Commonwealth of Massachusetts
Board of Registration in Medicine
Quality and Patient Safety Division

The Importance of Safety and Quality Review (SQR) Reporting

October 2012

Issue

Through submission of Safety and Quality Reviews (SQRs), health care facilities are able to demonstrate to the Quality and Patient Safety Division (QPSD) that they have systems to identify and review unexpected or adverse patient outcomes. SQRs provide reassurance that these systems include both internal incident reporting and medical record screening processes; are applied consistently across patient care services; and reflect a culture that encourages health care providers to report quality and safety concerns that cause or can potentially cause patient harm. The recent findings by the Office of Inspector General for Health and Human Services (OIG) on Incident Reporting Systems provide additional guidance.[1]

The types of events that the QPSD expects to be reported as SQRs occur in significant numbers in health care facilities. A 2010 OIG Report found about one in seven hospitalized Medicare beneficiaries experienced an adverse event that resulted in a prolonged stay, permanent harm, life-sustaining intervention or death. [2]

The QPSD has begun sending letters to health care facilities that have not reported any SQRs in a recent quarter. These letters are intended to call this information into view and to pose the question to facility leadership: "Are we confident that our systems for identifying and reporting adverse events are robust?"

This issue of reporting adverse events also calls attention to the Board of Trustees' responsibilities, as they are accountable for and should be expected to regularly review cases meeting this definition as demonstration of the organization's robust reporting mechanisms and more importantly, the organization's response in learning and acting upon the event.[3]

These points are also reinforced by the Centers for Medicare and Medicaid Services' (CMS) Conditions of Participation: Quality Assessment and Performance Improvement (QAPI) program. The QAPI program requires hospital and ambulatory surgery center governing bodies to be responsible for ensuring that facilities are tracking adverse events, analyzing their causes and implementing preventative actions and mechanisms that include feedback and learning.[4]

What can be done?

The National Quality Forum (NQF) recommends that risks and hazards should be identified from multiple sources including: independent retrospective, real-time, near real-time and prospective reviews. The organizational culture should be framed on a system focus and blame-free reporting and should use data to support a just culture.[5] This culture should encourage and expect reporting of adverse events to come from all employees and the medical staff.

The OIG report cited above (OEI-6-09-00091) found that none of the hospitals involved in the study maintained a list of events required to be reported to incident reporting systems and of the events found, only 14% were reported. Of the 86% of events that were not reported, administrators recorded that 62% would not have been perceived by staff as reportable. Hospitals should create a list of reportable events and regularly train staff on what and how an event should be reported.

The OIG recommends that the Agency for Healthcare Research and Quality and CMS should create and promote a list of potentially reportable events and provide technical assistance to hospitals in using the list. According to the OIG report, both agencies support the recommendation.[6]

A health care facility's senior leadership should implement proactive efforts on patient safety design, measurement, assessment and improvement. Leaders should set a goal of establishing an environment of trust with a non-blaming, responsibility based approach to the cause of incidents and errors and establish these practices as policy.[7]

Boards and senior leaders should be regularly and thoroughly briefed on the results of the activities undertaken to identify risks and hazards. Meetings and documentation should ensure that leaders are kept knowledgeable about the issues and involved in the processes to ensure that issues are addressed and patient safety is improved.[8]

Conclusion

The QPSD hopes this advisory will call health care facility leadership, including Boards of Trustees, to examine their processes for reporting, tracking and analyzing adverse events, and their role and accountability in this important process. This in turn, we believe, will encourage and support more internal reporting and subsequently, more SQR reporting to the QPSD.

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[1] Levinson, D.R. (2012, January). Hospital incident reporting systems do not capture most patient harm. Office of the Inspector General, Dept. of Health and Human Services. http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf

[2] Levinson, D.R. (2010, November). Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries. Office of Inspector General, Dept of Health and Human Services. p15. http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

[3] Safe Practices for Better Healthcare – 2010 Update. NQF. April, 2010. p75. Accessed on September 5, 2012 at http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx

[4] 42 CFR §482.21; 42 CFR § 416.43.

[5] NQF, p105, (citing Nuckols 2009; Provonost, 2009b).

[6] Levinson, 2012, January, pp 20, 22.

[7] Strategies for Leadership, Hospital Executives and Their Role in Patient Safety. American Hospital Association. 2001, p5.

[8] NQF, p6, citing IHI, 2009a and Conway 2008.