Patient Safety Event Reporting in Vermont – 2017

A November 2010 study by the Office of the Inspector General found that almost 14 percent of hospitalized Medicare beneficiaries experience adverse events resulting in prolonged hospital stay, permanent harm, life-sustaining intervention, or death. Forty-four percent (44%) of those events are considered preventable.[1] To support safer healthcare systems, Vermont has implemented the Patient Safety Surveillance and Improvement System (PSSIS).

The purpose of the PSSIS is to:

1. Evaluate systems and processes in place within a healthcare organization that affect patient safety, and

2. Identify opportunities to improve those processes to prevent future events.

The Vermont Department of Health (VDH) is charged by statute to operate the PSSIS and contracts with the Vermont Program for Quality in Health Care, Inc. (VPQHC) to administer the System.

All Vermont hospitals, with exception of the White River Junction Veteran's Administration Medical Center, must report every Serious Reportable Event (SRE), as defined by the National Quality Forum's (NQF) Serious Reportable Event report, to VPQHC for entry into the PSSIS within seven days of the hospital becoming aware of the event. The NQF SRE report which contains a complete list of reportable events can be reviewed here:
http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx.
This list was last revised in 2011 and remains the standard for identifying patient safety events.

Vermont hospitals must conduct a Root Cause Analysis (RCA) for any identified SRE. An RCA is a structured method used to identify and analyze underlying systemic issues and process shortcomings that led to the event, or could result in a future event if they are not addressed properly. The most important component of an effective RCA is the 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. A comprehensive 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 items is completed appropriately, the anticipated and actual

[1] Prompted by the Tax Relief and Health Care Act of 2006, the Department of Health and Human Services Office of the Attorney General (OIG) was mandated to evaluate the incidence of patient safety events among Medicare beneficiaries. In 2010, Inspector General Daniel R. Levinson released the findings in the "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries" report (https://oig.hhs.gov/oei/reports/OEI-06-09-00090.pdf)

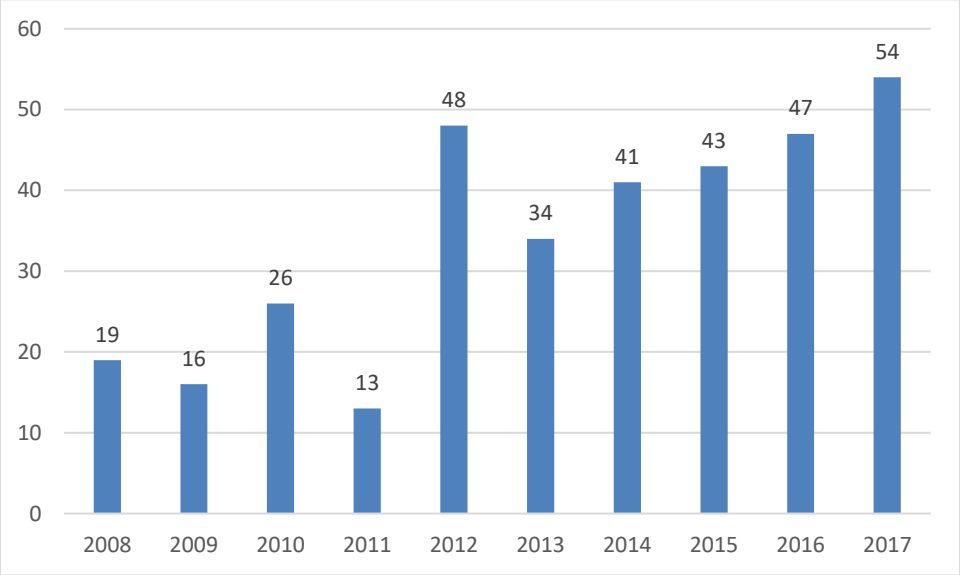
completion date, and acceptable measurable outcomes to demonstrate compliance and sustainability of the corrective actions.

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. More information about Vermont's PSSIS can be reviewed here:
http://healthvermont.gov/health-professionals-systems/hospitals-health-systems/patient-safety

Vermont SRE rates

Serious Reportable Events have been reported in Vermont since the PSSIS was implemented in 2008. Figure 1 shows the total number of events reported each year since the program's implementation. In order to maintain confidentiality of the involved patients, staff members, and hospitals, we do not publically report any hospital-specific event data. While the 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.[2] Additional years of tracking events and continuing to work with the hospitals will be essential to appropriately evaluate trends.

