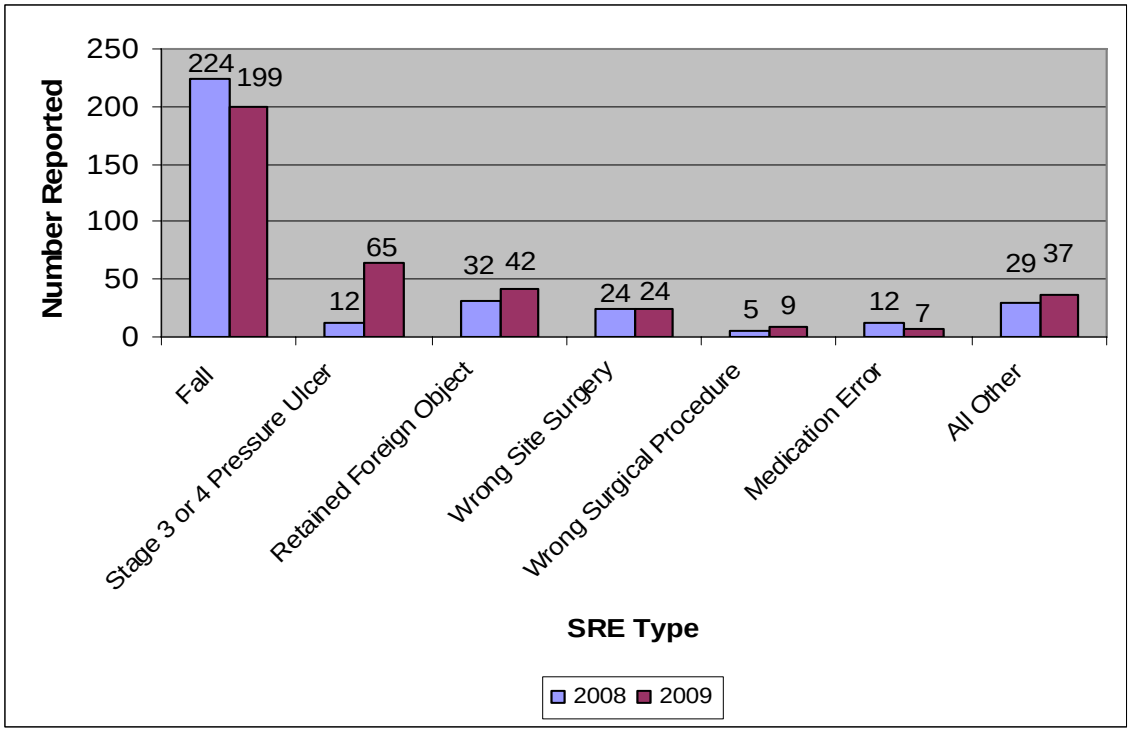
Figure 1
Massachusetts Acute Care Hospital SREs by Number and Percentage: January through December, 2009

Event	Count	Percent
Fall	199	52%
Stage 3 or 4 Pressure Ulcer	65	17%
Retained Foreign Object	42	11%
Wrong Site Surgery	24	6%
Wrong Surgical Procedure	9	2%
Medication Error	7	2%
Sexual Assault	6	2%
Device Malfunction	6	2%
Burn	4	1%
Maternal Death / Disability	4	1%
Restraints/Bedrails	4	1%
Physical Assault	4	1%
Suicide/Suicide Attempt	3	1%
Hypoglycemia	2	1%
Air Embolism	2	1%
Elopement	2	1%
Wrong Patient Surgery	0	0%
Hyperbilirubinemia in Neonate	0	0%
Death < 24 Hours ASA 1 Patient	0	0%
Contaminated Drugs or Device	0	0%
Infant Discharged to Wrong Person	0	0%
Transfusion Error	0	0%
Spinal Manipulation	0	0%
Artificial Insemination Error	0	0%
Electric Shock	0	0%
Oxygen or Gas Error	0	0%
Abduction	0	0%
Impersonation of Health Professional	0	0%
Total	**383**	**100%**

