

# FIRST

## Do No Harm

Quality and Patient Safety Division Massachusetts Board of Registration in Medicine

### Message from QPSD Leadership

Julian N. Robinson MD  
Chairperson QPSC

Deborah Farina Mulloy PhD, RN, CNOR  
Director QPSD

Dear Colleagues,

Since our Spring issue of **FIRST**, the Quality and Patient Safety Division (QPSD) has been hard at work to implement some of the changes we discussed at the spring Quality and Patient Safety conference held in March.

QPSD continues rebuilding and redesigning our efforts with key objectives in mind. These include more regular visits to health care facilities across the state and sharing trends that emerge as “hot topics” for educational sessions at individual health care facilities, and at our spring 2020 program, scheduled for March 27, 2020. Through onsite visits and face to face educational offerings we are building relationships with health care facilities, sharing lessons learned and effective patient safety practices. This newsletter will be published three times a year as another way to communicate. Look for Quality and Patient Safety advisories biannually for more in depth information on emerging trends. We will continue to provide feedback annually through the Health Care Facility Reports (HCFR,) which now include highlights of improvement initiatives implemented and sustained from facilities across the state. Over 95% of health care facilities have received a HCFR from us over the summer.

The transparency of reporting by health care facilities helps each individual facility to improve while providing valuable information that allows QPSD to identify trends, share alerts, best practices and lessons learned.

We look forward to your feedback and continued engagement with us to make Massachusetts the safest health care system.

### We Heard You... Changes in Reporting

Based on feedback from PCA Coordinators, QPSD will now accept the 30day DPH Incident Report Form for reporting quarterly Pressure Injury and Falls. It's as easy as 1 2 3

- 1) photocopy the DPH 30day Incident Report Form and send it with a cover letter to the Massachusetts BORiM Quality and Patient Safety Division 200 Harvard Mill Square Suite 330 Wakefield, MA 01880.
- 2) In the cover letter include the total number of falls and pressure injuries (SREs) that are enclosed
- 3) Submit quarterly to QPSD

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*The first quarterly report  
for pressure ulcers and  
falls is due by*

*January 31, 2019 for  
data collected from  
October 1, 2019-  
December 31, 2019*

## Resolving Challenges of Type IV Reporting

Marc S. Rubin MD, Chair, NSMC Department of Surgery and QPS Committee Member

### Major Reportable Events

#### Type I:

Maternal deaths that are related to delivery

#### Type II:

Death in the course of, or resulting from, elective ambulatory procedures

#### Type III:

Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part

#### Type IV:

All deaths or major or permanent impairments of bodily functions (other than those reported above) that are not ordinarily expected as a result of the patient's condition on presentation

Type IV case reporting is an ongoing challenge for many of us. Each quarter, health care facilities (HCF) are required to report Major Incidents as defined in 243 CMR 3.08(2) (a) through (d) to the Board of Registration in Medicine (BORiM) Quality and Safety Division (QPSD). This reporting is not punitive. Rather it provides the QPSD with a window into the structure and processes that facilities have in place to ensure their systems and providers are delivering safe, high quality care. Reporting also enables aggregation of safety events so that the QPSD can provide alerts and early warnings to facilities and providers about event trends, risks and developing safety concerns.

### To Report or Not To Report?

While the first three incident types are straightforward to interpret, Type IV cases can be challenging. What is considered a major impairment can be subjective. What might reasonably be expected given a particular patient presenting with particular constellation of findings may be open to debate. To assist facilities in thinking about Type IV reporting, the QPSD recommends considering a yes answer to any of the following questions as an indicator that reporting is appropriate:

- 1) Did the event meet the criteria for a Serious Reportable Event (SRE)?
- 2) Was there a gap in process, communication, and/or coordination of care that may have led to a delay in diagnosis/treatment or a missed finding?
- 3) Did the event involve clinicians who did not adhere to process, protocol, or evidence-based practice?
- 4) Did the event result in a change in your systems?
- 5) Did the event uncover ineffective processes in your systems, providers, or employees?

### Other Considerations to Keep in Mind

- preventability should not impact reporting. Whether an event is determined to be preventable or non-preventable, opportunities for improvement may be identified.
- near miss events are not required, however, if the near-miss events resulted in a significant process improvement or initiative, QPSD recommends reporting of the event as a near-miss event.
- QPSD is primarily focused on a HCF's review and response to the event rather than the event itself

Guidance may be obtained from QPSD Analysts. Please contact Mali Gunaratne, Administrative Assistant, at 781-876-8243 or [mali.gunaratne@massmail.state.ma.us](mailto:mali.gunaratne@massmail.state.ma.us) for assistance.

