State of New Hampshire

ADVERSE EVENT REPORTING
2018 REPORT

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

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Since January 2010, all New Hampshire Hospitals and Ambulatory Surgical Centers (ASCs), except for New Hampshire Hospital, have been required to report all **serious reportable events (SREs).** As defined by the National Quality Forum's (NQF) Serious Reportable Events In Healthcare-2011Update: A Consensus Report. The NQF definitions were broadened and additional event types added to the list of SREs by NQF, in 2011. 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, the law (RSA 151:38) was revised to include an additional event in 2013, related to the exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act. In accordance with New Hampshire law (NH RSA 151-39), the annual report is being submitted which requires the Bureau of Health Facilities Administration to report to the Legislature. This report includes health care facilities aggregate number and type of adverse events in the 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 intent of the NQF list is to capture clearly identifiable and measurable events, that are considered 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. Within 60 days of the identification of the event, the facility will submit to Bureau of Health Facilities Licensing the Root Cause Analysis (RCA) and Corrective Action Plan (CAP).

The facility must conduct a 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 not addressed and or corrected. Recognizing the importance of a Just Culture, identifying underlying issues is the focus rather than blaming individuals.

A CAP is developed and submitted which outlines action steps to address findings, assigns responsible persons to ensure actions are completed, delineates times for completion and describes measurable outcomes to demonstrate completion of corrective actions.

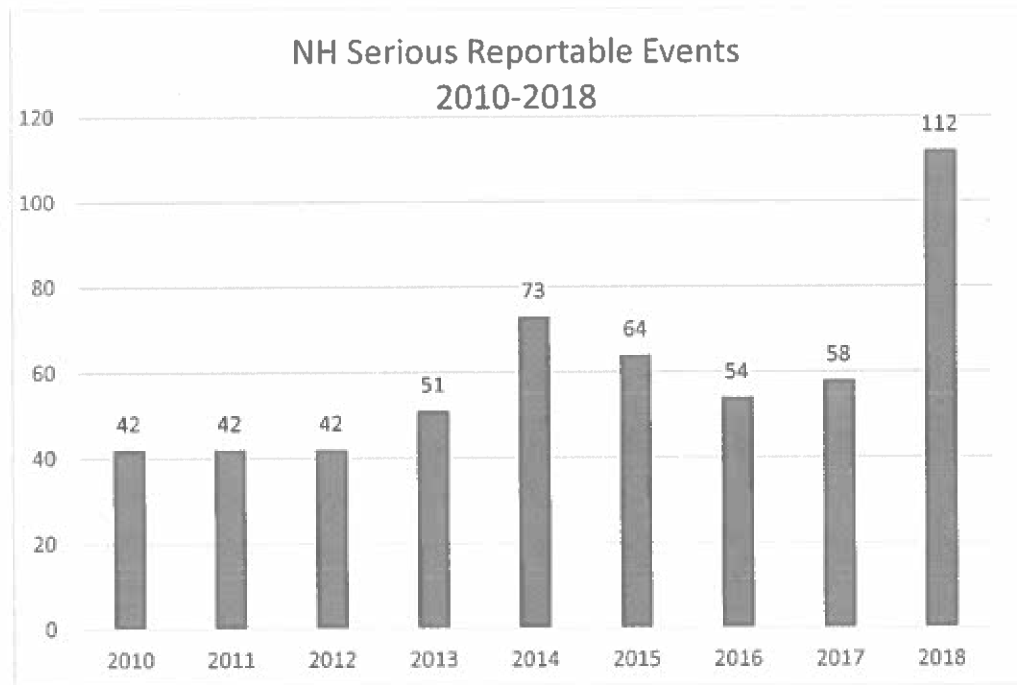
It is important to remember that this data should not be used to compare the quality of care and safety of the facilities by the number or the type of SRE's reported. Consumers need to look at all factors such as size of the facility, scope and complexities of the procedures as well as

the number of procedures that are performed at the facility. The following table lists the 2018 events:

NH SERIOUS REPORTABLES EVENTS/ADVERSE EVENTS 2018

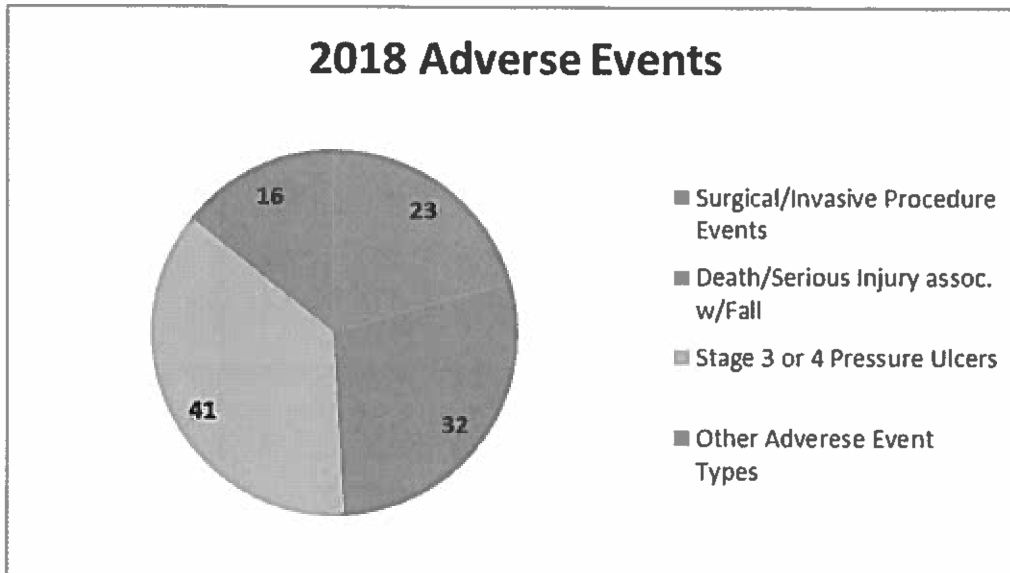
CY2018		Surgical Event	Surgical Event	Surgical Event	Surgical Event	Protection Event	Care event	Care event	Care event	Care Event	Care Event	Environmental Event	Pot. Criminal Event	
Provider Name	# of staff Beds	Wrong Body Part	Wrong Procedure	Foreign Object	death w/i 24 hours	Suicide	Medication Error	Labor & Deliver	Stage 3 & 4& unstageable	Fall	Lab	Burn	Physical Assault	Total reported
Alice Peck Day	25			2										2
Catholic Medical Center	330			1					8	3				12
Cheshire Medical Center	169								8					8
Concord Hospital	295			1			2			1		1	1	6
Cottage Hospital	25	1								3				4
Elliot Hospital	296			1					6	2				9
Encompass Health Rehabilitation Hospital	50									1				1
Exeter Hospital	100	1		2				1	14	1		1		20
Hampstead Hospital	111					1								1
Huggins Hospital	25									1				1
Lakes Region Gen Hospital	137						1			1				2
Littleton Regional Healthcare	25									1				1
Mary Hitchcock Mem Hospital	396		1	6					1	1	1			10
Monadnock Gen Hospital	25									1				1
Northeast Rehabilitation Hospital Network	135								1	1				2
Parkland Hospital	86								1	1				2
Portsmouth Reg Hospital	209									5				5
Southern NH Med Center	188	2								2			4	8
Speare Hospital	25									1				1
St. Joseph Hospital	208	1					2		2	3				8
The New London Hospital	25									1				1
Upper Connecticut Valley Hospital	25									1				1
Valley Reg Hospital	25	1								1				2
Wentworth Douglass Hospital	178	1						1						2
Elliot One Day Surgical Center		1												1
Stratham Ambulation Surgical Center					1									1
Total		8	1	13	1	1	5	2	41	32	1	2	5	112

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



In analyzing the events reported in CY 2018, there continue to be three major areas responsible for 87%of the events reported. These areas were as follows:

Pressure Ulcers	**37%**
Falls	**29%**
Surgical Events	**23%**



Considering that these event types represent **87%** of the total events, it is important that we concentrate our efforts on these and address what NH Hospitals and ASCs are doing in these areas to improve outcomes.