The top six most common events (falls, stage 3 or 4 pressure ulcers, retained foreign object, wrong site surgery, wrong surgical procedure, and medication error) account for 90% of all events reported in 2009. The prevalence of these events is fairly consistent with Massachusetts data from 2008. However, falls accounted for 66% of total events in 2008 (versus 52% in 2009). This decrease in the percentage of

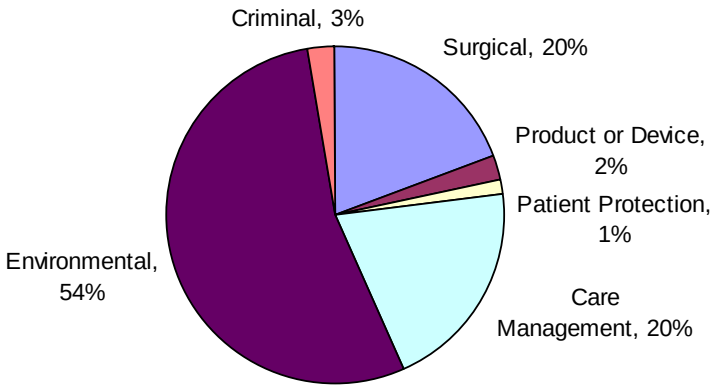
reported falls reflects both an actual reduction in the raw number of falls, and a relative increase in other events. The difference from 2008 to 2009 in the actual number of reported events can be seen in the table below.

Figure 2
Comparison of the Most Common SRE Types Reported, 2008 and 2009



The fact that only a few types of events made up over 90% of all serious reportable events in both 2008 and 2009 provides specific areas of focus for the Department and hospitals as work continues on SRE reduction.

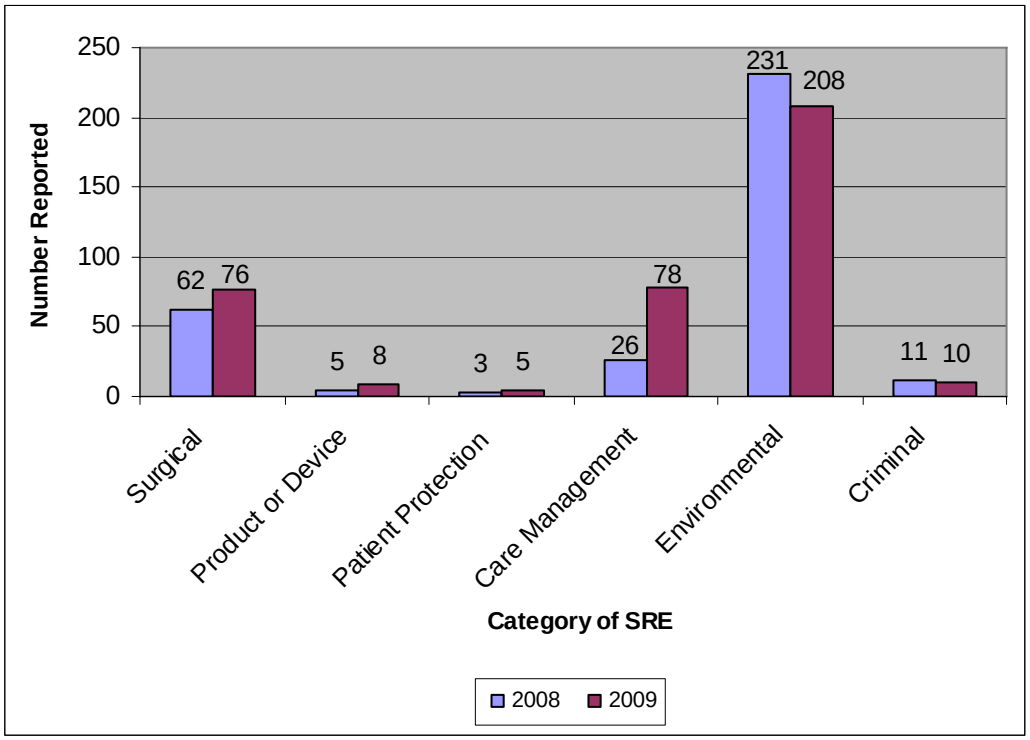
Figure 3
SREs by Category, 2009
(N=383)



Environmental events remained the largest category in 2009, due largely to the number of falls; care management events and surgical events are the next largest categories.

