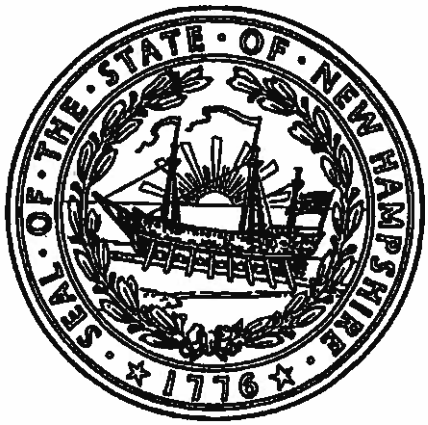

State of New Hampshire
ADVERSE EVENT REPORTING
2019 REPORT

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

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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

Falls 43%
Pressure Injuries 34%
Surgical Events 16%

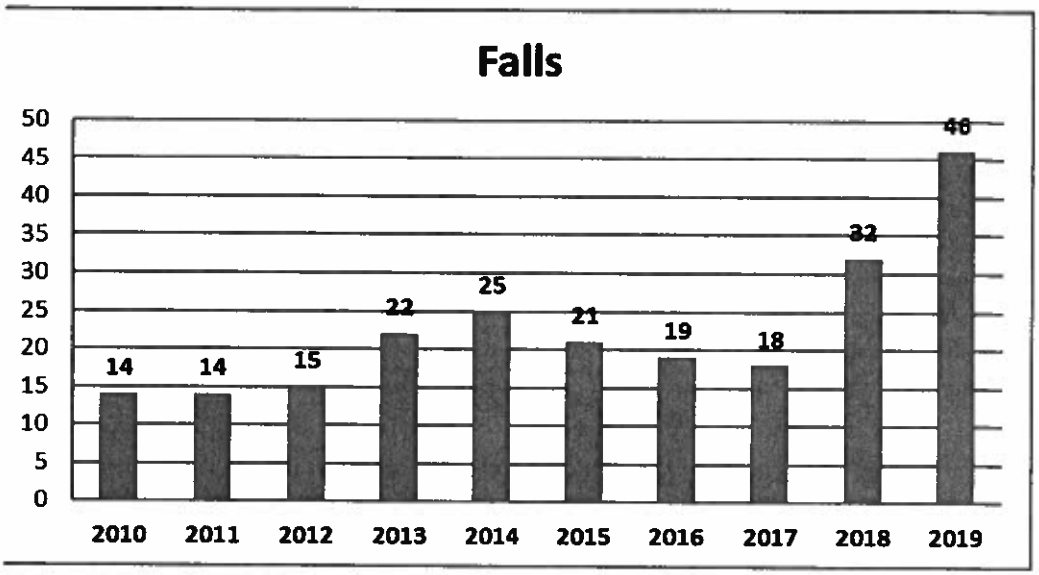
Considering that these event types represents 93% of the total events, it is important that we focus our efforts on these and address what NH Hospitals and ASC's are doing in these areas to improve outcomes.

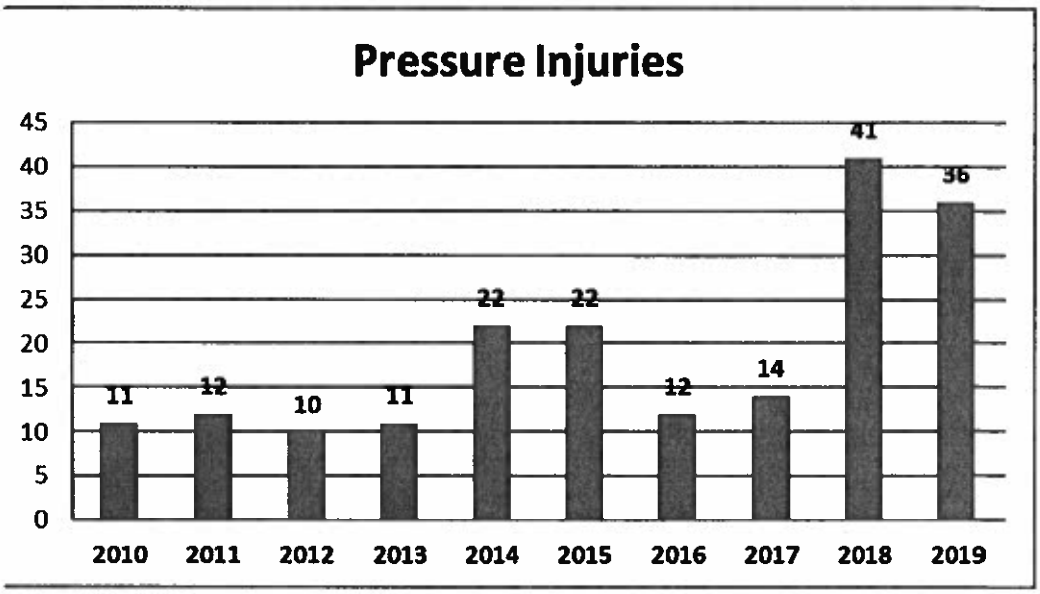
Organizations have used their root cause analysis process to learn the weaknesses in their systems, identify opportunities in systems and processes, and implement approaches to improve the quality of care the patients receive within their Hospitals and ASCs.

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 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.

- 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.