for Patient Safety and Medical Error Reduction

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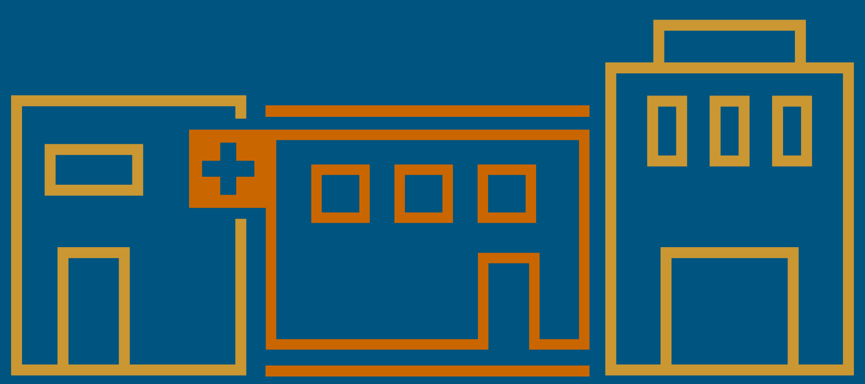
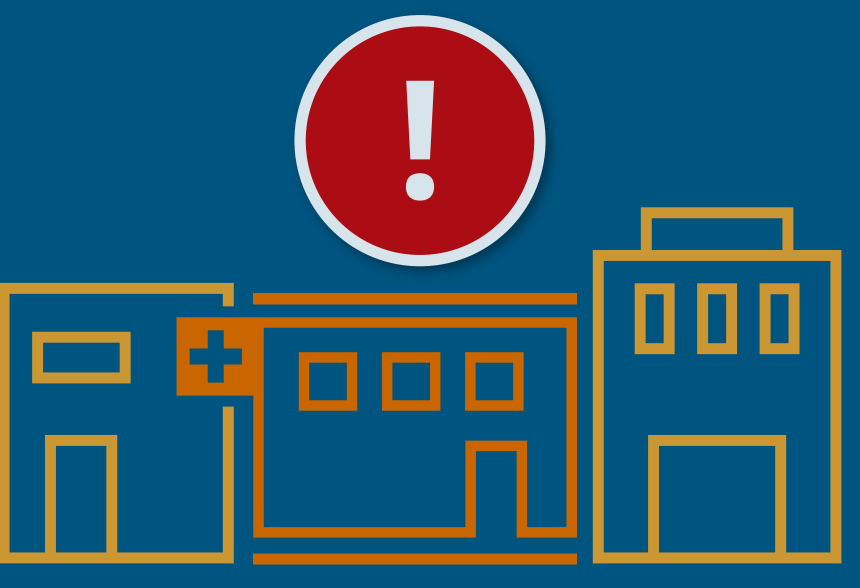
How to Use the Patient Safety Navigator

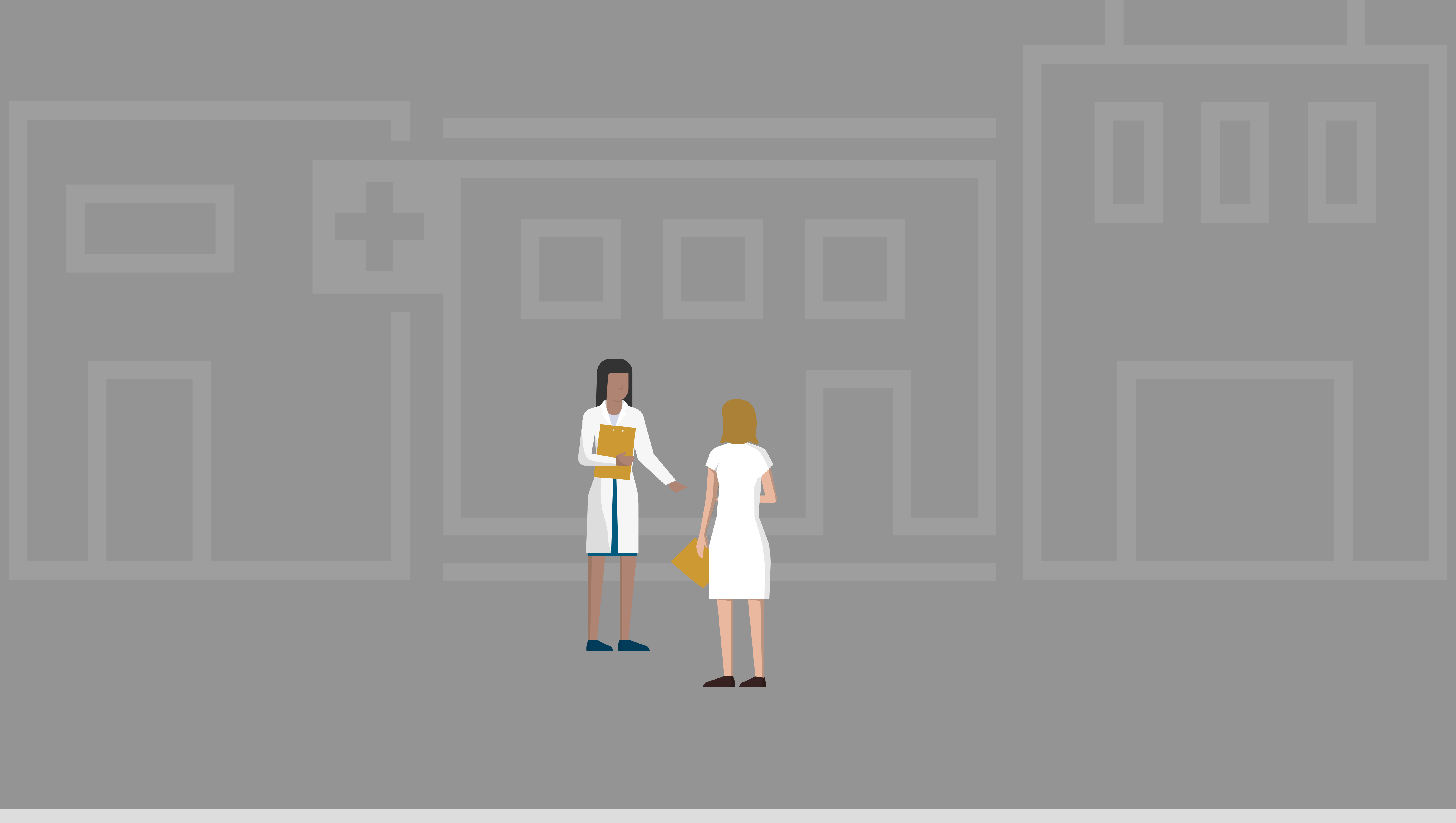


In our complex healthcare system,



patient harm happens every day, despite best intentions

The Betsy Lehman Center created the Patient Safety Navigator to help Massachusetts healthcare organizations of all sizes respond effectively to patient safety events …



