### Serious Reportable Events in 2014

More about our improvement efforts at [http://qualityandsafety.massgeneral.org](http://qualityandsafety.massgeneral.org) and [http://qualityandsafety.partners.org](http://qualityandsafety.partners.org)

<table>
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<tr>
<th>Case</th>
<th>SRE Categories</th>
<th>MDPH/NQF Listing of Serious Reportable Events</th>
<th>Event Description</th>
<th>Lessons Learned/Actions to Prevent Future Events</th>
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</table>
| 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  
- 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 | Developed process for reviewing radiographs prior to surgically removing hardware  
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 |
| 5-9  | 5 – Retained Foreign Objects | | | |
| 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 |
### Massachusetts General Hospital
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<tr>
<th>Page</th>
<th>Type</th>
<th>Event</th>
<th>Description</th>
<th>Response and Preventive Measures</th>
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| 43-44 | Device Failure | 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 | Air Embolism | 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 intravascular 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  
• High risk and resuscitation scenario simulations ongoing |
| 52-56 | Neonatal Injury or Death | 5 – Neonatal Injury or Death | • Emergent C-section with unexpected neonatal death |  |
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| 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
| 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 nasogastric tube (NGT) positioned in the nares
| 92    | 1 – Irreplaceable specimen | One (1) irreplaceable eye specimen was lost when tissue from an enucleation was discarded
|       |                        | - 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
|       |                        | - 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
|       |                        | - 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
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<table>
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<tr>
<th>93-94</th>
<th>Environmental Events</th>
<th>2 – Burn Injury</th>
<th>Implementation of a protocol for eye specimen preparation with annual competencies and retraining</th>
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<tbody>
<tr>
<td></td>
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<td>● Blisters developed after lying on a water circulating heating pad</td>
<td>● A hospital-wide practice alert was issued to emphasize the need to protect the patient’s skin from direct pressure from the heating pad</td>
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<td>● Second-degree burn from electrocautery device pencil that was placed on sterile field and accidentally activated</td>
<td>● The foot pedal controlled electrocautery device devices were removed from OR surgical service and replaced with hand operated devices only</td>
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|  | Radiologic Events | No events in this category |
|  |                  |                              |

|  | Criminal Events | No events in this category |
|  |                |                              |