State of New Hampshire

ADVERSE EVENT REPORTING
2017 REPORT

Provided by
New Hampshire Department of Health and Human Services
Office of Operations Support
Bureau of Licensing & Certification

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NH Serious Reportable Events / Adverse Events 2017

Since January 2010, all NH hospitals and ASCs, except for New Hampshire Hospital, have been required to report every **serious reportable events (SREs)** as defined by the National Quality Forum's (NQF) Serious Reportable Event report. The NQF definitions were broadened and additional event types were added to the list of SREs by NQF, in 2011, which resulted in an increased number of NH reports starting in 2014, when the NQF SRE list was adopted for NH use. This list serves as the standard for identifying patient safety events. The list of events with complete descriptions can be viewed here:
http://www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx
In NH, there is an additional event related to the exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act that is required to be reported by RSA 151: 38, which was revised in 2013.

This report is submitted in accordance with New Hampshire law (NH RSA 151-39) which requires the Bureau of Health Facilities Administration to annually report to the Legislature, health care facilities and the public on the aggregate number and type of adverse events prior calendar year; including rates of change, causative factors and activities to strengthen patient safety in New Hampshire.

The National Quality Forum (NQF) is a national, consensus-driven, private-public partnership aimed at developing common approaches to the identification of events that are serious in nature and have been determined to be largely preventable. (National Quality Forum 2002.) Sometimes referred to as "never events', the NQF list has increasingly become the basis for state mandatory reporting systems. The list of NQF serious events is intended to captures that are clearly identifiable and measurable, largely preventable and of interest to the public and other stakeholders.

Adverse events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or the proper treatment of that illness or underlying condition.

All hospitals and ASCs must submit an initial report to the Bureau of Health Facilities Licensing within 15 days of becoming aware of the event. The notification is filed in a format specified by the DHHS and does not include any identifying information of the healthcare professionals, facility employees, or patients involved. They must conduct a Root Cause Analysis (RCA), which is a structured method to identify and analyze any systemic issues or processes that may have contributed to the event or could create risk of a future event if they are not addressed and corrected. Recognizing the importance of a Just Culture, identifying underlying issues is the focus rather than blaming individuals. A Corrective Action Plan (CAP) is developed and submitted that outlines action steps to address findings, assigns responsible persons to ensure actions are completed, delineates time frames for completion and describes measurable outcomes to demonstrate completion of corrective actions. The RCA and CAP must be submitted within 60 days of identification of event.

It's crucial to remember that this data should not be used to compare the quality of care and safety of the facilities by the number or the type of SRE's reported. Consumers need to look at all factors such as: size of the facility, scope and complexities of the procedures as well as the number of procedures that are performed at the facility. The graph below shows the a

NH Serious Reportable Events / Adverse Events 2017

CY2017		Surgical Event	Surgical event	Protection Event	Care event	Care event	Care event	Care Event	Environmental Event	Pot. Criminal Event	
Provider Name	# of staff Beds	Wrong Body Part	Foreign Object	Suicide	Medication Error	Labor & Delivery	Stage 3 & 4& unstageable	Fall	Burn	Physical Assault	Total reported
Alice Peck Day	25							1			1
Androscoggin Hospital	25							2			2
Cheshire Medical Center	169							1			1
Concord Hospital	295	1	1		3		1	2			8
Cottage Hospital	25						1				1
Elliot Hospital	296						2	3		1	6
Exeter Hospital	100						5	3			8
Franklin Hospital	25										
Frisbie Hospital	112		1	1							2
Healthsouth Rehab Hospital	50							1			1
Mary Hitchcock Mem Hospital	396	2	2	1			2			1	8
Monadnock Gen Hospital	25					1					1
Northeast Rehabilitation Hospital Network	135						2	2			4
Parkland Hospital	86	1					1				2
Portsmouth Reg Hospital	209				1			1	1		3
Southern NH Med Center	188	1									1
Speare Hospital	25	1									1
St. Joseph Hospital	208		2			1					3
The New London Hospital	25							2			2
Wentworth Douglass Hospital	178					1					1
Bedford Ambulation Surgical Center		1									1
Portsmouth Region Ambulation Surgery Center		1									1
Total		8	6	2	4	3	14	18	1	2	58

