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Serious Reportable Events in 2016

Acute Care Hospitals, Non-Acute Care Hospitals

and Ambulatory Surgical Centers

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* Overview
* Purpose
* Background
* Serious Reportable Event Category Definitions
* Outcomes
* Quality Improvement Activities

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This presentation is given for the following purposes:

* To provide an update of the Serious Reportable Event program and related quality improvement activities at the Bureau of Health Care Safety and Quality; and
* To share the trends in the types and volume of Serious Reportable Events reported in 2016 and previous years.

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Background

* Adverse events that occur in the health care setting are a patient safety concern and public health issue.
	+ The Office of the Inspector General found that adverse events occur in 13.5% of hospital admissions of Medicare beneficiaries (2010).
	+ It is projected that 10% of Medicare patients nationally experience an adverse event during a rehabilitation hospital stay (OIG, 2016).
	+ Section 51H of chapter 111 of the Massachusetts General Laws authorizes the Department to collect adverse medical event data and disseminate the information publicly to encourage quality improvement.

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Background

* The National Quality Forum (NQF) has operationalized a group of adverse events into measurable, evidence-based outcomes called Serious Reportable Events (SRE).
* MA adopted SREs as its adverse event reporting framework in 2008.
* 27 other states have state-based adverse event reporting programs and over half use the SRE framework including Connecticut, Minnesota and New Hampshire.

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SREs Defined

* Section 51H of Chapter 111 of the General Laws: “Serious reportable event”, an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.
* 105 CMR 130.332 and 105 CMR 140.308:

 Serious Reportable Event (SRE) means an event that occurs on premises covered by a hospital's license that results in an adverse patient outcome, is clearly identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital. The Department issued a list of SREs based on those events included on the NQF table of reportable events to which 105 CMR 130.332 and 105 CMR 14.308 apply in guidance.

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Reporting

* Hospitals and ambulatory surgical centers (ASCs) are required to report SREs to the patient/family, and the Bureau of Health Care Safety and Quality (BHCSQ) within seven days of the incident.
* An updated report to the patient/family, BHCSQ and third party payer is required within 30 days of the incident, including documentation of the root cause analysis findings and determination of preventability as required by 105 CMR 130.332(c) & 105 CMR 140.308(c).
* In June 2009, the Department implemented regulations prohibiting health care facilities from charging for services provided as a result of preventable SREs.
* Amendments adopted as part of the hospital regulatory review completed earlier this year streamlined the reporting process without removing transparency.

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SRE Types: Surgical or Invasive Procedure Events, Product or Device Events, and Patient Protection Events

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SRE Types: Care Management Events

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SRE Types: Environmental Events and Radiologic Events

Slide 11:

SRE Types: Potential Criminal Events

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Acute Care Hospital Data: There were 1012 SREs reported in acute care hospitals in 2016.

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* Acute Care Surgical Data: There were 35 wrong site surgeries or procedures reported in 2015.
* Increasingly these events occur outside of the operating room in radiology, labor and delivery and ambulatory units.
* The most frequently reported outcome is that patients require an additional surgery or procedure.

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* Acute Care Hospital
Product/Device Data: There were 138 contaminated drug, device or biologic events reported in 2015.
* In the contaminated drugs, device or biologics event, one incident, that affected a significant number of patients in 2016, represents most of the category.
* The hospital engaged in corrective action plan to address the root causes of these incidents.

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* Acute Care Hospital
Environmental Data: The burns event represents second degree or more severe burns.
* They result from hot beverage spills, cautery devices, chemotherapy spills and instant hot packs.
* There were 29 burns with serious injury or death reported in 2015.

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* Acute Care Hospital
Patient Protection Data:
* There was 1 completed suicide and 40 self-harm or attempted suicide events in 2016.
* Inpatient psychiatric units followed by emergency departments are the locations with the highest incidence of suicide and self-harm events.

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* Acute Care Hospital
Potential Criminal Event Data:

Over half of the physical assaults or abuse events that resulted in serious injury were patient on staff member encounters. There were 21 physical assaults that resulted in serious injury or death.

Since the beginning of SRE reporting there has never been any provider impersonation or patient abduction reported.

Inpatient psychiatric units are the most frequently reported location within the hospital for these events.

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* Acute Care Hospital
Care Management Data:

Falls and pressure ulcers are the two most common events.

Fractures are the most common serious injury. There were 285 falls that resulted in serious injury or death reported and 272 Stage 3, Stage 4 and unstageable pressure ulcers reported in 2016.

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* Non-Acute Care Hospital Data: There were 237 SREs reported in non-acute hospitals in 2015.

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* Non-Acute Care Hospital
Category Data: Three types: public health, rehabilitation or psychiatric.
* Like acute care hospitals, falls and pressure ulcers continue to be the most common events. There were 119 falls that resulted in serious injury or death and 71 Stage 3, 4 or unstageable pressure ulcers reported in 2016.

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* Ambulatory Surgical Centers 2014-2015 SRE Totals:
	+ There are 59 ASCs in Massachusetts.
	+ 2014 was the first year ASC SRE data was publicly reported.
	+ Outreach and education regarding reporting and trends in order to encourage submissions is ongoing.
	+ There were 6 SRES in ASCs in 2016.

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Quality Improvement Activities:

* Continued collaboration with DPH’s Suicide Prevention Program to share event data and promote use of online curriculum detailing best practices for reducing suicide and self-harm in the facility setting.
* Sharing de-identified pressure ulcer events with wound ostomy and continence nurse stakeholder groups.
* Actively participating in MA Coalition for the Prevention of Medical Errors.
* Partnering with Betsy Lehman Center to address the following:
* Utilize their monthly newsletter to share patient safety trends; and
* Maintaining an Interagency Service Agreement to allow for more seamless data sharing, as intended by the 2012 cost containment act.
* Working with individual facilities after a SRE occurs to develop corrective action plans and prevent an event of a similar type from happening in the future.
* Utilizing DPH list serves for widespread education and to share appropriate guidance.

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* Contact Information:

Thank you for the opportunity to present this information today.

Please direct any questions to:

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