Massachusetts General Hospital

Serious Reportable Events in 2011

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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
1-7	Environmental	Falls	Seven (7) 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 and every 24 hours thereafter. Measures, including increased observation, were in place for those identified as being at high risk for falling.	Fall prevention continues to be a challenge for all hospitals. In spite of a comprehensive fall prevention program, there is a variable response to interventions among patients. Clinical leadership continues to assess the effectiveness of current fall prevention strategies.
8-16	Care Management	Pressure Ulcers	Nine (9) 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 in bed to reduce the risk of developing pressure ulcers. Each patient had medical or surgical conditions that were known to contribute to skin breakdown. All had been appropriately assessed as being at-risk for skin breakdown.	A comprehensive "Save Our Skin" program of prevention, assessment and management of pressure ulcers has been implemented. We determined that none of the pressure ulcers could have been prevented.
17-20	Surgical Event	Retained Foreign Bodies	Four (4) patients were found to have retained foreign bodies after undergoing procedures. All foreign bodies were successfully removed without harm to the patients. The foreign bodies included a surgical sponge, a surgical needle, a small portion of the coating used to mark instruments, and a piece of a two-part surgical instrument.	Hospital leadership and procedural teams continued to evaluate the environment to identify and minimize risks during procedures. This included working with manufacturers and vendors of surgical supplies to improve product safety. Adherence to the surgical count policy was re-emphasized with all procedural staff.
21	Surgical Event	Wrong Body Part	A patient had spine surgery at the incorrect level of the spine.	The surgeons are revising the process for site verification during spine surgery.
22	Surgical Event	Wrong Patient	A minor, incisional, fat-pad biopsy was performed on the wrong patient. The physician identified the patient using the first name only. In this case both patients in the room had the same first name.	The involved physician, along with the entire physician community, was retrained in the use of the Universal Protocol and the need to use two separate identifiers to confirm the correct patient before beginning procedures.