Patient Safety Event Reporting in Vermont – 2018

Nearly fourteen percent (14%) of US hospitalized Medicare beneficiaries experience adverse events resulting in prolonged hospital stays, permanent harm, life-sustaining intervention, or death. Forty-four percent (44%) of those events are considered preventable. The cost associated with these preventable adverse events is over $118 million. (1)

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 five states where hospitals report on all of the National Quality Forum's Serious Reportable Events. (2) 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 the future recurrence of similar events. 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.

Quick Facts – Vermont Serious Reportable Events (SREs)

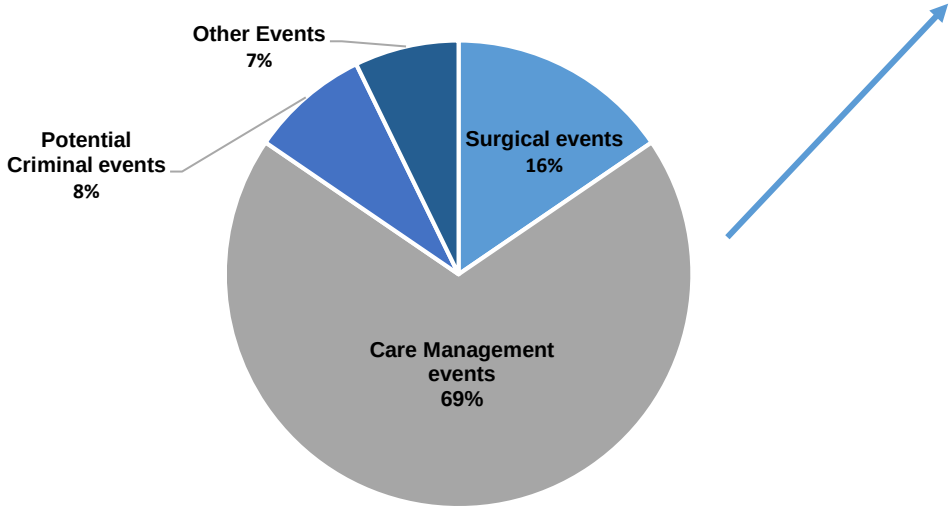
Total Vermont SREs Reported and Corrective Action Plans Implemented (2008-2018)

384

Total Vermont SREs Reported and Corrective Action Plans Implemented (2017-2018)

97

Categories of SREs reported in Vermont 2017-2018



The majority of Vermont Serious Reportable Events (SREs) are classified as "Care Management Events." Within this category, during the 2017-2018 period, **close to 40% were due to a "patient death or serious injury associated with a fall while being cared for in a healthcare setting."**

Refer to the **Vermont Department of Health's website on Injury Prevention** and the **Falls Free Vermont website** for a variety of injury, and falls prevention resources.

Surgical or Invasive Procedure Events comprised 16% of the reported events. Examples of this event category include:

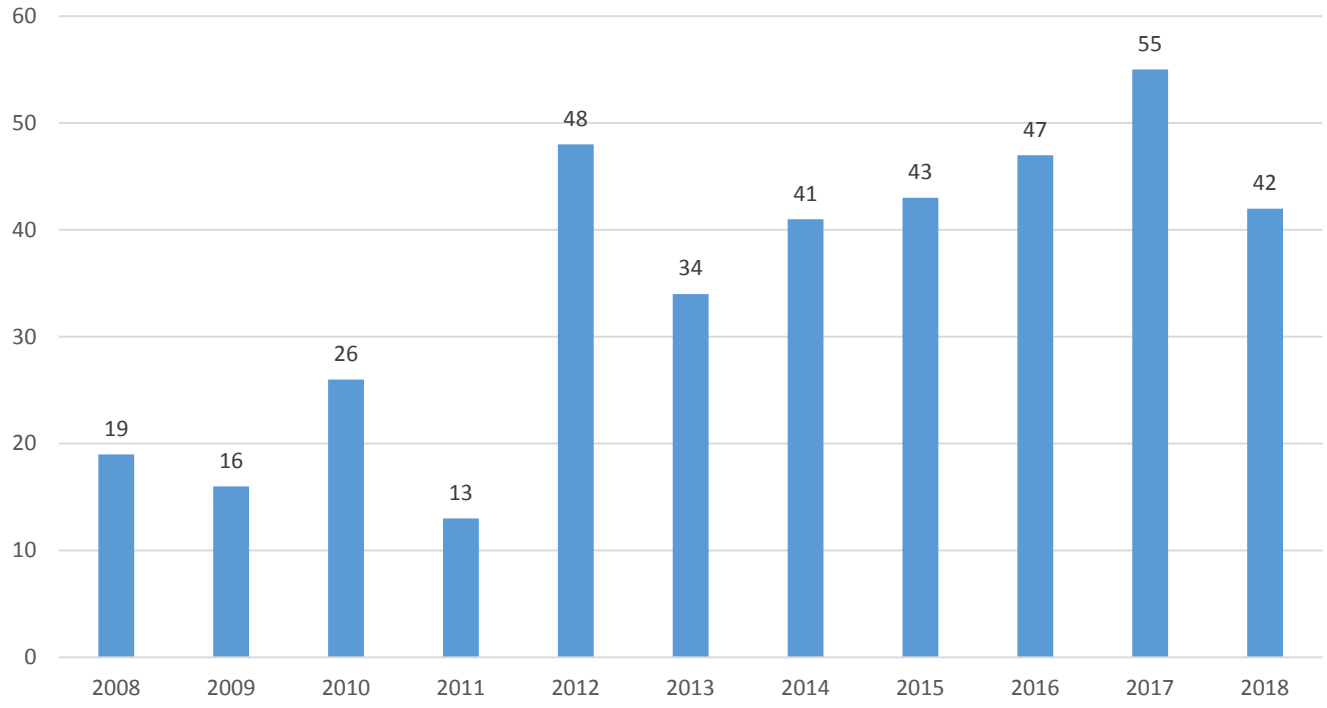
- Surgery or other invasive procedure performed on the wrong site, or the wrong patient.
- Wrong surgical or other invasive procedure performed on a patient.
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
- Intraoperative or immediately postoperative/post procedure death in a low risk patient.

Potential Criminal Events account for 8% of the reported events. This event category includes:

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Abduction of a patient/resident of any age.
- Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.

Other Events account for 7% of the reported events. In order to assure confidentiality of patients, hospitals and staff, SRE categories with fewer than six events reported were combined. Combined SRE categories include: Product or Device Events, Patient Protection Events, Environmental Events, and Radiologic Events.

Serious Reportable Events (SREs) reported by Vermont Hospitals by Year 2008 - 2018



Serious Reportable Events (SREs) have been reported in Vermont since the VPSSIS was implemented in 2008. **Figure 1** shows the number of events reported each year since the implementation of the PSSIS. In order to ensure the confidentiality of patients, we do 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. Additional

years of tracking events and continuing to work with the hospitals will be essential to appropriately evaluate trends.

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 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. 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 actions 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 liaison 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.

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 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 adverse events. 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. 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 and ensure that patients receive safe care.

Bibliography

1. ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES. (2010). [online] Department of Health & Human Services - Office of the Inspector General. Available at: https://oig.hhs.gov/oei/reports/OEI-06-09-00090.pdf.

2. Variability of State Reporting of Adverse Events. (2012). [online] National Quality Forum. Available at: http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx