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April 08, 2009 - For immediate release:

Massachusetts Department of Public Health Releases First Annual Report on Serious Reportable Events at Hospitals

Site-specific patient safety data collected from all acute-care hospitals in Massachusetts

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BOSTON — The Massachusetts Department of Public Health (DPH) today released its first annual report on Serious Reportable Events (SRE) at acute care hospitals in Massachusetts. Initial data indicates that patient falls are the single most frequently reported event affecting patient safety, with surgical errors and care management errors following well behind. The report is the first such document to detail hospital-specific information on serious adverse medical events in Massachusetts.

Health officials hope the report will play a key role in helping to reduce and eventually eliminate Serious Reportable Events at hospitals in the state.

“This is a very important step we are taking for patient safety in Massachusetts,” said DPH Commissioner John Auerbach. “This new reporting system — and the data collected — will provide a roadmap for hospitals, health care providers and public health professionals to follow as we work together to prevent many of these errors in the future. I want to thank the hospitals for being such good partners in this effort.”

Hospitals have always been required to report patient safety data to DPH, however beginning in 2008 Massachusetts adopted a reporting framework based on the National Quality Forum (NQF) reporting system. This new system required hospitals to report a total of 28 discrete adverse medical events, grouped in six major categories:

- Surgical
- Product or device-related
- Patient protection-related
- Care management-related
- Environmental
- Criminal

Massachusetts acute care hospitals reported a total of 338 Serious Reportable Events in 2008. More than 68 percent (231) were environmental events, with falls as the leading category (224 events). Sixty-two surgical events were reported (18 percent of the total), and care management events comprised 8 percent of the total, at 26 events. The remainder were criminal events (11 events, 3 percent of the total), product or device events (5 events, 1 percent of the total), and patient protection events (3 events, 1 percent of the total).

The goal of the reporting is to gain a greater understanding of why these events happen, and how to prevent them in the future. Towards this end, the new reporting system provides a forum for hospitals to share best practices on ways they addressed SRE rates in their facilities.

Health officials stress that the first year's worth of data is useful for providing a baseline by which to judge future years of reporting, but is not a reliable indicator for judging the quality of care at any specific hospital at this time. Lack of familiarity with the new reporting requirements, subjectivity in interpretation of events, and the relatively small number of incidents make it very difficult to draw reliable conclusions in this area.

During the second year of data collection, SRE analysis will be expanded to include demographic data including race, ethnicity, age and gender; and incident-specific data such as location of occurrence in hospital, time of day, and protocols and procedures in place at the time of the event. Health officials expect that these further details will assist hospitals in developing policies and procedures to reduce Serious Reportable Events in the future.

For a copy of the full report, visit www.mass.gov/dph.