Massachusetts General Hospital
Serious Reportable Events in 2008
More about our improvement efforts at http://qualityandsafety.massgeneral.org and http://qualityandsafety.partners.org

SRE Categories	MDPH/NQF Listing of Serious Reportable Events	Key Finding Contributing to Event	Lessons Learned/Actions to Prevent Future Events
1. Surgery	Surgery performed on wrong body part	Patient received an injection in the wrong shoulder, as part of a radiology procedure. The correct site was identified, but not marked. The team experienced an unexpected delay disrupting regular check processes. When the case finally started, they did not confirm the site. Error was noted immediately, disclosed to the patient, and the correct procedure was performed.	Policy to ensure the right person, right procedure, and right site also known as the Universal Protocol, has been updated and specifically included the requirement for site marking in outpatient areas.
2. Surgery	Surgery performed on wrong body part	Patient received an injection for pain in the wrong side of the neck in the Pain Clinic. Patient had pain on both sides, contributing to the error. Error was disclosed to the patient. The patient experienced pain relief from the misplaced injection.	The way care is planned and administered in the Pain Clinic was extensively reviewed. The updated Universal Protocol policy emphasizes that all involved in procedures such as injections, must come to a completed hard-stop time-out before beginning. The time-out ensures all understand and agree with the plan of care
3. Surgery	Surgery performed on wrong body part	Patient received an injection for pain at the wrong level of spine in the Radiology Department. The space adjacent to the planned space was injected in error. Mistake was noted immediately and disclosed to the patient.	As previously noted, the Radiology Department has made extensive corrections to its policies, and intensive education has been conducted regarding the Universal Protocol. For spine cases, the correct procedure and site is reviewed and confirmed several times before the procedure begins.
4. Surgery	Wrong procedure performed	Non-English-speaking patient had the wrong minor surgical procedure performed and had a very similar minor surgical procedure instead. The staff believed a time-out had been accomplished before the procedure began, but the time-out did not involve all of the team. Soon after the procedure, the surgeon recognized the error, disclosed it to the patient, and performed the correct procedure.	This event was thoroughly reviewed and discussed. The policy regarding the Universal Protocol has been updated, to ensure the right person, right procedure, and right site are identified before the procedure begins. The Operating Room has given particular attention to the issue of the whole team coming to a complete time-out before beginning the case.

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5. Surgery	Retention of a foreign body	Patient had outpatient oral surgery. After the procedure, an x-ray showed a very small piece of instrument was in the wound. This was a highly complex procedure involving multiple small pieces of an instrument that was not routinely used. The piece was successfully removed.	The manufacturer provided a newly designed version of this particular instrument that prevents detachment of the small piece.
6. Product or Device	Device functions other than as intended	Very sick patient was transferred from another hospital for an aneurysm procedure. The coil used malfunctioned and released prematurely. We did not find any error involved in using the device.	The Food & Drug Administration (FDA) and the manufacturer were notified, noting the requirement for an improved device.
7-16. Environmental Events	Death or serious disability associated with a fall	10 patients fell while getting out of bed, off a table, or while walking, sometimes with assistance. A risk assessment had been performed on all patients prior to the events.	Extensive attention to falls includes a fall risk assessment standard, and falls prevention program that incorporates interventions based on the risk assessment. Patient and family are instructed to ask for assistance before getting up, among other interventions.