Maryland Patient Safety Program

Office of Health Care Quality

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Maryland Patient Safety Conference
April 3, 2012

Reports Received

➢ 1500 Level 1 adverse events reported through 12/31/2011.

➢ In CY11, 264 Level 1 Adverse Events reported, affecting 360 patients.

➢ There were 56 fatalities among the 360 patients involved in Level 1 adverse events reported in CY11 (16%).
Which Hospitals Reported

➢ 64 of 65 hospitals have reported at least one Level 1 adverse event since 3/15/2004.
➢ Acute care hospitals reported 92% of the Level 1 adverse events. All acute care hospitals have reported events.
➢ Special hospitals (chronic, children’s, rehabilitation) reported 3%.
➢ Psychiatric Hospitals account for 5% of the reported events.

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Reporting Patterns for CY 2011

➢ For the first time, hospitals with 200 to 300 beds reported more events than the largest hospitals, an average of 7.5 Level One Events per hospital versus 5.7 for hospitals with >300 beds.
➢ Special hospitals reported an average of 0.8 Level One Events in 2011.
➢ Hospitals with <100 beds reported an average of 0.9 events in 2011, it should be noted that half of these hospitals are special hospitals, which historically are subject to fewer adverse events than acute care hospitals.

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Reporting

- Commitment by the hospital leadership and the patient safety director clearly plays a role.
- Personnel changes appear to have an negative impact on reporting, which likely indicates a learning curve for new PSOs and a lack of support/oversight by management.
- We’ve also noted a decrease in reports and timely RCA submission if the PSO is on sick leave.
- Hospital internal reporting systems appear to be more problematic than the fear of reporting among individual staff.

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Top 10 Reported Events Since 3/15/04

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>494</td>
</tr>
<tr>
<td>Hospital Acquired Pressure Ulcers (HAPU)</td>
<td>217</td>
</tr>
<tr>
<td>Delays In Treatment</td>
<td>137</td>
</tr>
<tr>
<td>Airway Management</td>
<td>68</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>58</td>
</tr>
<tr>
<td>Suicides/Suicide attempts</td>
<td>52</td>
</tr>
<tr>
<td>Retained Foreign Bodies</td>
<td>51</td>
</tr>
<tr>
<td>Unanticipated Complications</td>
<td>46</td>
</tr>
<tr>
<td>Maternal/Fetal Deaths or Serious Disability</td>
<td>44</td>
</tr>
<tr>
<td>Health Care Acquired Infections</td>
<td>44</td>
</tr>
<tr>
<td>Wrong site/patient/procedure</td>
<td>24</td>
</tr>
</tbody>
</table>
## Top 10 Reported Events for CY11

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Acquired Pressure Ulcers (HAPU)</td>
<td>156</td>
</tr>
<tr>
<td>Falls</td>
<td>101</td>
</tr>
<tr>
<td>Retained Foreign Bodies (RFB)</td>
<td>17</td>
</tr>
<tr>
<td>Delays in Treatment</td>
<td>16</td>
</tr>
<tr>
<td>Maternal/Fetal Deaths or Serious Disability</td>
<td>9</td>
</tr>
<tr>
<td>Suicides/Suicide attempts</td>
<td>8</td>
</tr>
<tr>
<td>Airway Management</td>
<td>7</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>7</td>
</tr>
<tr>
<td>Wrong site/procedure/patient</td>
<td>7</td>
</tr>
<tr>
<td>Failure to Act</td>
<td>4</td>
</tr>
</tbody>
</table>

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## Hospital Acquired Pressure Ulcers (HAPU) in 2011

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Enforcement activities

- Two on-site patient safety surveys completed.
- Five RCAs from four hospitals failed to meet 10.07.06 requirements.
- One hospital fined and put on directed plan of correction for failing to report events and complete RCAs within a timely manner.
Other Activities

- Annual report cards about patient safety activities to each hospital with an attestation. All hospitals should have received the first one by April 30, 2012.
- Two Clinical Alerts released:
  - Delays in Treatment
  - Assessing Physician Quality
- Clinical Alerts available at http://dhmh.maryland.gov/ohcq/regulated_programs/h_alerts.htm?id=1
- Continued coordination with the MHA and MPSC on falls and patient safety education programs.

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CASE STUDIES

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Adverse Event #1

- 71 y/o unstable female ICU patient had a central line inserted then was to go to CT. The transporter came and a RN, not the patient's nurse, told him it was OK to take her without a nurse. The transporter took her to radiology and told the CT tech she was there and left the patient in the hall. The CT tech did not know how unstable the patient was & left her in the hall long enough for the family to walk down the hall and find her with agonal respirations. She was initially resuscitated and taken back to ICU on vent, but arrested later that day and died.