The increase in care management events as a percentage of total reported SREs from 2008 (8%) to 2009 (20%) is due largely to the rise in stage 3 or 4 pressure ulcers reported to the Department in 2009. This is consistent with the Department's expectations. There has been a great deal of work done by hospitals in the last year on addressing pressure ulcers, and these efforts have led to improvements in recognizing and reporting pressure ulcers. While the total number of reported stage 3 or 4 pressure ulcers has increased significantly, there is no evidence to conclude that there has been an increase in actual occurrence of pressure ulcers. Hospitals may in fact now be in a better position to design and implement reduction strategies, some of which are highlighted later in the report.

Figure 4
SREs by Category, 2008 vs. 2009



In 2009, increases in reporting were seen across all categories except environmental events, with 23 fewer reported, and criminal events, with 1 fewer reported. The Department believes that consistent increases are representative of hospitals' progress in recognizing and reporting SREs. Improved reporting provides the public with more transparency, and provides hospitals with more opportunities for the implementation of reduction strategies that will hopefully help to reduce SREs in the future.

Serious Reportable Events by Hospital

In this report, SREs are identified by individual hospital, rather than simply in aggregate. However, it is misleading to draw any conclusions about the overall quality of care at an individual hospital based on a raw number or types of SREs reported by that hospital.

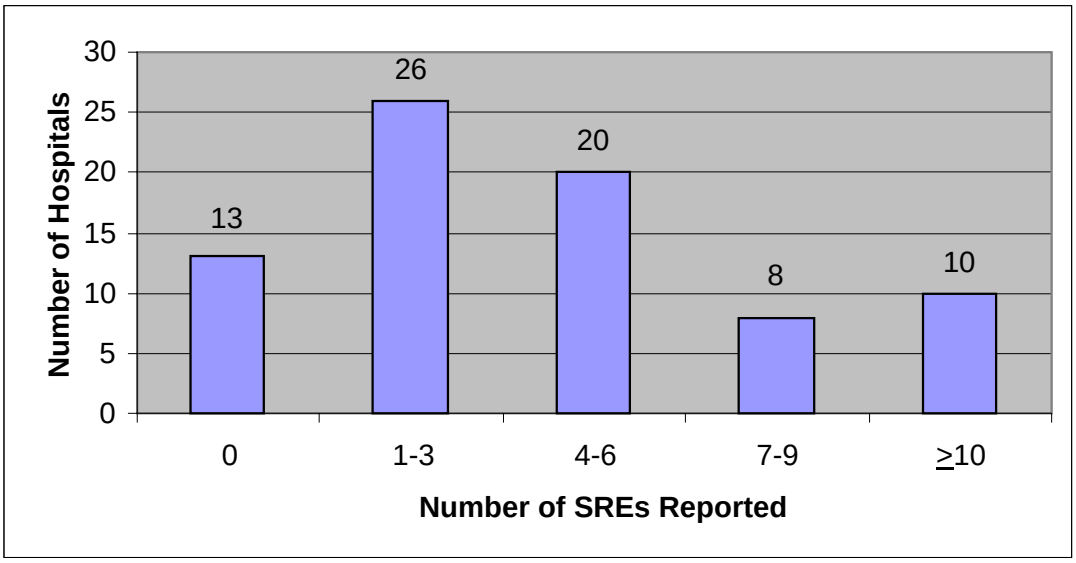
The raw number of SREs may not be an indicator of either good or poor quality hospital care. Because the reporting requirements are still relatively new, especially given reporting changes in 2009, some hospitals may be more proficient in reporting, resulting in a higher number of SREs. A higher number of SREs may indicate a strong reporting culture, rather than a quality concern. Just as a higher number of SREs does not

necessarily suggest poor patient care, a lower reported number does not necessarily suggest higher quality care.

The National Quality Forum makes the point that not all occurrences of SREs may be preventable and is no longer referring to them as “never events”. Despite hospitals’ best efforts, specific circumstances may render particular SREs unavoidable. This fact is acknowledged in the non-payment statute and regulations, with SREs that are not considered preventable still being eligible for payment.

