Massachusetts General Hospital
Serious Reportable Events in 2009
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Case	SRE Categories	MDPH/NQF Listing of Serious Reportable Events	Key Finding Contributing to Events	Lessons Learned/Actions to Prevent Future Events
1	Device	Device functions other than as intended	An episode involved a malfunction between a bedside monitor and the central monitoring system	Biomedical engineering performed a review of all systems of this type and developed an educational program to ensure that malfunctions are immediately recognized and addressed.
2	Device	Device functions other than as intended	A surgical patient suffered a leg injury that was likely caused by kinked tubing leading to increased pressure in leg boots designed to prevent blood clots post operatively. The patient experienced pain, numbness and swelling that required a second surgery to relieve a pressure build up in the leg.	Examination of the compression boots indicated the presence of a crease in the tubing which did not allow the boots to function correctly. All Operating Room (OR) and Post Anesthesia Care Unit (PACU) staff was informed of this event and the proper application of compression boots was reviewed. Particular attention was paid to the appropriate checking of the boot position before the patient is draped in the OR.
3-13	Environmental	Falls	Eleven (11) patients suffered injuries from falls while getting out of bed, walking to the bathroom, or walking without needed assistance. All patients had a fall risk assessment on admission. Those identified as being at high risk for falling had plans in place that provided increased observation.	There has been a pilot of the use of hourly rounding on designated nursing units with successful reduction in falls. This fall prevention program will be spread throughout the hospital setting. Education for nursing staff regarding successful fall prevention interventions is continuing.
14	Environmental	Burn	A protective covering on a heating pack slipped, causing a burn to a patient's foot.	A Limb Warming Policy was reviewed and redefined to included specified times for recheck of the patient. Staff was educated on management of heating packs.
15	Criminal	Injury from Physical Assault on Grounds	A patient, while waiting to be seen in the Emergency Department was physically assaulted and injured, without warning, by another patient.	This assault was unprovoked and the assailant showed no signs of aggression prior to the assault. MGH Policy and Security staff continues with their frequent surveillance of the Emergency Room waiting areas.
16-22	Care Management	Pressure Ulcers	Seven (7) patients developed Stage 3 or 4 pressure ulcers (on a 1 to 4 scale). All of these patients were critically ill and could not be safely moved to reduce the risk of developing pressure ulcers. Each patient had medical and surgical conditions that are known to contribute to skin breakdown. All were appropriately assessed as being at risk for skin breakdown and all possible prevention strategies were in place.	Education of nursing staff regarding assessment and staging of wounds is ongoing. Evaluation of new technology for pressure relief is planned.

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23-26	Surgical	Wrong Site Procedure	A patient was planned to have shoulder surgery. During preparation for the procedure the patient had a needle placed for a regional block, used to help manage pain, in the wrong shoulder. No medication was injected.	The event was thoroughly reviewed and discussed with all departmental staff. The Universal Protocol Policy was reviewed with each staff member to ensure the correct person, correct procedure and correct site verification is carried out.
	Surgical	Wrong Site Procedure	During a complex pediatric procedure, surgery was performed on the pulmonary artery rather than the pulmonary vein.	The clinical program underwent a comprehensive institutional review.
	Surgical	Wrong Site Procedures (2)	Two (2) patients had a peripherally inserted central catheter (PICC) inserted into an artery instead of a vein. The mis-location of the catheters was discovered through further testing, and the lines were removed.	A policy development team was convened and a standardized set of guidelines has been developed for confirming the position of central lines using alternative methods in addition to x-ray.
27	Surgical	Wrong Procedure	A patient had the wrong outpatient heart procedure performed when there was a communication failure among members of the care team. Staff were immediately aware this had occurred. While the procedure was not the intended intervention, it resolved the heart issue for which he was being treated, and the patient was discharged home.	The event was thoroughly reviewed and discussed with all departmental staff. The Universal Protocol Policy was reviewed with each staff member to ensure the right person, right procedure and right site verification is carried out.
28-34	Surgical	Retained Foreign Body	A guide wire used to help place a central catheter into a vein came apart during the insertion procedure. The thread-like thin metal wire was discovered during an x-ray and the patient required a procedure to remove the coiled wire.	The event was reported to the manufacturer. These findings were reviewed by the clinical service to inform changes in insertion techniques.
	Surgical	Retained Foreign Body	A patient had a laparoscopic bowel surgery for cancer. During the procedure a small piece of the stapler used to close the surgical site was left behind. After the operation, the surgeon realized the piece had not been removed and the patient was brought into the operating room to remove it through the previous laparoscopic incisions.	All components of the stapler are now accounted for as part of the count procedure. The model of stapler used for this procedure was replaced with a product in which the piece in question does not separate.
	Surgical	Retained Foreign Body	A patient had an intravenous catheter removed that was placed under the skin on the chest. It was removed because of concern for infection. During the removal of the catheter, a small plastic cuff was left under the skin. The patient returned to the hospital, and the cuff was easily removed.	This event was reviewed in the departmental rounds to familiarize the physicians with the presence of the cuff and the process for assessment of removed items.

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	Surgical	Retained Foreign Body	A patient had a surgical procedure and during a routine post-operative visit to the surgeon a small device was discovered during the examination. The object was easily and immediately removed.	The hospital's instrument count policy was revised. The new policy "Countable Items Policy" includes a list of specific items to be counted. This has been reviewed and discussed in depth with the staff and the policy has been implemented.
	Surgical	Retained Foreign Body	A retained sponge used during surgery was detected on a routine chest x-ray following surgery. The patient required re-opening of the incision to remove the sponge.	The hospital's instrument count policy was reviewed. Standard processes for first and second counts were established and implemented. Devices were trialed to enhance visual inspection of the sponges during counts.
	Surgical	Retained Foreign Body	A patient had abdominal surgery that involved the use of vessel loops to safely move blood vessels away from the operative area. Shortly after the procedure was completed the surgeon realized that a vessel loop had not been removed. The patient was returned to the operating room, the incision was re-opened, and the vessel loop was removed.	The hospital's instrument count policy was revised to include specific attention to vessel loops. Efforts to purchase vessel loops that can easily be visualized on x-ray are underway.
	Surgical	Retained Foreign Body	A patient had robot-assisted surgery to repair a heart valve. A chest x-ray showed that a small needle had been retained. The patient required a return to the operating room for removal of the retained needle.	A comprehensive revision of the hospital's count policy was completed and implemented. All OR and surgical staff were trained and have adopted this standardized practice.