

State of New Hampshire
ADVERSE EVENT REPORTING
2023 REPORT

Prepared by

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

9/27/24

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 basis 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 Administration- Certification Unit (BLC-HFA-C) 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 to 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.

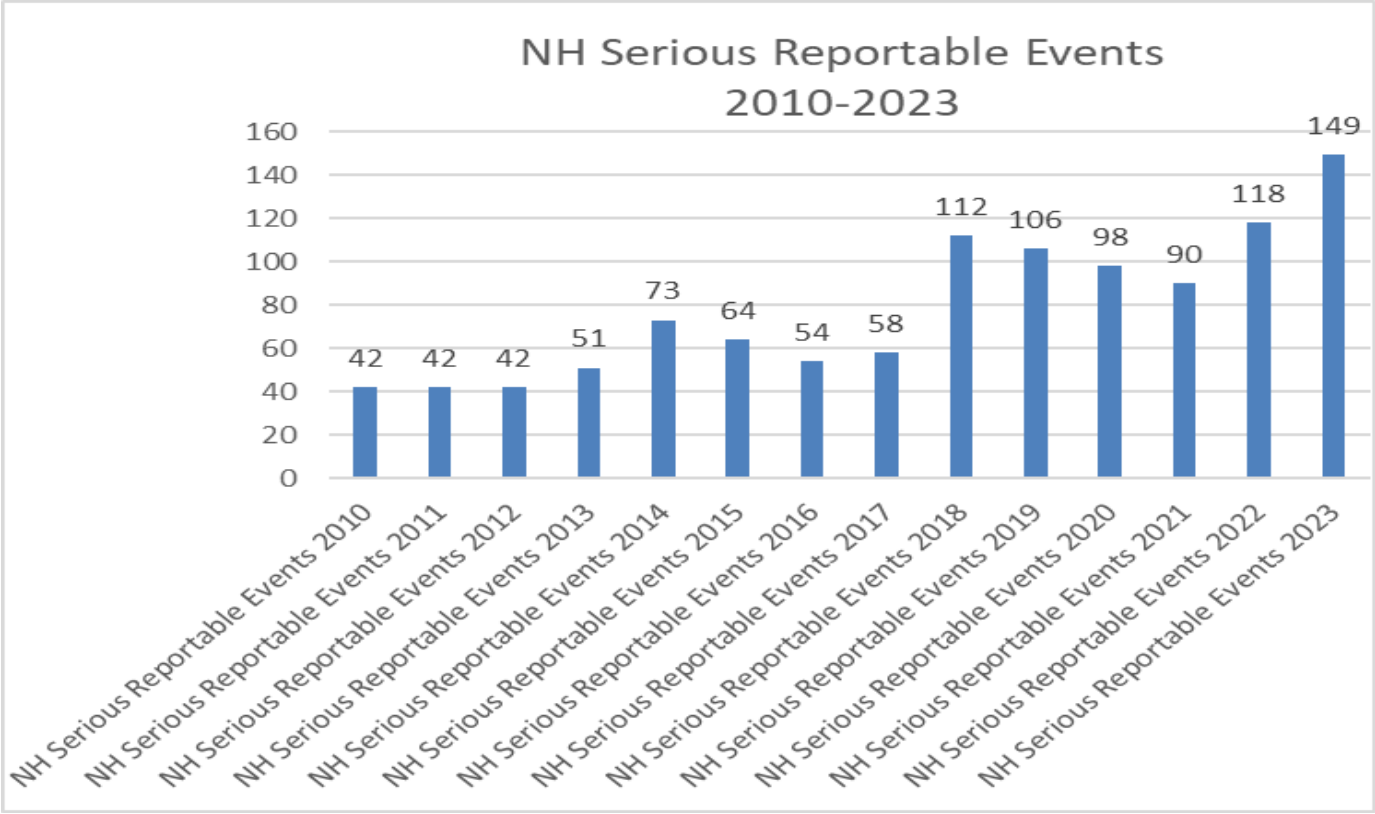
All Hospitals and ASCs must submit an initial report to the BLC-HFA-C within 15 days of becoming aware of the event to the Department of Health and Human Services (DHHS). Once DHHS receives the initial report, DHHS checks for completeness and acknowledges receipt of the initial report. DHHS has a specified 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 DHHS, through the Bureau of Licensing and Certification, Health Facilities Certification (BLC-HFA-C), the Root Cause Analysis (RCA) and a Corrective Action Plan (CAP). BLC-HFA-C determines if all submitted documents are complete and accurate, and if the CAP is created in accordance with current professional standards. BLC-HFA-C 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 RCA, to implement a CAP, or to provide findings of an RCA or CAP shall be subject to disciplinary actions and any other appropriate sanctions.

