Patient Safety Surveillance & Improvement System (PSSIS) Event Reporting in Vermont – 2022

I. Introduction

Serious Reportable Events (SREs), as defined by the National Quality Forum (NQF), are largely preventable clinical events that result in serious harm to the patient. While these events are rare, the impact to patients, families, providers, and the healthcare community can be devastating. Vermont is one of 26 states and the District of Columbia that have enacted reporting systems requiring facilities to report on all 28 of the National Quality Forum's Serious Reportable Events, as specified under the Vermont Patient Safety Surviellence and Improvement System (PSSIS). There remains some inconsistency among states in reporting requirements of all elements of the NQF SRE list (National Quality Forum , 2023).

When an SRE occurs at a Vermont hospital or Ambulatory Surgery Center (ASC), the event must be reported to the Vermont Patient Safety Surveillance and Improvement System (PSSIS). For each event, the Vermont PSSIS requires that the hospital or ASC conduct an analysis to get to the root of *why* the event occurred, and create and implement a corrective action plan to prevent the same event from reoccurring in the future. The Vermont Department of Health (VDH) and The Vermont Program for Quality in Health Care (VPQHC) support Vermont hospitals and ASCs through the PSSIS in their commitment to creating safer care environments.

II. Vermont Serious Reportable Event Process and Patient Safety Oversight

VDH contracts with VPQHC to administer the PSSIS Program. If an SRE occurs at a facility, the hospital or ASC must report the event to the PSSIS within seven days of the discovery of the event. For each event, the Vermont hospital or ASC conducts an analysis of the event to identify causes and contributing factors and analyze underlying systemic issues that led to the event, or that could result in a future event if not addressed properly. The most important component of this analysis is a focus on the larger systemic issues rather than assigning blame to the individuals or facilities involved. Following the analysis and identification of system or process issues, the hospital or ASC must develop a comprehensive corrective action plan (CAP) that addresses the findings identified during the event analysis to prevent a similar event from occurring in the future.

A summary of the event, the supporting documentation, and the CAP must be submitted to VPQHC for review within 60 days of the initial event report. Once a comprehensive review is completed to ensure that the root cause or causes that led to the event are appropriately addressed, and that all of the required elements are included, the documents are submitted to VDH by VPQHC.

VDH supports VPQHC with conducting routine periodic site visits at each hospital and ASC at least once every three years. During the site visit, the VPQHC patient safety representative reviews the hospital and/or ASC's policies, procedures, and education provided for event reporting and disclosures. VPQHC staff review the hospital and ASC's SREs and the follow through with corrective action plans. Staff from multiple departments at the hospital and ASC are interviewed to assess their knowledge of the patient safety program, event-reporting procedure, and the culture of reporting within the facility.

III. Vermont Patient Safety Landscape 2022

PSSIS routine periodic site visits were paused in 2020 and for the majority of 2021, due to the COVID-19 pandemic restrictions. VPQHC, at the discretion of VDH, reinstated PSSIS routine periodic site visits at the end of 2021, and VPQHC performed eleven PSSIS routine periodic site visits in 2022.