The number of events at each hospital ranges from 0 to 31. Figure 5 shows this distribution. Thirteen hospitals reported zero events, while 10 hospitals reported 10 or more events (versus 7 hospitals in 2008). The mean number of SREs for Massachusetts acute care hospitals in 2009 was 5.0. This is compared to the 2008 mean of 4.3.

Figure 5
Frequency of SRE Reporting, 2009

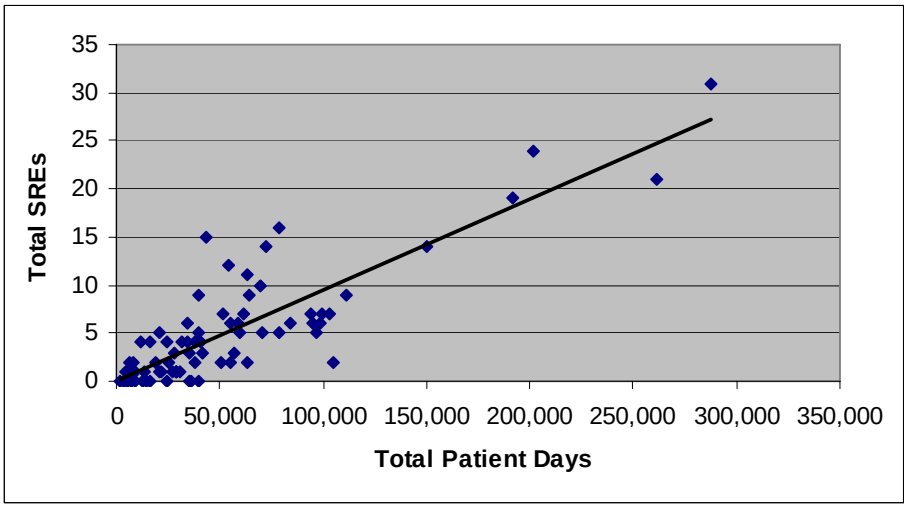


There is no evidence that changes in the frequency of SREs reported at hospitals is due to an actual increase in SREs, and it is possible that these changes are due to improved reporting and proficiency with reporting processes. Given that there are only two years of reported data, long-term trends can not be analyzed.

Serious Reportable Events and Volume

One obvious explanation for variation among hospitals with respect to the number of reported SREs is volume. Figure 6 is a graph of SREs and patient days; each data point is a hospital. Higher volume institutions tend to report more SREs than lower volume institutions.

Figure 6
SREs Versus Patient Days, 2009



Serious Reportable Events and Rates

Figure 7 shows the number of serious reportable events per hospital, along with a calculated SRE per 10,000 patient days. Attachment A provides a complete listing of SREs by hospital by type. Attachment A also shows how hospitals have responded to the specific SREs they have reported. Over time, the Department hopes that responses collected are helpful in identifying best practices.

The calculation of rates of occurrence of SREs is controversial. However, rates are included here in order to provide some context for the raw number of SREs. Opponents of the practice argue that the reporting of rates legitimizes events that should in fact be occurring with a frequency of zero. Supporters of rate calculations argue that the rarest of events will in fact occur more frequently in hospitals with larger volumes, and that the calculation of rates allows comparison and analysis that would not be possible with raw numbers of SREs.

Massachusetts Eye and Ear Infirmary is excluded from this comparison due to an error in the reporting of their patient days. Since the hospital had one SRE, the total number of SREs in this chart is slightly smaller than the total elsewhere. MetroWest Medical Center's number includes both its Framingham Union and Leonard Morse campuses, although they are reported separately elsewhere in the report.

Figure 7
Serious Reportable Events by Hospital: Acute Care Hospitals, 2009.

Acute Care Hospital	Total SREs	Patient Days	SREs per 10,000 Patient Days
Anna Jacques Hospital	4	34,560	1.16
Athol Memorial Hospital	0	3,188	0.00
Baystate Franklin Medical Center	1	20,635	0.48
Baystate Mary Lane Hospital	0	5,262	0.00
Baystate Medical Center	19	191,730	0.99

