Patient Safety Event Reporting in Vermont

Introduction

Approximately one in four Medicare patients experiences an adverse event when in the hospital.[1] While not all of these events cause harm or are serious, they highlight the need for safer healthcare systems. Many states, including Vermont, require that certain patient safety events which occur in state licensed hospitals must be reported publically.

Patient Safety Surveillance and Improvement System

The purpose of the Patient Safety Surveillance and Improvement System (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 is charged by statute to operate the PSSIS and contracts with the Vermont Program for Quality in Health Care (VPQHC) to administer the System.

All 16 Vermont hospitals must report Serious Reportable Events (SRE), as defined by the National Quality Forum, to the PSSIS within seven days of becoming aware of an event. A complete list of reportable events is accessible here: http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx.

A hospital reporting an SRE must conduct a Root Cause Analysis (RCA). An RCA is a structured method used to identify and analyze underlying process issues that led to the event, or could result in an SRE if they are not addressed. The most important component to an effective RCA is its focus, which should be on the underlying process issues rather than mistakes made by individuals.

Following the RCA and identification of system or process issues, the hospital must develop a Corrective Action Plan (CAP) that addresses the findings. The CAP must include: the specific actions to correct the identified causes of the event to prevent a similar event occurring in the future, the name of the person responsible for the completion of each item, the completion date, and measurable outcomes that will demonstrate progress with the action plan.

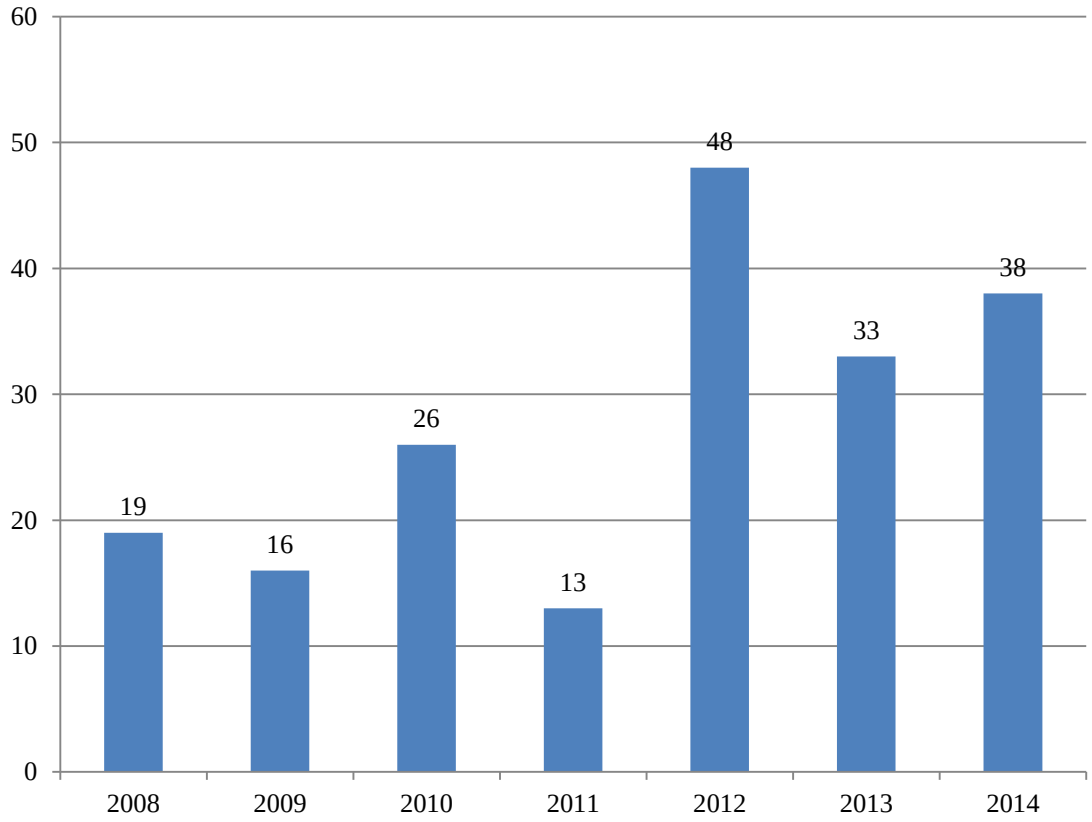
Both the RCA and CAP must be submitted to VPQHC within 60 days of reporting an event. Once a comprehensive review is completed by VPQHC, the documents are submitted to the State for review. More information on Vermont's PSSIS is accessible here: http://healthvermont.gov/hc/patientsafety.aspx

Vermont SRE rates

[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.

Serious Reportable Events have been reported in Vermont since the PSSIS was implemented in 2008. Figure 1 shows the number of events reported each year since the implementation of the PSSIS. (In order to assure 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. [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 - 2014*.

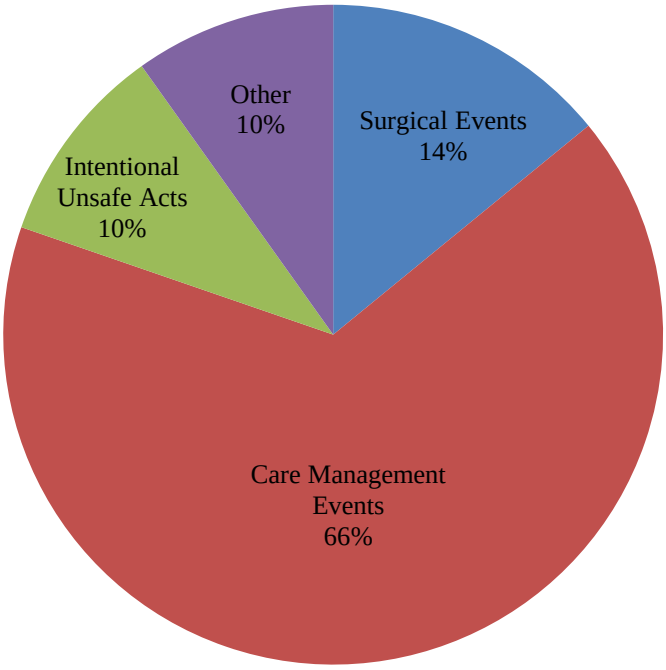


* Definition of SRE changed in December 2011.

[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 SREs reported in Vermont between 2013 and 2014. Note that both years of data have been combined due to the small number of events. For more detail on what events are included in each category, please visit the National Quality Forum: http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx.

Figure 2. Categories* of SREs reported in Vermont, 2013-2014.



*In order to assure confidentiality of patients, SRE categories with less than 6 events reported have been combined.

In Vermont, Care Management Events comprise 66% of all SREs. Some 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.

Surgical events comprise 14% of all reported events in Vermont and include surgery or other invasive procedures performed on the wrong site, on the wrong patient, or performing the wrong surgery or procedure on a patient. Unintended Retention of a Foreign Object following surgery is also included in this category. The remaining 20% of events in Vermont for 2013 and 2014 are comprised of Intentional Unsafe Acts (IUA), Potential Criminal Events, Product or Device Events, Environmental Events, and Patient Protection Events.

Conclusion

The Vermont Department of Health and the Vermont Program for Quality in Health Care are committed to promoting safe, high quality patient care through the PSSIS. We accomplish this by supporting hospitals in Vermont to develop safe systems and processes for their patients and by ensuring that events are appropriately reviewed and result in comprehensive action plans that can prevent future events. Increased awareness and the implementation of processes that promote learning from system 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. Open communication and active participation from family members provide the strong foundation necessary to effectively address issues and ensure that patients receive safe care.