Special Edition

Massachusetts Board of Registration in Medicine
Quality & Patient Safety Division

Fall 2025

Spotlight on Quality & Patient Safety

Spotlight on Quality & Patient Safety **is published by the Massachusetts Board of Registration in Medicine's Quality & Patient Safety Division (QPSD) to present aggregated data from Safety and Quality Review (SQR) reports. The QPSD and the Board's Quality & Patient Safety (QPS) Committee are responsible for monitoring Patient Care Assessment programs at hospitals, ambulatory surgery centers, and certain ambulatory clinics throughout the Commonwealth.**

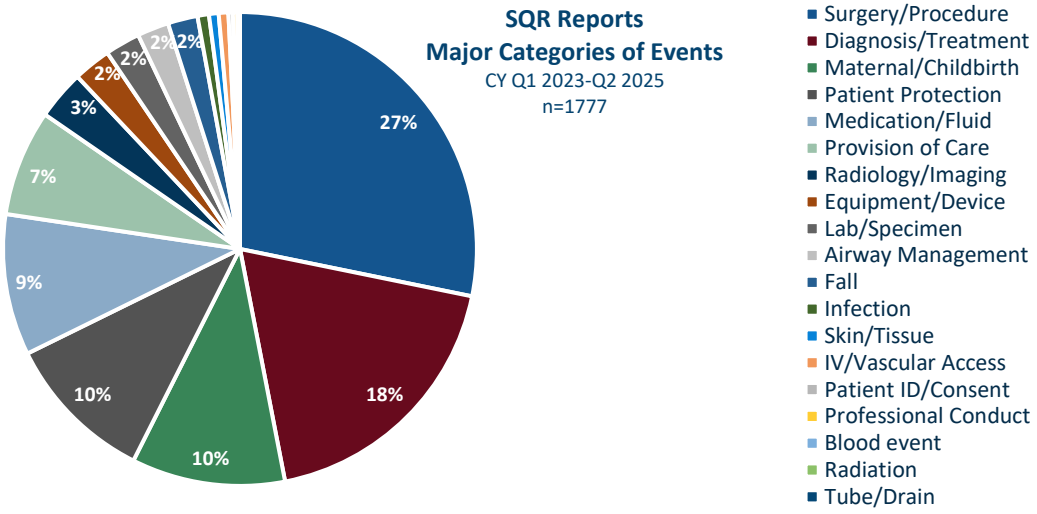
Over the past two years, the Quality & Patient Safety Division (QPSD) has undergone a significant transition to online reporting. This shift has streamlined the process for healthcare organizations to submit reports, with Safety and Quality Review (SQR) reports becoming the most frequently submitted report type. SQR reports specifically focus on documenting patient safety events, allowing for a comprehensive understanding of trends and areas for improvement.

This issue of *Spotlight* will offer SQR aggregate data collected over the last two and a half years. This data provides insight into the patient safety events reported by healthcare organizations during this period, supporting ongoing efforts to enhance quality and safety across the Commonwealth.

Next, *Spotlight* will provide content from the recent Massachusetts Board of Registration in Medicine Quality & Patient Safety 2025 Conference held at **UMass Memorial Medical Center (UMMMC)**. This event was designed to enhance education and foster transparency regarding the committee's patient safety event review process. During the conference, the Board's Quality & Patient Safety Committee engaged participants through role playing and active audience participation. The interactive conference provided valuable Patient Care Assessment education and allowed attendees to gain a deeper understanding of the committee's approach to reviewing patient safety events.

The conference attracted significant interest, with over 230 physicians, nurses, and administrators from all 14 counties of the Commonwealth in attendance. It is important to note that the hospital, the SQR report, and the meeting depicted during the conference were entirely fictional. The scenario was intentionally designed with elements of humor to maintain audience engagement. In this issue, we will highlight some of the key learnings from the conference, as well as share photographs from the event.

QPSD – DATA CENTER UPDATE

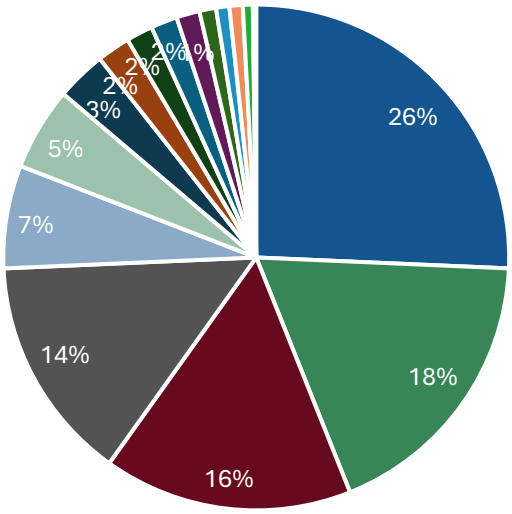


QPSD Mission is to assist Massachusetts healthcare facilities in maintaining and improving systems for patient care that are evidence and team based, sustainable, safe, and inclusive. We achieve this by reviewing data, listening, collaborating, and educating teams in healthcare facilities throughout the state.

Spotlight on Quality & Patient Safety

Surgery/Procedure Events By Type

CY Q1 2023- Q2 2025
n=471



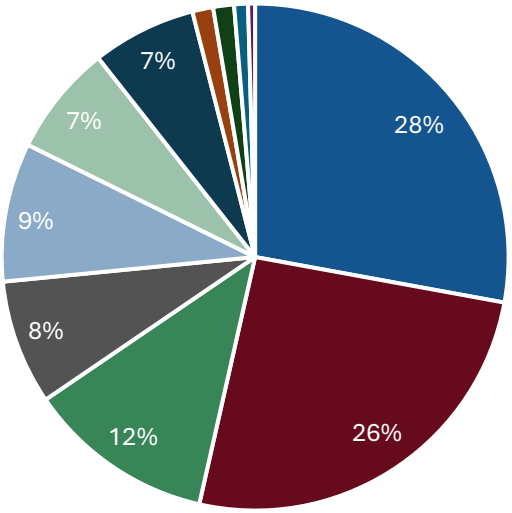
- Complication - Intra-Op
- Wrong site/side/procedure
- Foreign Object Retained
- Complication- Post-Op
- Cardiopulmonary - Intra-Op
- Cardiopulmonary - Post-Op
- Burn
- Neurological - Post-Op
- Irretrievable lost specimen
- Other
- Infection
- Loss/Impairment of limb or eye
- Anesthesia related event
- Wrong Patient
- Contamination
- Implant Issue

Surgery/Procedure Events: A Closer Look

- Intra-Op Complications
  - Perforation w and w/o Hemorrhage/ injury to adjacent organs/structures
- Wrong Site Surgery
  - Central lines
  - Thyroid nodules
  - Dobhoff in lungs
  - Wrong eye/lens
  - Spinal level
  - Nerve block
- Foreign Objects Retained
  - Needles
  - Guidewires-Dobhoff and central lines
  - Plastic sheath
  - Sponges
- Post-op Complications
  - Compartment syndrome extremities
  - Anastomotic leaks
  - Bleeding
  - Infection
  - Toxic Anterior Segment Syndrome (TASS)
  - Post –op retinal detachment

Most Common Locations for Delays in Diagnosis/Treatment

Jan 2023-June 2025
n=226



- ED
- Med/Surg
- Outpatient
- Radiology/Imaging
- Maternal/Child Unit
- OR
- Intensive Care Unit
- Behavioral Health
- Pedi
- Lab
- Endoscopy

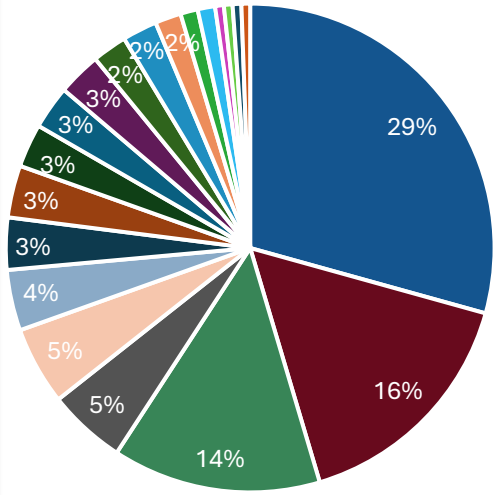
Delay in Diagnosis/Treatement Events: A Closer Look

- Gaps in COMMUNICATION
  - Among specialist consulted
  - Imaging/Lab result not communicated
  - Coordination of Care
- Unable to transfer to higher level of care due to capacity
- Calling RRT (Inpatient)
- Recognizing Sepsis (ED, Inpatient, MCH)
- Recognizing vascular ischemia
- Incidental findings (breast, colon) not communication with delays in treatment
- Arrythmias not noted while on telemetry
- Misread imaging
- EKG readings not appreciated (ED)
- Identification of compartment syndrome
- ED Boarders
  - Lack of behavioral health bed, did not ambulate/provide prophylaxis-PE/DVT
  - Medical process not appreciated due o anchoring on BH diagnosis