The facility must conduct an 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.

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

The bar graph below shows the total number of events reported in NH since the statute was effective in 2010. The number of adverse events reported has increase which in part is attributed to the ongoing collaboration between the New Hampshire Healthcare Quality and Safety Commission, which discussions highlight and reinforce the importance of reporting and indirectly promote a safe and strong reporting culture by hospitals and ASCs. 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.

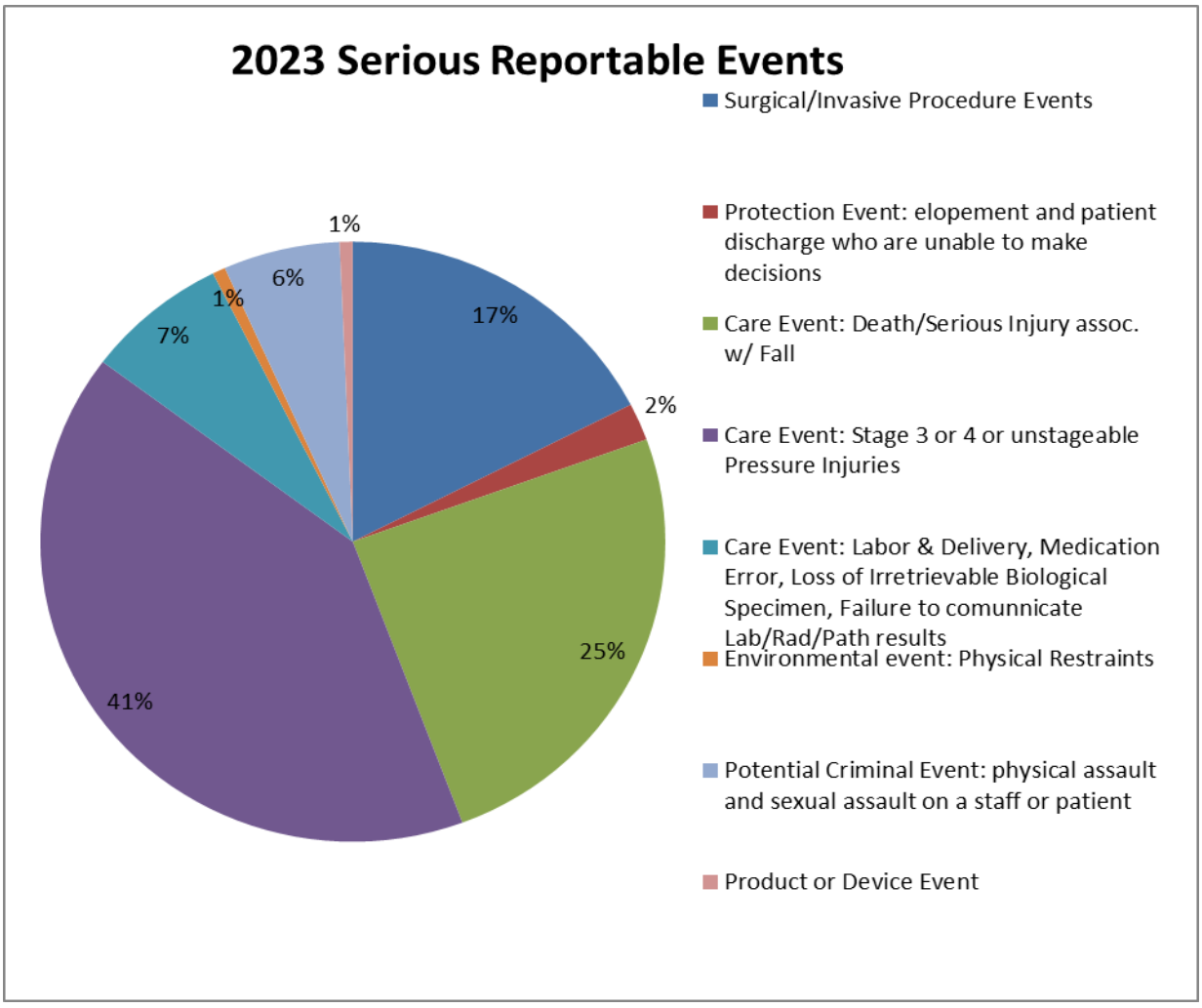


The following table lists is the 2023 Adverse Event/Serious Reportable Events:

New Hampshire Reportable Events/Adverse Events 2023

CY 2023		Surgical Event	Surgical Event	Surgical Event	Device Related Event	Protection Event	Protection Event	Care event	Care event	Care event	Care Event	Care Event	Care Event	Environmental Event	Pot. Criminal Event	Pot. Criminal Event	
Provider Name	# of staff Beds	Sugery or other invasive procedure perfomed on the w rong site/body part	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	Patient death or serious injury associated w ith intravascular air embolism that occurs w hile being care for in a healthcare setting	Patient suicide, attempted suicide, or self-harm that results in serious injury, w hile being cared for in a healthcare setting	Discharge or release of a patient/resident of any age, w ho is unable to make decisions, to other than an authorized person	Patient death or serious injury associated w ith a medication error	Death or serious injury of a neonate associated w ith labor or delivery in a low -risk pregnancy	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	