State of New Hampshire
ADVERSE EVENT REPORTING
2019 REPORT

Prepared by

New Hampshire Department of Health and Human Services
Legal & Regulatory Services
Bureau of Licensing & Certification

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Since January 2010, all New Hampshire Hospitals and Ambulatory Surgical Centers (ASCs), except for New Hampshire Hospital, have been required to report all Serious Reportable Events (SREs). As defined by the National Quality Forum's (NQF) Serious Reportable Events in Health-2011 Update: A Consensus Report. In 2011, The NQF broadened their definition of SREs and added additional event types to the list of SREs. This list serves as the standard for identifying patient safety events. Refer to the link below for a list of SREs:

http://www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx

The National Quality Forum (NQF) is a national, consensus-driven, private-public partnership aimed at developing common approaches to the identification of events that are serious in nature and have been determined to be largely preventable, which is sometimes referred as "Never Events" (NQF 2002). The NQF list of serious reportable events has become the bases for state mandatory reporting systems. The intent of the NQF list is to capture clearly identifiable and measurable events that are considered preventable and of interest to the public and other stakeholders.

In New Hampshire, the law (RSA 151:38) was revised to include an additional event in 2013, related to the exposure of a patient to a non-aerosolized blood borne pathogen by a healthcare worker's intentional, unsafe act. In accordance with the New Hampshire law (NH RSA 151:39), the annual report is being submitted which requires the Bureau of Licensing and Certification, Health Facilities Certification (BLC-HFC) to report to the Legislature. This report includes healthcare facilities aggregate number and type of adverse events in the prior calendar year including rates of change, causative factors, and activities to strengthen patient safety in New Hampshire.

Adverse events, also referred as Serious Reportable Events (SREs), are outcomes determined to be unrelated to the natural course and/or proper treatment of the patient's illness or underlying conditions. The purpose of reporting these events is to balance quality improvement accountability, not to punish hospitals, ambulatory surgery centers or the dedicated practitioners that provide the care.

All Hospitals and ASCs must submit an initial report to the Bureau of Licensing and Certification, Health Facilities Certification within 15 days of becoming aware of the event. Once the Bureau of Licensing and Certification, Health Facilities Certification receives the initial report, the BLC-HFC checks for completeness and acknowledges receipt of the initial report. The Department of Health and Human Services (DHHS) has a specified format for the initial report and does not include any identifying information of the healthcare professionals, facility employees and patients involved. Within 60 days of the identification of the event, the facility must submit to the Bureau of Licensing and Certification, Health Facilities Certification the Root Cause Analysis (RCA) and a Corrective Action Plan (CAP). BLC-HFC determines if all submitted documents are complete and accurate, and if plans are in accordance to current professional standards. BLC-HFC acknowledges receipt of the RCA and CAP. Submission of SRE's can be via E-mail, US Mail or other methods.

New Hampshire law (RSA 151:40) states that any facility which violates this subdivision for failure to file a timely adverse event report or failure to conduct a Root Cause Analysis (RCA) to implement a Corrective Action Plan (CAP), or to provide findings of a RCA or CAP shall be subject to disciplinary actions and any other appropriate sanctions.

The facility must conduct a RCA, which is a structured method to identify and analyze systematic issues or processes that may have contributed to the event or could create risk of a future event if not addressed and/or corrected. It is important to recognize a Just Culture, focusing on identifying underlying issues rather than blaming individuals.

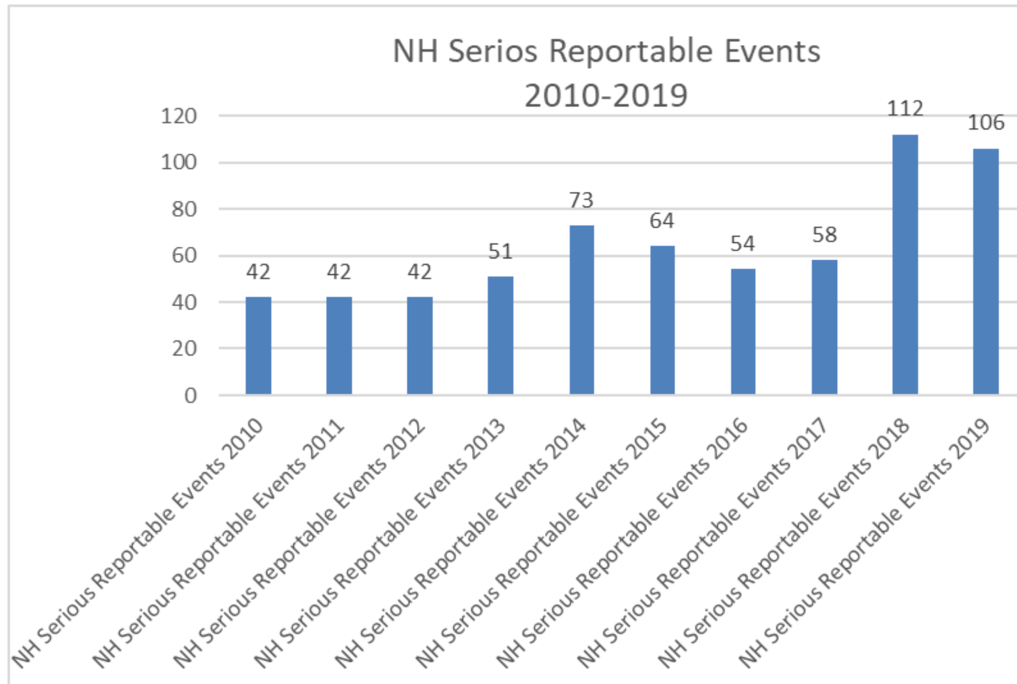
The facility CAP must outline steps to address RCA findings- assign responsible persons to ensure actions are completed, delineates timeframes for completion, and describes measurable outcomes to demonstrate completion of the CAP.

It is important to remember that consumers should not compare the quality of care and safety of the facilities by the number or types of SRE reported. Consumers need to look at all factors such as size of the facility, scope and complexities of the procedures as well as the number of procedures performed at the facility. The following table lists the 2019 Serious Reportable Events:

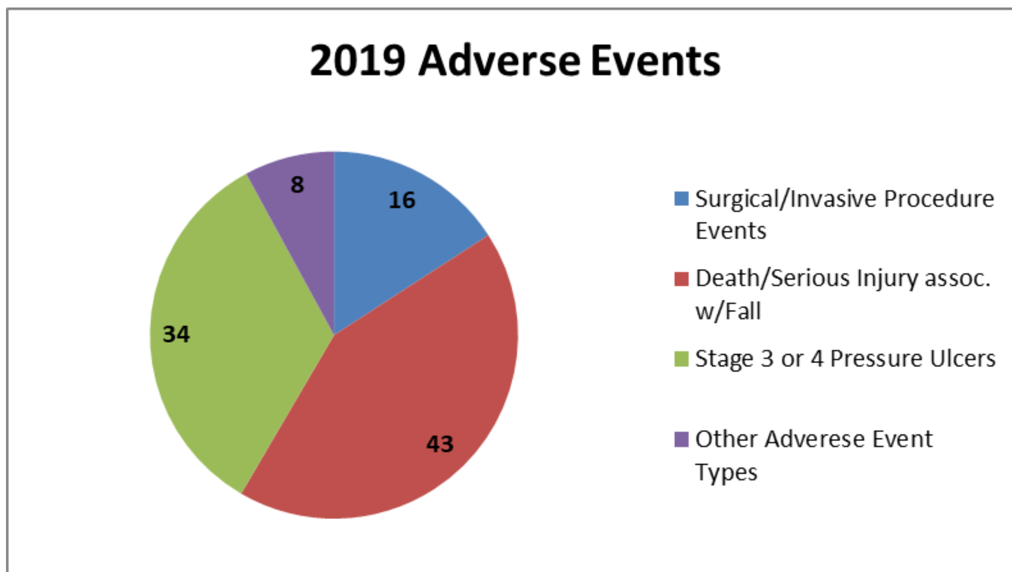
New Hampshire Reportable Events/Adverse Events 2019

