

# State of New Hampshire

## ADVERSE EVENT REPORTING 2015 REPORT



### Provided by

New Hampshire Department of Health and Human Services  
Office of Operations Support  
Bureau of Licensing & Certification

**November 18, 2016**

### **Adverse Event Report 2015 - Hospitals & Ambulatory Surgery Centers**

In 2010, the state of New Hampshire enacted RSA 151-38 which adopted the National Quality Forum's Serious Reportable Events and added a specific event related to the transmission of blood borne pathogens. The law requires hospitals and ambulatory surgery centers to report any of these events should they occur in their facility. There are twenty-nine (29) NQF Serious Reportable Events (SREs) structured around seven categories: surgical, product or device, patient protection, care management, environmental, radiologic events and potential criminal.

This report is submitted in accordance with New Hampshire law (NHRSA 151-39) which requires an annual report to the Legislature. The Bureau of Licensing and Certification submits the annual report to the Legislature that includes the aggregate number and type of adverse events by facility for the prior calendar year. Lessons learned from the root cause(s) and corrective action plan(s) for each reported adverse event are also included. The Bureau and the healthcare organizations work together to continuously improve patient safety.

## National Quality Forum:

The National Quality Forum (NQF) is a not-for-profit nonpartisan, membership based organization that works to catalyze improvement in healthcare. This status allows the federal government to rely on NQF-defined measures or healthcare practices as the best, evidence-based approaches to improving care. Sometimes referred to as 'never events', the NQF list has increasingly become the basis for state mandatory reporting systems. The list of NQF serious reportable events (SREs) is intended to capture events that are clearly identifiable and measurable, and largely preventable.

## Definition of Adverse Event:

Adverse events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or the proper treatment of that illness or underlying condition.

The law further characterizes an adverse event according to the NQF SREs:

### SURGICAL OR INVASIVE PROCEDURE EVENTS

- Surgery or other invasive procedure performed on the wrong site
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Intraoperative or immediately postoperative/post procedure death in an ASA (American Society Anesthesiologist) Class 1 patient

### PRODUCT OR DEVICE EVENTS

- Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

### PATIENT PROTECTION EVENTS

- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- Patient death or serious injury associated with patient elopement (disappearance)
- Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

### CARE MANAGEMENT EVENTS

- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious injury associated with unsafe administration of blood products

- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- Artificial insemination with the wrong donor sperm or wrong egg (updated)
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

#### ENVIRONMENTAL EVENTS

- Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contain no gas, the wrong gas, or are contaminated by toxic substances
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

#### RADIOLOGIC EVENTS

- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

#### POTENTIAL CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient/resident of any age
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- Death or serious injury of a patient or staff from physical assault (battery) within or on the grounds of a healthcare setting

#### The state law also had the following addition to the RSA 151:38:

The exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act. An act by hospital or ambulatory surgery center staff resulting in an infection or disease shall be considered to be purposefully unsafe if it meets all of the following criteria:

- (1) There was an intentional act or reckless behavior;
- (2) No reasonable person with similar qualifications, training, and experience would have acted the same way under similar circumstances; and
- (3) There were no extenuating circumstances that could justify the act.

**2015 Adverse Events per Organization and Event**

CY2015	Surgical Event	Surgical Event	Surgical Event	Device Event	Care Management Event	Care Management Event	Care Management Event	Care Management event	Care Management Event	Environmental Event	Potential Criminal Event	
Provider Name	Wrong Body Part	Wrong Procedure	Foreign Object	Use/ Function	Medication Error	Labor & Delivery	Fall	Stage 3/4& unstageable	Lab	Burn	Physical Assault	Total reported
Alice Peck Day Memorial Hospital					1	2	1					4
Androscoggin Valley Hospital							3					3
Catholic Medical Center								4				4
Cheshire Medical Center (The)						1		1				2
Concord Hospital				1			2					3
Dartmouth-Hitchcock Medical Center	2		2				3	8		1		16
Elliot Hospital-City of Manchester							1	2	1			4
Franklin Regional Hospital					1							1
Frisbie Memorial Hospital							2		1			3
HealthSouth Rehab Hospital							1	1				2
Lakes Region General Hospital	1		2									3
Littleton Regional Healthcare							1					1
New London Hospital							1					1
Northeast Rehab							1	2				3
Portsmouth Regional Hospital		1					1					2
Southern New Hampshire Medical Center											1	1
Speare Memorial Hospital								1				1
St. Joseph Hospital							1	1				2
Wentworth-Douglass Hospital	1		1			1	1	2				6
Weeks Medical Center							1					1
Rye ASC							1					1
Total	4	1	5	1	2	4	21	22	2	1	1	64