Patient death or serious injury associated w ith a fall w hile being cared for in a healthcare setting	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen	Patient death or serious injury associated w ith the use of physical restraints or bedrails w hile being cared for in a healthcare setting	Death or serious injury of a patient or staff member resulting from a physical assault	Sexual abuse/assault on a patient or staff member w ithin or on the grounds of a healthcare setting	Total reported
Alice Peck Day	25									1							1
Catholic Medical Center	330	3		2						23	1						29
Cheshire Medical Center	169			1					2		5			1	1	1	11
Concord Hospital-Concord	295					1				5		2					8
Cottage Hospital	25														1		1
Elliot Hospital	296									9	4	1				2	16
Encompass	50					1				4	1						6
Exeter Hospital	100	1								3	2				1		7
Concord Hospital-Franklin	25										1						1
Frisbie Hospital	112									1							1
Huggins Hospital	25										2						2
Concord Hospital-Laconia	137									1							1
Mary Hitchcock Mem Hospital	396	2		6	1					3	5		1				18
Memorial Hospital	25		1														1
Monadnock Gen Hospital	25	1															1
Northeast Rehabilitation Hospital Netw ork	135										1						1
Parkland Hospital	86	1															1
Portsmouth Reg Hospital	209	1							1		6						8
Southern NH Med Center	188	2					1	1		4	1	3				2	14
Speare Hospital	25	1									1						2
St. Joseph Hospital	208			1						4	4						9
The New London Hospital	25										2						2
Valley Reg Hospital	25									2	1					1	4
Wentw orth Douglass Hospital	178			1						1							2
Elliot One Day Surgical Center		1															1
Nashua Ambulatory Surgical Center		1															1
Total		14	1	11	1	2	1	1	3	61	37	6	1	1	3	6	149

The pie graph below shows the total number by event type reported in CY 2023.