CY2019		Surgical Event	Surgical Event	Surgical Event	Protection Event	Care event	Care event	Care Event	Environmental Event	Environmental Event	Pot. Criminal Event	
Provider Name	# of staff Beds	Wrong Body Part	Wrong Procedure	Foreign Object	Suicide	Medication Error	Stage 3 & 4& unstageable	Fall	Burn	Restraints	Physical Assault	Total reported
Alice Peck Day	25							2				2
Catholic Medical Center	330			2			4	4				10
Cheshire Medical Center	169						4					4
Concord Hospital	295					1	1	9	1			12
Cottage Hospital	25			1				1				2
Elliot Hospital	296	1					8	4				13
Encompass	50							1				1
Exeter Hospital	100		1				7	1	1			10
Frisbie Hospital	112			1			4	3				8
Hampstead Hospital	111				1					1		2
Huggins Hospital	25			1				2				3
Lakes Region Gen Hospital	137	1						3				4
Littleton Regional Healthcare	25						1					1
Mary Hitchcock Mem Hospital	396	2				1	3	3			1	10
Memorial Hospital	25				1							1
Monadnock Gen Hospital	25			1				1				2
Northeast Rehabilitation Hospital Network	135	1						2				3
Parkland Hospital	86							5				5
Portsmouth Reg Hospital	209	1					2	1				4
Southern NH Med Center	188	3										3
St. Joseph Hospital	208							3				3
The New London Hospital	25							1				1
Upper Connecticut Valley Hospital	25						1					1
Wentworth Douglass Hospital	178						1					1
Total		9	1	6	2	2	36	46	2	1	1	106

The bar graph below shows the total number of events reported in NH since the statute was effective in 2010.



The pie graph below shows the total number by event type reported in CY 2019.



In analyzing the events reported in CY 2019, there continues to be three major areas responsible for 93% of the events reported. These areas were as follows:

Falls	**43%**
Pressure Injuries	**34%**
Surgical Events	**16%**

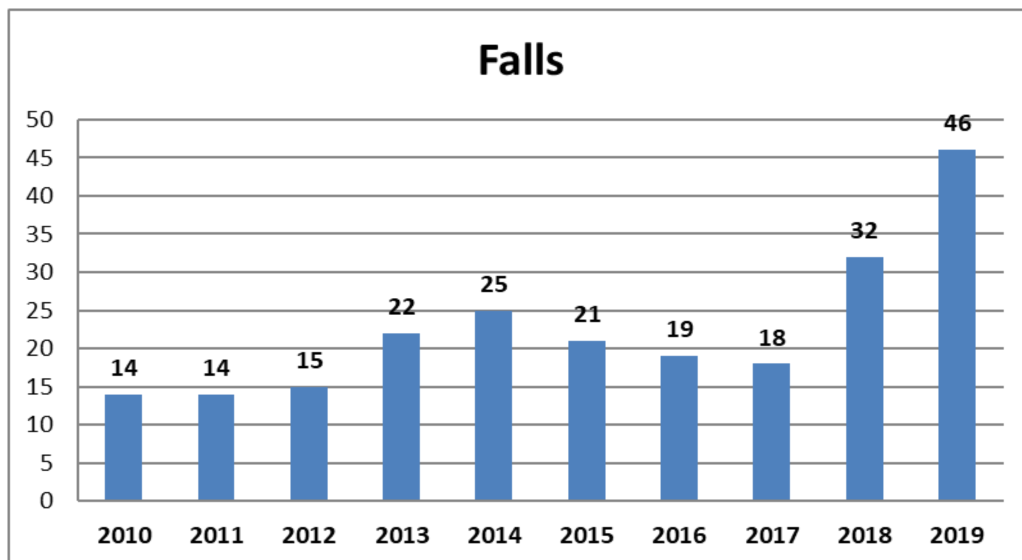
Considering that these event types represents 93% of the total events, it is important that we focus our efforts on these and address what NH Hospitals and ASC's are doing in these areas to improve outcomes.

