Massachusetts General Hospital
Serious Reportable Events in 2014
More about our improvement efforts at http://qualityandsafety.massgeneral.org and http://qualityandsafety.partners.org

Case	SRE Categories	MDPH/NQF Listing of Serious Reportable Events	Event Description	Lessons Learned/Actions to Prevent Future Events
1-3	Surgical or Invasive Procedure Events	3 - Wrong Site Procedure	• Wrong biopsy • Wrong tooth extraction • Wrong bone fused	• Improved training and staff supervision for site marking during the Universal Protocol • Identify and refer to actual tooth name prior to extraction • A site verification check was implemented for surgery involving small bones
4		1 – Wrong Surgical Procedure	• Failure to remove all of surgically implanted hardware/removed one of two	• Developed process for reviewing radiographs prior to surgically removing hardware
5-9		5 – Retained Foreign Objects	• An inner guidewire was not removed after a dialysis catheter placement • Gauze packing placed in the patient's oropharynx during surgery was discovered and removed in the recovery room • A guidewire remained in an infusion catheter • Guidewire fractured during cardiac catheterization and it was not able to be removed • A portion of a fractured guidewire from a femoral cannula was retrieved after being identified on an X-ray film	• Implementation of pre- and post-procedure checklist to note line removal and nurse assistance during line placement • Implemented observation audits of count practices and revised the policy • A safety alert was communicated to Anesthesia staff and a report filed with the FDA • Two catheter lots were removed and a report filed with the FDA • Removed guidewires are to be inspected to ensure intact
10-42	Product or Device Events	33 – Patient exposures to contaminated devices	• Thirty-two patients were exposed to reusable devices that underwent non-standard equipment cleaning • A child that picked up a contaminated item from a disposal bucket	• The practice setting replaced reusable equipment with disposable equipment and supplies. • The disposal buckets for collecting used equipment were removed

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43-44		2 – Device Failure	• Rupture of an Intra-Aortic Balloon (IABP) requiring surgical removal of the device • Migration of a central venous catheter resulted in medication leakage into chest wall tissue	• The vascular team developed response protocol to IABP ruptures. The IABP catheter was reported to the manufacturer. • Practice change in use of catheters
45-47		3- Air Embolism	• Two patients were believed to have had air enter their intravascular system during central line removal • Air entered the system of a third patient during sequential infusion of blood products in the operating room	• Policy and practice changed to require all central lines be removed with the patient in Trendelenburg position and application of occlusive dressings with petroleum ointment • Review of guidelines on how to prevent air entering the intravenous line during fluid resuscitation
48-49	Patient Protection Events	2 – Patient Attempted Suicide or Self-Harm	• Self administered intravenous drug overdose within minutes of arriving to the hospital • Patient cut himself and required sutures to close a 10cm	• Not anticipated/predictable • Not anticipated/predictable. 1:1 observer after event
50-51	Care Management Events	2 – Medication Events	• Procedure cancelled after patient received antibiotic listed as having previously caused an allergic reaction • Patient required medical intervention after receiving larger dose of warfarin due to confusion over pill strength	• An institutional process was reviewed for identifying allergies and referring patients to the Allergy & Immunology service for testing • The Anticoagulation Management Service reviewed with providers the need to only prescribe one-milligram tablets for all patients new to warfarin therapy
52-56		5 – Neonatal Injury or Death	• Emergent C-section with unexpected neonatal death	• High risk and resuscitation scenario simulations ongoing

			• Neonate experienced oxygen deprivation as a result of a difficult delivery and shoulder dystocia • Newborn sustained a right humeral fracture after a difficult, shoulder dystocia delivery. • Newborn sustained a femur fracture during a C-section delivery – cause related to positioning • Neonate resuscitated at time of delivery but died unexpectedly days later	• OB team simulation training with shoulder dystocia maneuvers • Learning and emphasis on positioning to avoid similar events in the future • High risk and resuscitation scenario simulations ongoing
57-74		18 – Falls with Injury	Eighteen (18) patient fall events resulted in serious injury events • seven (7) fractures; • eight (8) required sutures • one (1) sustained a fracture and required sutures • one (1) sustained a subdural hemorrhage • one (1) fall involved a newborn	• Fall prevention continues to be a priority. The hospital experienced a slight decrease in overall falls with injury in 2014. Efforts continue to reduce falls with serious injury. A post-fall algorithm was introduced to improve the assessment and management of patients that do fall. Focus on increased awareness of patient fall risk assessment in Outpatient Physical Therapy areas
75-91		17 – Pressure Ulcers (PU)	Seventeen (17) patients developed unstageable, stage 3, or stage 4 pressure ulcer (1 to 4 scale) • . Sixteen (16) patients were critically-ill and had a limited ability to be safely repositioned while in bed • One (1) patient developed a PU from a naso-gastric tube (NGT) positioned in the nares	• A comprehensive "Save Our Skin" program of prevention, assessment, and management of pressure ulcers continues to be improved in all areas of the hospital • The hospital has introduced a NGT securing bridle to relieve pressure from the nose
92		1 – Irreplaceable specimen	• One (1) irreplaceable eye specimen was lost when tissue from an enucleation was discarded	

				• Implementation of a protocol for eye specimen preparation with annual competencies and retraining
93-94	Environmental Events	2 – Burn Injury	• Blisters developed after lying on a water circulating heating pad • Second-degree burn from electrocautery device pencil that was placed on sterile field and accidentally activated	• A hospital-wide practice alert was issued to emphasize the need to protect the patient's skin from direct pressure from the heating pad • The foot pedal controlled electrocautery device devices were removed from OR surgical service and replaced with hand operated devices only
	Radiologic Events		No events in this category	
	Criminal Events		No events in this category	