Spotlight on Quality & Patient Safety

Maternal/Childbirth Events

Jan 2023-June 2025
n=174



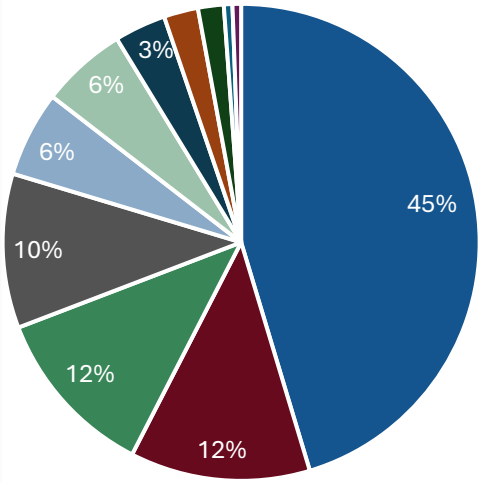
- Post-Partum Hemorrhage
- Neonate - Injury
- Fetal /Neonatal- Death
- Event Related to FHT
- Foreign Object Retained
- Shoulder dystocia
- Maternal Death
- Anesthesia-related event in OB
- Unexpected Transfer ICU/NICU
- Uterine Rupture (VBAC)
- Other
- Cardiovascular event
- Infection
- Complication cesarean section
- AFE/PE
- Neonatal fall
- Magnesium Toxicity
- Maternal - Injury to Body Part or Organ
- Wrong Patient Breastmilk
- Failed instrument delivery

Maternal/Childbirth Events: A Closer Look

- Post-Partum Hemorrhage
  - Abruption
  - Uterine rupture/trial of labor after cesarean Use of estimated (EBL) vs. quantitative blood loss (QBL)
  - Delays in recognizing hemorrhage
- Neonatal Injury
  - Neurological injury
  - Skull fracture
  - Hematoma
  - Laceration
  - Clavicle fracture/arm injury
  - Newborn falls
- Neonatal/Fetal Death
  - Prolonged Category II fetal heart tracing with worsening features
  - Inadvertently tracing maternal heart rate
  - Delay in non-stress test /induction (capacity), returning with demise/distress
- Maternal – Death/Injury
  - Sepsis
  - Cardiovascular collapse/AFE
  - Covid
  - Bladder injury

Patient Protection Events

Jan 2023-June 2025
n= 172



- Self-harm
- Aggressive Behavior
- Abuse
- Suicide
- Inappropriate Discharge or Release
- Elopement
- Unintentional overdose
- Restraint related - Non-head injury
- Other
- Abduction
- Homicide after Discharge

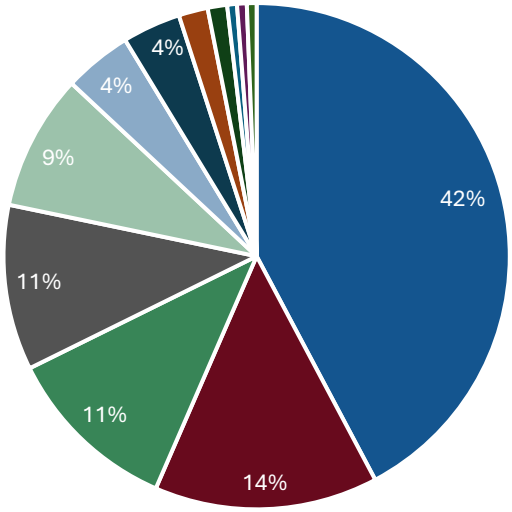
Patient Protection Events: A Closer Look

- Self-harm events
  - Ligature most common
    - Cords of medical devices (CPAP, Oxygen)
    - Cables/cords (phones, personal devices)
    - Hospital Gown ties
  - Ingestion (glass shards, razors, hand sanitizer, button, melatonin, make up, batteries)
  - Laceration (staples, phones, emesis bag
- Aggressive behavior (adolescent, ED boarders)
  - Often lapse with search or visitor policy
- Suicide
  - Soon after discharge and/or while at home
- Lapses in 1:1 monitoring whereby face and hands of patient are not observed at all times