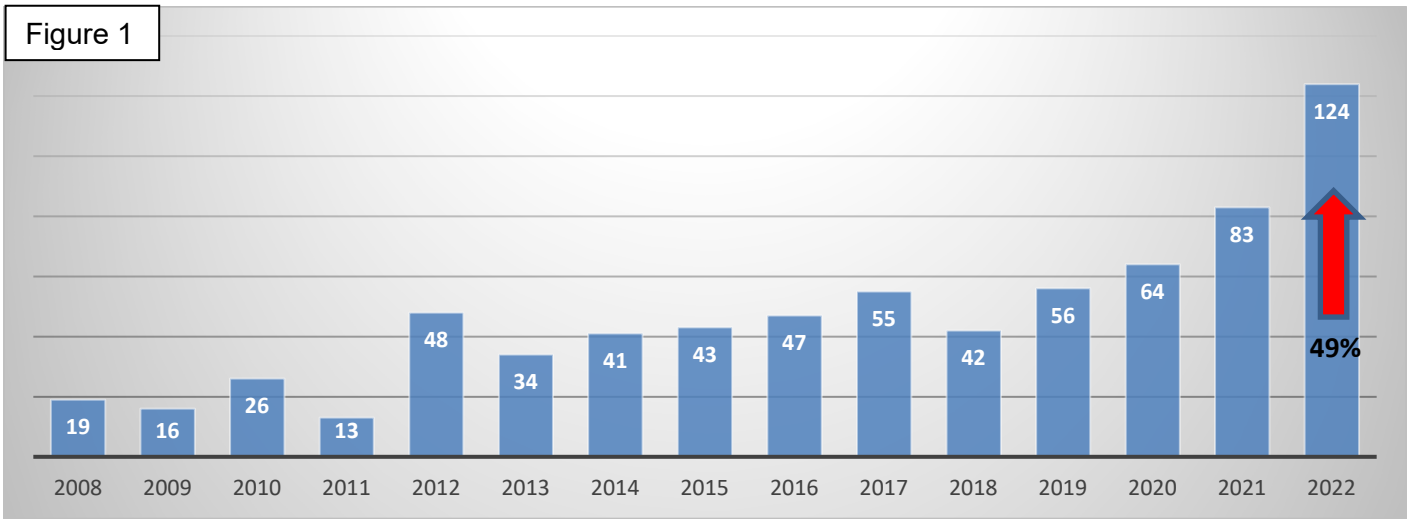
Beginning in 2020, ASCs became subject to the Vermont PSSIS Statute. In 2022, VPQHC provided ASCs with an orientation to the PSSIS program, along with guidance regarding event reporting, analyzing root causes, and developing corrective action plans. VPQHC staff conducted routine periodic PSISS site visits for the first time at the ASC's, following the pause due to the COVID-19 pandemic. VPQHC has been able to cultivate strong working relationships with the ASC's over the past few months and will continue to offer support for their patient safety programs as requested by the ASCs or as needed through serious reportable event reviews.

In 2022, VPQHC staff has also supported approximately five hospitals through transitions in quality and patient safety staff through informational meetings and orientation to the PSSIS program, as well as further support, recommendations and assistance with policy review, event review, root cause analysis, and developing corrective action plans.

IV. Vermont Serious Reportable Events 2022

In 2022, VPQHC reviewed 124 SREs submitted by Vermont hospitals and ASCs (Figure 1), which is an increase of approximately 49% from 2021.

Figure 1



VPQHC staff has reviewed the causal analysis and corrective action plans that were submitted for events submitted in 2022 and themes that were identified include:

Staffing:

- Variation in staff education due to an increase in the number of travelers that receive limited orientation to hospital workflows
- Increases in staffing shortages and staff turnover

COVID-19 and Isolation:

- Patients unable to have family/visitors present at the bedside to offer assistance/support and engage in the plan of care

- Communication challenges between staff and patient to staff, due to wearing personal protective equipment (PPE)
- An increase in the amount of time it takes for staff to respond to a patient call light or alarm due to donning PPE
- Bundling care or limiting the number of staff encounters with patients due to concerns regarding COVID-19 transmission

Patients:

- The COVID-19 disease process and patients being admitted with concurrent complex medical needs leading to challenges with competing priorities for patient care
- Challenges associated with complex social needs and barriers to patient engagement in care plans
- Patient discharge placement difficulties and extended hospitalizations

Surges/hospital capacity:

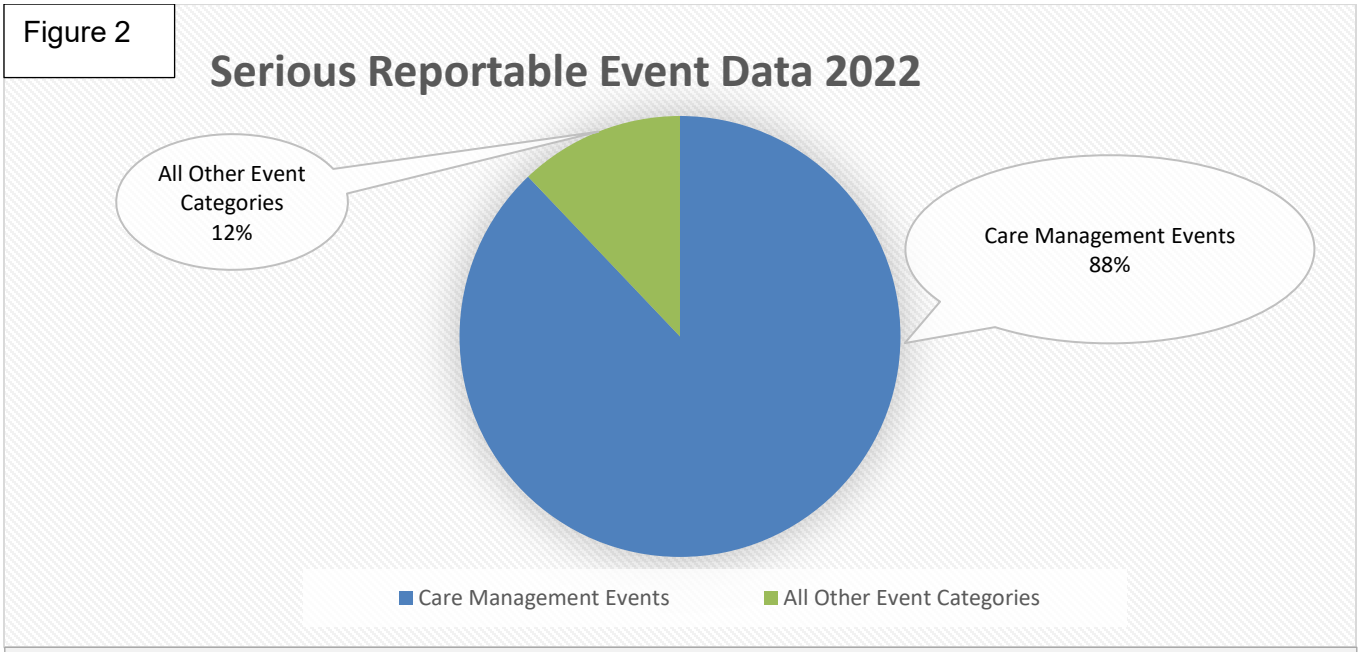
- Patients receiving care in atypical settings within the hospital, i.e. other units with beds available, causing challenges with staff knowledge, equipment needs, and equipment availability

Quality/Leadership

- Quality improvement initiatives and leadership activities were also at times put on hold due the need to focus on meeting the needs of the pandemic

The majority of the Serious Reportable Events reported in 2022 (Figure 2) were classified in the Care Management Event Category (88%).

Figure 2



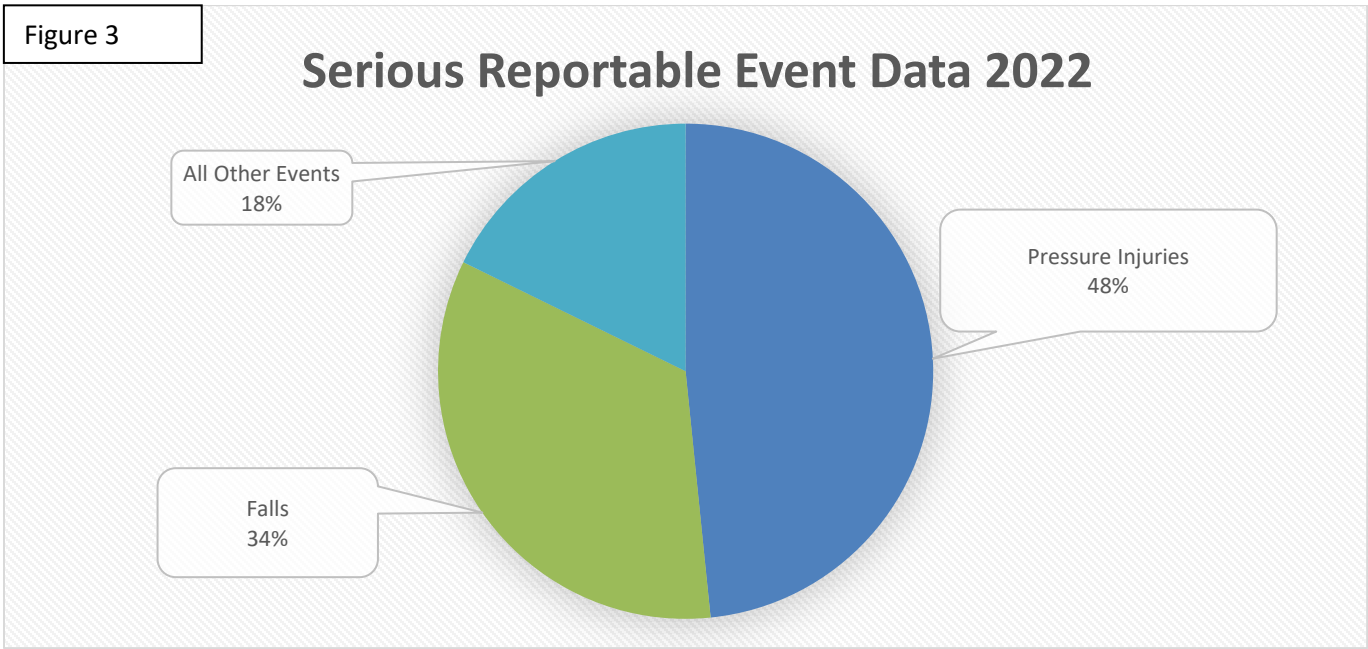
*In order to assure confidentiality of patients, hospitals, ASCs and staff, Serious Reportable Event categories with fewer than six events reported were combined. Combined Serious Reportable Event categories for this period under ALL OTHER EVENT CATEGORIES include **Patient Protection Events**, **Environmental Events, Potential Criminal Events**, **Surgical Events, Product or Device Events, Radiological Events**