Acute Care Hospital	Total SREs	Patient Days	SREs per 10,000 Patient Days
Berkshire Med Ctr /Berkshire Campus	9	63,932	1.41
Berkshire Med Ctr /Hillcrest Campus	0	8,729	0.00
Beth Israel Deaconess Med Ctr/Boston	24	201,894	1.19
Beth Israel Deaconess Hospital – Needham	2	8,412	2.38
Beverly Hosp/Addison Gilbert Campus	0	12,528	0.00
Beverly Hosp/Beverly Campus	6	83,978	0.71
Boston Medical Center	14	150,369	0.93
Brigham & Women's Hospital	21	261,154	0.80
Cambridge Health Alliance/Cambridge	6	33,976	1.77
Cambridge Health Alliance/Somerville	0	24,789	0.00
Cambridge Health Alliance/Whidden	1	28,572	0.35
Cape Cod Hospital	10	69,667	1.44
Caritas Carney Hospital	2	38,321	0.52
Caritas Good Samaritan Med Ctr	6	58,838	1.02
Caritas Holy Family Hospital & Med Ctr	6	55,424	1.08
Caritas Norwood Hospital	7	61,721	1.13
Caritas St Elizabeth's Medical Ctr	5	70,929	0.70
Children’s Hospital Boston	2	104,907	0.19
Clinton Hospital	1	8,806	1.14
Cooley Dickinson Hospital	4	37,573	1.06
Dana Farber Cancer Institute	1	8,290	1.21
Emerson Hospital	4	41,124	0.97
Fairview Hospital	1	4,373	2.29
Falmouth Hospital	4	23,976	1.67
Faulkner Hospital	5	39,501	1.27

Acute Care Hospital	Total SREs	Patient Days	SREs per 10,000 Patient Days
Hallmark Health - Lawrence Memorial	1	29,370	0.34
Hallmark Health – Melrose-Wakefield	7	51,187	1.37
Harrington Memorial Hospital	1	13,698	0.73
HealthAlliance Hosp-Burbank Campus	0	7,360	0.00
HealthAlliance Hosp-Leominster Campus	1	27,095	0.37
Heywood Hospital	2	24,905	0.80
Holyoke Medical Center	3	41,480	0.72
Hubbard Regional Hospital	0	3,979	0.00
Jordan Hospital	15	43,023	3.49
Lahey Clinic Hospital	7	99,566	0.70
Lawrence General Hospital	12	54,499	2.20
Lowell General Hospital	2	50,485	0.40
Marlborough Hospital	4	16,065	2.49
Martha's Vineyard Hospital	0	5,831	0.00
Mass General Hospital	31	287,993	1.08
Mercy Medical Center	3	57,251	0.52
Merrimack Valley Hospital	5	20,425	2.45
MetroWest Medical Center	9	63,483	1.42
Milford Regional Medical Center	0	36,371	0.00
Milton Hospital	2	18,693	1.07
Morton Hospital & Medical Ctr	0	35,526	0.00
Mount Auburn Hospital	5	60,140	0.83
Nantucket Cottage Hospital	0	2,070	0.00
Nashoba Valley Medical Center	2	6,749	2.96
New England Baptist Hospital	1	28,936	0.35

Acute Care Hospital	Total SREs	Patient Days	SREs per 10,000 Patient Days
Newton-Wellesley Hospital	14	72,612	1.93
Noble Hospital	1	21,680	0.46
North Adams Regional Hospital	0	14,080	0.00
North Shore Med Ctr/Salem Hospital	16	79,002	2.03
North Shore Med Ctr/Union Hospital	4	31,535	1.27
Quincy Medical Center	9	33,482	2.69
Saints Medical Center	3	28,090	1.07
Signature Healthcare Brockton Hospital	2	62,856	0.32
South Shore Hospital	5	96,468	0.52
Southcoast Hospitals Grp /Charlton	7	93,638	0.75
Southcoast Hospitals Grp /St Luke's	7	103,097	0.68
Southcoast Hospitals Grp /Tobey	0	16,160	0.00
St. Anne's Hospital	3	35,320	0.85
St. Vincent Hospital	5	79,027	0.63
Sturdy Memorial Hospital	1	30,884	0.32
Tufts Medical Center	6	98,600	0.61
UMass Memorial Med Ctr/Memorial Campus	6	94,510	0.63
UMass Memorial Med Ctr/University Campus	9	111,557	0.81
Winchester Hospital	2	55,499	0.36
Wing Memorial Hospital & Med Ctr	4	11,431	3.50
Total	**382**	**4,012,866**	**0.95**

Rates range from 0.00 to 3.50 per 10,000 patient days. Several of the hospitals with the highest rates have relatively few patient days. The statewide average is approximately 1 SRE per 10,000 patient days.