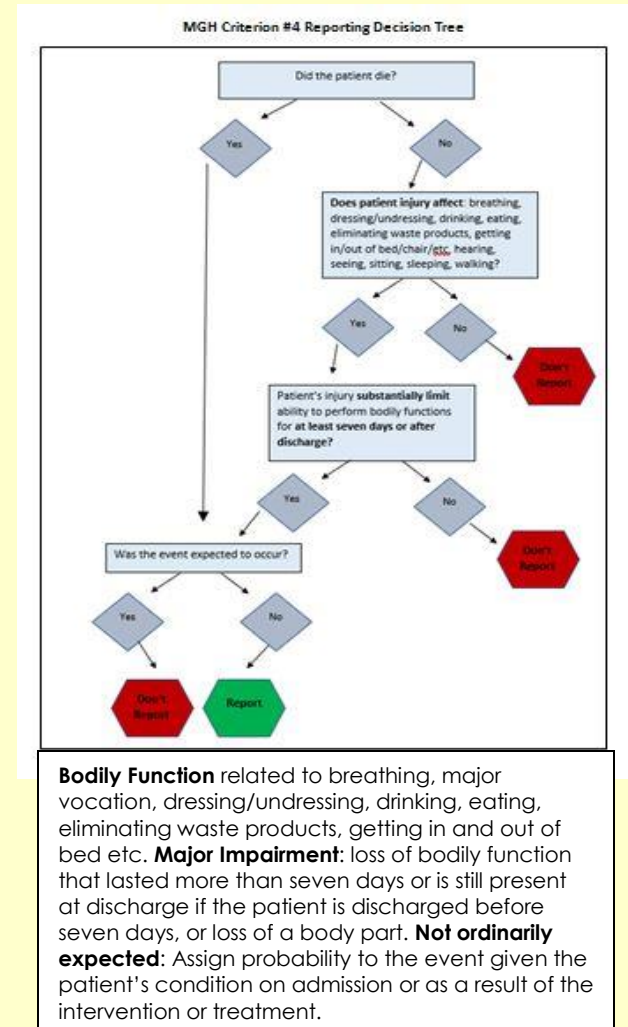
## Massachusetts General Hospital (MGH) Decision Tree for Case IV Reporting

Kayla McEachern JD, Sr Consultant Patient Safety, Jana Deen RN, BSN, JD Associate Chief Patient Safety and Elizabeth Morf MD, MPH Sr VP Quality & Safety

In 2010, MGH conducted a research and improvement project to better understand our threshold for reporting Criterion #4s to the BORIM. While the first three Safety and Quality Review (SQR) criteria involve specific outcomes and are clear, the fourth criterion is more general and interpretive.

We conducted a retrospective analysis of all our 2009 SQRs and assessed the degree of consistency in our Criterion #4. We discovered three main areas of ambiguity that lead to variable reporting: (1) major vs. minor, (2) causality, and (3) expected vs. unexpected. With these three ambiguities in mind, we sought out a tool that would help provide us with more clarification and definitions.

The Minnesota Hospital Association Patient Safety Registry Advisory Council had been working on recommendations for definitions related to adverse events in 2010. We chose to use its definitions for "bodily function," "major impairment," and "not ordinarily expected." These definitions are at the right. The tool at the right is used for quality and patient safety meeting.



## Decreasing Maternal Mortality Levels of Maternal Care

Regionalization of maternity care in which high-risk women are referred to delivery centers equipped with the resources and personnel to manage their anticipated needs is one proposed strategy to decrease maternal mortality. National guidelines use existing evidence from the trauma and neonatal literature to outline a framework for Levels of Maternal Care but provide little guidance about implementation. A collaborative among the Perinatal Quality Improvement Network (PNQIN), of Massachusetts, the Department of Public Health, and the BORIM Quality and Patient Safety Division (QPSD), has investigated strategies for instituting a system for designating maternal levels of care in the state.

PNQIN is leading this effort by engaging key stakeholders in a Task Force dedicated to improving systems to provide risk-appropriate maternal care through a quality-improvement oriented collaborative approach. The Task Force led by Sarah Rae Easter MD, held its inaugural meeting in June at the Betsy Lehman Center for Patient Safety and is looking forward to the ongoing engagement of stakeholders as the process moves forward. More information on levels of maternal care is available at <https://s3.amazonaws.com/cdn.smfm.org/publications/277/download-ad-8e5adbfe83851c8179e78667026d13ca.pdf>

Send your questions, concerns, or interest about the designation of Levels of Maternal Care in MA to Daniela Brown, RN, Nurse Analyst at [Daniela.brown@state.ma.us](mailto:Daniela.brown@state.ma.us)

## Betsy Lehman Center Resources and Updates

**Sepsis Awareness: The Massachusetts Sepsis Consortium** is a multi-stakeholder effort to reduce sepsis morbidity and mortality in the state. Together, the Consortium is:

- Launching a "Sepsis Smart" public awareness campaign this fall. Targeting family health care decision-makers, the key message is: Sepsis Smart: Know the Signs. Act in Time.
- Supporting emergency departments to improve diagnosis and treatment of sepsis across the state through recommendations and resources compiled by a special task force of the Consortium.
- Working with long term care and home health providers to develop recommendations and tools for early detection and response to sepsis symptoms.

