Massachusetts General Hospital
Serious Reportable Events in 2012
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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
1-9	Surgical or Invasive Procedure Events	8 - Retained Foreign objects	Eight (8) patients had unintentionally retained foreign objects after their completed procedure. These included: a vaginal packing, a broken piece of guidewire, a guidewire within a central line, a stylet in a non-tunneled dialysis catheter, a broken catheter tip, a sponge post spinal procedure, a nasal trumpet after a bronchoscopy, and an orthopedic guidepin.	For the retained foreign objects related to line placement, the Intravenous (IV) Therapy team has changed its policy regarding the guidewire verification. All guidewires used during line placement by the IV team are examined and measured upon removal to ensure that they are intact. For guidewires used during procedures for line placements, the same procedure of measuring will be used. In addition, the guidewire removal will be documented on a checklist prepared for this procedure. The Operating Room has added a process to identify and account for those items that are introduced during the OR case and removed prior to the end of the procedure. The OB/GYN service has added documentation to their assignment board tracking each item that is placed during a procedure and then ensuring that each item has been later removed. Visual site confirmation will include review of current Imaging studies at the time of a bronchoscopy.
		1 - Wrong site procedure	A wrong site diagnostic bronchoscopy occurred in regards to bronchial tissue sampling. Both lungs had bronchoscopic evaluation, but tissue sampling only occurred on the incorrect side.	
10-12	Product or Device Events	2 - Air Embolism	Two (2) patients experienced an air embolism during a procedure. One patient sustained an air embolism during an interventional radiology procedure to place a central access catheter for providing intravenous nutrition. A second patient had an anatomical anomaly that allowed air to seep into the patient's vascular system.	The Imaging Department has changed its practice to limiting the placement of optional invasive central lines until a patient's nutritional status has improved.
		1- Device Event	During an invasive heart procedure, one (1) patient had a piece of a cardiac device, which is used to unclog arteries, break within an artery.	The device event prompted notification to the product manufacturer and a request for a change in the product design.

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13-18	Care Management Events	6 - Pressure Ulcers	Six (6) patients developed Stage 3 or 4 pressure ulcers (on a 1 to 4 scale). Each of these patients was critically ill and had limited ability to be safely moved while in bed. The patients also 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.
19		1- Medication event	One (1) event involved a wrong medication administered at the wrong rate. The infusion pump rate was set for a different medication, so the wrong medication was infused at a faster rate than ordered. The patient was unharmed.	Medications are matched to a patient using bar code scanning technology. This bar code scanning helps confirm the 5 rights to safe medication administration. Intravenous medications are administered by selecting the medication name from a list included within the infusion pump; this matches the medication, the concentration of the infusion, and the rate limits for how the medication is to be infused over time.
20-32		13 - Falls w/ injury	Thirteen (13) patients suffered injuries from falls while getting out of bed, walking to the bathroom, or walking without necessary assistance. Twelve of the patients had a fall during their inpatient care stay. One patient sustained a fall event in a procedural area. The injuries included fractures (6), intracranial (5) bleeds, and lacerations requiring sutures (2).	Fall prevention continues to be a priority for all hospitals. In spite of a comprehensive fall prevention program, there is a variable response to interventions among patients. Clinical leadership called for a Task Force to review the elements of the Falls Prevention program in 2012 to evaluate the effectiveness of current fall prevention strategies. As a result, additional chair alarms will be purchased to help reduce the number of falls even further.

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