Race and Ethnicity

Beginning in mid-2008, hospitals began to include race and ethnicity data as part of the SRE reporting process. Below is a chart showing the distribution of race for patients involved in SREs.

Figure 8
Distribution of Patients Involved in SREs by Race

Race	Number	Percent
Asian	6	2%
White	272	71%
Black/African American	11	3%
American Indian/Alaska Native	0	0%
Hawaiian/Pacific Islander	0	0%
Unknown/Not Specified	32	8%
Other Race	16	4%
Blank	46	12%
Total	**383**	**100%**

When compared to the patients in the overall hospital discharge data set, it does not seem that minority populations are disproportionately represented among SRE patients. However, given that 8 percent of the SRE patients are listed as unknown and 12 percent are blank, it is difficult to draw any conclusions from this comparison.

Figure 9
Distribution of Patients Involved in SREs by Race
Compared to Total Hospital Discharge Data Set Patients

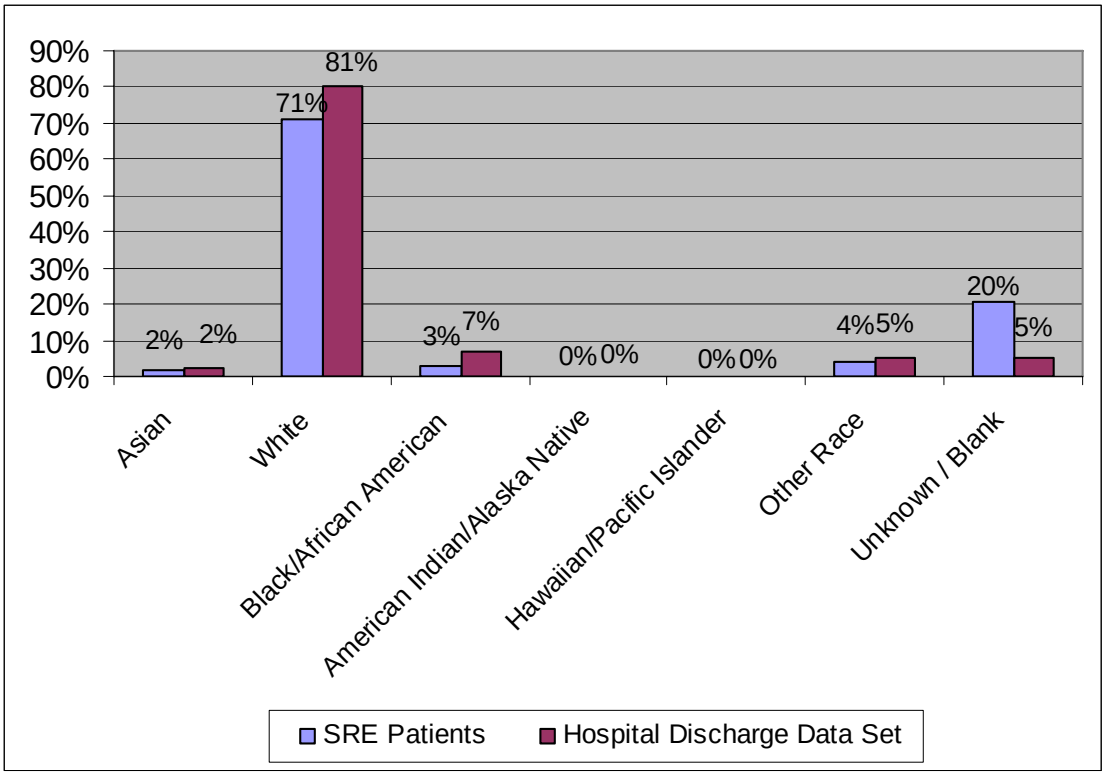


Figure 10 shows the occurrence of SREs by gender. The Department will continue to report gender in future years in order to determine if there are correlations between gender and certain types of SREs.