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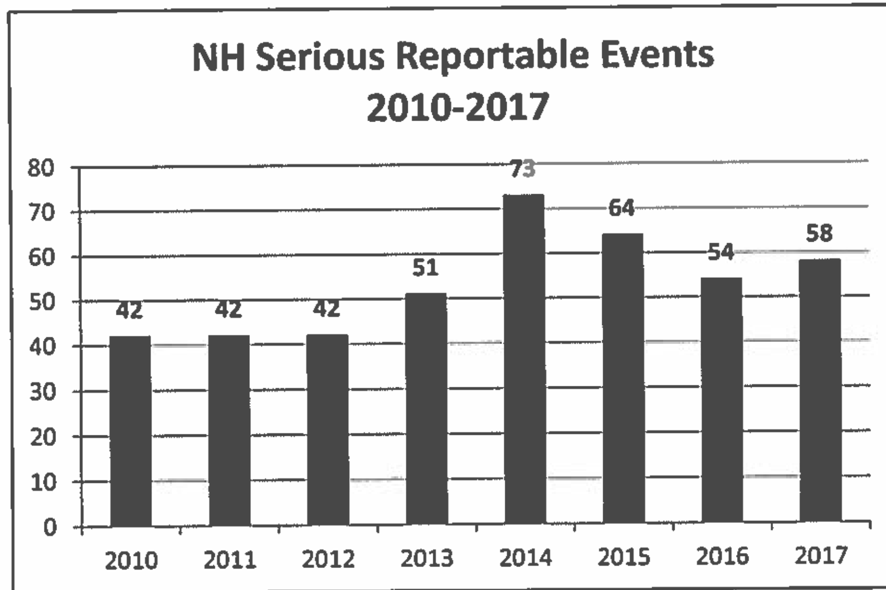
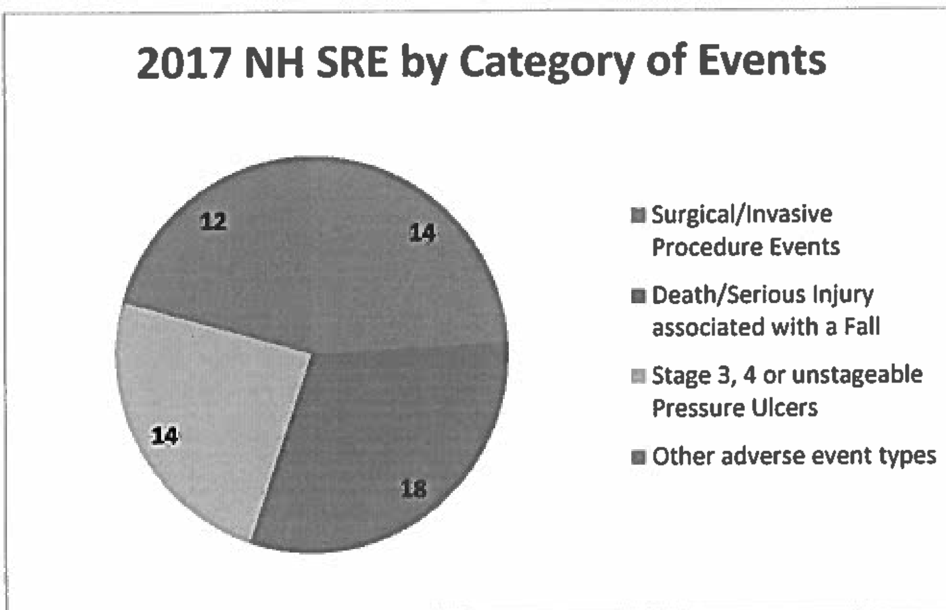
The bar graph below shows the total number of events reported in NH, since the statute was effective in 2010.



It is notable to report that in 2016 there was a **16% decrease** in total SREs since 2014, with a slight increase in 2017.

In analyzing the events reported in CY 2017, there continue to be three major areas responsible for 79% of the events reported. These areas were as follows:

Falls	**31%**
Pressure Ulcers	**24%**
Surgical Events	**24%**



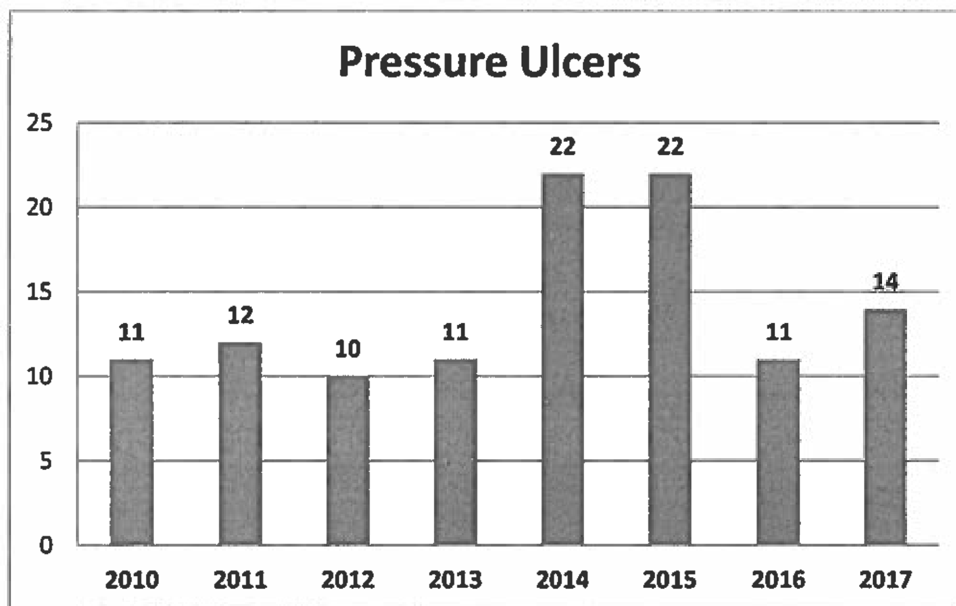
Considering that these event types represent 79% of the total events, it is important that we focus on these and address what the NH hospitals are doing in these areas to improve outcomes. Organizations have used their root cause analyses to learn about the weaknesses in their systems, to identify opportunities in systems and processes, and implement new approaches to improve the quality of care the patients receive within their hospitals and ASCs.

In addition to strategies specific to Falls, Pressure Injuries and Surgical Events, outlined in the next section, other overall approaches have included:

- Initiation of a Safety Champion program which provides for focused training on tactics to reduce falls and pressure injuries through education and peer to peer support. The safety champions are trained to evaluate their peers on how well they can complete the falls and pressure injury prevention bundles and apply their advanced subject matter expertise to help peers problem solve on complex or high-risk patients and share new advances for prevention and management.

- Sharing lessons learned from case reviews throughout the organization

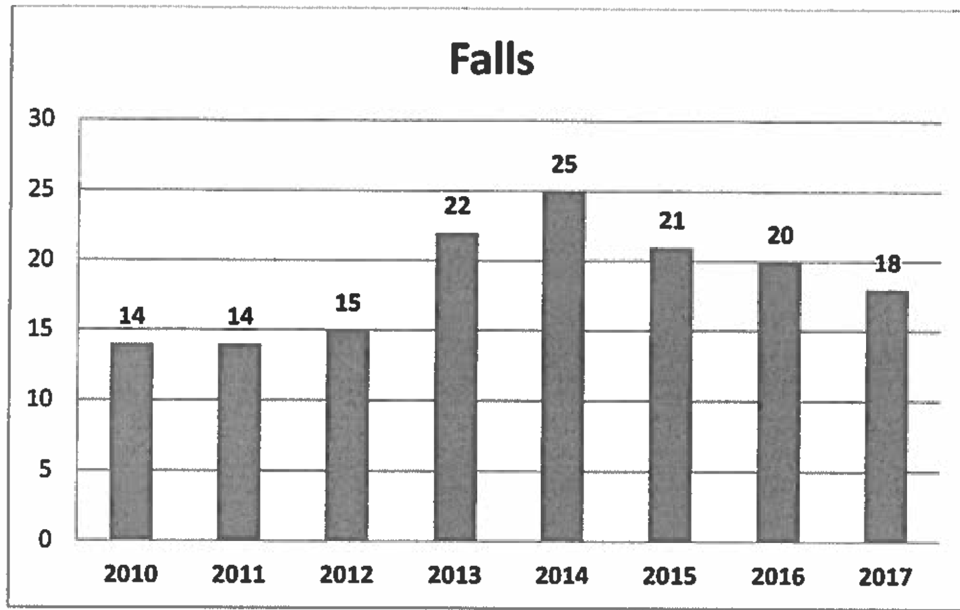
- Utilizing Culture of Safety data to identify areas at risk for falls, HAPU, & surgical events



Strategies utilized by NH hospitals and ASCs include:

- Complete a Skin Assessment upon admission to identify pressure injuries at the time of admission so that prompt care can be initiated and reassessed every 8 hours to detect early development of pressure injuries to prevent progression. Include a review of skin condition and risk in daily multidisciplinary rounds with the care team.