In analyzing the events reported in CY 2023, there continues to be three major areas responsible for 83% of the events reported. These areas were as follows:

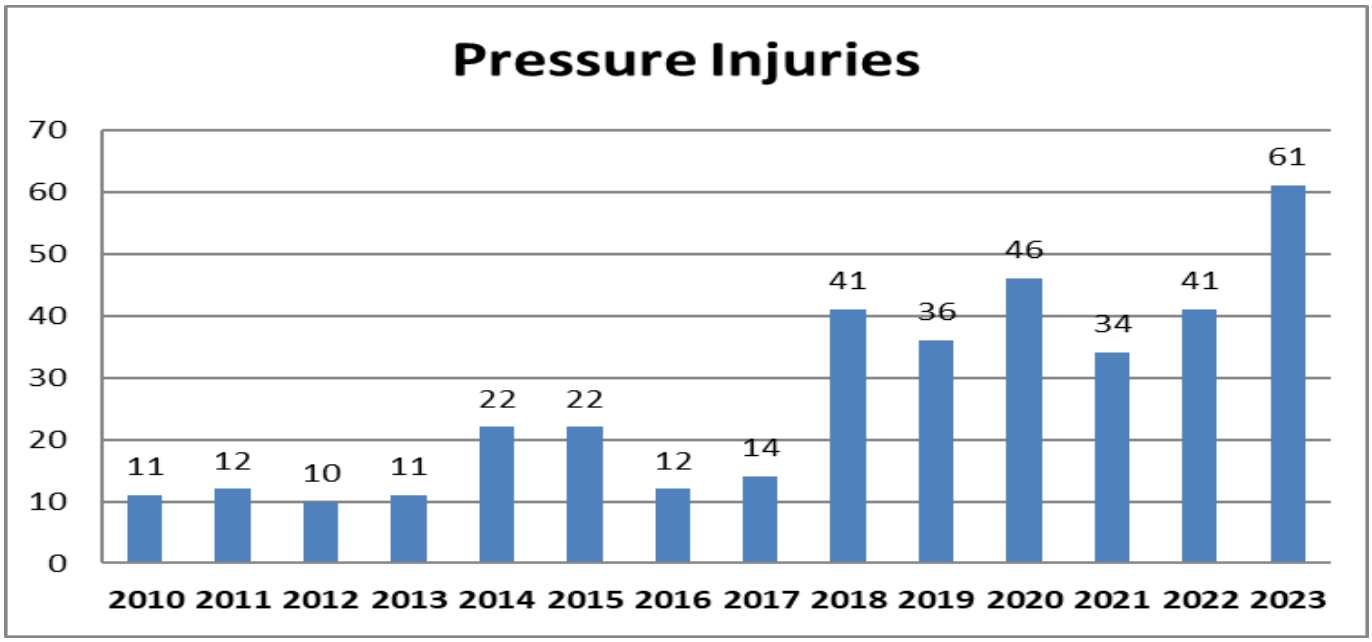
Falls	**25%**
Pressure Injuries	**41%**
Surgical Events	**17%**

Organizations have used their root cause analysis process to learn 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.

Considering that these event types represent 83% of the total events, it is important that we continue to focus our efforts on these and address what NH Hospitals and ASCs are doing in these areas to improve outcomes.

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 2023. There was a significant increase in the number of pressure events reported in CY 2023 compared to the last 5 years (CY 2018 to CY 2023).