Spotlight on Quality & Patient Safety

Location of Medication/Fluid Events

Jan 2023-June 2025
n= 161



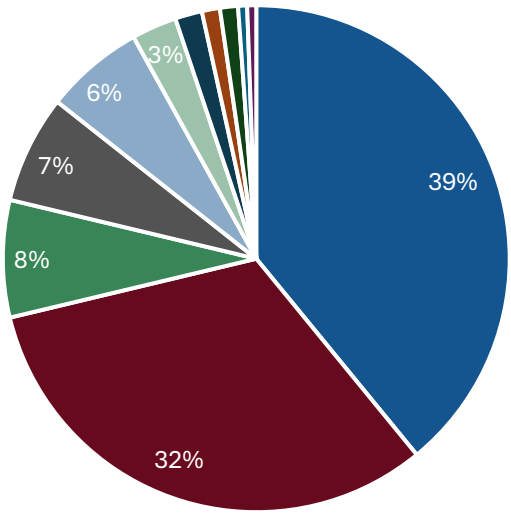
- Inpatient Unit
- Outpatient Unit/Clinic
- Emergency Department
- Operating Room
- Intensive Care Unit
- Behavioral Health
- Interventional Radiology/Cardiology/Neurology
- Pediatric unit
- Labor & Delivery
- NICU/SCN/Well Baby Nursery
- Other
- Radiology/Imaging

Medication/Fluid Events: A Closer Look

- Anticoagulation order issues (especially in post-op period)
- Medications not reconciled appropriately on admission (change of dose)
- IV Pumps Concentration programmed with incorrect dose
- Infusion of entire bag at once due to programming error
- Fall with medication error/issue as possible contributing factor
- Verbal order (order to "give 10", 10mL given instead of 10mg)
- Vancomycin titration protocol not followed
- Data entry error for weight leading to incorrect dose and order
- EMR auto populating incorrect dose
- Failure to scan medication and administering vial with wrong dose

Events Reported By Ambulatory Sites

Jan 2023-June 2025
n=174



- Surgery/Procedure
- Provision of Care
- Diagnosis/Treatment
- Patient Protection
- Fall
- Maternal/Childbirth
- Airway Management
- Infection
- IV/Vascular Access
- Professional Conduct
- Medication/Fluid

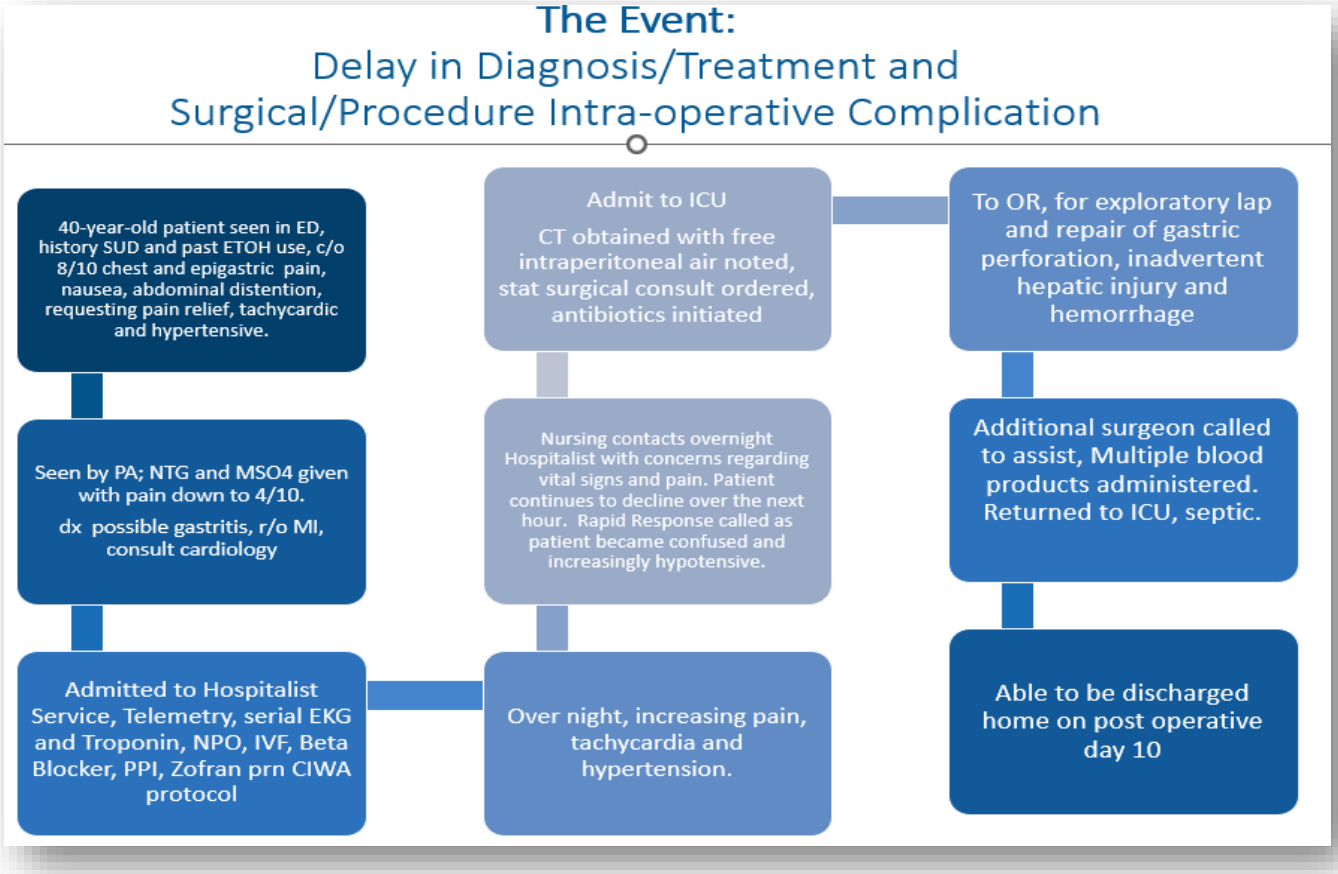
Ambulatory sites refers to clinics and ambulatory surgery centers licensed pursuant to M.G.L. c. 111, § 51