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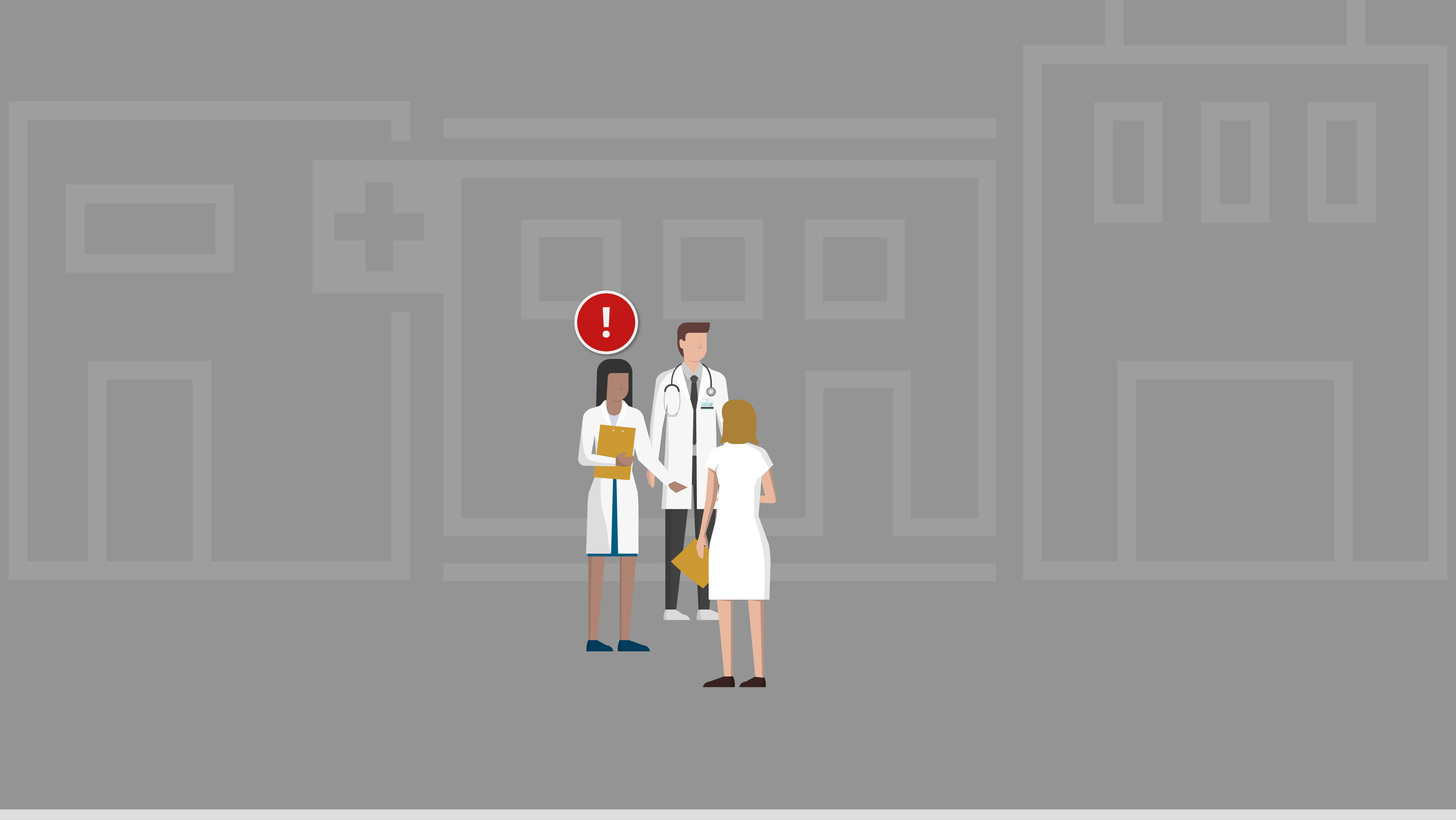

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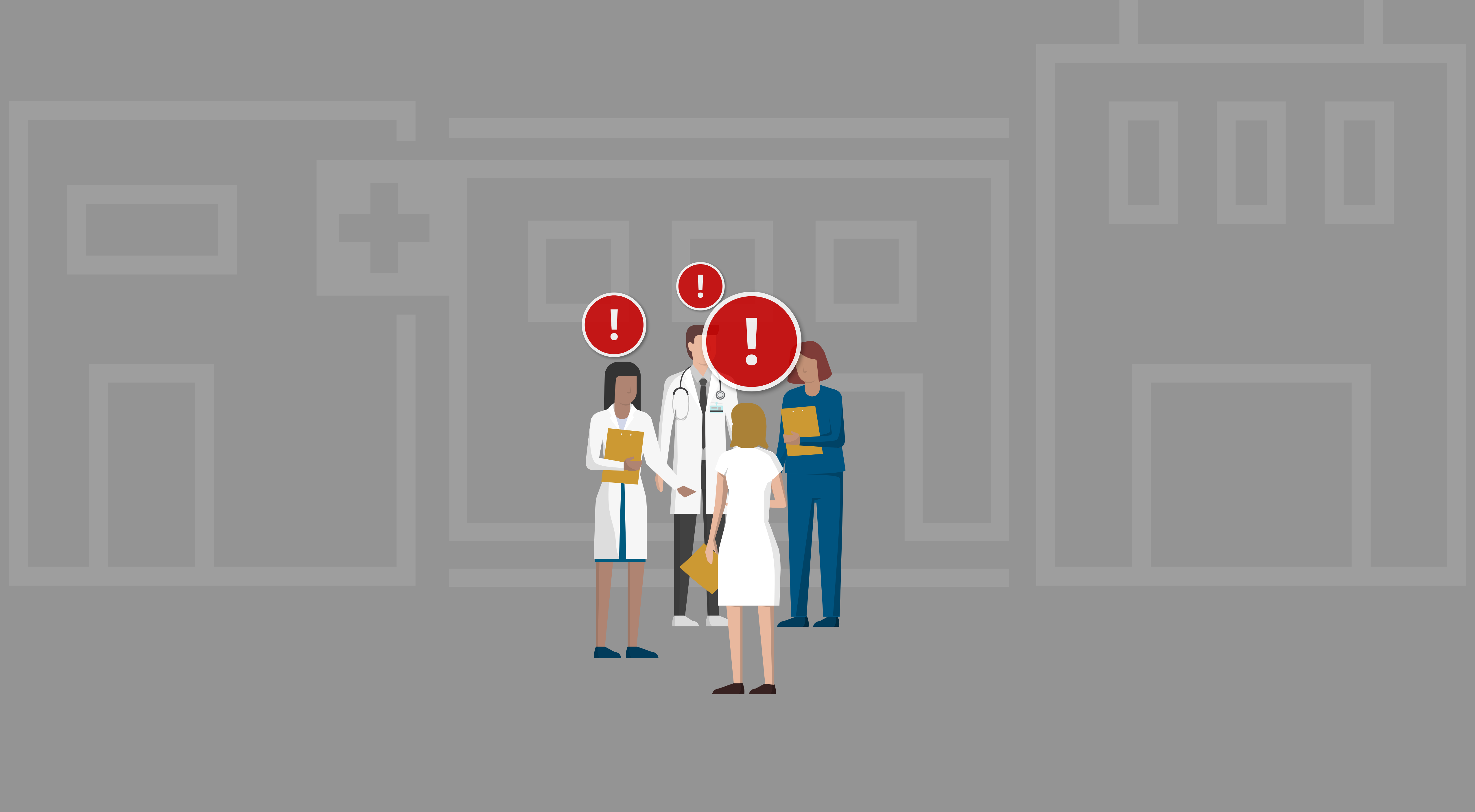