Figure 1: Vermont Serious Reportable Events, 2008 - 2017*.

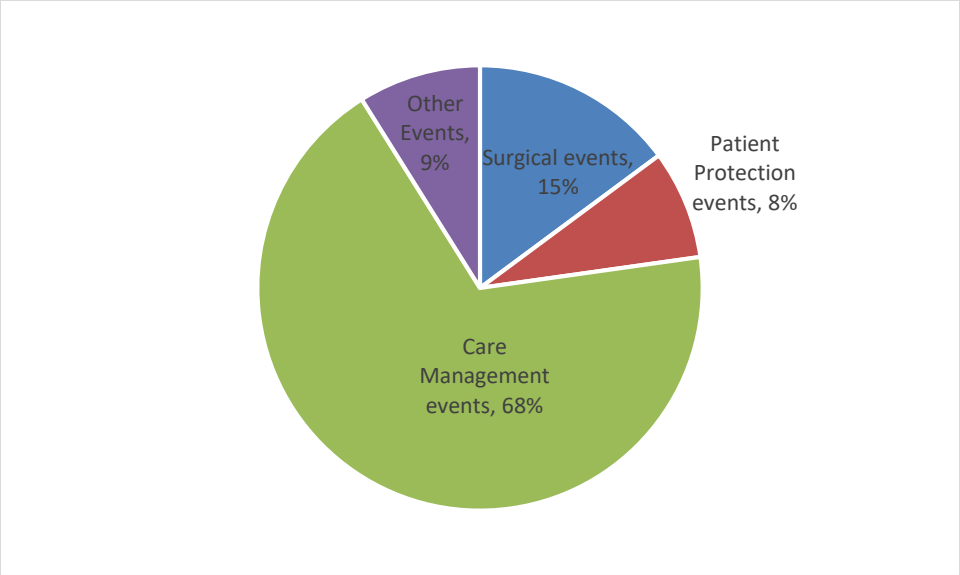


* Definition of SRE changed in December 2011.

[2] Some categories were removed or subsumed while other categories were added: for example, "surgical events" now includes "other invasive procedures" capturing SREs that occur outside the surgical suite; additionally, the definition of "disability" was revised to include "injuries" that require more care or monitoring.

Figure 2 shows the categories of events reported to the PSSIS in 2016 and 2017. Note that data from both years was combined due to the small number of events to protect hospital and patient confidentiality.

Figure 2: Categories* of SREs reported in Vermont, 2016 - 2017.



*In order to assure confidentiality of patients, categories with fewer than 6 events reported were combined.

During 2016-2017 in Vermont, Care Management Events comprised 68% of the reported events. Examples of the events included in this category are: patient death or serious injury following: medication errors; falls; test result communication failures; and the development or progression of a stage 3 or 4 pressure ulcer.

Patient Protection Events comprised 8% of the reported events. Examples of these event types are: the discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person; patient death or serious injury associated with patient elopement; or patient suicide, attempted suicide, or self-harm, while being cared for in a healthcare setting that results in serious injury or death.

Surgical or Invasive Procedure Events comprised 15% of the reported events. Examples of this event category include: Surgery or other invasive procedure performed on the wrong site, or the wrong patient; wrong surgical or other invasive procedure performed on a patient; unintended retention of a foreign object in a patient after surgery or other invasive procedure; or intraoperative or immediately postoperative/post procedure death in a low risk patient.

The remaining 9% of reported events are comprised of Intentional Unsafe Acts (IUA), Potential Criminal Events, or Product/Device Events. Further details regarding these event types can be reviewed in the NQF SRE report linked earlier in this report.

Conclusion

VDH and VPQHC are committed to promoting safe, high quality patient care through our work with the PSSIS. We accomplish this by supporting hospitals in Vermont to develop and implement safe systems and processes for their patients and staff. Additionally, we ensure that events and other reports are appropriately reviewed and result in comprehensive action plans that work to prevent future harm events. Increased awareness of unsafe conditions and harm events, and the implementation of processes that promote learning from systemic issues and process shortcomings will continue to strengthen the statewide culture of patient safety.

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. Open communication and active participation from family members provide the strong foundation necessary to effectively address issues and ensure that patients receive safe care.