## 2015 Adverse Events per Organization Bed Staffing and Activity

Hospital	2015 Adverse Events	ICU Beds	Staffed Beds	Admissions	Patient Days	Inpatient Surgeries	Outpatient Surgeries
ALICE PECK DAY MEMORIAL HOSPITAL	4	-	25	1,288	4,944	593	1,574
ANDROSCOGGIN VALLEY HOSPITAL	3	5	25	1,459	5,720	274	1,419
CATHOLIC MEDICAL CENTER	4	33	240	10,566	55,661	4,161	5,480
CHESHIRE MEDICAL CENTER (THE)	2	20	116	3,667	19,714	581	3,330
CONCORD HOSPITAL	3	18	237	13,647	58,220	3,609	6,684
COTTAGE HOSPITAL	0	3	25	503	2,190	124	743
DARTMOUTH-HITCHCOCK MEDICAL CENTER	16	94	417	19,479	116,887	8,553	11,001
ELLIOT HOSPITAL CITY OF MANCHESTER	4	50	266	13,104	64,417	3,024	5,190
EXETER HOSPITAL INC	0	10	99	4,892	19,871	1,442	4,679
FRANKLIN REGIONAL HOSPITAL	1	-	35	1,196	7,500	25	1,168
FRISBIE MEMORIAL HOSPITAL	3	6	96	3,290	15,580	1,187	6,113
HUGGINS HOSPITAL	0	4	25	890	3,833	170	1,372
LAKES REGION GENERAL HOSPITAL	3	10	88	4,614	23,863	1,686	8,125
LITTLETON REGIONAL HEALTHCARE	1	4	25	1,623	5,313	531	2,598
MEMORIAL HOSPITAL	0	3	25	1,631	6,139	301	2,728
MONADNOCK COMMUNITY HOSPITAL	0	2	25	1,474	4,735	263	1,273
NEW LONDON HOSPITAL	1	-	25	1,250	5,885	216	1,479
PARKLAND MEDICAL CENTER	0	8	82	3,530	13,468	629	4,344
PORTSMOUTH REGIONAL HOSPITAL	2	14	165	8,381	40,234	2,289	2,359
SOUTHERN NEW HAMPSHIRE MEDICAL CENTER	1	17	163	7,909	34,307	1,173	3,627
SPEARE MEMORIAL HOSPITAL	1	4	25	1,344	5,374	322	752
ST JOSEPH HOSPITAL	2	11	126	5,261	25,118	1,117	2,537
UPPER CT VALLEY HOSPITAL	0	-	12	397	2,183	7	343
VALLEY REGIONAL HOSPITAL, INC	0	4	21	786	3,952	45	712
WEEKS MEDICAL CENTER	1	3	25	832	3,515	71	865
WENTWORTH-DOUGLASS HOSPITAL	6	10	114	6,269	27,108	1,301	5,609
CROTCHED MOUNTAIN REHAB	0	-	45	53	14,301	-	-
HAMPSTEAD REHAB	0	-	111	1,689	17,654	-	-
HEALTHSOUTH REHAB	2	-	50	873	11,701	-	-
NEW HAMPSHIRE HOSPITAL	0	-	158	2,009	57,013	-	-
NORTHEAST REHAB	3	-	135	3,266	38,570	-	-
RYE ASC	1	-	-	-	-	-	-

Note: Data is reported based on the hospitals Fiscal Year

Data Source: AHA Survey 2015 & hospitals

Data Date: 10/17/2016

Compiled By: Foundation for Healthy Communities (FHC)



## **Requirements: Reporting**

Any hospital or ambulatory surgical center facility must notify the New Hampshire Department of Health and Human Services within 15 working days after the discovery of the event. The notification shall be filed in a format specified by the Department and shall not include any identifying information of the healthcare professionals, facility employees, or patients involved. The notification should include a brief description of the event. Within 60 days the facility needs to submit a credible root cause analysis and corrective action plan (CAP).