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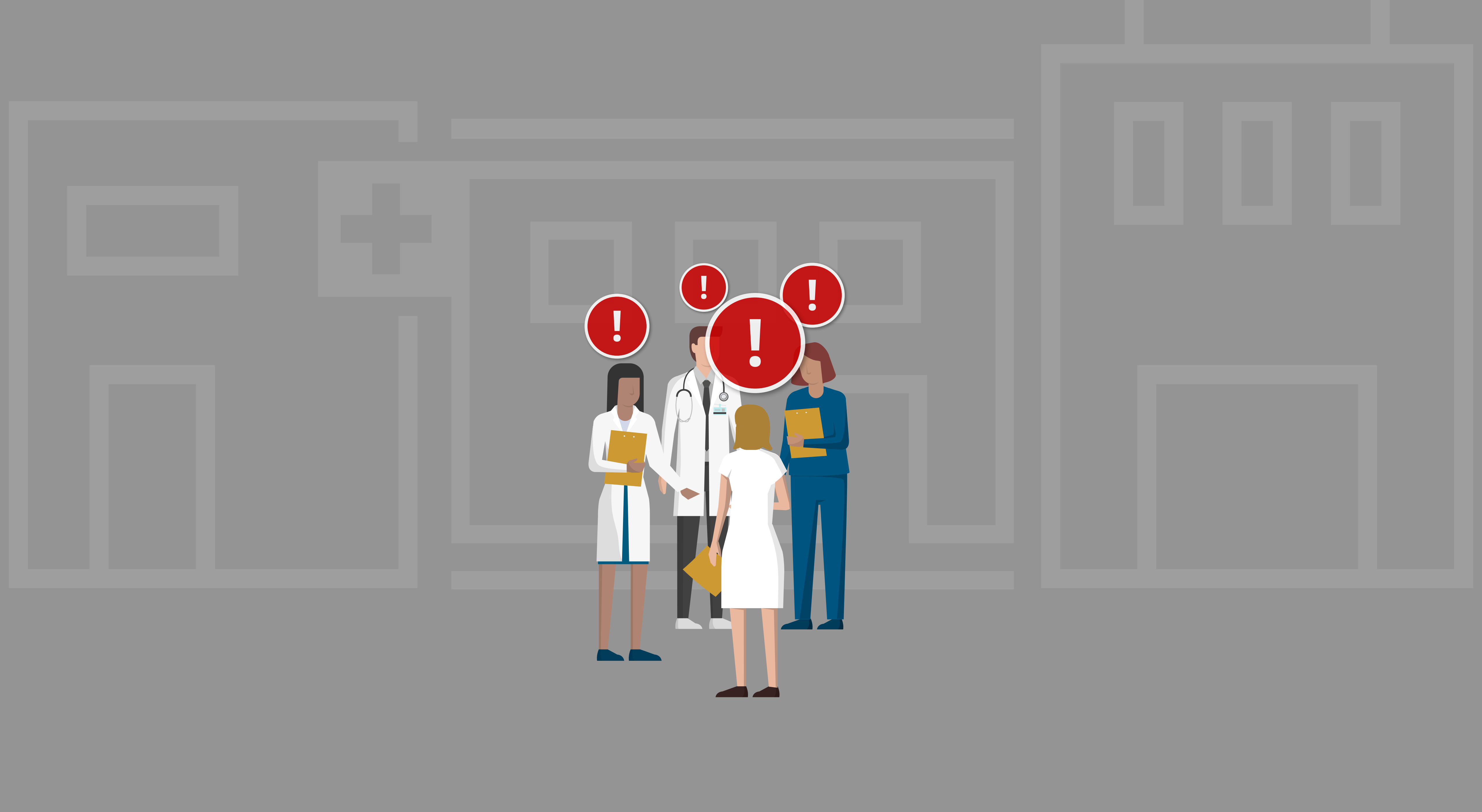