Organizations have used their root cause analyses process 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.

The 2018 Adverse Event Report (aka Serious Reportable Events); will reflect a significant increase in total events. This will most notably be in the categories of Hospital Acquired Pressure Injuries and Falls with Injury. The occurrence of Adverse Events at our organizations was a regular topic at Commission meetings, and we believe there are several reasons why this increase is occurring.

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

- Utilizing Culture of Safety data to identify areas at risk for HAPI, falls & surgical events
- We are growing our ability to identify events through our persistent efforts to develop a reporting culture. Safety event reporting is an indicator of a strong safety culture which is foundational that promotes learning and high reliability rather than presenting as a

set of events as a marker of quality. An increase in reporting by all staff has been noted, as people are not fearful that they will be blamed - all in the context of applying principles of Just Culture. Recent data from safety culture surveys reinforce this. Heightened vigilance helps foster an organizational culture.

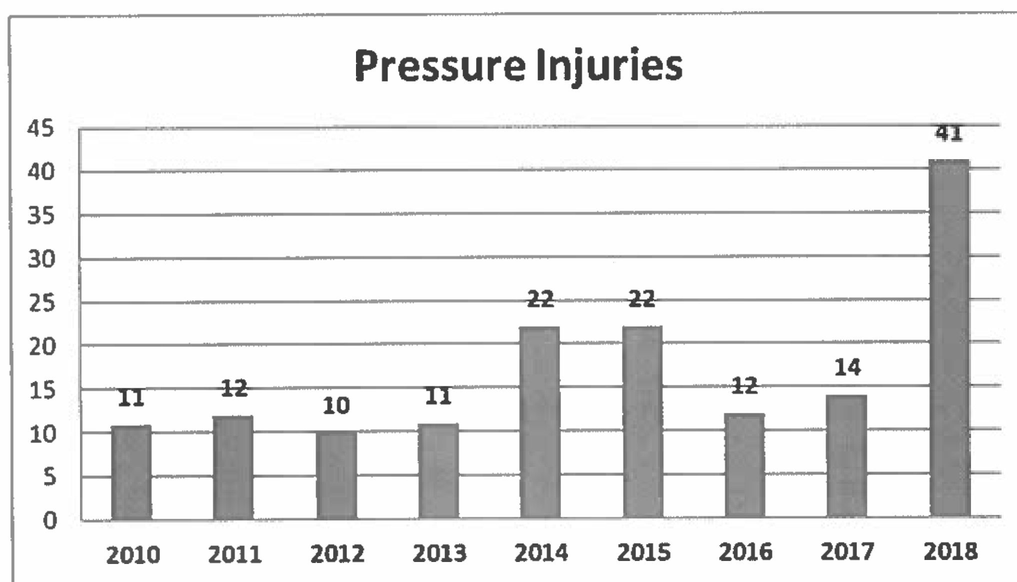
- Sharing lessons learned from case reviews throughout the organization.

- Our patient population is changing. There are changes in case mix, increased volumes, greater complexity, higher acuity and other factors – none of which are captured in the Adverse Event Report. It is also very important to note external environmental factors contributing to patients being in a setting of higher risk – such as delays in being able to transfer patients to designated receiving facilities and admission to long term care settings.

- When there is more transparency in sharing event data, the focus isn't on the numbers but on the depth in learning opportunities. Psychological safety, teamwork and communication, commitment to reliability, how we conduct RCA's etc., all need to be nurtured if staff are going to commit to transparency for learning and improvement.