Ambulatory Site Reported Events: A Closer Look

- Intra and post-operative complications
  - Perforation (endoscopic) and hemorrhage (OB and GYN)
  - Cardiovascular complications
  - Injury/Infection to eye
  - Burns
  - Bleeding after restarting anticoagulation too soon after procedure
  - Toxic Anterior Segment Syndrome (TASS)
  - Cellulitis at IV site
- Wrong site/side surgery
  - Joint injections
  - Skin lesions
  - Eye/lens
- Provision of care events
  - Primarily transfers to a higher level of care (cardiac issues)
  - Issues with "add-on" patients
  - Issues with medication instructions
- Patient Protection events included:
  - Suicide
  - Self-harm events
  - Aggressive Behavior

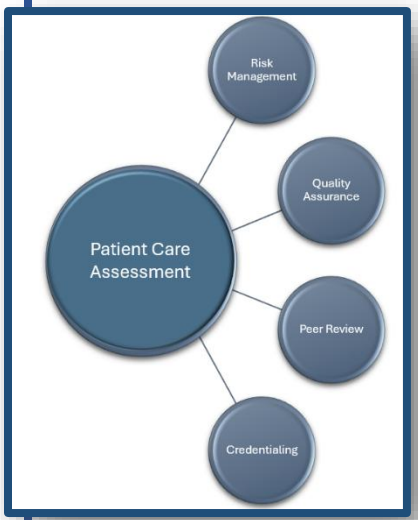
Quality Patient Safety Committee - Fall Conference 2025

The audience reviewed a fictitious SQR report involving a delay in diagnosis. The audience (acting as the QPS Committee) deliberated and determined that the information provided in the SQR did not illustrate a comprehensive Patient Care Assessment Program, and therefore a meeting was in order. Using role-playing techniques, a meeting between the fictitious hospital's leadership and the QPS Committee representatives was demonstrated. During this session, participants were asked to evaluate whether the hospital's safety structure was sufficiently robust to identify and address both system-level and practitioner-specific issues. The audience expressed the concerns and suggestions noted on page six.



Patient Care Assessment Program Components

- **Risk Management-** Includes the ability to identify and respond to patient safety events.
- **Quality Assurance-** Includes the ability to create strong actions plans to mitigate risk of occurrence or recurrence of patient safety events and near misses. Ability to use internal incident reporting and complaint data to prioritize performance improvement activities.
- **Peer Review-** Demonstrates the implementation of ongoing processes to assess provider performance, skill, and judgement that utilizes provider performance/outcome metrics.
- **Credentialing**- Compliance with biannual requirement that incorporates peer review findings, performance metrics, and ongoing/focused professional practice evaluations.



Quality Patient Safety Committee - Fall Conference 2025

Audience concerns and suggestions:

Organizational Quality Structure of the fictitious hospital

- Flow of information throughout organization appeared siloed.
- Suggested that organization consider rebuilding the reporting structure so that information and reporting flows horizontally in addition to vertically.
- The Board did not appear to be engaged. Unclear if the organization's board understands quality.
- Unclear if leaders understood the need for adequate resources for quality, risk, patient safety work.