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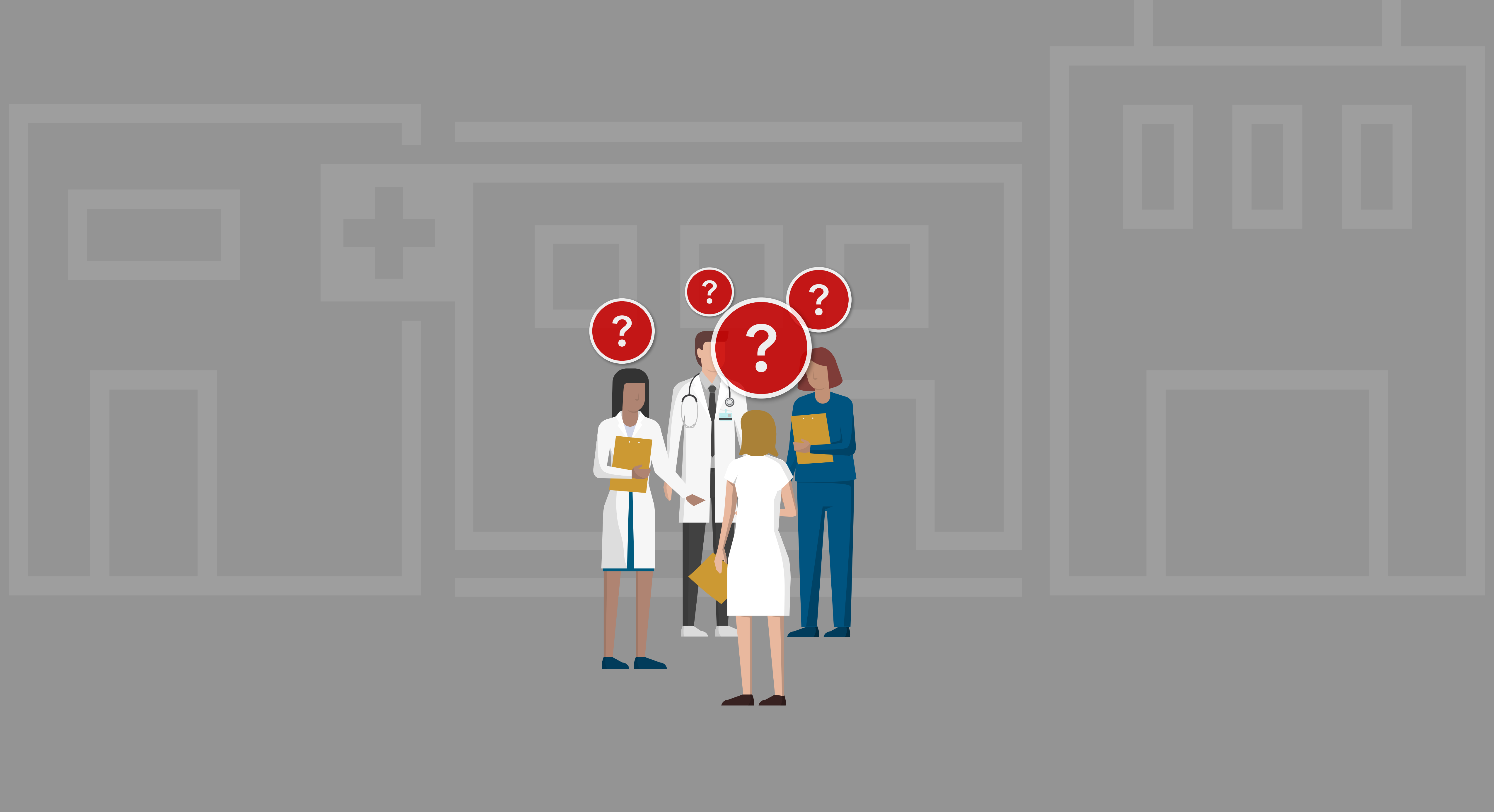
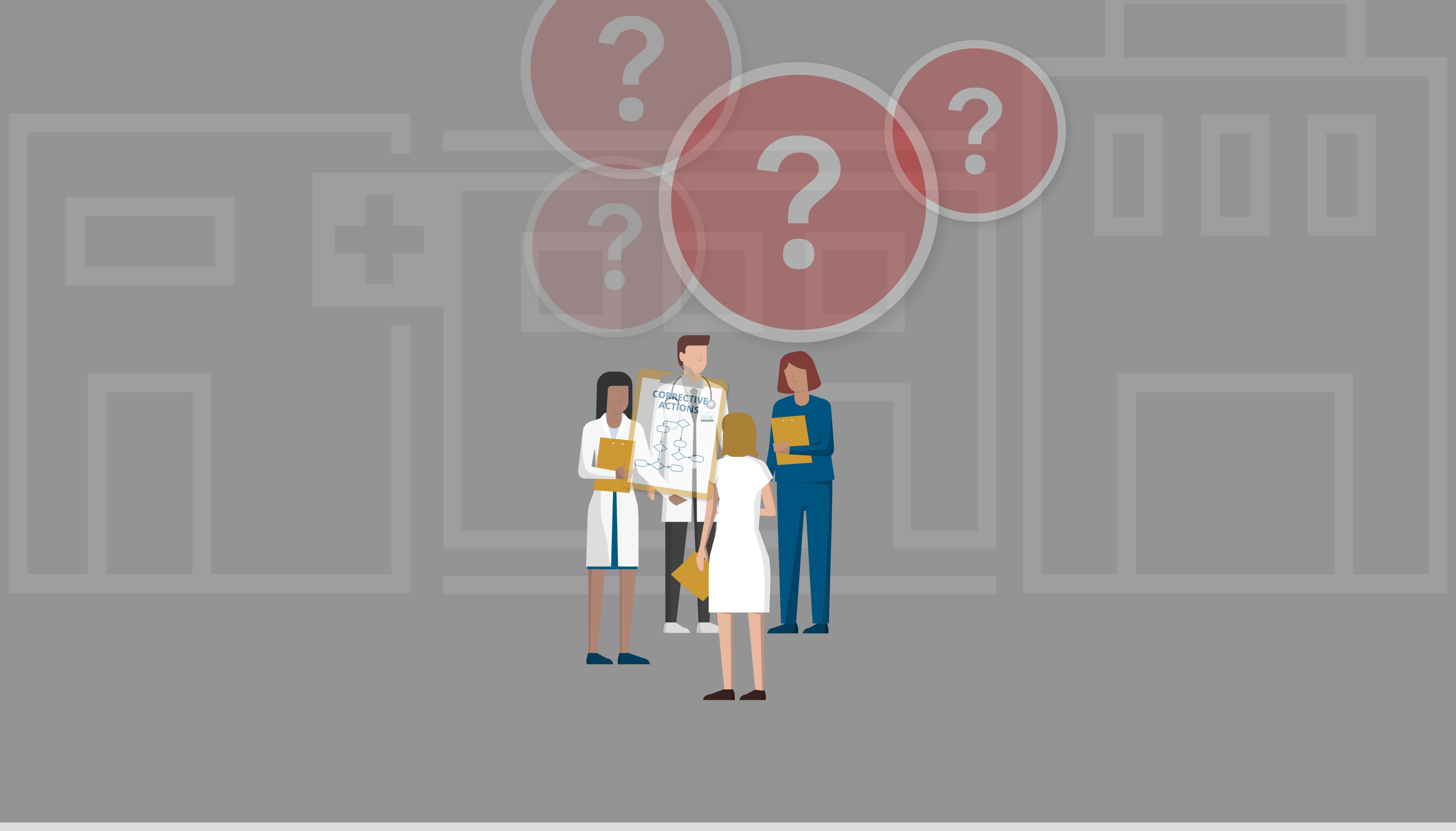
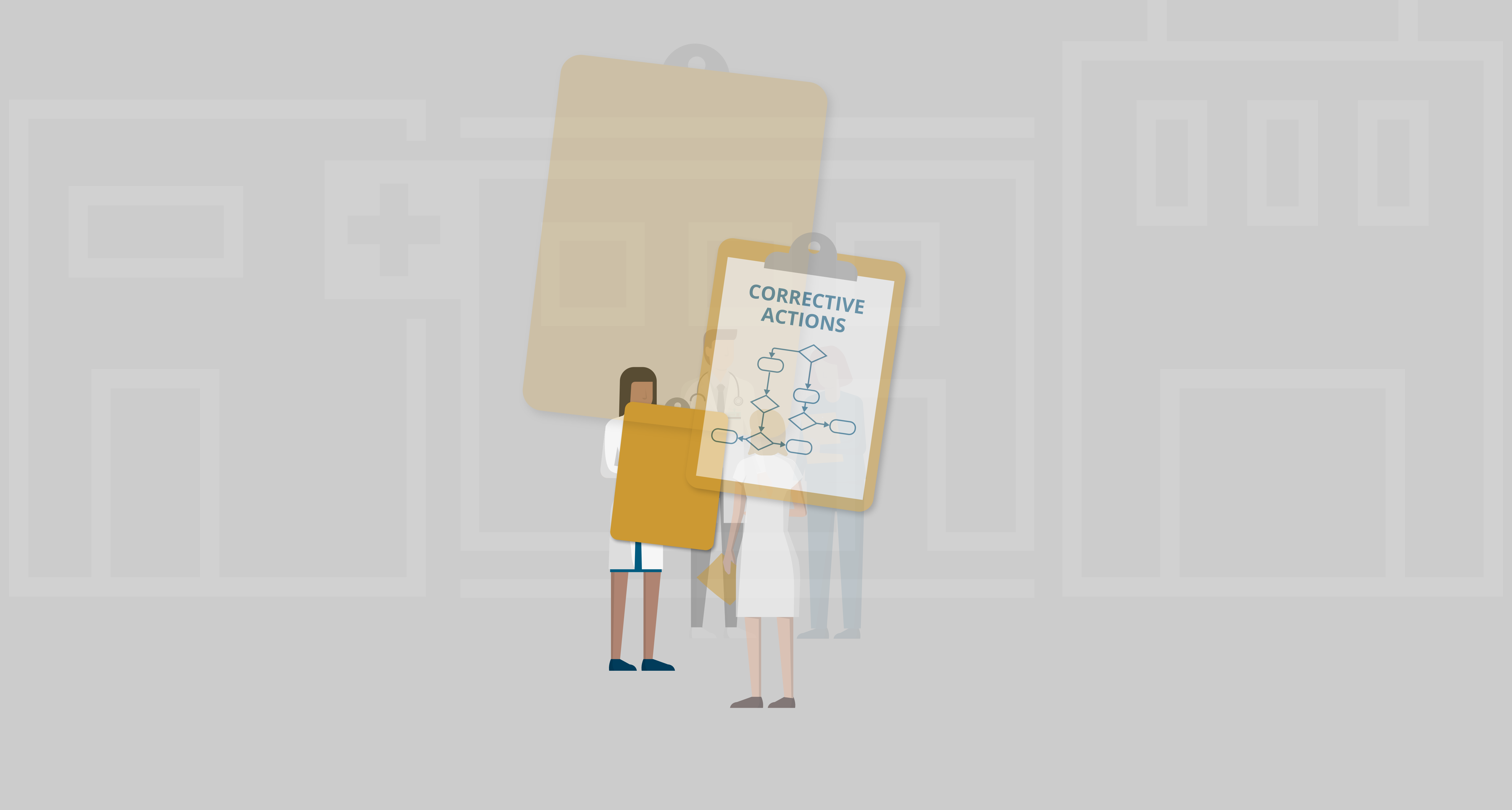


…learn from these events…



…and take action to prevent future harm.