- Surveillance has improved within the organizations, aided in part by an ability of electronic alerts and monitoring via more efficient and effective reporting systems that have been developed in conjunction with transitions to new electronic health record systems.

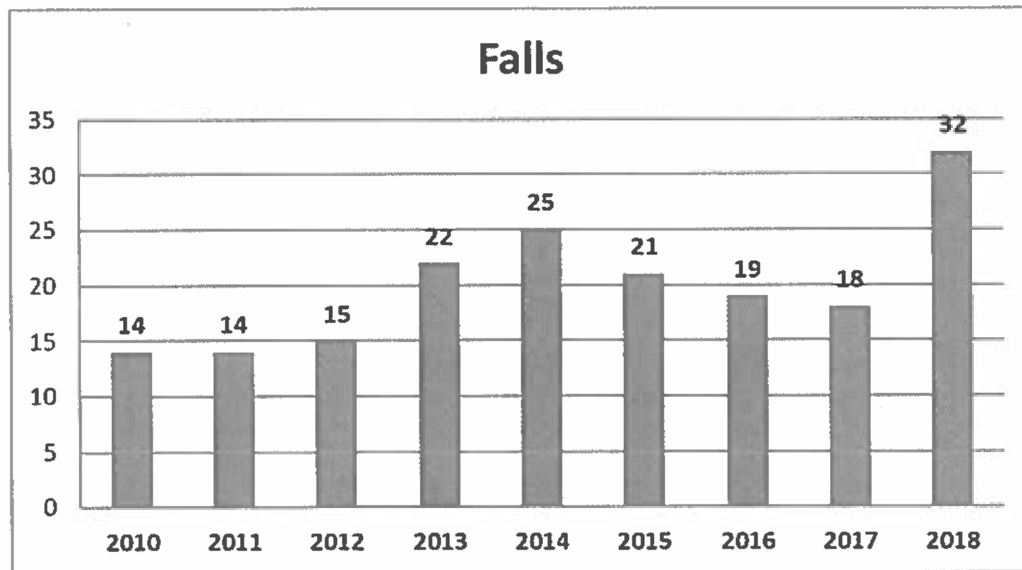
PRESSURE INJURIES



Strategies utilized by NH hospitals and ASCs include:

- Complete a Skin Assessment upon admission to identify pressure injuries at the time of admission to enhance prompt evidence-based care being initiated followed by reassessment 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.
- Pressure injuries are most suffered by critically ill patients for whom all known prevention methods have been employed and failed. Our focus now is on early detection of any compromise in skin integrity, as well as increased engagement by patients and families to assist in reducing risks.
- Use of the Braden Scale and similar evidence-based tools 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 identified- promptly and preventative interventions can be initiated.
- 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. Involving Respiratory Therapists to daily assess the skin for potential breakdown in patients using noninvasive ventilation pressure masks.
- Adoption of new evidence-based practices including new wound care treatments for faster healing.
- Engaging and educating the patient / family on informed refusal of care interventions and the potential risks when interventions are not implemented.
- Use of smooth soft surfaces and special pads for surgical patients undergoing lengthy procedures and added 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 Registered Nurse (RN) documents the time of repositioning and any findings if applicable.
- 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.
- Increase the role of Registered Dietitian Nutritionists to create care plans to address improving hydration and nutritional status.
- 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 assessments, and preventative treatment and patient/family education.