Figure 10
SREs by Gender

SRE	Number of Events	Percent Female	Percent Male
Fall	199	57%	43%
Stage 3 or 4 pressure ulcers	65	32%	68%
Retained foreign object	42	56%	44%
Wrong site surgery[7]	24	67%	29%
Wrong surgical procedure	9	50%	50%
Medication error	7	43%	57%
Device misuse or malfunction	6	33%	67%
Sexual assault on a patient	6	100%	0%
Burn	4	50%	50%
Maternal death/disability	4	100%	0%
Physical assault[8]	4	25%	50%
Restraint or bedrail use related death/disability[9]	4	25%	50%
Suicide	3	100%	0%
Hypoglycemia	2	50%	50%
Elopement	2	50%	50%
Intravascular air embolism	2	100%	0%
Grand Total	**383**	**53%**	**47%**

[7] The gender of 5 percent of the wrong site surgery patients is unknown
[8] The gender of 25 percent of the physical assault patients or staff is unknown
[9] The gender of 25 percent of the restraint/bedrail patients is unknown

D. SRE Prevention

As anticipated in last year's report, 2009 saw an increase in reported serious reportable events, particularly in stage 3 or 4 pressure ulcers. This is consistent with the Department's expectations that improved familiarity with the reporting process would lead to increases in SRE reporting.

There has been considerable work done statewide on SRE prevention, especially related to falls and pressure ulcers. The groups and initiatives mentioned below are just a sample of the work being done.

- The statewide Falls Prevention Coalition has been working to spread knowledge and create connections among providers to share best practices. With more than 40 members, the mission and vision of the group is to reduce the incidence and severity of falls and fall-related injuries among older adults in Massachusetts. The practice committee of the Coalition hosts call-in sessions for providers to ask questions about fall prevention in practice.

- The Department, along with Senior Whole Health, co-sponsored the May 19th, 2009 Second Annual Falls Prevention Symposium. Over 850 participants around New England and representatives of national organizations came to discuss best practices in falls prevention across all settings of care.

- The Massachusetts Pressure Ulcer Collaborative is in the formative stage of development, with work beginning in early 2009 and a plan for implementation in 2010. The mission of this collaborative is to "support participating health care organizations working together to implement a statewide quality initiative to prevent pressure ulcers across the continuum of care. This will be accomplished through the promotion of best practice, education, and improved communications"[10]. Approximately 30 organizations (hospitals, long term care facilities, home care providers) have expressed an interest in participating in this collaborative.

- In March of 2010, the Massachusetts Hospital Association (MHA) and the Massachusetts Organization of Nursing Executives (MONE) launched the PatientCareLink website[11], which contains extensive information about patient safety, including work being done around falls and pressure ulcers.

- In 2009, the Betsy Lehman Center (BLC), in conjunction with the Bureau of Health Care Safety and Quality and the Board of Registration in Medicine (BORIM), produced the first in a series of patient safety updates. The first update focused on wrong-site surgery and provided case studies and resources to hospitals. This publication is available on the BLC website: http://www.mass.gov/dph/betsylehman. The second update focuses on retained foreign objects.

- The Department is currently working to improve its reporting process in terms of data collection, storage, and sharing among the Department, BORIM, and health care facilities. By February 2011, the Department expects to be operating a single, web-based SRE system that will allow for improved data quality, increased efficiency, and a reduction in system maintenance and cost.

These activities and initiatives, along with many others being conducted statewide, are advancing the work of identifying and reducing SREs in the Commonwealth.

[10] Massachusetts Strategic Plan for Care Transitions
http://www.mass.gov/lhqcc/docs/meetings/2010_02_17_Strategic_Plan_for_Care_Transitions_handout.pdf, p.54
[11] www.patientcarelink.org

E. Hospital Responses

Because the ultimate goal of adverse event reporting is the improvement of patient care, both hospitals and the Department have an interest in developing strategies to help reduce the occurrence of SREs. Since the 2008 report was published in April 2009, many hospitals have made progress in reducing both specific SREs and events across the 6 categories. By highlighting success stories in individual hospitals, the Department hopes to provide examples of effective strategies that can be implemented and disseminated in facilities across the state.