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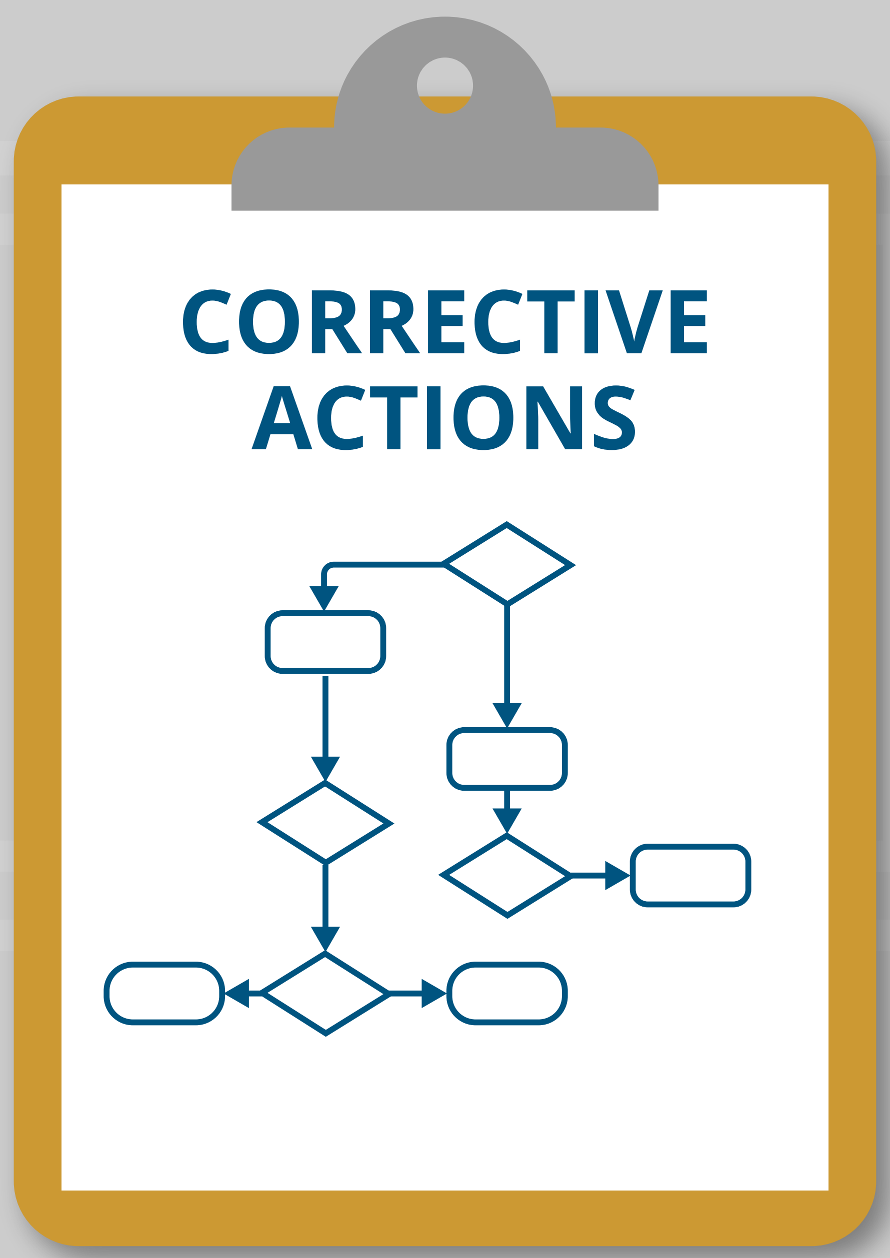