Care Management Event Category Includes

A. Patient death or serious injury[1] associated with a medication error
B. Patient death or serious injury associated with unsafe administration of blood products
C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
E. Patient death or serious injury associated with a fall while being cared for in a health care setting
F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a health care setting
G. Artificial insemination with the wrong donor sperm or wrong egg
H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
I. Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results

A review of previous SRE report data in VT Hospital Report Card indicates that in the years 2016 and 2017 combined, Care Management Events totaled 68% of the events and Surgical Events accounted for 15%. In 2018, Care Management Events accounted for 69% of events and Surgical Events accounted for 16%. In the recent years, as shown above in Figure 2, Care Management Events comprise a greater majority of the events reported.

Figure 3



As noted in Figure 3, the falls and pressure injury category under Care Management Events comprised 82% of events reported in 2022. VPQHC reviewed VT Hospital Report Card data in 2018 and 2019 and noted that falls were the leading category of events reported in the Care Management Event reports. In 2020, VT Hospital Report Card information indicates SREs classified as "Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission to a healthcare setting" showed significant increase from 22% of the Care

[1] National Quality Forum (NQF) defines serious injury as "a loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery)."

Management Events to 57% and has remained the highest category of events reported in the Care Management Events since 2020.

Figure 4

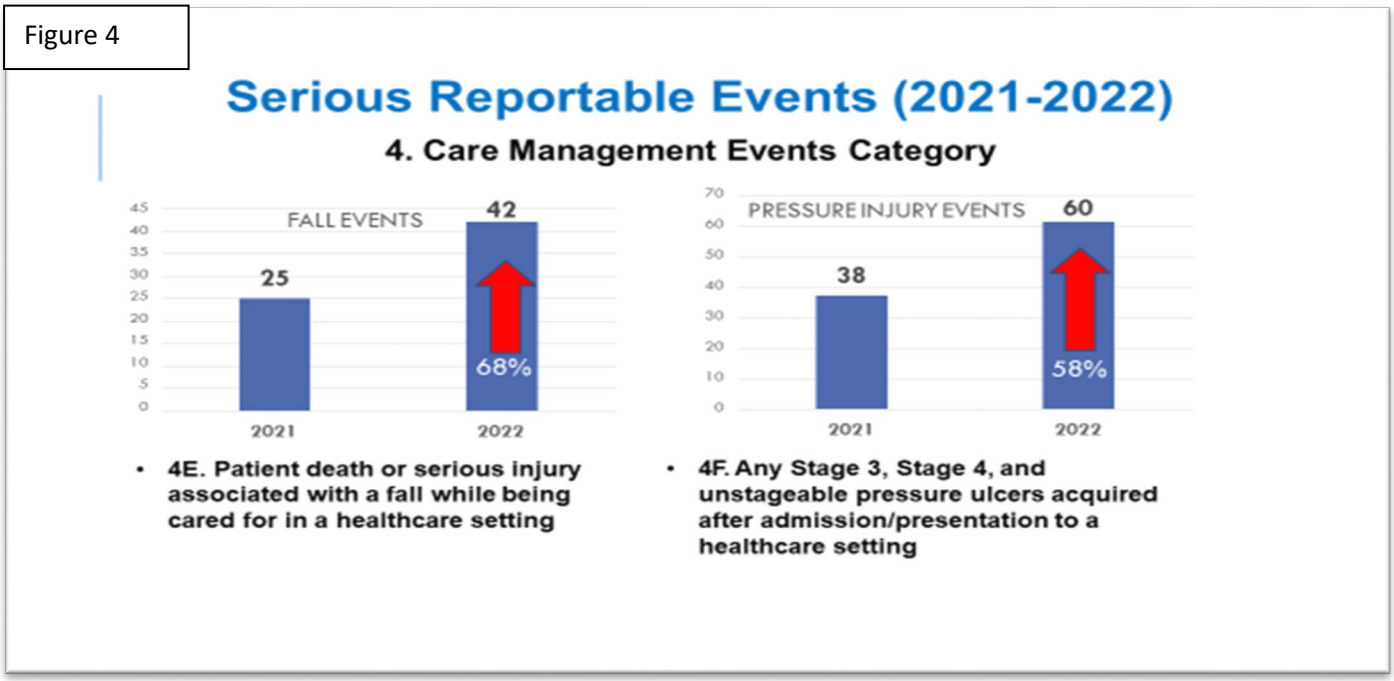


Figure 4 highlights the increase in both fall and pressure injury events in 2022. Fall and pressure injury events comprised 82% of all the events reported in 2022.

V. Recommendations

This section will focus on recommendations for fall and pressure injury prevention for hospitals and ASCs as these events represent the greatest number of SREs reported in Vermont in 2022.

VPQHC staff attended a virtual patient safety conference through the Eastern Quality Improvement Collaborative (EQIC) titled, *Patient Safety: Navigating the New Normal*. Dr. Patricia Quigley, PhD, MPH, APRN, CRRN, FAAN, FAANP, a nurse Consultant, known for her research on fall prevention, offered best practice information to enhance fall prevention programs.

Below are fall prevention highlights from Dr. Patricia Quigley's presentation:

- Establishing an interdisciplinary fall prevention team