### **What happened in 2015?**

It is important to note that no consumer complaints were received by the Department concerning the 64 adverse events reported. Complaints and adverse events are handled by Health Facilities Administration-Certification (HFA-C) as two distinct actions. The Department is responsible for the health, safety and well-being of New Hampshire's citizens. HFA-C evaluates facilities in determining that the facilities are in compliance with patient safety, quality assurance and federal and state regulatory laws.

RSA 151:40 establishes that failure of a facility to report timely, adverse events to include root cause analysis and plans of correction, be subject to disciplinary actions. During the calendar year 2015 no disciplinary actions were required for late reporting.

In order to answer the question, "How do you know the reporting facility did what they said they were going to do to correct the problem?" HFA-C sampled over 10% of the adverse events and asked for and received specific performance data to be submitted as a follow up to their CAP. All facilities sampled provided performance information. It was concluded that the hospitals followed through with actions to correct the problems.

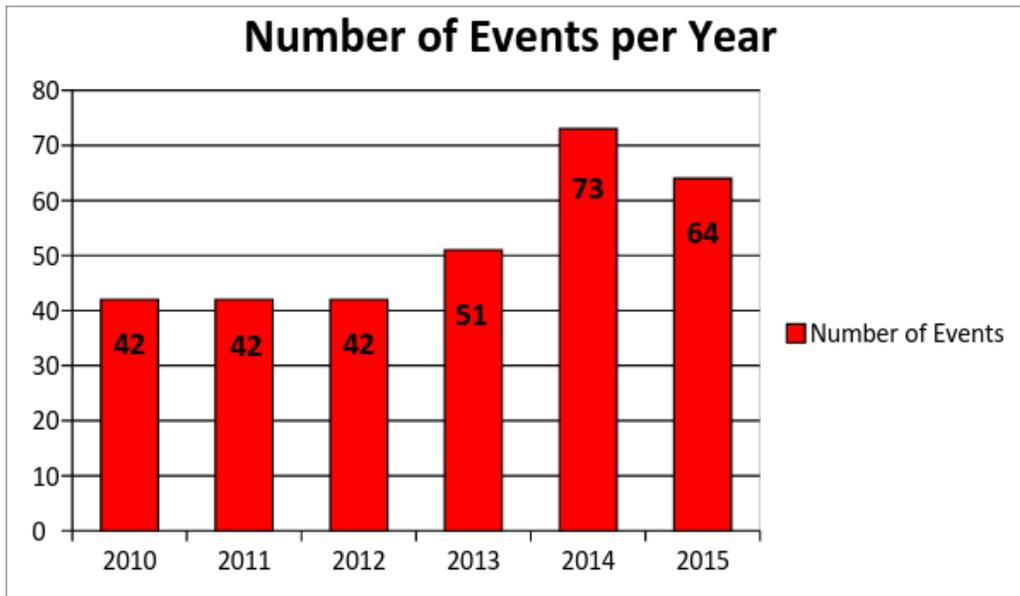
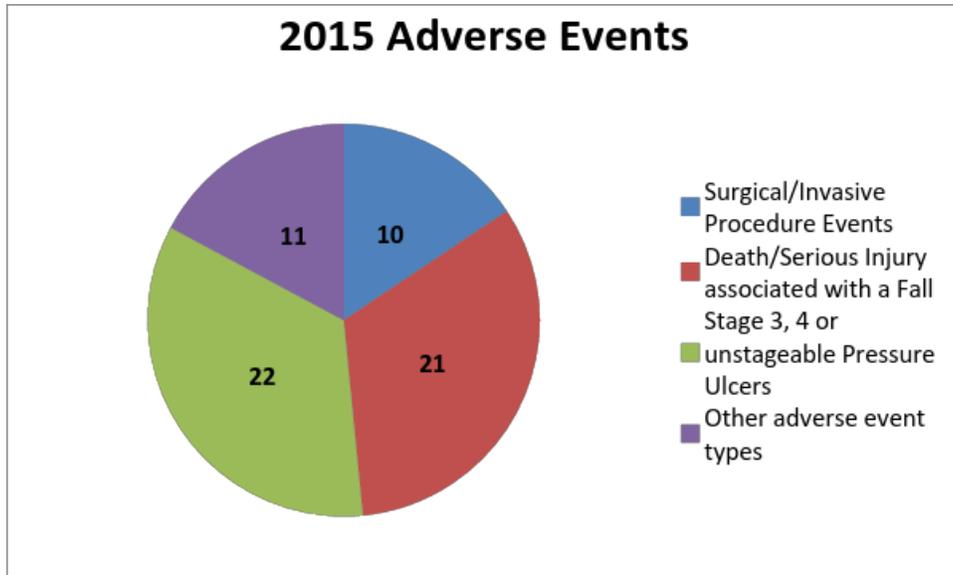
### **Unpreventable / Unavoidable Harm**