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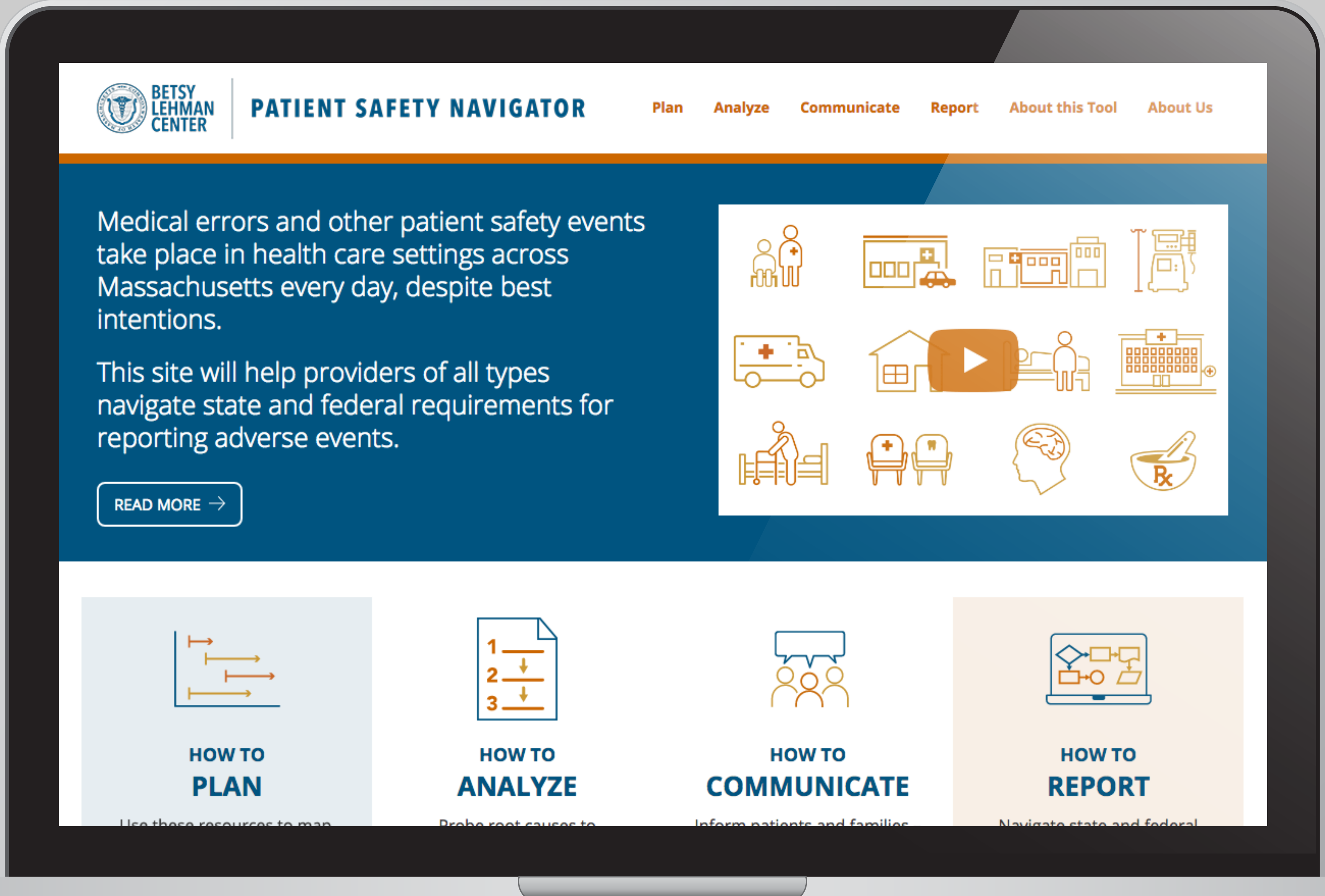
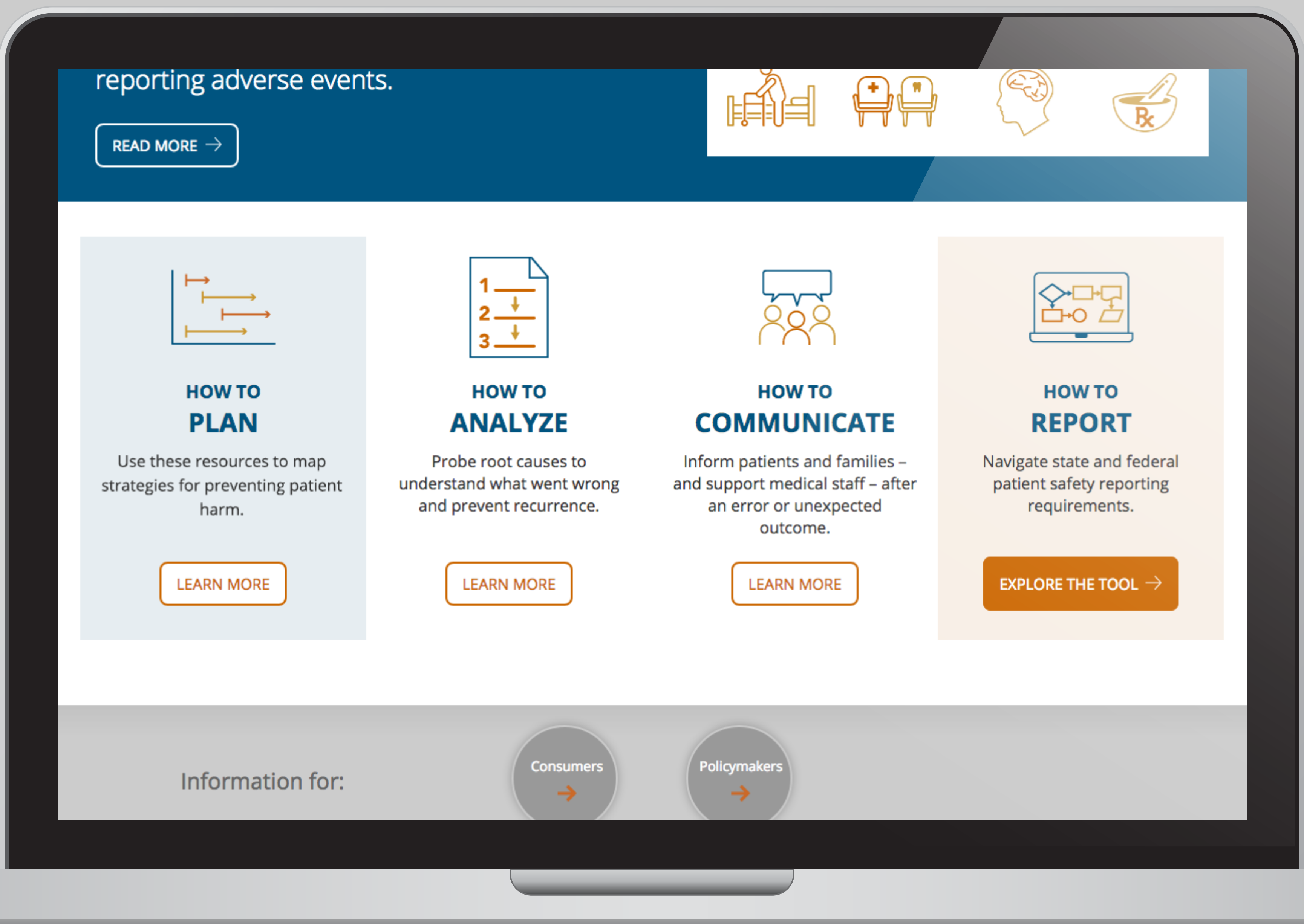


The Patient Safety Navigator offers four intuitive modules to assist you.