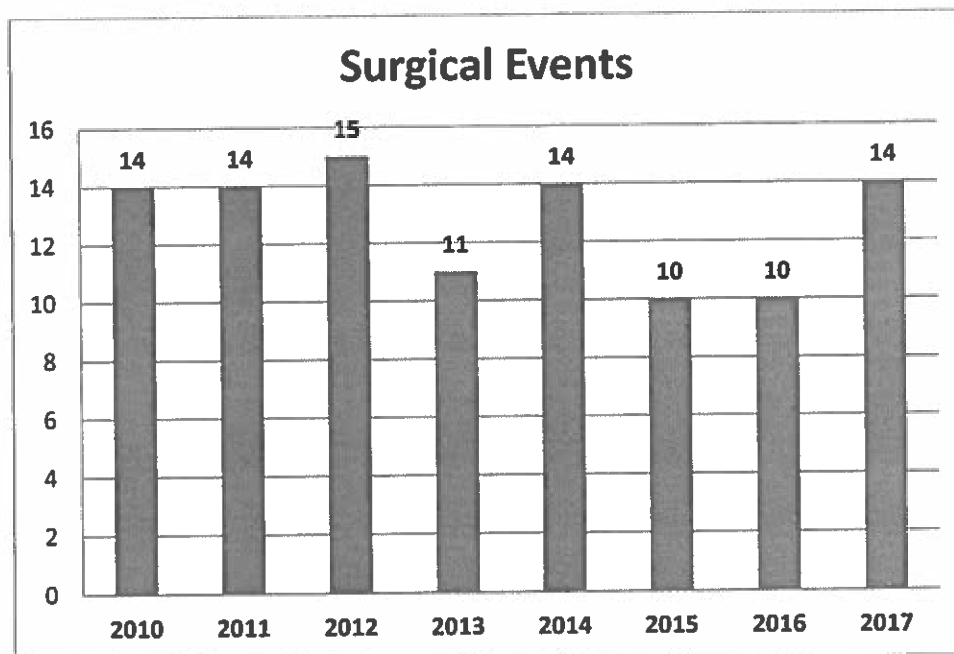
- Use of Braden Scale and similar tool for predicting pressure injury risk to determine other risk factors such as poor nutrition, dehydration, and hygiene issues so that high risk patients can be promptly identified, and preventative interventions can be implemented before a pressure injury occurs.
- Operative procedures which necessitate the patient's position be maintained in a single place for extended periods of time.
- Inspection of equipment and devices that touch skin such as nasal oxygen prongs, ear loops and vascular access ports. Use of preventative padding of skin areas at risk for skin breakdown from medical equipment. Involve Respiratory Therapist to daily assess the skin at potential for breakdown in patients using noninvasive ventilation pressure masks.
- Adoption of new evidence-based practices including new wound care treatments for faster healing.
- Education on wound dressing application and specialty beds.
- Use of smooth soft surfaces and special pads for surgical patients undergoing lengthy procedures and add positioning policies for any surgical case that goes over 4 hours, the patient is to be repositioned and checked for any redness or breakdown. The circulating RN documents the time of repositioning and any findings if applicable.
- Development of protocols for cleaning and treating wounds, use enhanced protocols for wound debridement (removal of dead tissue to allow for healing).
- Clinical staff education / training on wound care at orientation, with refresher classes offered at least every 2 years, on skin inspection / assessment and documentation of any sign of pressure injury development.
- Addition of Certified Wound Care Nurse to round and assess patients at risk for skin breakdown and patients with pressure injuries.
- Allow nursing the ability to order Wound Care Nurse consult.
- Use of a valid tool to measure nutritional status and increase role of Registered Dietitian Nutritionist to create care plan to address improving hydration and nutritional status.
- Increase Provider engagement in early detection and planning for risk of skin breakdown during hospitalization.
- Standardize the hand off/huddle reports to communicate pressure injury risk or presence, including current treatment plan.
- Engagement of local provider practices and home care agencies in inspections, assessments, and preventative treatment and patient/family education.