- Establishing individual risk and developing an individualized plan of care based on
  - Injury risk
  - Fall risk
  - Population specific risk
- Interventions that focus on the need to reduce injury to those that do fall
- Developing standardized education to patient and families regarding fall risk
- Standardized Communication/Hand-offs
- Learning from Falls
  - Post-Fall Huddle

    - Process for tracking/trending/analyzing post-fall information to inform improvement
- Increasing physical activity to prevent deconditioning
- Standardized and frequent medical review to minimize the effects of treatments

(Quigley, 2023)

Dr. Barbara Delmore, PHD, RN, CWCN, Senior Nurse Scientist, and Center for Innovations in the Advancement of Care (CIAC) presented at the EQIC Patient Safety Conference, *Patient Safety: Navigating the New Normal* and focused on Pressure Injury Prevention.

Best Practice Pressure Injury Prevention Highlights from Dr. Barbara Delmore's presentation include:

- Evaluating your patient population to identify the **vulnerable populations** based on both disease process or conditions that make a patient more at risk, as well as the location or circumstance that increase risk
    - High Risk Populations
        - Pediatrics
        - Bariatrics
        - Older Adult
        - End of Life
    - High Risk Location
        - Emergency Department
        - Perioperative
        - Critical Care

- Develop a pressure injury **Prevention Plan** to target your vulnerable population
- Identify **Resources** needed for pressure injury prevention
    - People-review the vulnerable populations to identify the interdisciplinary team needed
    - Products
    - Processes/Protocols/Procedures
- Continued **Education/Support** (industry partners, experts National Pressure Injury Advisory Panel (NPIAP))
- **Sustainment** (skin and risk assessments, skin care resources and champions, track pressure injuries)

(Delmore PHD, 2023)

In response to themes VPQHC identified in event reviews, RCAs and CAPs, and as organizations continue to focus on a culture of safety, VPQHC staff would like to highlight *Safer Together: A National Action Plan to Advance Patient Safety*. This report was developed by the National Steering Committee (NSC) for Patient Safety, convened by The Institute for Healthcare Improvement (IHI) in May 2021. NSC was formed in 2018 in an attempt to "encourage greater coordination of collective patient safety efforts". VPQHC would like to encourage hospitals and ASCs to review the report as a guide for developing a culture of safety within their organization. *Safer Together: A National Action Plan to Advance Patient Safety* lists four foundational areas that are essential for broader system wide safety initiatives to take place.