Organizations have used their root cause analysis process to learn the weaknesses in their systems, identify opportunities in systems and processes, and implement approaches to improve the quality of care the patients receive within their Hospitals and ASCs.

The 2019 Adverse Event Report (aka Serious Reportable Events) reflects a decrease in total events compared to CY 2018; however, it is still an increase in total events compared to the events reported prior to CY 2018. There is an increase in the number of falls, a slight decrease in pressure injuries and a significant decrease in the number of surgical events reported in CY 2019 compared to events reported in CY 2018.

FALLS

The bar graph below shows the total number of SRE that fall into the event type of Death/Serious injury associated with a fall in CY 2019.



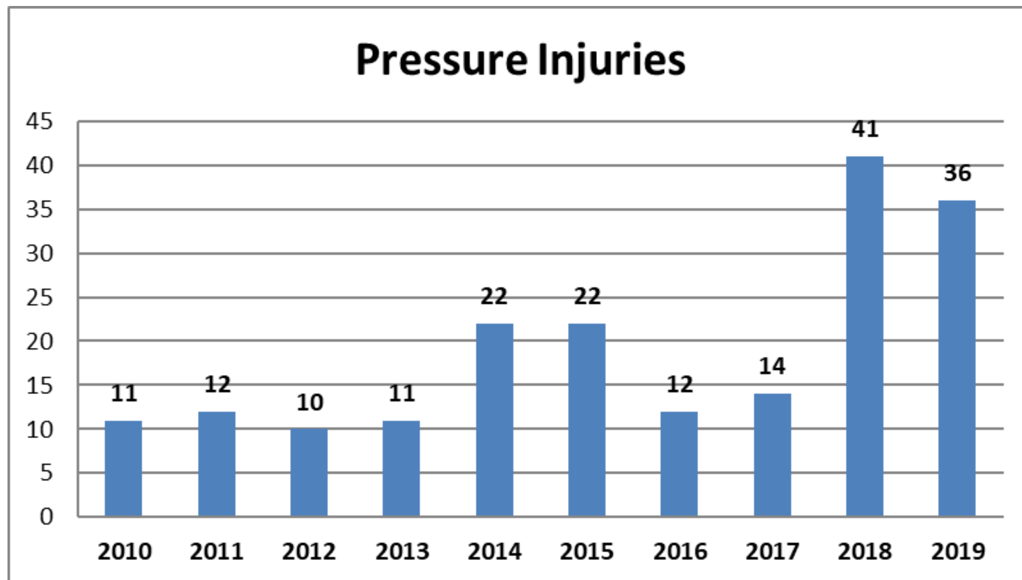
Strategies utilized by NH Hospitals and ASCs include:

- Develop and implement a standardized approach in noting patient's fall risk status, recent falls, ambulatory status, patient care needs, fall prevention devices (e.g. sensor alarms) utilized, and assistive device used on admission and during hospital stay.
- Frequent re-assessment of patient's conditions and needs to determine appropriate fall prevention interventions.
- Delineate the multidisciplinary team's role on developing, implementing, monitoring and reporting actual/potential falls.

- Communication of patient condition and care needs through shift-to-shift huddles, nurse-to nurse reports, and within different departments if or when moved.
- Engage and educate patient/families on patient-specific fall prevention strategies and expectations on admissions and during hospital stay.
- Standardized documentation of fall-risk assessment; fall prevention interventions and patient refusal of fall prevention interventions in the EMR (Electronic Medical Record).
- Optimization of gait belts and assistive devices to maintain patient balance during ambulation/transfers.
- Monitor safety monitoring devices regularly for functionality and replace as needed.
- Ensure that patient environment is safe, such as making sure the floor is dry before leaving patient in the bathroom.
- Medication review incorporate in fall prevention strategies, such as post-operative pain medications, sedatives, and BEERS (Potentially Inappropriate Medications) list.
- Implement the Falling Star program and similar evidence based tools to identify patient's with high-risk of falls and initiate appropriate interventions.
- Provide staff with a regular or as needed training on technology to improve use of sensor alarms, documentation of patient risk assessment and fall interventions, evidence-based practices to prevent falls, and policy review and changes regarding fall prevention strategies.
- Staff debriefing (huddles) immediately after every fall to determine contributing factors to learn how to prevent falls.
- Fall Prevention Committee will be reviewing resources and materials for communicating and educating patient/families on safe mobility/fall prevention.
- Share feedback with staff on falls, noting event and opportunities, as well as kudos for all interventions in place and teaching patient engagement.

