

Massachusetts General Hospital  
 Serious Reportable Events in 2013

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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
1-4	Surgical or Invasive Procedure Events	4 – Wrong Site Procedure	Four (4) wrong site procedures were performed. These included: a spinal fusion that was completed at the incorrect level; a chest tube that was placed below the intended pleural space target; a delay in recognizing a central venous catheter that was placed in an adjacent artery; and using the distal colon rather than the proximal colon to create a colostomy.	<p>To avoid incorrect spine level surgery, a spine level verification policy was revised and disseminated.</p> <p>Indications for when to use ultrasound versus CT scan guided placement of a pleural tube were reviewed.</p> <p>Trainees were instructed to confirm central venous catheter placement by transducing the line.</p> <p>Surgeons were alerted to double check the orientation of bowel loops used to create a colostomy.</p>
5		1 - Wrong Surgical Procedure	One (1) consented intracytoplasmic sperm injection (ICSI) technique for in-vitro fertilization was not the one which the patient had decided upon. She had changed her request and this information was not conveyed to all caregivers.	<p>Staff reviewed the use of closed loop communication and the need to reconfirm consents with patients during each IVF cycle visit to see if there have been any changes in their preferences. To affirm planned treatment for the cycle using the UP, the department has approved a standardized procedural confirmation form.</p>
6-10		5 - Retained Foreign Objects	Five (5) patients had unintentionally retained foreign objects after their completed procedure. These included: a protective eye shield that was removed in the post anesthesia care unit; a retained fragment from a previously removed central catheter; a surgical glove tip that tore during a chest tube placement; an oral bite block that remained in place after a surgical procedure; and the metal pin tip from a meniscal repair device that bent and broke off into the soft tissues behind the patient's knee.	<p>Eye shields were added to the perioperative nursing count documentation and an easily visible shield has been purchased to replace the previous product.</p> <p>A MedSun (FDA) report was filed because the silicon fragment is not meant to separate from the catheter.</p> <p>Surgical staff was alerted to the risk of surgical gloves tearing during invasive procedures.</p> <p>The OR Count policy was revised to include bite blocks. All bite blocks now have double looped tape attached that remains outside the patient's mouth.</p> <p>Orthopedic surgeons and surgical team members were in-serviced regarding the use of the meniscal repair device including reinforcing the need to inspect the equipment with full lighting at the end of the case.</p>

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11	Product or Device Events	1 - Air Embolism	One (1) patient experienced an air embolism during an Interventional Radiology procedure. The patient had air enter the vascular system through the catheter that was being used for the procedure.	The Imaging Department retrained the staff that prepares catheters used in invasive procedures.
12-19	Care Management Events	8- Medication event	Eight (8) medications events occurred. These events included: concentrated potassium chloride (KCL) infusing too quickly into the patient's peripheral intravenous line; a delay in restarting continuous intravenous heparin after an interventional procedure; a delay in administering Solumedrol to a patient with a mental status change resulting in an ICU admission; a readmission for a patient that was dispensed double the dose of the prescribed Fentanyl patches; a hospitalization for a patient that received two antihypertensive agents because of confusion over medication lists in two different computer systems; an urgent evaluation for a patient who was inadvertently prescribed a higher dose strength of warfarin; a post-operative patient required ICU monitoring after receiving a larger dose of pain medication than intended; and a renal patient that received digoxin dosing that caused toxicity.	<p>The policy for KCL infusion has been reviewed by the trainees and attending Anesthesia physicians.</p> <p>The templates used to prescribe heparin starts &amp; restarts after interventional procedures were made more explicit. The new template includes a hard stop that forces the prescribing physician to select one of the ordering choices for post-procedure patients.</p> <p>The failure to communicate a STAT high dose steroid order was reviewed by the medical and nursing teams.</p> <p>A computer server was installed in the pharmacy to allow for bi-directional scanning of patient's medications and point-of-sale receipts. This allows the pharmacy to detect when a prescription is dispensed to the wrong patient.</p> <p>A change was made to the physician ordering systems that allows the prescriber to visualize and compare both patient medication lists at the time of ordering.</p> <p>Prescribers were encouraged to use the computer icon that displays the correct prescribed anticoagulation dose strength every time that a patient's warfarin is reordered.</p> <p>The nurses in the post anesthesia care area reviewed the hospital policy for reading back a verbal order prior to administering the medication to confirm the medication, desired dose, route, and timing for the particular patient.</p> <p>The event was reviewed between all team members to respond to requests about clarification before prescribing, dispensing, or administering digoxin if a</p>