FALLS

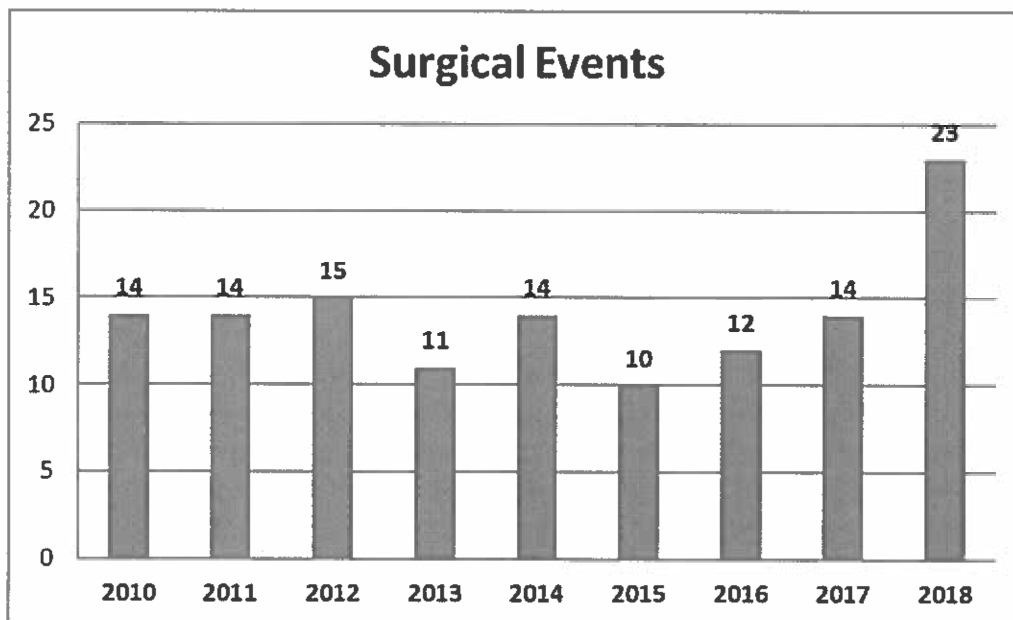


Strategies utilized by NH Hospitals and ASCs include:

- 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 surgical status.
- There are few evidence-based practices to prevent falls in any setting, so our current focus is on improving mobility and addressing delirium.
- 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.
- 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 of technology to improve the use of motion sensors - pads and alarms activated by patient movement that alert staff to movement.
- 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 personal items within reach.

- Nurse to nurse reports, which would include patient care needs would also include communication of changes of condition within the different units if or when moved.
- 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.
- Many organizations are participating in CMS sponsored programs focused on early mobility and early detection/prevention of delirium in the acute care setting to reduce incidence of falls with injury.

Surgical Events



Strategies utilized by NH hospitals and ASCs:

- A 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.
- 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 during all phases, always advocating for the patient.

Ongoing discussions with the Bureau staff in clarifying and refining criteria for reporting as well as regular distribution of reported events to all Commission members continues to change the threshold for reporting. These discussions highlight and reinforce the importance of reporting which indirectly has increased the reporting by hospitals and ASCs.

We are growing our ability to identify events through our persistent efforts to develop a reporting culture. Safety event reporting is an indicator of a strong safety culture which is foundational that promotes learning and high reliability rather than presenting as a set of events as a marker of quality. An increase in reporting by all staff has been noted, as people are not fearful that they will be blamed - all in the context of applying principles of Just Culture. Recent data from safety culture surveys reinforce this. Heightened vigilance helps foster an organizational culture.

The Bureau and the NH Healthcare Quality and Safety Commission continue to monitor the number of Adverse Events to determine the cause for this year's spike in total reportable events. Survey results are not indicative of any causal factors nor has there been any increase in complaints for this population. Review of the number of events reported in 2019 to date indicate a return to the 2017 totals. Open communication is maintained throughout the year between the Bureau of Health Facilities and the facilities to encourage open discussion of events to ensure accuracy from initial report to the RCA and CAP.

NH Hospitals and ASCs continue to share their experiences via Storytelling at Commission meetings, thereby ensuring they all learn from their identified RCAs and 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.

Bureau of Health Facilities sampled over 10% of the adverse events of received RCA and CAP. All facilities sampled provided performance information. It was concluded that the hospitals followed through with actions to correct the problems.