Peer Review

- Inconsistent among departments. Some areas did have a process, but they were not explained.
- Nursing peer review absent in report.
- Impact on "third victim"….not included in any information submitted in SQR nor in the discussions at the site visit. No supports or resources for providers discussed.
- No system of monitoring and tracking of skills, knowledge, judgement of providers.
- No provider performance metrics were considered in review.
- Surgical complication was accepted as a "known complication" without a review of provider performance or a review for possible trends.

Systems

- There was a missed opportunity to improve systems like early warning systems, sepsis, etc.
- Physicians did not participate in the root cause analysis (RCA).
- How does this organization decide who the participants of RCA should include? Some organizations include the staff involved; others do not. It is worthwhile to ask the staff proximal to the event to participate as there is a potential wealth of information to share.
- Was the internal review process thorough? Were they asking "why"? Were the delays addressed?
- Concern re: culture of safety and communication in this organization.
- Can they do more than just education as an action plan to prevent recurrence of the event?

In considering the strength of an action plan in response to a Patient Safety event, the QPSD suggests referring to the Veterans Affairs Root Cause Analysis System: *An Analysis of Adverse Events in the Rehabilitation Department: Using the Veterans Affairs Root Cause Analysis System, 2018.* An Analysis of Adverse Events in the Rehabilitation Department: Using the Veterans Affairs Root Cause Analysis System - PubMed. By combining several actions of different strengths, the action plan to prevent a recurrence of a patient safety event is stronger. Some examples of action items in response to the fictitious event presented at the conference are listed below.

Behaviors & Systems: Strength of Actions

STRONGER ACTIONS SYSTEM-FOCUSED	Resilient system solutions that make the behavior contributors (Human error and choices) inconsequential • Effective automation • Forcing functions • Architectural plan improvements • Elimination of universal adaptors for medical equipment such as IV tubing/connectors
MODERATE ACTIONS SYSTEM/BEHAVIORS FOCUSED	Strengthened systems solutions combined with improved perception of risk and behavioral choices • Eliminate /reduce distractions • Checklist /cognitive aides • Standardization of equipment and processes (IV pumps, bar code scanning) • Education with simulation/drills (challenge how to include all staff/MDs, etc.) • Double independent checks • Standardized communication tools (read backs, IPASS, SBAR hand off)
WEAKER ACTIONS BEHAVIOR –FOCUSED	Behavior-Focused attempts to manage risk solely through rule compliance, education, or the addition of procedural steps without strengthening system • Education • Additional documentation • Warnings, signs • Review and/or implement new procedures /polices

The goal is to create a sustainable, strong action plan to mitigate the chance of recurrence of a patient safety event.

Possible Actions:

Behavior focused (weak): Ongoing implicit bias training. Consider incorporating an "awareness pause" in decision making.
Behavior focused (weak): Educate nurses on recognition and response to changes in patient status.

Combination behavior and system focused (moderate): Create a formal orientation and ongoing learning quality assurance and Patient Care Assessment educational program for Board members.
Combination behavior and system focused (moderate): Implement a didactic and experiential learning experience by pairing diagnostic error CMEs with case studies, simulation, and collaborative learning with group discussions.
Combination behavior and system focused (moderate): Consider creating a Chairs and Chiefs Committee to support Chairs and Chiefs in the peer review process and assist with creating a process within the system for external peer review.
Combination behavior and system focused (moderate): Education and implementation of communication tool (SBAR, IPASS).
Combination behavior and system focused (moderate): Implement a fair and consistent approach/process to peer review (see below).
Combination behavior and system focused (moderate): Create a resource program during off hours whereby the resource nurse rounds on novice nurses and reviews patient assignments and concerns OR develop a program whereby a resource nurse can identify patients in the EMR with abnormal vital signs or changes in vital signs to be able round on those patients.

System-focused (strong): Explore addition of (IT) early warning systems for sepsis and changes in vital signs to alert nurses for need for urgent further assessment and action
System-focused (strong): Force function which limits or regulates copy/paste function in EMR (electronic medical record).
System-focused (strong): Create a quality organizational structure that flows laterally as well as upward. Improve transparency by sharing information regarding patient safety events with the Board, Departments, Nursing, and Ancillary departments to promote a non-punitive culture of learning.

Adopt a fair and consistent approach to peer review

Peer review: A review of performance, skill, and judgement.

- Establish and document standard workflows for peer review.
- Create a fair and consistent process by
  - Standardizing the process and frequency so it is the same for all
  - Define clinical performance measures and benchmarks.
  - Include performance metrics that are outcome-based and not just fiscal-based.
  - Using internal and/or external benchmarks to compare providers to peer groups.
  - Define the methods used for collecting information (e.g., chart review, direct observation, etc.).
  - Ensure feedback to credentialed providers is consistent and respectful.
- Determine when external review would be indicated.
- Ensure tools, education, and supports are available.
- Document guidelines for how peer review is used for re-credentialing.