PRESSURE INJURIES

The bar graph below shows the total number of SRE that fall into the event type of pressure injuries (Stage 3, Stage 4, unstageable) acquired after admission in CY 2019. (see next page)



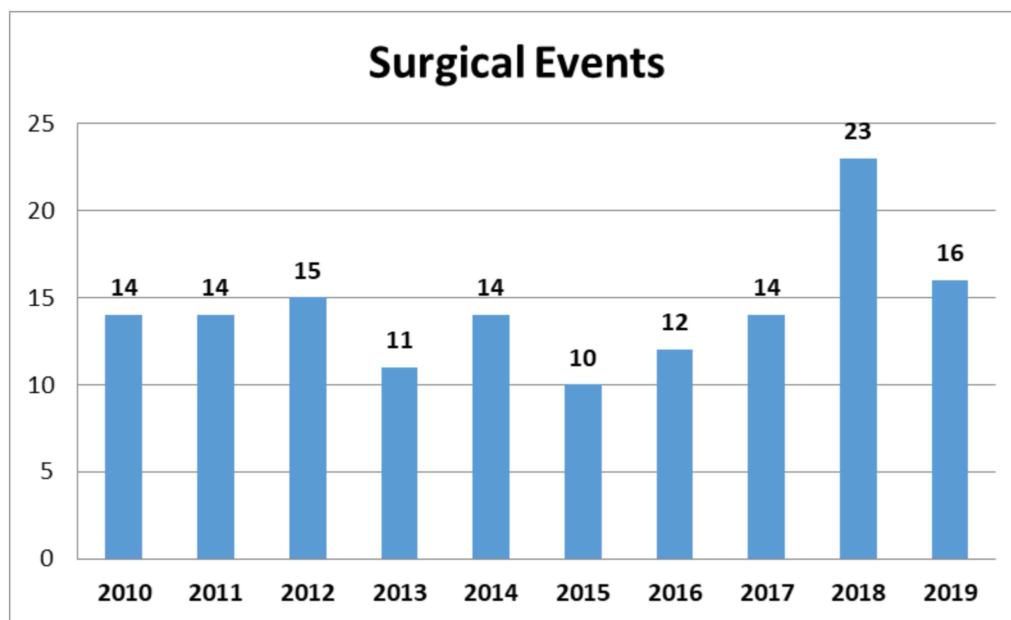
Strategies utilized by the NH Hospitals and ASCs include:

- There are few evidence-based practices to prevent pressure injuries in any setting. The focus is on early identification of patients with high risk of skin breakdown to ensure prompt and appropriate interventions are in place to prevent pressure injuries and/or progression of pressure injuries.
- Completion of a Head to Toe Skin Assessment upon admission to identify pressure injuries to enhance prompt evidence-based care implementation followed by re-assessments every 8 hours to detect early development of pressure injuries to prevent progression, including a review of skin condition and risk in daily multidisciplinary rounds with the care team.
- Utilization of Braden Scale and similar evidence-based tools for predicting pressure injury risk to determine other risk factors such as poor nutrition, dehydration, hygiene, comorbidities for prompt identification of patients at high-risk for skin break down and implementation of preventative interventions.
- Inspection of equipment and skin surrounding the equipment such as nasal oxygen prongs. Use of preventative padding of skin area at risk for skin breakdown from medical equipment. Communicate with staff the need to remove medical equipment/devices for skin inspection
- Utilization of smooth soft surfaces and special pads for patients with high-risk for skin breakdown such as surgical patients and critically ill patients.
- Focus on scheduled turning and repositioning at least every 2 hours to offload patient's skin areas at high-risk of skin breakdown such as offloading bony prominence.
- Standardize communication of pressure injury risk or presence between the nursing staff and multidisciplinary team.
- Engage and educate patient/family on patient-specific prevention strategies and expectations on admissions and during hospital stay.