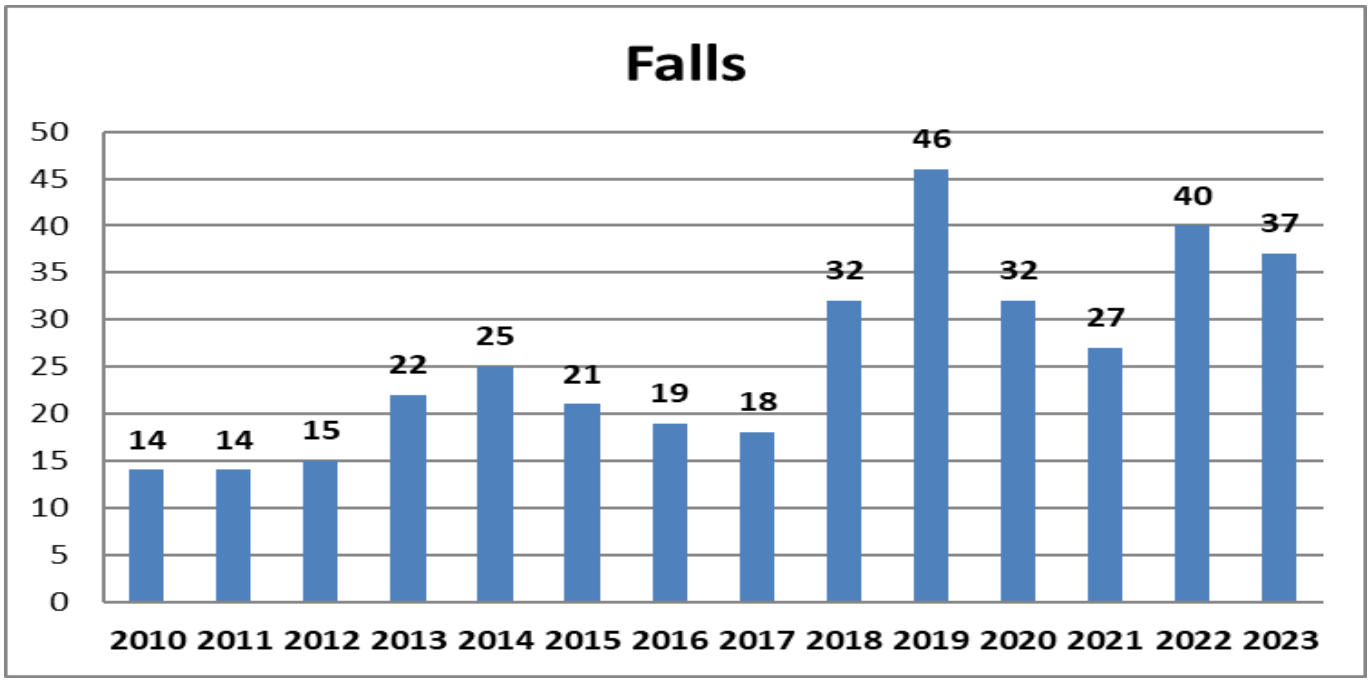
Strategies utilized by the NH Hospitals and ASCs include:

- Standardize communication of pressure injury risk or presence between the nursing staff and multidisciplinary team.
- Inform patient/family refusal of care interventions and the potential risks when interventions are not implemented.
- Clinical staff education/training on wound at orientation and as needed about 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.
- 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.
- 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.

- Completion of a Head-to-Toe Skin Assessment upon admission by two licensed staff, preferably including a wound certified nurse, 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 smooth soft surfaces and special pads for patients with high-risk for skin breakdown such as surgical patients and critically ill patients.
- 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.

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 2023.



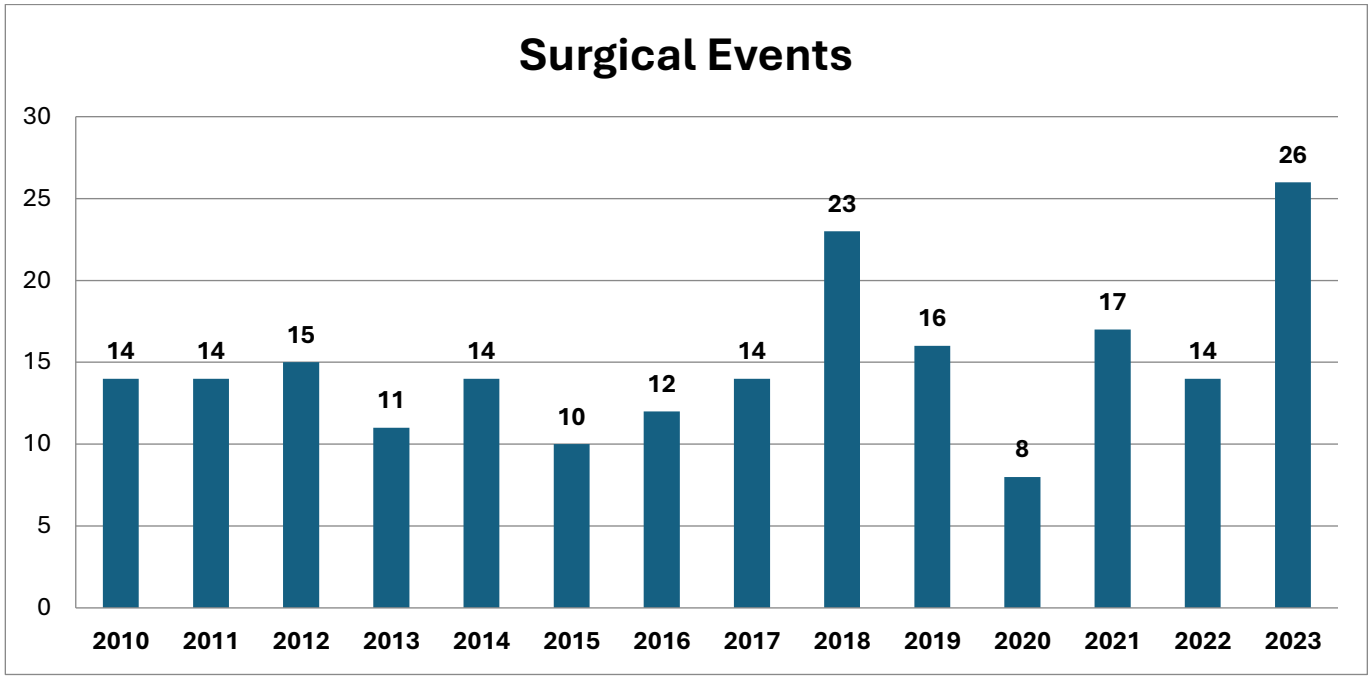
Strategies utilized by NH Hospitals and ASCs include:

- Develop and implement an individualized 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.
- Communication of patient condition and care needs through shift-to-shift huddles, nurse-to-nurse reports, and within different departments if or when moved.
- Delineate the multidisciplinary team's role on developing, implementing, monitoring, and reporting actual/potential falls.

- 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).
- Monitor safety monitoring devices regularly for functionality and replace as needed.
- 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.

SURGICAL EVENTS

The bar graph below shows the total number of SRE that fall into the event type of surgical events in CY 2023.



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.
- Team building strategies to promote just culture and expectation of speaking up and problem identification by all surgical team members.

Summary

The BLC-HFA-C continues to track and trend reportable adverse events and ensures that NH Hospitals and ASCs submit initial reports, RCAs and CAPs timely. Open communication is maintained throughout the year between the BLC-HFA-C and the facilities, clarifying criteria for reporting and encouraging open discussion of events to ensure accuracy from initial report to the RCA and CAP. BLC-HFA-C continues to share trends of reportable adverse events throughout the year to the New Hampshire Healthcare Quality and Safety Commission.

The New Hampshire Hospital Association (NHHA) has collected data to provide context on patient volumes related to the reportable adverse events, which is shared and discussed at the commission meetings. NH Hospitals and ASCs continue to share their experiences through discussions and "story telling" at commission meetings, thereby ensuring that they all learn from their RCA and CAP to enhance safety. NH Hospitals and ASCs remain committed to educating their personnel and professional staff about patient safety to promote the best outcomes for their patients.

BLC-HFA-C completed a quarterly ten percent sample audit of the Hospitals and ASCs submitted corrective action plans for the reported adverse events for the calendar year. The ten percent sample of the adverse event reports were selected at random taking into consideration that the sample would include the most reported adverse event categories and the least reported adverse event categories, which were the surgical events, care events, protection events, and potential criminal events. BLC-HFA-C requested evidence of CAP implementation (i.e. educations, audits, revised policies) from the Hospitals or ASCs. BLC-HFA-C reviewed the submitted evidence of corrective action plan implementation. In conclusion, for the 2023 CY, the Hospitals or ASCs followed through with their corrective action plan to address and correct the problems identified in their Root Cause Analysis (RCA) reports.

Acknowledgements:

The Department's Adverse Event Reporting Staff would also like to thank the many staff at New Hampshire's hospitals for their prompt reporting of events and reporting of root cause analysis and corrective action plans. Of note was the fast response by facilities for additional data concerning quality progress metrics. Questions concerning this report may be directed to Lizette.C.WeeSit@dhhs.nh.gov and/or Kristie.Holtz@dhhs.nh.gov.