Quality Patient Safety Committee - Fall Conference 2025

Many thanks to the following individuals that participated in the conference:

- ***Booker T. Bush, MD**, Chair, Massachusetts Board of Registration in Medicine (BORIM)
- ***Yvonne Y. Cheung, MD, MPH, MBA**, **CPHQ**, Chief Medical Officer, Baystate Health; Physician Member, BORIM; Chair, BORIM Quality & Patient Safety Committee
- ***Carrie Arrieta, MSHM, CPHRM**, Vice President, Patient and Family Relations, Mass General Brigham
- ***Sarah Rae Easter, MD,** Maternal Fetal Medicine & Critical Care Medicine, Brigham and Women Hospital
- **Janell Forget RN, BSN, JD, CPHRM, FASHRM,** Associate Vice President of Risk Management, UMass Memorial Health
- ***William H. Goodman, MD, MPH,** VP Medical Affairs & Ambulatory Practices, Merrimack Health
- ***Diane Hanley, MSN, RN-BC, EJD**, Associate Chief Nursing Officer, Nursing Education, Quality & Professional Practice, Boston Medical Center
- ***Michael E. Henry, MD,** Medical Director, Dauten Family Center for Bipolar Treatment Innovation, Director of Electroconvulsive Therapy (ECT), Massachusetts General Hospital
- **Beth Jackson, MS**, Senior Risk Manager, Tufts Medical Center
- **Andrew Karson, MD, MPH**, President, UMass Memorial Medical Group, and Chief Physician Executive, UMass Memorial Health
- ***Pardon R. Kenney, MD, MMSc, FACS**, Staff Surgeon, Brigham and Women's Faulkner Hospital, Senior Lecturer in Surgery, Harvard Medical School
- **Kimi Kobayashi, MD, MBA, SFHM, VP**, Chief Medical Officer, UMass Memorial Medical Center
- **Erica Ravenelle,** Project Coordinator, UMass Memorial Health
- ***Julian N. Robinson, MD, MBA,** Obstetrics and Gynecology-Maternal-Fetal Medicine, Beth Israel Deaconess Medical Center and Winchester Hospital
- ***Marc S. Rubin, MD,** Chair of Surgery, Colon and Rectal Surgery, General and Gastrointestinal Surgery, Salem Hospital
- ***Melissa J. Sundberg, MD, MPH**, Associate Physician in Pediatrics, Division of Emergency Medicine, Boston Children's Hospital; Physician Member, Board of Registration in Physician Assistants
- ***Meghna C. Trivedi, MD, FACP, FHM,** Hospital Medicine, UMass Memorial Medical Center
- **George Zachos, Esq.,** Executive Director, Massachusetts Board of Registration in Medicine

*Member, BORIM Quality & Patient Safety Committee

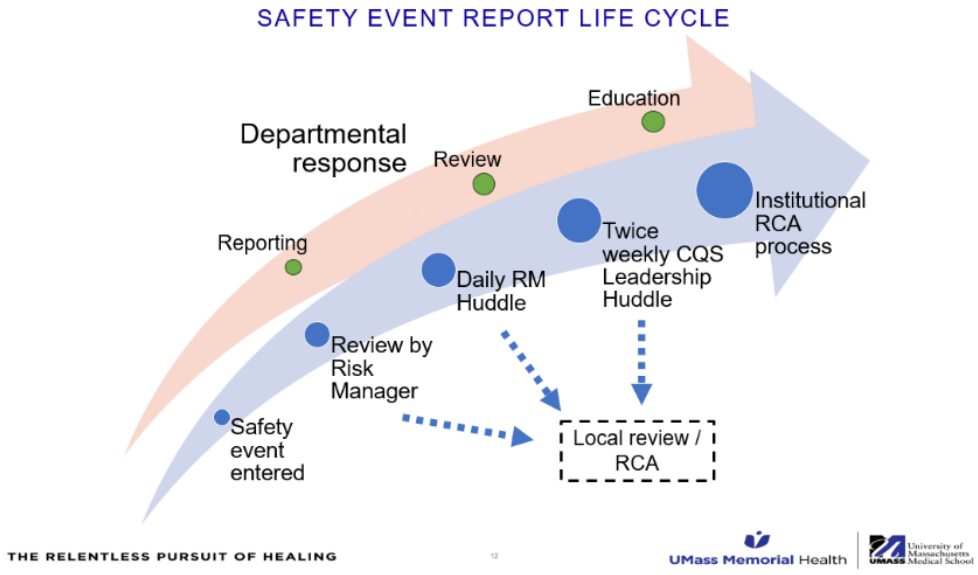
SPOTLIGHT: UMass Memorial Health

When a safety event turns into a peer review event

Janell Forget RN, BSN, JD, CPHRM, FASHRM, Associate Vice President of Risk Management
Andrew Karson, MD, MPH, President, UMass Memorial Medical Group, and Chief Physician Executive
Kimi Kobayashi, MD, MBA, SFHM, VP, Chief Medical Officer, UMass Memorial Medical Center