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Adverse Event #1 (Continued)

- RN did not notify MD of VS on admission so MD did not see patient for 1.5 hours.
- RN did not check VS after CL insertion or prior to patient going to CT.
- The transporter was concerned about patient's appearance and questioned the RN, but RN said it was OK to take patient to CT without a monitor.
- Policies tightened up about notifying MD for any change in patient condition, also empowered transporters to speak up and gave them simple tips on what to be concerned about. Also putting forcing function into CPOE so that ordered tests need MD to specify if patient needs monitor/RN/MD accompaniment.
Adverse Event #2

A patient notified the hospital that she had filed suit against a surgeon for operating on the incorrect ovary & fallopian tube. The patient was supposed to have a cyst removed from the right ovary, instead the left ovary & fallopian tube were removed.

The hospital reviewed nearly 100 GYN surgery cases & found the following:

- Widespread lack of laterality indicated when posting cases & no process for follow-up to determine laterality before surgery.
- Time-outs incorrectly indicated that laterality was not necessary since the procedure was laparoscopic.
- OR managers were tracking time-out documentation, but not paying attention to actual procedures for site marking & time-outs.
- There were insufficient safeguards in the processes to catch & remediate errors.

Fixes:

- Laterality now mandatory before posting any case.
- Using bracelets to indicate side for all internal procedures.
- Revised policies, orientation, supervision, and EMR.

A review of a similar number of non-GYN internal surgeries (thoracic, renal, GU) that required laterality found no widespread problems.
Adverse Event #3

- A young patient was sent to ED from sub acute rehab with diarrhea, nausea, dehydration & fevers. The patient was alert & ambulatory in ED & was admitted to Telemetry unit due to transient hypotension. She deteriorated over the next 12 hours & testing revealed a possible toxic megacolon. The surgeon did not think the patient was sick enough to warrant emergency surgery on Saturday so the decision was made for the on-call OR team to do an ortho wash-out first. The only anesthesiologist in house was busy with an emergency cath lab procedure. The ortho procedure took 2 hours instead of the planned 30 mins. & the anesthesiologist was also delayed resulting in a 6 hour delay after diagnosis. She arrested upon arrival in the OR & could not be resuscitated.

Adverse Event #3 (Continued)

- Both the anesthesiologist and general surgeon were moon-lighting and were used to hospitals with more support personnel.
- The patient was young and did not “seem sick.”
- Neither surgeon nor ICU staff communicated urgency of patient’s deteriorating condition to the OR so the second on-call team was not activated.
- The nursing supervisor was not notified of the situation, and in any case, was not in the habit of working with OR or cath lab staff to facilitate cases.
More Adverse Event # 3

➢ RCA said Root Cause was lack of communication of patient’s deteriorating condition to the OR.
➢ Fixes included developing a systematic approach to coordinating clinical resources by the shift supervisor, & improving management of patients in cath lab.
➢ Measure of effectiveness was that 90% of clinicians would feel communication has improved after implementation.

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Adverse Event # 4

➢ 88 y/o with dementia admitted from SNF for ORIF of hip fracture. Patient had elevated liver enzymes post-op & abdominal ultrasound revealed pancreatic cyst. GI consult done with orders for abdominal CT with oral & IV contrast.
➢ Over next 12 hours, three NG tubes were inserted without getting one in the right place. RN inserted a Salem tube that, per policy, did not need an x-ray to confirm placement & subsequently gave 2 bottles of contrast after auscultating for placement.
➢ Patient had CT after another 10-12 hour delay.
Adverse Event #4 (Continued)

➢ Radiologist called RN to say that CT showed tip of NGT in right lower lobe of lung & contrast noted in pleural space.
➢ Patient died two days later of respiratory failure after multiple chest tubes & respiratory support.
➢ RCA addressed the mechanical problems with inserting NGTs, not the ethical issues surrounding this patient’s care. If the test was so urgent, why the 24 hour delay? What would have been done with the results?

Are Maryland Hospitals Getting Safer?

➢ We note increased engagement of hospital medical staff with RCA process.
➢ RCAs usually very open about causes of events.
➢ Corrective/preventive actions continue to be problematic, as are expected outcomes.
➢ Fewer fatal falls.
➢ Too many retained foreign bodies!
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