Strategies utilized by NH hospitals and ASCs include:

- Educate patients (and caregivers) of their fall risk due to medications that may interfere with mobility and judgment, such as post-operative pain medications, medical conditions and impact of femoral nerve block.
- Focus on purposeful rounding to determine the safety and comfort of patients at least every hour and expand the act to include toileting at least hourly, as indicated.
- Use a standardized Fall Risk Assessment upon admission, expanded to include a history of falls at home (including asking family members or caregivers) as well as assessing for evidence of falls such as bruising. Fall Risk Assessment will be updated every eight hours and re-evaluated after every fall.
- Link specific interventions to prevent falls to the fall risk assessment score. Staff education orientation/refresher on fall prevention including the content of assessment and making changes in interventions as needed to address the changes in fall risk.
- Staff debriefing (huddles) immediately after every fall to determine contributing factors to learn how to prevent further falls.
- Re-evaluate and improve use of dedicated sitter programs and incorporate patient family engagement in the process, by providing human companionship and help alert nurses in a timely manner when a patient is trying to get up creating a risk for potential fall.
- Regular training and technology to improve the uses of motion sensors - pads and alarms activated by patient movement that alert staff to movement.
- Revitalize Fall Prevention Teams, rotating new staff and clinicians into committees for a fresh approach in reviewing the events and determining organizational strategies.
- Increased use of Gait Belts and other mobility aids, to help maintain balance and give staff more control if patient demonstrates weakness while walking.

- Keep patients needed personal items such as tissue, eye glasses, tv controls within reach.
- Nurse to nurse reports which would include patient care unit to unit reports; adding interdepartmental communication of fall risk. Communication of changes in condition to providers and hand off discussion when patient is moved from unit to unit.
- Work with skilled nursing facilities to develop and implement transfer forms noting patient's fall risk status, any recent falls, ambulatory status, and assistive devices used.
- Promote early mobility, with appropriate physical and occupational therapy consults, to maintain functional status. Plan and develop mobility assessment training for nursing to improve identification of patients at risk in between fall risk assessments, and more quickly update plans and interventions to prevent falls.
- Use Nursing Dashboards so staff will see fall outcome data and fall prevention process measures to further engage clinicians and improve reduction of harm.
- Engaging patients and families through information exchange and education about the patient's specific risks during the stay and after discharge.



Strategies utilized by NH hospitals and ASCs:

- Improve consistency in hand-offs of information during the continuum of care from the time of the original diagnosis of the issue requiring surgery to the actual team preforming the procedure; to ensure vital information is accurately and appropriately communicated.
- Measure adherence to policies that address supply counts, time-outs, consents and other processes deemed to be contributing causes to the event.

- Continue to educate staff in the use of the checklist and time out process including the awareness of potential limitations of these tools to prevent all surgical errors.
- Enhance high reliability performance of the surgical team by including the patient's goals of care in the safety checks or briefings, ideally including the patient prior to induction of anesthesia.
- Explore and consider the implementation of pauses during the procedure prior to critical steps to assure all team members understand the plan and their role in executing it.
- Utilize practice guidelines and resources for achieving optimal perioperative practice from professional organizations such as the Association of periOperative Registered Nurses (AORN) and others.
- Reinforce all components of the Surgical Safety checklist, to include the pre-operative area in the time out and then follow through all during all phases, advocating for the patient always.

Throughout the Commission year there was regular contact with the staff from the Bureau of Health Facilities Licensing to promote open and ongoing communication about events; provide data of adverse events report for validation of number of events to ensure accuracy; and to improve processes of report notification to include closed loop communication of receipt of initial event report form, RCA and CAP. Meetings were held with the Bureau and representatives of the Commission, to clarify reporting rules and address areas of confusion. A flowchart was created to describe the reporting process and overall education provided to all Commission members at the May meeting. In addition, a tool that was developed at Frisbie Memorial Hospital, "Consideration and Evaluation in Determining State Reporting of Adverse Events" was reviewed and shared with all as a guide. The DHHS Bureau and the representatives from the NH Healthcare Quality Assurance Commission will plan to meet again in August to review the Adverse Events of 2018.

NH hospitals and ASCs continue share their experiences via Storytelling at Commission meetings, thereby ensuring we can all learn from their identified root causes and Corrective Action Plans (CAPs) that can enhance patient safety. The Hospitals and the ASCs remain committed to educate their personnel and professional staff about patient safety to promote the best outcomes for their patients.

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