According to NQF, to qualify for the list of SREs an event must be "largely, if not entirely, preventable" in addition to other criteria. All hospitals and ASCs report Adverse Events as required by law. Upon completion of a detailed root cause analysis, they may occasionally find that, despite adoption of evidence based protocols and strict adherence to established standards of care, an optimal outcome is not achieved and harm still occurs. Individuals may have clinical conditions that can create a complex set of processes that lead to an event, despite providing the best prevention and/or treatment known. The goal of patient care is to do all that is possible and learn from all events, whether or not a reported event was considered unavoidable.

### **Serious Reportable Events / Adverse Events**

Since January 2010, NH hospitals and ASCs have been reporting adverse events to the Bureau of Health Facilities Certification as required by RSA 151: 38. The law was revised in 2013. It is important to note that changes and additions to the list of SREs, including changes in definitions, resulted in an increased number of reports in 2014. This was particularly evident in the category of pressure ulcers, whose definition was expanded to include "unstageable", which resulted in a doubling of pressure ulcer reports between 2013 and 2014, from 11 to 22. The number of reportable events of pressure ulcers stabilized in 2015. It is worthy to note there was a 12% decrease in total adverse events in 2015. Organizations have scrutinized their root cause analyses to determine opportunities to

improve the quality of care that patients receive within their hospitals. Over the years of reporting, organizations have worked to improve identified weaknesses in systems of patient care.



### Comparison by Events - 2013 - 2015

SURGICAL OR INVASIVE PROCEDURE EVENTS	2013	2014	2015
Wrong site	2	1	4
Wrong patient	0	1	0
Wrong procedure	2	2	1
Unintended retention of a foreign object	7	10	5
Intraoperative or immediately postoperative death of ASA Class 1 patient	0	0	0
PRODUCT OR DEVICE EVENTS			
Use of contaminated drugs, biologics or device	0	0	0
Misuse/malfunction of a device	0	0	1
Air embolism	0	0	0
PATIENT PROTECTION EVENTS			
Release of a patient of any age, who is unable to make decisions, to the wrong person	0	0	0
Patient elopement	0	0	0
Patient suicide, attempted suicide, or self-harm	0	3	0
CARE MANAGEMENT EVENTS			
Death or serious injury due to a medication error	0	0	2
Death or serious injury due to unsafe transfusion practices	0	0	0
Maternal death or serious injury In a low-risk pregnancy, labor or delivery	1	0	0
Death or serious injury of a neonate in a low risk pregnancy, labor or delivery	1	1	4
Death or serious injury associated with a fall	22	25	21
Stage 3 or 4 or unstageable pressure ulcers acquired after admission	11	22	22
Artificial insemination with the wrong donor sperm or donor egg	0	0	0
Death or serious injury from irretrievable loss of an irreplaceable biological specimen	0	0	0
Death or serious injury from failure to follow up or communicate laboratory, pathology, or radiology test results	0	3	2
ENVIRONMENTAL EVENTS			
Death or serious injury associated with an electric shock	0	0	0
Wrong gas, no gas or contamination in patient gas line	0	0	0
Patient or staff death or serious injury associated with a burn	1	2	1
Death or serious injury associated with the use of physical restraints or bedrails	0	0	0
RADIOLOGIC EVENTS			

Death or serious injury if a patient or staff with the introduction of a metallic object into the MRI	0	0	0
<b>POTENTIAL CRIMINAL EVENTS</b>			
Care ordered by or provided by someone impersonating an MD, RN, Pharmacist or other LIP (Licensed Independent Practitioner)	0	0	0
Abduction of a patient of any age	0	0	0
Sexual abuse/assault of a patient or staff member	1	1	0
Death or serious Injury of a patient or staff from physical assault (battery)	2	2	1
<b>TOTAL</b>	<b>51</b>	<b>73</b>	<b>64</b>

What are NH hospitals doing about Serious Reportable Events?

