

Patient Safety Event Reporting in Vermont – 2020

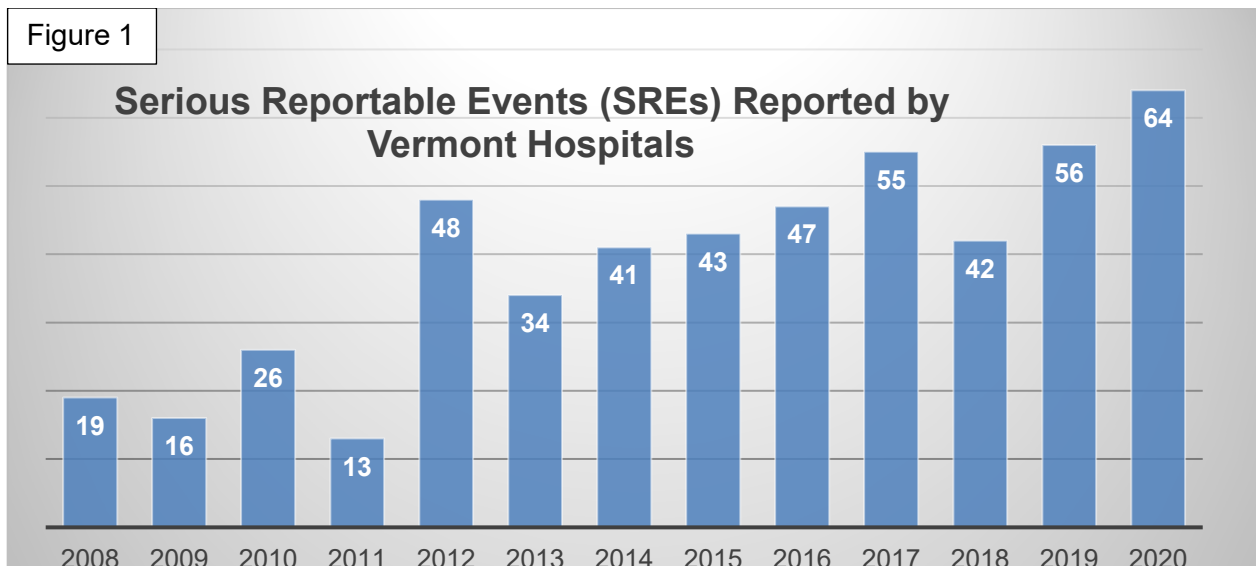
The impact of the COVID-19 pandemic on hospitals and health systems in Vermont, the United States, and around the world will be felt for years to come. COVID-19 placed a significant strain on our health care delivery system and disrupted the usual way in which patient care was provided. Disparities that previously existed within our healthcare system were brought to the forefront. Looking to the future, we must continue to examine the impact the pandemic has had on patient safety outcomes - such as whether higher rates of pressure injuries occur when patients with COVID-19 are prone and immobile for longer periods of time, and the effect on the rate of Hospital Acquired Conditions (HACs) when staff and resources are prioritized (Stocking, Sandroock, Fitall, Hall, & Gale, 2021).

I. Introduction

Serious Reportable Events (SREs), as defined by the National Quality Forum, are largely preventable clinical events that result in serious harm to the patient or even death. While these events are rare, the impact to patients, families, providers, and the community can be devastating. Vermont is one of eight states in which hospitals report on all of the [National Quality Forum's Serious Reportable Events](#) (Hanlon, Sheedy, Kniffin, & Rosenthal, 2015).