Hospitals were given the opportunity to share success stories in detecting and preventing SREs with the Department. Given the large percentage of Massachusetts SREs that are falls and pressure ulcers, it is not surprising that the stories related to these two events. Not every aspect of the hospital's comprehensive program is presented here. Two of the hospitals (Cambridge Health Alliance and Brigham and Women's Hospital) specifically mentioned internal self-assessments that drew attention to key issues. Identification of safety issues is critical before any improvement can begin, and many hospitals are constantly monitoring and re-evaluating their patient safety needs.

Falls

Cambridge Health Alliance (CHA) – Systemic Risk Assessment Change and Fall Prevention from the Patient's Point of View

When falls were identified as one of their primary adverse events in 2007, CHA looked at their systems and tools and switched from the Morse Scale to the Hendrich II Fall Risk Model, which uses a point system to determine risk. CHA also began using the Get Up and Go Test and found that its ability to determine a patient's risk for falling improved dramatically. Along with improving risk assessment techniques, CHA also took measures to help reduce the number of falls among high-risk patients. Staff began performing additional intentional rounding, which includes asking patients about specific wants or needs that may need to be addressed. They also reassessed the physical environment of the hospital from a patient's point of view, eliminating loose cords and poor lighting that could increase the likelihood of a fall. CHA keeps an internal record of all falls, not just those that are serious reportable events, and has seen an overall decrease in the number of falls that have resulted in injury since 2007.

For more information, contact:

Mary Samost, MSN, RN
Director, Nursing Quality Improvement
msamost@challiance.org

Pressure Ulcers

Beth Israel Deaconess Medical Center (BIDMC) - Using Electronic Systems to Increase Awareness and Prevent Pressure Ulcer Progression

BIDMC has focused on earlier identification of skin breakdown and a consistent intervention response to help prevent the progression of the ulcer. Using their electronic patient safety reporting system, nursing staff report all stage 2, 3, 4 pressure ulcers as well as deep tissue injuries and unstageable ulcers. This alerts the Senior Nursing Leadership team, the Patient Safety Coordinators and the Certified Wound Care Nurses, and the list is widely shared with other nursing staff. Patients with identified pressure ulcers are highlighted on an electronic dashboard, increasing awareness for all members of the health care team. Regular assessment and follow up is done and tracked.

For more information, contact:

Patricia H. Folcarelli RN, PhD
Director, Patient Safety
Silverman Institute for Health Care Quality and Safety
pfolcare@bidmc.harvard.edu

Berkshire Medical Center – Wound Care Specialist "Champions" as Resources for Patients, Family, and Staff

Berkshire modeled its program to prevent pressure ulcers around a similar infection-control program that was already in place. Berkshire established wound care specialist "champions" on every unit to act as a resource for patients, family and staff. Champions attend special pressure ulcer-related information sessions and then bring that knowledge to each unit. Champions are available when staff members have questions about preventing, identifying, staging and treating pressure ulcers. The Berkshire program emphasizes the need for continual re-education for staff members, and the hospital stated that a key element of a champion's job is to "update and reinforce education on things that staff already knows."

For more information, contact:

Victoria Simon, RN,WOCN
Department Director
Wound Ostomy
VictoriaS@bhs1.org

Brigham and Women's Hospital (BWH) – Making Pressure Ulcer Prevention a Hospital-Wide Goal

BWH has focused on reducing the occurrence of pressure ulcers through their Pressure Ulcer Prevention Program, which combines prevention education with new technology throughout the entire hospital. By requiring re-education for the entire nursing staff on current standards, BWH has created a team that is not only competent, but also passionate about preventing pressure ulcers in their patients. Technologies such as pressure redistribution mattresses and the use of Dolphin Pads (computer-controlled mattresses that can redistribute pressure based on a series of patient-specific calculations, such as body weight) during long surgeries are also helping to address pressure ulcers. Much of BWH's work on pressure ulcers has involved staff from different units working together in a holistic approach to prevention. They have cultivated a culture of sharing techniques and methods across units and in multi-disciplinary teams that has helped to make pressure ulcer prevention a hospital-wide goal.

For more information, contact:

Lucy Feild, Ph.D., RN
Quality Program Director
Cardiovascular, Medical, and Emergency Nursing
E-Mail: MLFeild@partners.org