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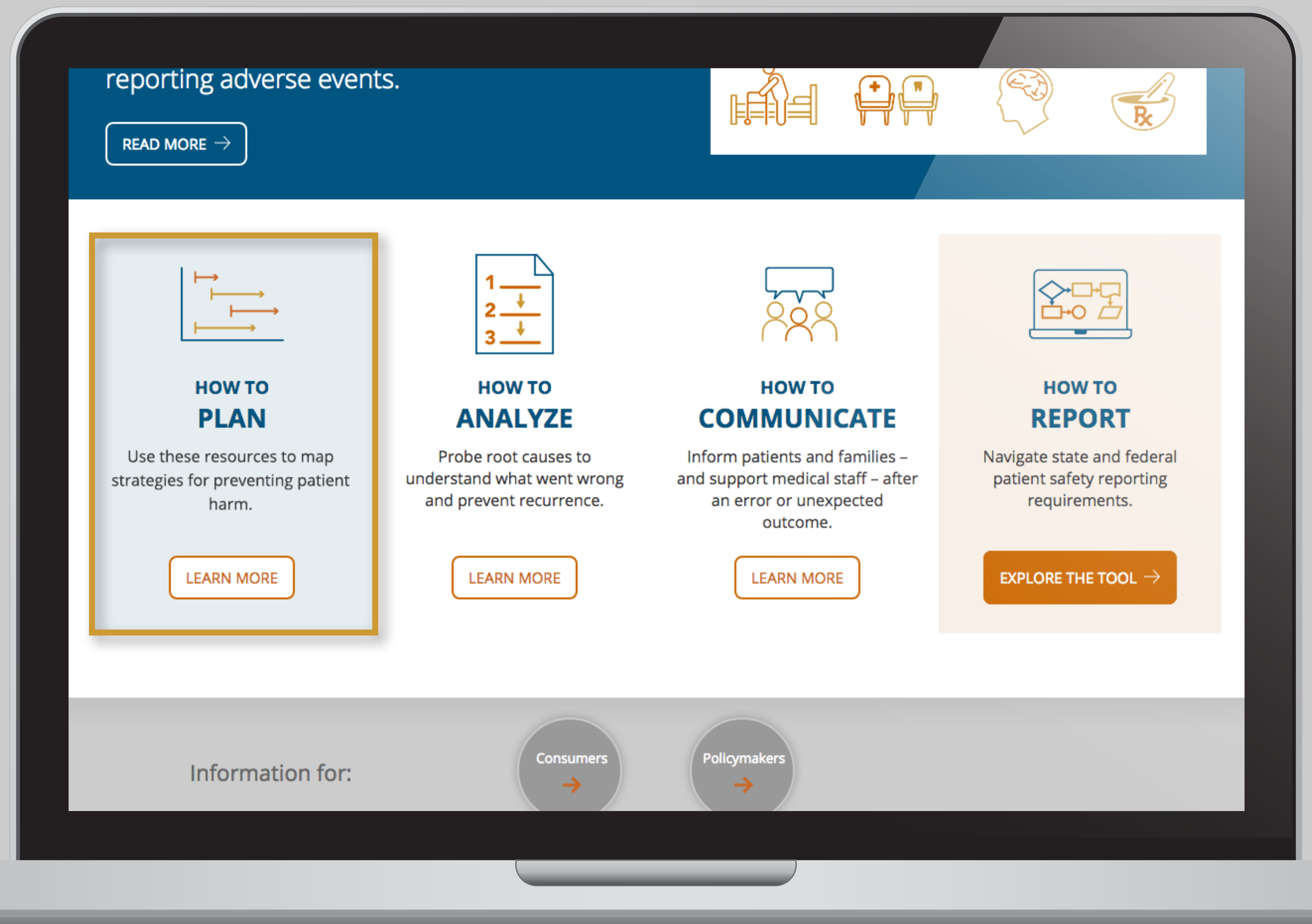
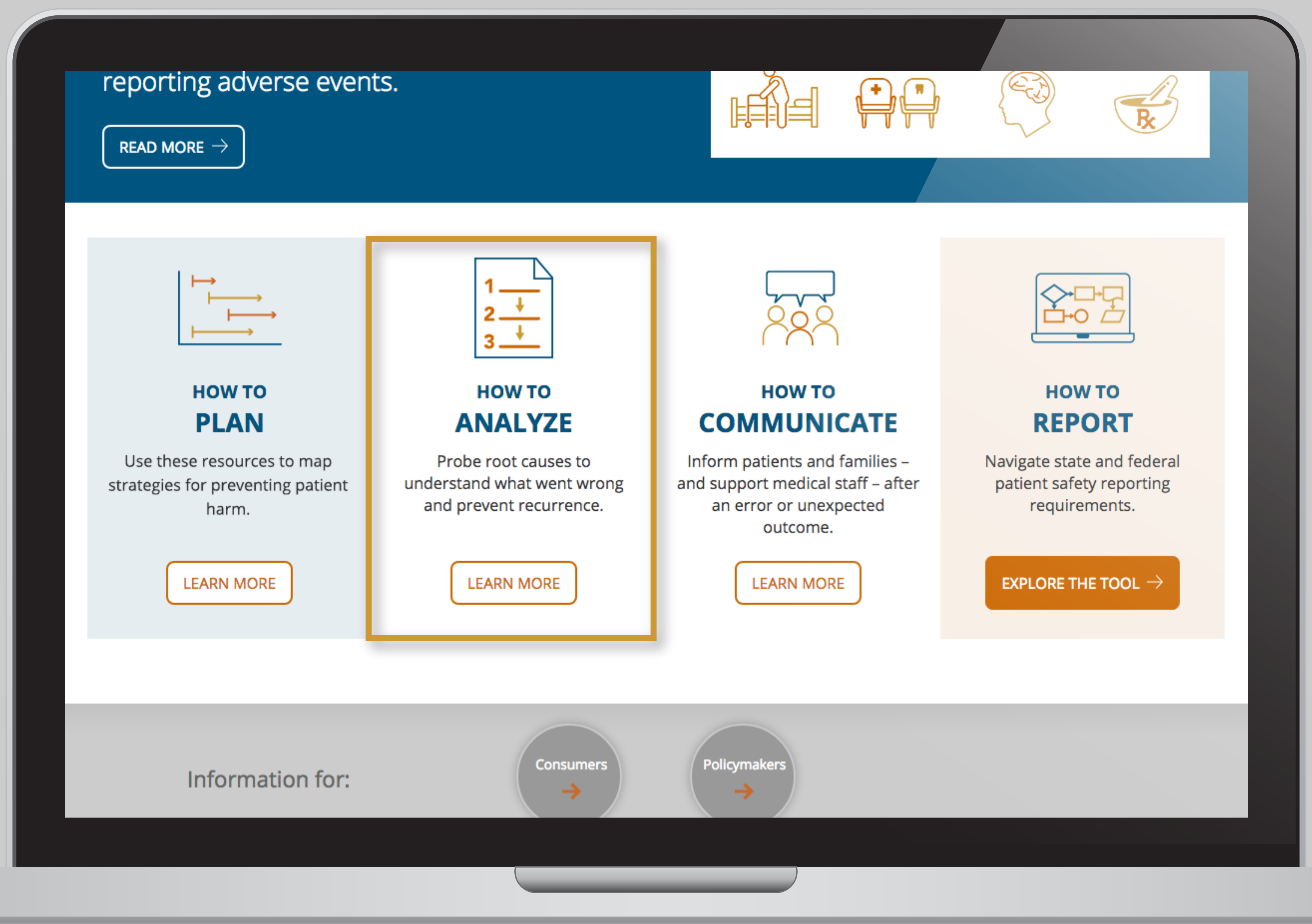
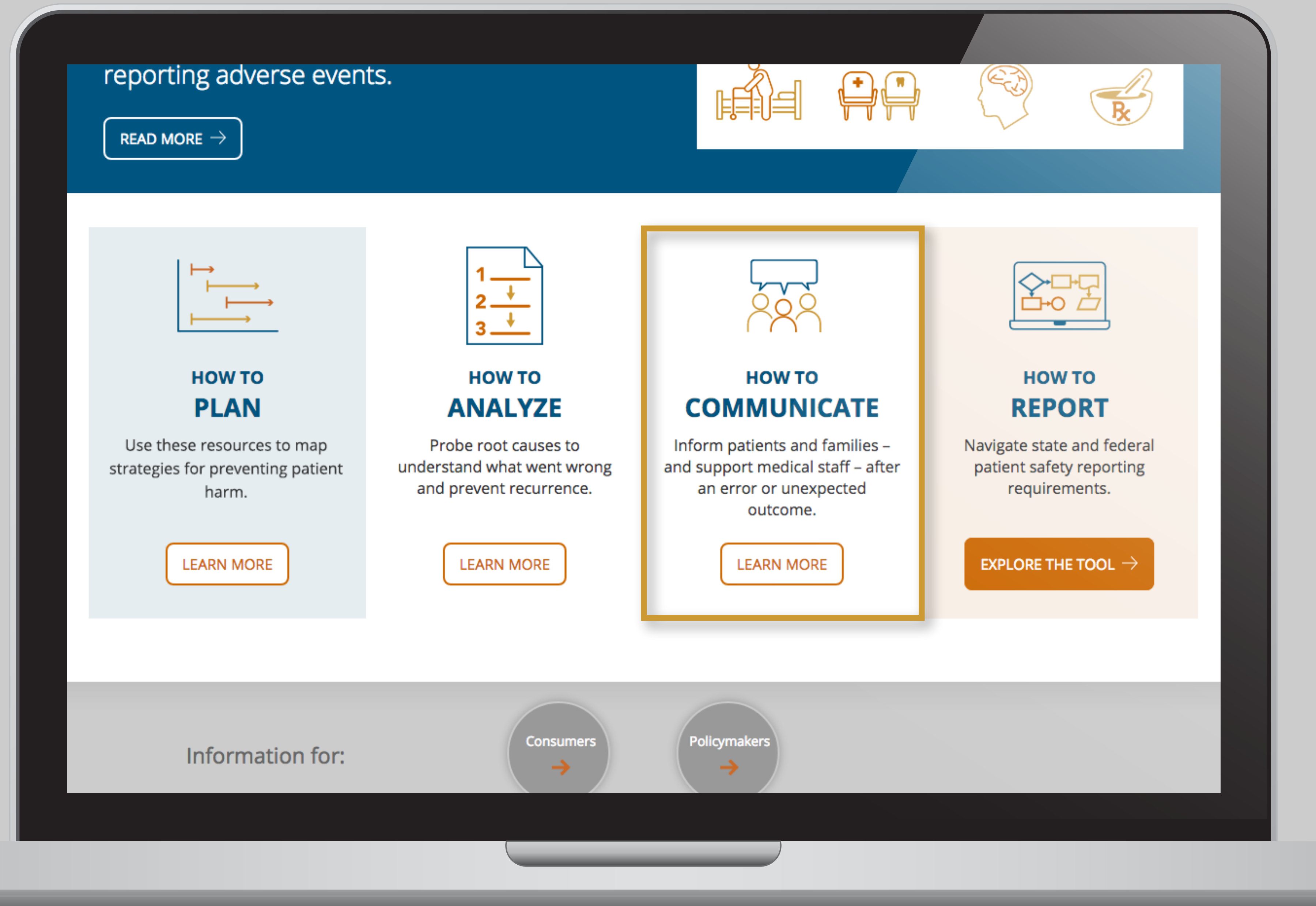