In analyzing the events reported in 2015 it should be noted that there were three major areas responsible for 83% of the events reported. These areas were as follows:

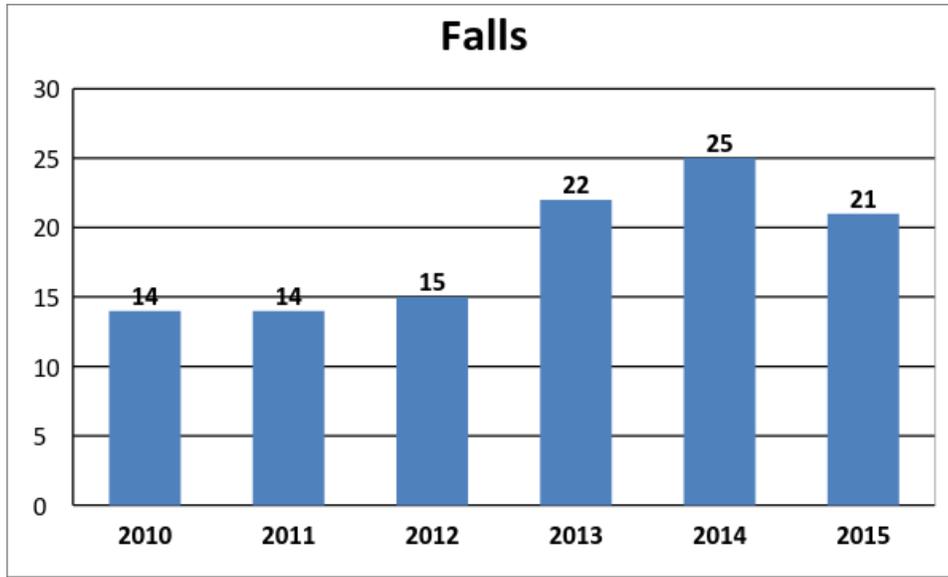
- Falls 33%**
- Pressure Ulcers 34%**
- Surgical Events 16%**

In consideration of the fact that these event types represent **83%** of the total events it is important that we focus on these and address what the NH hospitals are doing to prevent them from occurring.

Falls with Injury

**Problem Summary:**

A fall is defined a “sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, on the ground, other than as a consequence of a sudden onset of paralysis epileptic seizures, or overwhelming external forces.” Falls in a hospital can, and often do, complicate the hospital stay and keep the patient from returning to the community. Many falls that occur are injury free and would not be considered an adverse event. However, for the few who suffer from injuries it may mean additional testing and an increased duration of stay in the hospital. The majority of falls occur when patients are moving to and from the bathroom or attempting to get up from the commode on their own. Patients who suffer serious injury are typically over the age of 60 and suffer from several chronic diseases and conditions that impact balance, strength, and mobility due to the medications or because of their medical condition.



#### Contributing Factors:

Many factors over the years have been identified by NH hospitals. These include but may not be limited to the following:

- Advanced age of hospitalized patients
- Physical challenges with mobility and oxygenation impairments
- History of falls in the past several months prior to admission
- Adults who fall while walking to bathroom may not call the nurse because:
  - They don't remember to call the nurse
  - They are adults who have independently toileted themselves up until recently
  - Since men void while standing they can experience a sudden decrease in blood pressure when standing which may lead to disorientation
- Patients admitted to hospitals are much more ill and present with complicated care issues
- Medical conditions may impact mobility such as impaired blood flow to lower legs
- Medications may interfere with mobility and judgment, such as post-operative pain medications
- History of Substance abuse - alcohol or non-prescribed medications - many may have self-medicated in lieu of seeking medical help or because medical support was too expensive

#### Strategies in place in NH hospitals include but are not limited to:

- Focus on patient rounding to see and determine the safety and comfort of patients at least every hour

- Completion of a Fall Risk Assessment upon admission, updated every shift and re-evaluated after every fall
- Staff debriefing (discussion) after every fall to determine contributing factors and how events occurred in an attempt to learn how to better provide the patient care to prevent further falls
- Dedicated resources to a “sitter” program to provide human companionship and help alert nurses in a timely manner when a patient is trying to move creating a fall risk
- Use of family visitors to help keep patients calm and alert staff of activity that may be a falls risk
- Use of motion sensors - pads and alarms activated by patient movement that alert staff to movement
- Fall Prevention Teams – interdisciplinary team to review and discuss ways to prevent falls and reduce injury
- Gait Belts – Used to help maintain balance and give staff more control if patient demonstrates weakness while walking – to help lower patients to the floor instead of patients falling to the floor