- Inform patient/family refusal of care interventions and the potential risks when interventions are not implemented.
- Addition of Certified Wound Care Nurse to round and assess patients at risk for skin breakdown and patients with pressure injury as early as on admission, if indicated.
- Increase the role of the Registered Dietician/Nutritionists to create a plan of care to address patient nutrition and hydration status.
- Clinical staff education/training on wound at orientation and as needed in regards to pressure injury staging, skin inspection, assessment, evidence-based pressure injury prevention/management interventions, wound consults, and documentation of any signs of pressure injury development and interventions placed.
- Increase role of the multidisciplinary team in weekly skin/wound rounds/huddles to identify and communicate actual or potential skin injury and to address barriers to monitoring and reporting; and involve other disciplines as needed for feedback.

SURGICAL EVENTS

The bar graph below shows the total number of SRE that fall into the event type of surgical events in CY 2019.



Strategies utilized by NH Hospitals and ASCs include:

- Improve consistency in hand-offs of information during the continuum of care from the time of original diagnoses of the issue requiring surgery to the actual team performing the procedure to ensure that vital information is accurate and appropriately communicated.
- Reinforce implementation of no-interruption zone for critical phases such as time-out, critical dissections, surgical counts, confirming/opening implants, induction/emergence, and care/handling of specimens.

- Measure adherence to policies that address supply counts, time-outs, consents, and other processes deemed to contributing causes to the event.
- Utilization of technology, such as C-arm, to confirm and verify device placement and supply count.
- Utilize practice guidelines and resources for achieving optimal perioperative practices from professional organizations such as the Association of perioperative Registered Nurses (AORN) and others.
- Continue to educate staff in the use of checklist, standard practice of supply count, and time-out process including the awareness of potential limitation of these tools to prevent all surgical errors.

Ongoing discussions with the BLC-HFC staff in clarifying and refining criteria for reporting as well as regular distribution of reported events to all Commission members continues to change the threshold of reporting. These discussions highlight and reinforce the importance of reporting which indirectly has increased the reporting by hospitals and ASCs.

We are increasing our ability to identify events through our collaborative efforts to develop a safe reporting culture. Safety event reporting is an indicator of a strong culture, which is foundational that promotes learning and high reliability by all staff has been noted. Recent data from safety culture surveys reinforces the application of principles of a Just Culture. Heightened vigilance helps foster an organizational culture.

The BLC-HFC and the New Hampshire Healthcare Quality and Safety Commission continue to monitor the number of Adverse Events to determine the cause of the total reportable events. Survey results are not indicative of any causal factors nor has there been any increase in complaints for this population. Review of the number of events in 2020 to date indicate a potential return to the 2017 totals. Open communication is maintained throughout the year between the BHFA-C and the facilities to encourage open discussion of events to ensure accuracy from initial report to the RCA and CAP.

NH Hospitals and ASCs continues to share their experiences via story telling at commission meetings, thereby ensuring they all learn from their identified RCA and CAPs that can enhance safety. The Hospitals and ASCs remain committed to educate their personnel and professional staff about patient safety to promote the best outcomes for their patients.

Bureau of Licensing and Certification, Health Facilities Certification annually samples at least 10% of the adverse events received each calendar year to ensure that the submitted Corrective Action Plans (CAPs) have been implemented by the hospital. Due to the increase in survey activity during the COVID-19 pandemic, BLC-HFC is currently in the process of completing the 2019 audit of CAPs and will provide an update in the next meeting.

Acknowledgements:

The Department's Adverse Event Reporting Staff would like to thank the many staff at New Hampshire's hospitals and ASCs for their prompt reporting of events and reporting of RCAs and CAPs. Of note was the fast response by facilities for additional data concerning quality progress metrics. Questions concerning this report may be directed to kristie.holtz@dhhs.nh.gov.