Massachusetts General Hospital
Serious Reportable Events in 2010

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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
1-8	Environmental	Falls	Eight (8) 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.	Developed and launched a comprehensive "Let's Eliminate All Falls" (LEAF) program with widespread adoption. Extensively trained the program across inpatient units, including providing unit-based expert support during implementation. The program included all Registered Nurses and Patient Care Associates.
9-18	Care Management	Pressure Ulcers	* Ten (10) 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 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.	We are evaluating advanced technologies for pressure relief in critically ill patients.
19	Device	Air Embolus	A patient's artery was blocked by air during a heart procedure when a piece of equipment was not completely cleared of air.	A full stop "time out" was implemented when there is a change from a diagnostic to an interventional procedure. Standards for training and supervision of new fellows were reviewed and reinforced with staff physicians within the department.
20	Device	Air Embolus	The patient experienced an air embolus during placement of a tunneled catheter in spite of proper placement technique	Radiology Dept is now studying the use of a new alternatively designed sheath which may have a better air-guarded design and provide a more secure valve, reducing the risk of air embolism.
21	Surgical Event	Wrong-side procedure	A chest tube was inadvertently placed on the wrong side during a bedside procedure.	Training was conducted related to the conduct of Universal Protocol for all bedside procedures. New Universal Protocol forms were incorporated into the chest-tube insertion kits to prompt providers.
22	Surgical Event	Wrong Body Part	A patient was scheduled for an invasive diagnostic test that was canceled and then rescheduled. When the test was rescheduled, the wrong body part was identified as the target for the procedure.	The practice changed its policy regarding how invasive tests are ordered to reduce the risk of this happening in the future.
23	Surgical Event	Wrong Body Part	A patient underwent finger surgical procedure in which the surgeon incised the incorrect finger. This error was immediately recognized, and the planned surgical procedure on the correct finger was performed.	The Surgical OR team completed the Universal Protocol correctly per policy. The Surgeon inadvertently put his gloved hand over his site marking, blocking view of the site mark when he incised the incorrect finger.
24	Surgical Event	Retained Foreign Body	During the insertion of an invasive catheter, a small wire inside the catheter, which should be removed after the catheter is inserted, was left in place. There was no harm to the patient.	Catheter packaging was changed to alert clinicians to remove the wire after the catheter is inserted. Education and updating of the entire staff was completed.

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25	Surgical Event	Retained Foreign Body	A patient underwent a kidney procedure. A retained sponge used during surgery was detected on a postoperative abdominal x-ray following surgery. The patient required re-opening of the incision to remove the sponge. All OR count policies were followed according to our hospital policy. Intraoperative imaging did not reveal the missing sponge.	Improvement actions include new imaging guidelines to include full abdominal views with anatomic landmark overlap to visualize entire surgical field.
26	Surgical Event	Retained foreign body	During a radiographic imaging for the evaluation of new abdominal pain, a foreign object was noted and presumed to have been a piece of a drain placed during a procedure performed two years earlier.	Reinforced with all staff the importance of inspecting all drains at the time of removal.
27	Surgical Event	Retained foreign body	Two months following abdominal surgery, a sponge that was used to pack the patient's wound was noted during imaging. The patient required repeat surgery to remove the sponge which was done without further complications.	Planned enhancements to our standard counting practices and policies were well underway at the time this retained foreign body was discovered. The enhancement includes tracking sponges placed as packing and reconciling this during the debriefing at the completion of each procedure.
28	Surgical Event	Retained foreign body	A patient was taken to surgery and had an abdominal drain in place. The drain was cut before the procedure with the intention of removal during the procedure. A small piece of the catheter was unknowingly retained.	Implementing a new process for documenting the presence of drains and handling their preoperative removal.
29	Surgical Event	Wrong site	A patient underwent spine surgery. The patient did well but during her recovery, it was discovered that the procedure was performed at the wrong level of the spine.	Utilizing high definition radiology cassettes and making other technology improvements to permit a more complete picture of the patient's anatomy and verify the intra-operative level for spine surgery.
30	Care Management	Medication Error	A patient was inadvertently given too large a dose of a medication that decreases the ability of the blood to clot.	Implemented changes in the ordering, monitoring and administration of this medication.
31	Criminal	Injury from Physical Assault on Grounds	A staff person, in an attempt to get the attention of a patient who entered a health center to inform them of the food and beverage policy, was assaulted and suffered a broken arm that required surgical repair.	The assailant showed no signs of aggression prior to the assault. MGH Policy and Security reassessed the signage in the area. The policy was re-evaluated with administration, and staff was re-trained in how to approach patients, including involving Police and Security.

* Note: Pressure Ulcers - Two of these patients had pressure ulcers present on admission that were identified and treated upon admission to Mass General.