#### Plan Moving Forward:

- Link specific interventions to prevent a fall to the fall risk assessment score
- Staff education refresher on fall prevention including the intent of assessment and making changes in interventions as needed to address the changing fall risk of the patient
- Expand the act of purposeful rounding to include toileting at least hourly. Current standard is to “ask” the patient but in high risk cases we may need to trial a new standard of actually taking patients to the bathroom
- Revitalize fall prevention teams, rotating new staff and clinicians into committees for a fresh approach in reviewing the events
- Re-evaluate and improve use of sitter programs and incorporate patient family engagement in the process
- Expand risk assessments upon hospital admission to include a history of falls at home as well as assessing for signs of falls such as bruising

#### Conclusion:

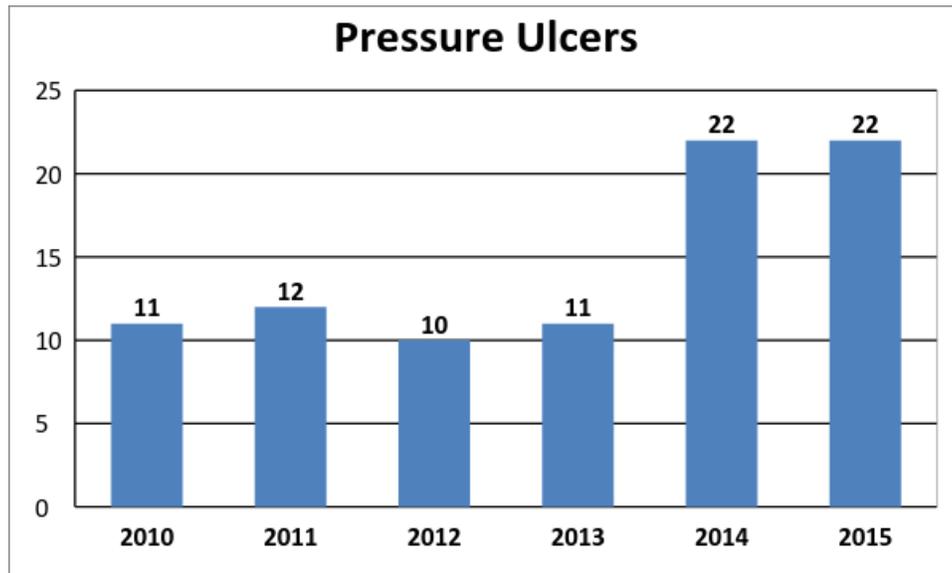
Over the next 10 years the population of NH Seniors (age 65+) is expected to double to 325,000 people. Many may have multiple medical conditions and changing mentation. The typical patient will be on no fewer than 8-10 routine medications, many that may interfere with mobility. Hospitals in New Hampshire will continue to assist patients and their families with falls prevention during the hospital stay. Hospitals will educate patients and their families while in their care about a patient’s high risk areas and work with them for a safe discharge/ return to home and community.

#### Hospital Acquired Pressure Ulcers Adverse Events

#### Problem Summary:

Pressure ulcers, also more commonly referred to as “bedsores”, “decubitus ulcers” or “pressure sores” are skin lesions which can be caused by friction, humidity, temperature, continence, medication, shearing force, age and unrelieved pressure. Patients prone to pressure ulcers are those who sit or lie down in one position for more than 2 hours at a time. In addition, poor nutrition and dehydration, and medical conditions that cause poor blood circulation to extremities, such as diabetes can cause pressure ulcers. Inadequate performance of proper skin inspections,

infrequent repositioning, and inability to maintain clean, dry skin can contribute to the development of a hospital acquired pressure ulcer. However not all pressure injuries are preventable. The skin is an organ just like the heart and lungs. Sometimes overwhelming illness contributes to the failure of the underlying skin tissue and despite excellent care the tissue breakdown will progress to a pressure injury. The most common areas for pressure ulcers include hips, backs, ankles, and buttocks.