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20		1- Serious injury to a neonate associated with delivery	One (1) prolonged labor and delivery was complicated by a nuchal cord. The infant was delivered and had low Apgar scores at 1, 5, and 10 minutes requiring admission to the neonatal intensive care unit (NICU).	<p>concern is voiced by providers or staff at any point in the process. Escalation is encouraged to ensure differences of opinion are reconciled in a timely manner.</p> <p>The resuscitation of the infant was immediate and successful. The infant was admitted to the NICU in hemodynamically stable condition. The monitoring policy was reviewed to emphasize communication between the nurses, nurse midwives, and physicians in Labor and Delivery to switch intermittent monitoring to continuous fetal monitoring when the duration of the second stage of labor is more than three hours.</p>
21-38		18 - Falls w/ injury	Eighteen (18) patient fall events resulted in reportable injury events. These injuries included: eight (8) fractures; seven (7) patients requiring suturing; two (2) patients that sustained a fracture and required sutures; and one (1) patient sustained an intra-cerebral hemorrhage.	Fall prevention continues to be a priority for all hospitals. The comprehensive Let's Eliminate All Falls (LEAF) prevention program has been implemented throughout MGH. Clinical leadership, quality specialists, nurses, and therapists review all fall events each month and implement changes to the program based upon their ongoing learning from reviewing fall events, new equipment options, and from literature reviews.
39-52		14 - Pressure Ulcers	Fourteen (14) patients developed an unstageable, stage 3, or stage 4 pressure ulcer (1 to 4 scale). Each of these patients was critically-ill and had a limited ability to be safely repositioned while in bed. The patients also had medical or surgical conditions that were known to contribute to skin breakdown. Each patient 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.
53		1- Artificial insemination with wrong donor sperm	One (1) patient learned that her previous successful insemination was performed with one of her two selected donor specimens, but it was not the one she had decided upon in a late change that was not communicated to all staff.	In response to this event, a step in processing was added for in-vitro fertilization and intrauterine insemination pregnancies involving donor sperm. The new process requires the patient to indicate in writing, on the day of the procedure, using a newly developed form, the donor number she intends to use. Semen is then thawed for use. If the patient cannot indicate the donor semen number, then all available specimens will be reviewed with the patient to be sure both patient and staff agree on which specimen will be used.

54-57	Environmental Events	4 – Injury associated with a Burn	<p>Four (4) patients sustained burns as a result of the following: a chemical warm pack was applied to the patient’s scapula causing redness and two blisters; a hot water beverage spilled on the patient’s skin causing redness; a bipolar forceps used during a procedure caused a burn to the patient’s upper lip; and contained heated fluids were applied directly to a patient’s skin causing erythema and a mixed thickness burn.</p>	<p>The nurses reviewed the event and were alerted to avoid applying chemical warming packs directly to patient’s skin.</p> <p>A plan was implemented to avoid providing any fluids other than lukewarm beverages to this patient.</p> <p>Operating Room Nurses were alerted by a practice update that monopolar and bipolar electrosurgical unit forceps conduct electricity and get hot when in contact with metal instruments. The OR is now using insulated bipolar forceps for oral procedures.</p> <p>The QA Chair shared locally and among leadership how to warm fluids according to exiting policy.</p>
58	Criminal Events	1 – Physical Assault on a staff member	<p>One (1) staff member was injured as a result of a patient’s bite event that resulted in an injury to the nurse’s finger.</p>	<p>The Safe Medication Administration Subcommittee reviewed the use of orally dissolving medications. A multidisciplinary team developed guidelines for the management of the delirious patient to include both pharmacologic and non-pharmacologic techniques.</p>