**Massachusetts Healthcare Quality and Safety Consortium:** More than 25 public and private organizations, including QPSD, have joined forces to accelerate the pace of improvement in the safety of the state's health care system in response to the Center's research on the financial and human cost of medical error. The group held its first meeting in July and will develop a statewide strategic approach to reducing persistent and emergent safety risks in all care settings.

**Safety in Massachusetts Emergency Departments:** In July, an Expert Panel on Safety in Emergency Medicine released recommendations to address three key areas of concern to ED clinicians: crowding, cognitive overload and care transitions.

**Peer Support:** The Center is working with 15 health care organizations across Massachusetts to pilot [peer support programs for clinicians and staff](#) involved in patient harm and other difficult events in their workplaces. Concurrently, the Center is working to connect patients and families harmed by these events with trained peer supporters who have been through similar experiences.

### QPSD Hosts Successful Spring Conference

One hundred and forty-four participants attended the Board's Quality and Safety Program held at UMass Medical Center in March 2019. The program featured updates on the Patient Care Assessment (PCA) Program and presentations on "Hot Topics" ranging from Sepsis, postoperative mortality, and psychiatric patients in the ED to systems improvements in obstetrics generated by a "near miss event."

By popular demand, QPSD will host a spring conference: Collaborating to Promote Safe Patient Care Practices-Diverse Settings Common Goals on **March 27, 2020** (see upcoming events on page 5).

### September is.... Sepsis Awareness Month

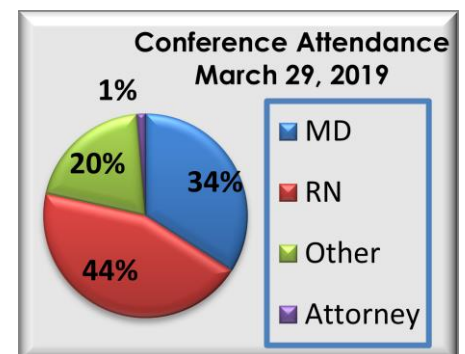
For More Information on Sepsis Visit

[BetsyLehmanCenterMA.gov/initiatives/sepsis](https://BetsyLehmanCenterMA.gov/initiatives/sepsis)

See the research and read about the MA Healthcare Quality And Safety Consortium's first steps at [BetsyLehmanCenterMA.gov/initiatives/massachusetts-healthcare-safety-and-quality-consortium](https://BetsyLehmanCenterMA.gov/initiatives/massachusetts-healthcare-safety-and-quality-consortium)

The report, toolkit, and case studies from Massachusetts hospitals can be found on the Center's website: [BetsyLehmanCenterMA.gov/EDsafety](https://BetsyLehmanCenterMA.gov/EDsafety)

If you know someone who might like to be trained to offer support to other patients and families, please share this link: [BetsyLehmanCenterMA.gov/for-patients/patient-support](https://BetsyLehmanCenterMA.gov/for-patients/patient-support)



## Hot Tips

### T<sub>AVR</sub> R<sub>ecall</sub>

Double check product recall lists for Transcatheter aortic valve replacements (TAVR). Reports have been made of loose fragments (RFO) on products that have been recalled.

### E<sub>MR</sub>

Do you have data fields that dictate patient care? Stay alert for information that automatically populates to complete the information field... It may be incorrect!

Do complex care plans (POC) follow the patient to different areas (inpatient and outpatient) and/or other healthcare facilities? This is especially important for highly complex patients who are seen in different healthcare facilities in a system/network.

### M<sub>RI</sub>

Patients who are not required to change into hospital provided gowns have been noted to retain metallic objects on their person. Stay alert to this potential patient safety issue.

Cochlear I<sub>mplants</sub> approved for the MRI suite may have additional manufacturer's guidelines to follow. Be sure to read the fine print!

## Regulation Update 243 CMR Chapter 2.0

The Board of Registration in Medicine recently amended regulations on licensing and the practice of medicine (243 CMR 2.00). To provide further clarification and guidance, please refer to the link on Frequently Asked Questions:

<https://www.mass.gov/files/documents/2019/09/06/243CMR2-FAQ-20190906.pdf>

All questions regarding these regulations should be directed to the Call Center at the Board of Registration in Medicine at 781-876-8230 press 1 then press 5.

## Hold The Dates

SEPTEMBER						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER						
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13	14	15	16	17	18	19
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27	28	29	30	31		

NOVEMBER 2019						
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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

September 30 Semi-Annual Reports Due

October 30 Safety Quality Review Due

November 1 Patient Care Assessment Workshop Board of Registration Offices Wakefield MA 8:00am -12:30pm Pre-registration required. Details to follow.

March 27, 2020 QPSD Spring Program UMASS Medical Center Albert Sherman Center ASC Auditorium 8:00-12:30pm Pre-registration required. Details to follow

## QPSD Staff Contributors

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