#### Contributing Factors:

Many factors over the years have been identified by NH hospitals. These include but may not be limited to the following:

- Lack of thorough skin inspection/assessment
- Incomplete skin inspections
- Inaccurate staging of pressure ulcers
- Poor communications between staff and providers
- Not repositioning every 2 hours to relieve pressure
- Attention to addressing and improving hydration and nutritional status
- Clinical lapses in diabetes management – leading to uncontrolled high blood sugars
- High risk medical conditions and history including: Diabetes, Smoking, Chronic Obstructive Pulmonary Disease, Vascular Disease, bed or chair bound patients, bladder and/or bowel incontinence, and poor hygiene
- Wearing constrictive clothing or shoes that can cause sores to form on feet and lower legs
- Operative procedures which necessitate the patient's position be maintained in a single place for extended periods of time

### Strategies in place in NH hospitals include but are not limited to:

- Skin Assessment upon admission to identify pressure injuries at the time of admission so that prompt care can be initiated and reassessed every shift to detect early development of pressure injuries to prevent progression
- Use of Braden Scale for predicting pressure ulcer risk to determine other risk factors such as poor nutrition, dehydration, and hygiene issues so that high risk patients can be promptly identified and preventative interventions can be implemented before a pressure injury occurs
- Use of smooth soft surfaces and special pads for surgical patients undergoing lengthy procedures
- Development of protocols for cleaning and treating wounds
- Enhanced protocols for wound debridement (removal of dead tissue to allow for healing)
- Use of specifically designed dressings that can enhance wound healing
- Education/training on wound care at orientation of clinical staff with refresher classes offered at least every 2 years

### Plan Moving Forward:

- Training and education on skin inspection/assessment and documentation of any sign of pressure ulcer development
- Provider engagement in early detection and planning for risk of skin breakdown during hospitalization
- Family Engagement – teaching family members the importance of nutrition, hydration, and disease management in prevention of wounds developing in the home
- Adoption of new evidence based practices including new wound care treatments for faster healing
- Engagement of local provider practices and home care agencies in inspections, assessments, and preventative treatment and patient/family education
- Consider appointment of wound care experts or a specialized team that can assist in cases of difficult evaluations or difficult patient issues requiring special prevention techniques/treatment
- Involvement of wound care specialists earlier in the assessment/documentation.

### Conclusion:

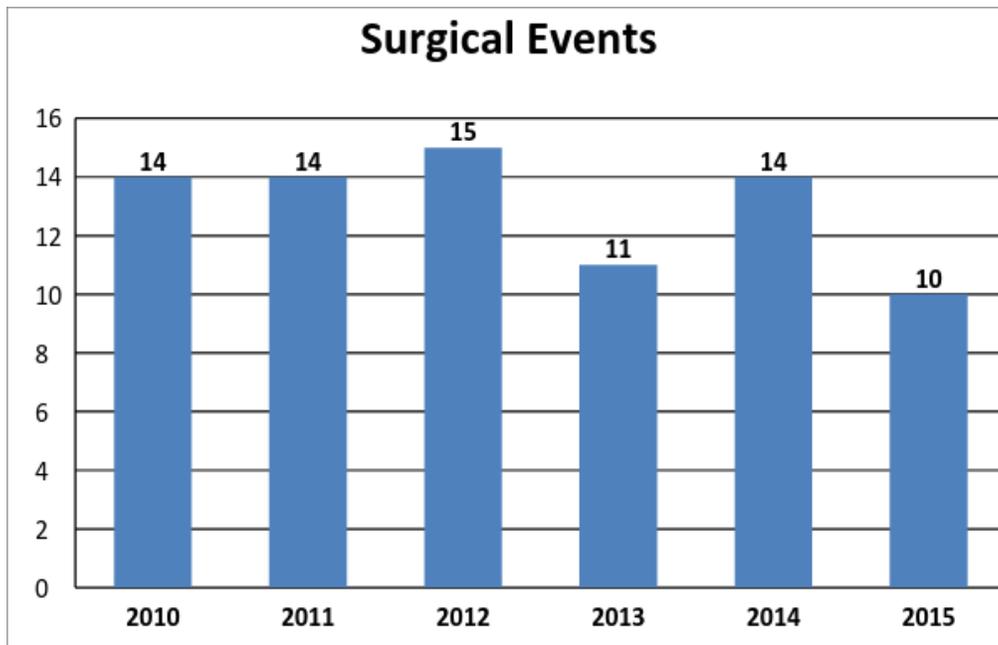
All NH hospitals are chasing zero – meaning they are striving for NO hospital acquired pressure ulcers. Since many wounds can begin in the community setting, reaching out to services that can influence prevention before and after hospitalization is being considered as part of efforts to reduce harm in NH communities.