- **Culture, Leadership and Governance:** Leverage the influence of leadership and governance to commit to safety as a core value of the organization and drive the creation of a strong organizational culture.
- **Patient and Family Engagement:** Commit to the goal of fully engaging patients, families, and care partners in all aspects of care at all levels.

- **Workforce Safety:** Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers.
- **Learning System:** Commit to continuous learning within organizations by creating and strengthening internal processes that promote transparency and reliability, and through sharing as part of an integrated learning system and networks.

To learn more about the action plan, perform an organizational self-assessment or to have further guidance with the implementation of the action plan, visit National Action Plan to Advance Patient Safety | IHI - Institute for Healthcare Improvement.

VI. Conclusion

As we examine recommendations for prevention of falls and pressure injuries within the hospital and ASC setting, we also must not disregard the fact that the healthcare system and environment, community resources, and access to care has a strong influence on how hospitals and ASCs are able to care for patients safely. When patients are unable to access the appropriate level of care, in the appropriate setting, the healthcare system is challenged to provide care to meet patients' varying needs. In reviewing the pressure injury and fall events further, VPQHC noted:

- Of the 42 fall events reported to PSSIS in 2022; 12 of the falls events occurred 14 or greater days after the patient's hospital admission (approx. 29%)

- Of the 60 pressure injury events reported to PSSIS in 2022; 31 of the pressure injury events occurred 14 or greater days after the patient's hospital admission (approx. 52%)

As VPQHC and VDH continue to support hospitals and ambulatory surgical centers in best practices for patient safety and creating a culture of safety, it is also crucial to highlight how the shortage of resources and/or access within the healthcare systems as a whole, outside of the hospital, can potentially impact care within the hospital. Patients are waiting for long-term care placement for extended periods within the hospital, patients are waiting for inpatient beds for extended periods within emergency rooms, patients are waiting for extended periods within the emergency room for inpatient psychiatric care, and patients are waiting for extended periods for transfer to another hospital for a higher level of medical care. If patients are not able to access the appropriate level of care in the appropriate setting, patient safety within the hospital will continue to be affected.

The NSC vision is "working together to ensure that health care is safe, reliable and free from harm (National Steering Committee (NSC) for Patient Safety, 2023)." The first NSC Core Principle states:

> *Work together to drive greater urgency to prevent harm to patients and those who care for them in all settings across the care continuum.*

In addition to focusing on patient safety within the hospital, VPQHC and VDH will continue to evaluate the health care environment in Vermont to identify opportunities to provide further support and resources to support patient care across the health care continuum at long-term care facilities, inpatient psychiatric facilities, outpatient clinics and to support patient access to the appropriate level of care in the appropriate setting.

References

Delmore PHD, R. C. (2023, February 7-8). Pressure Injuries: Back-to-Basics [Virtual Conference Presentation]. Hospital Assosication of New York (HANYS). Retrieved from https://qualityimprovementcollaborative.org/events/patient_safety/

National Quality Forum . (2023, March 27). *Improving Patient Safety through State-Based Reporting in Healthcare*. Retrieved from State-Based Reporting in Healthcare: https://www.qualityforum.org/Projects/State_Based_Reporting/State-Based_Reporting_in_Healthcare.aspx

National Steering Committee (NSC) for Patient Safety. (2023, March 20). *Safer together: A National Action Plan to Advance Patient Safety.* Retrieved from Institute for Healthcare Improvement (IHI): https://www.ihi.org/Engage/Initiatives/National-Steering-Committee-Patient-Safety/Pages/National-Action-Plan-to-Advance-Patient-Safety.aspx

Quigley, P. M. (2023, February 7-8). Innovations in Fall and Fall Injury Prevention and Reduction Strategies Within Hospitals [Virtual Conference Presentation]. Hospital Association of New York (HANYS). Retrieved from https://qualityimprovementcollaborative.org/events/patient_safety/