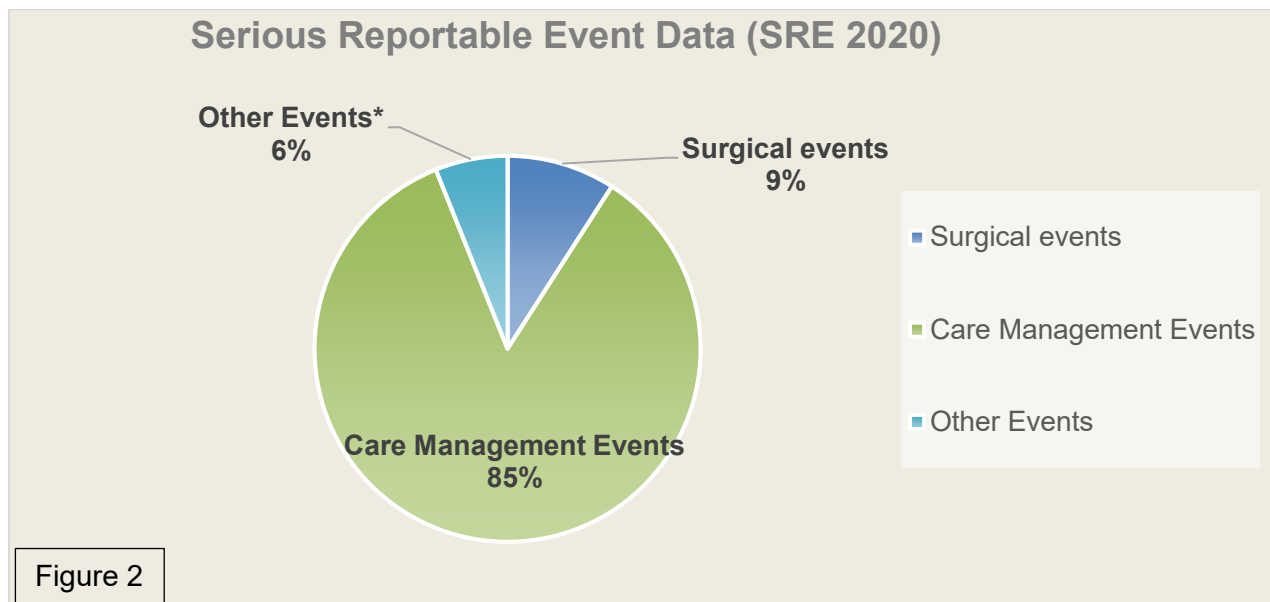
When an adverse event occurs at a Vermont hospital, the event must be reported to the [Vermont Patient Safety Surveillance and Improvement System](#) (VPSSIS) within seven days. For each event, Vermont hospitals conduct an analysis to get to the root of *why* the event happened, and create and implement a corrective action plan to prevent it reoccurring in the future. Through the VPSSIS, the Vermont Department of Health (VDH) and The Vermont Program for Quality in Health Care (VPQHC) support Vermont hospitals in their commitment to creating safer care environments, and to continuous quality improvement.

Figure 1



Serious Reportable Events (SREs) have been reported in Vermont since the VPSSIS was implemented in 2008. In order to ensure the confidentiality of patients, VPQHC does not report hospital-specific SRE information. While small numbers limit our ability to interpret significant changes between years, the increase in cases seen in 2012 is likely due in part to the expansion of SRE criteria by the National Quality Forum at the end of 2011. The increase in SREs from 2018 through 2020 will continue to be monitored as the effects of the COVID-19 pandemic on patient safety and SREs are further scrutinized.

II. Vermont Serious Reportable Events (SREs) 2020



*In order to assure confidentiality of patients, hospitals and staff, SRE categories with fewer than six events reported were combined. Combined SRE categories for this period include: **Product or Device Events, Patient Protection Events, Potential Criminal Events, Environmental Events, and Intentional Unsafe Acts (IUAs).**

In 2020, VPQHC reviewed 64 Serious Reportable Events (SREs), and Corrective Action Plans submitted by Vermont hospitals. The majority of SREs (Figure 2) were classified as Care Management Events (87%). Examples under this event category include:

- Patient death or serious injury associated with a medication error or unsafe administration of blood
- Maternal and/or neonatal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
- Patient death or serious injury associated with a fall while being cared for in a health care setting
- Any Stage 3, Stage 4 and unstageable pressure ulcers acquired after admission/presentation to a health care setting.
- Artificial insemination with the wrong donor sperm or donor egg
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- Patient death or serious injury resulting from failure to follow up or communicate test results