### Surgical or Invasive Procedure Adverse Events

### Problem Summary:

Surgical interventions in modern medicine take many different forms. Some are minor procedures performed in an office or bedside setting, taking a single clinician no more than a few minutes to complete. Others are highly complex

invasive procedures requiring a team of 10 or more experts in a traditional operating room where a single surgery may take anywhere from 1-30 hours and requires hundreds of instruments and a variety of technical equipment. More procedures are being done in highly technical settings designed for minimally invasive procedures such as interventional radiology, cardiology, and endoscopy suites and ambulatory surgery centers. Highly complex procedures can now be safely performed in these settings due to advances in the use of robotics, scopes, and procedural imaging. NH hospitals and ASCs are working to prevent surgical errors in all these settings through the use of checklists, team time outs, and briefings. Despite these efforts, surgical and procedural errors do occasionally happen. These errors include surgical instruments or objects such as sponges unintentionally left behind in the patient; the side, site or procedure is different than what was intended; or if a procedure is done correctly but was completed on the wrong patient.



#### Contributing Factors:

**Many factors over the years have been identified by NH hospitals and ASCs. These include but may not be limited to the following:**

- Frequent hand-offs of information during the continuum of care from the time of the original diagnosis of the issue requiring surgery to the actual team performing the procedure; vital information is sometimes misrepresented or lost completely as it is handed off along the way
- Complexity of the environment and the systems in use may divert attention and concentration of the surgeon and other team members at key points

- Inconsistent organizational expectations for training and orientation to surgical safety, time out, briefings and use of checklist in all settings where procedures occur

#### Strategies in place in NH hospitals and ASCs include but are not limited to:

- Organizational Leadership engaged in prevention of harm and establishing expectations for organizational performance
- Full investigations of near miss events to understand failures and improve reliability of systems before an error causing harm occurs
- Engagement of Medical Staff by incorporation of time out/checklist performance into the provider performance evaluation process
- Time outs or briefings that invite all members of the team, regardless of role, to be mindful of potential problems or errors, increase the likelihood of anyone on the team speaking up when a potential problem is detected
- Verification of information in surgical plan with “sources of truth” such as pathology reports, imaging reports, and consultations in order to catch prior communication lapses
- Patient engagement in development of patient safety steps regarding surgical preparations and communication about the process
- Include the patient in the safety checks, together with the goals of the procedure from the patient’s perspective, to get all team members unified on the plan of care

#### Plan Moving Forward:

- Continue to educate staff in the use of the checklist and time out process including the inherent limitations of these tools to prevent all surgical errors
- Continue to foster a safe culture that encourages staff to speak up and stop the process if they suspect a problem, by training the surgeon in leadership methods that invite team communication and collaboration
- Enhance high reliability performance of the surgical team by including the patient’s goals of care in the safety checks or briefings
- Extend surgical safety concepts and processes to all non-operating room procedural areas
- Explore and consider the implementation of pauses during the procedure prior to critical steps to assure all team members understand the plan and their role in executing it
- Track and trend near miss events to improve systems and processes before actual error occurs
- When a surgical error causing harm occurs, continue to develop methods for supporting the affected patient and family as well as the team members involved in the error
- NH hospitals and ASCs continue to work collaboratively to establish safe surgical practices

## Conclusion:

Surgical events are overwhelming to patients, families and the healthcare team involved with an error. Strong leadership during the surgical time out reinforces the important role of each team member in ensuring patient safety. Each team member must verbally state their name and purpose of the surgery and discuss any concerns before the surgery. With collaboration among team members, each member has a vested interest in the patient's outcome. Fostering communication among team members has helped reduce surgical events this year.

## Summary

The continued goal for the NH hospitals and ASCs is to utilize their root cause analyses and to make corrective action plans (CAPs) that can enhance patient safety. The Hospitals and the ASCs remain committed to educate their personnel and professional staff about patient safety to promote the best outcomes for their patients.

## 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, root cause analyses and corrective action plans. The assistance of members of the NH Health Care Quality Assurance Commission and staff of the Foundation for Healthy Communities is also acknowledged.

Questions concerning this report may be directed to: [michael.fleming@dhhs.nh.gov](mailto:michael.fleming@dhhs.nh.gov)