UMass Memorial Health provided a presentation during the conference describing their patient safety event report life cycle and peer review process. After a patient safety event is entered and reviewed by a Risk Manager, it may be presented at a safety huddle. During these safety huddles, factors such as reportability, potential review needs, and potential disclosure are discussed. The event may be referred for further leadership review.

Center for Quality and Safety Leadership Huddles



Review of a case may lead to one or more of the following:

- Continued investigation
- Decision to report case as a Serious Reportable Event (SRE) to DPH or a Safety Quality Review (SQR) report to BORIM
- Schedule Root Cause Analysis or Multi-disciplinary Review
- Send to Morbidity & Mortality (M&M) conference or Grand Rounds
- Requires potential Peer Review. This would be a decision reviewed by the Chief Medical Officer and Chair

Triggers of Peer Review

The current bylaws of UMass Memorial Medical Center define the following as triggers for a Peer Review:

- Failure to fulfill applicable standards of clinical practice, including conduct which is disruptive to the delivery of patient care, or disruptive behavior which negatively impacts the work environment for other members
- Unprofessional conduct
- Failure to comply with the bylaws, policies, procedures
- Failure to comply with regulatory standards, including BORIM
- Probation of a professional license
- Conviction of a misdemeanor indicative of poor moral or ethical behavior
- Question of performance by quality assessment

Peer Review Goal and Process

The Peer Review findings and any Corrective Action Plan (CAP) that is developed go to our:

- Medical Executive Committee for potential approval and/or modification
- Board of Trustee's Patient Care Assessment Committee (PCAC) for potential approval and/or modification
- At all times, patient safety is paramount, and modifications and/or restrictions to the physician's practice will stay in effect during the process based on the Chief Medical Officer's determination and as allowed by the institutional bylaws.

Corrective Action Plans and Follow-ups

Effective Correction Action Plans:

- Aim to address the specific quality, safety, behavioral, compliance, and/or other concerns raised through the Peer Review processes
- Are clear, actionable, and measurable
- Are well-documented with specific tracking and follow-up milestones, and with loop closure

An important consideration is that Peer Review Committee outcomes, and their associated Corrective Action Plans need to be well cataloged, stored and tracked within the institution's infrastructure. Over time, patterns may develop, and knowledge of previous events can be instrumental in ensuring the full assessment and actions related to future events.

Medical Staff Peer Review Vs. Human Resource Pathway

Often the behaviors and actions that lead to Peer Reviews are the very same actions that lead to a physician being disruptive from a human resources point of view.

- Poor and/or disruptive communication with others
- Creating non-productive working environment
- Being non-truthful
- Being non-compliance with policies, etc.

We have deliberate discussions regarding when to go down either or both the Peer Review versus the Human Resources pathways. Considerations include:

- Is there potential risk to patient safety that can be best understood and addressed through a Peer Review Process? This consideration is especially important when there is a real chance that the physician may end up being separated from the organization, because we do not want to "kick the can" down the road to future organizations.
- Which process will get us to the most expeditious outcome? Especially when considering the appeals processes embedded in our Peer Review processes.

Human Resource investigations, deliberations, and actions are not inherently peer protected.

SAVE THE DATE
Virtual Patient Care Assessment Bootcamp
February 6th, 2026
9am-12pm

More information to come in December for users of the online reporting portal.

Reporting Reminders

Ambulatory Surgery Centers and Ambulatory Clinics
PCA-QA Reports
(or Annual & Semi-Annual Reports)
Due by March 30, 2026

Hospitals
PCA-QA Reports
(or Annual & Semi-Annual Reports)
Due by April 30, 2026

Questions and comments may be directed to
Trinh Ly-Lucas, MSN, AGNP-BC
Quality Nurse Analyst

trinh.ly-lucas@mass.gov

Patient Care Assessment (PCA) program and online reporting guidance including video tutorials, examples of fictitious SQR reports, and an overview of Patient Care Assessment may be found at:
Patient Care Assessment Program | Mass.gov