Quick Facts – 2020

- **VPQHC reviewed 64 Serious Reportable Events (SREs) and Corrective Action Plans in 2020**
- **SREs increased approximately 14% from 2019 to 2020**
- **In the year 2020, SREs classified as “Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission to a healthcare setting” showed significant increase from 22% of the Care Management Events to 57%**

The following is a list of clickable links that contain a variety of falls, and pressure injury, prevention resources:

- [Vermont Department of Health’s website on Injury Prevention](#)
- [Falls Free Vermont Website](#)
- [Fall Prevention in Hospitals Training Program | Agency for Healthcare Research and Quality \(ahrq.gov\)](#)
- [National Pressure Injury Advisory Panel \(NPIAP\)](#)
- [Pressure Injury Prevention in Hospitals Training Program | Agency for Healthcare Research and Quality \(ahrq.gov\)](#)

III. Vermont Serious Reportable Event (SRE) Process and Patient Safety Oversight

The Vermont Department of Health (VDH) contracts with the Vermont Program for Quality in Health Care (VPQHC) to administer the Vermont Patient Safety Surveillance and Improvement System (VPSSIS). If a Serious Reportable Event (SRE) occurs at a facility, the hospital must report the event to the VPSSIS within seven days. For each event, Vermont hospitals conduct a Root Cause Analysis (RCA). An RCA is a structured method used to identify and analyze underlying systemic issues that led to the event, or that could result in a future event if they are not addressed properly. The most important component of an effective RCA is a focus on the larger systemic or process issues rather than assigning blame to the individuals or facilities involved. Following the RCA and identification of system or process issues, the hospital must develop a comprehensive Corrective Action Plan (CAP) that addresses the findings identified during the event analysis to prevent a similar event from occurring in the future. The CAP must include:

- the specific action steps needed to correct the identified findings of the event
- a specific person or persons responsible to ensure each action item is completed appropriately
- the anticipated or actual completion date of the action steps
- measurable outcomes to demonstrate compliance and sustainability of the corrective actions

Both the RCA and CAP must be submitted to VPQHC for review within 60 days of the initial event report. Once a comprehensive review is completed to ensure that the root cause or causes that led to the event are appropriately addressed, and that all of the required elements are included, the documents are submitted to the Vermont Department of Health Patient Safety Program for review.

VDH also supports VPQHC to conduct a periodic VPSSIS site visit at each hospital at least once every three years. During the site visit, the VPQHC patient safety representative and hospital safety officers review the hospital policies and procedures for reporting SREs, analyzing SRE causes and developing corrective action plans (CAPs) to prevent new SREs. Hospital staff are interviewed to assess their knowledge of SRE policy and procedure, and the effectiveness of selected CAPs that have been implemented to address reportable adverse events are reviewed. Site visits were suspended in 2020 due to the COVID-19 pandemic and are anticipated to resume in the near future at the discretion of the Vermont Department of Health.

Beginning in 2020, Ambulatory Surgery Centers (ASCs) became subject to the Vermont Patient Safety Statute. VPQHC provided an orientation to the PSSIS program to the ASCs, and provided guidance with regards to reporting events, analyzing root causes, and developing corrective action plans. ASCs will also receive periodic patient safety review site visits at least once every three years.

IV. Conclusion

VDH and VPQHC are committed to promoting safe, high quality patient care through our work with the VPSSIS. We accomplish this by supporting hospitals and ASCs in Vermont to develop and implement safe systems and processes for their patients and staff. In the upcoming year, VPQHC will be offering specific QI training for Root Cause Analysis and Corrective Action Plan development that features a systems-approach to event analysis and preventive interventions. This valuable training will benefit seasoned safety leaders as well as individuals who are new in their roles.

Moving forward, it is essential that hospital leadership maintain a commitment to patient safety from all levels within an organization. It is also important to remember that effective prevention of patient harm is achieved when both patients and their families are actively involved with their healthcare partners. The VPSSIS will continue to advocate for, and facilitate open communication and active participation from patients and family members that provide the strong foundation necessary to effectively address patient safety issues. Increased awareness of unsafe conditions and adverse events, and the implementation of processes that promote learning from systemic issues will continue to strengthen the statewide culture of patient safety.

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