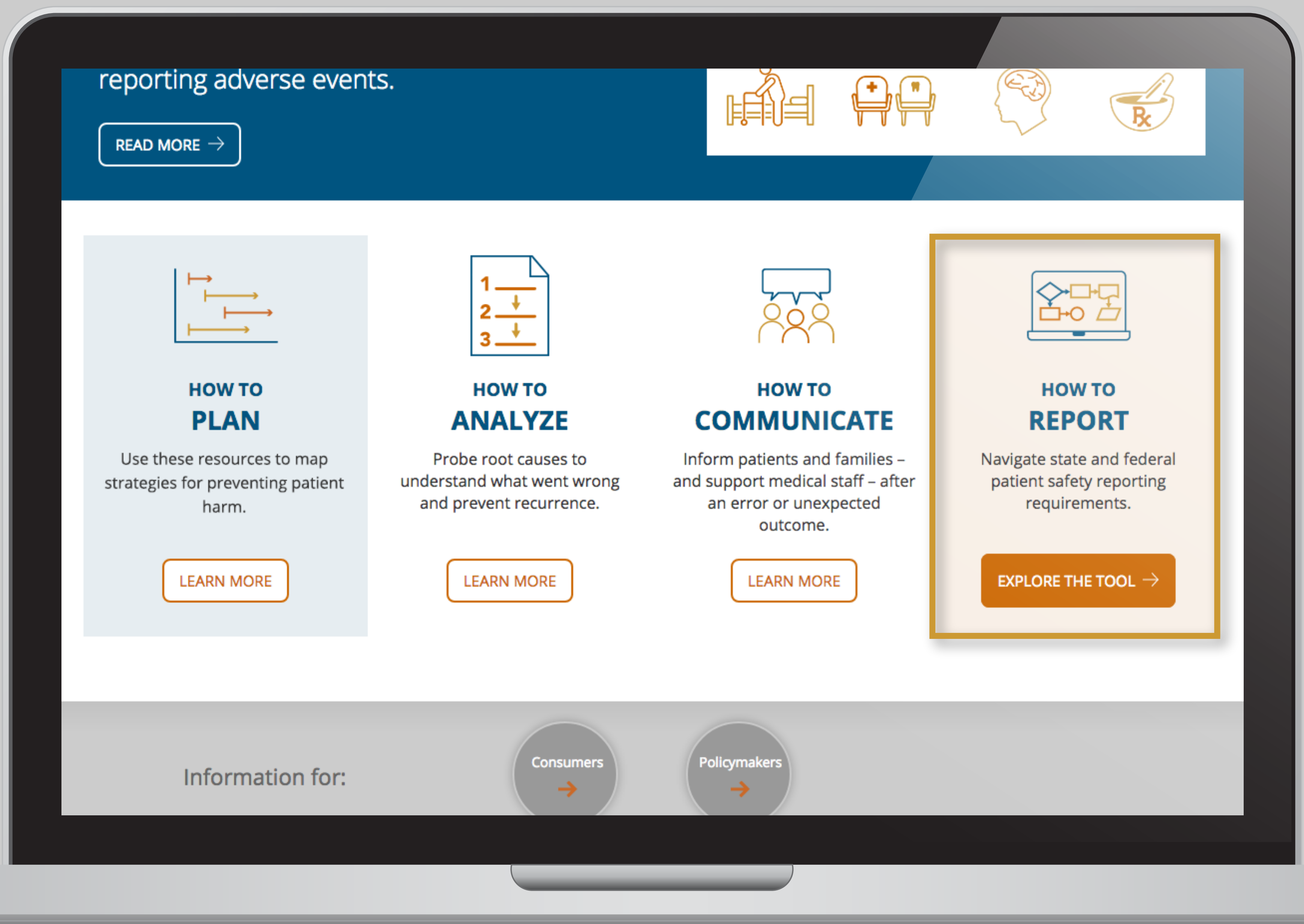
PLAN provides tools to help your organization develop a comprehensive blueprint for preventing patient harm.



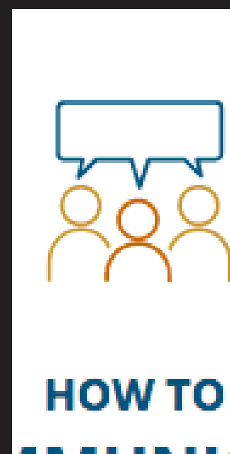
And, when something does go wrong,
ANALYZE provides step-by-step help in determining what happened and preventing recurrence.



COMMUNICATE informs conversations with patients, families and staff following an error or unexpected outcome.



And REPORT makes it easy to identify and report adverse events to state and federal agencies.



HOW TO

MMUNICATE

patients and families –
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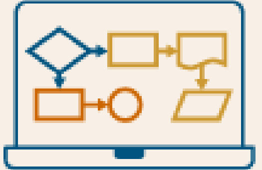
LEARN MORE



HOW TO

REPORT

Navigate state and federal
patient safety reporting
requirements.

EXPLORE THE TOOL →

Let's take a closer look at the REPORT tool.

It leads you through the process of reporting a patient safety event to the appropriate agencies, step by step.

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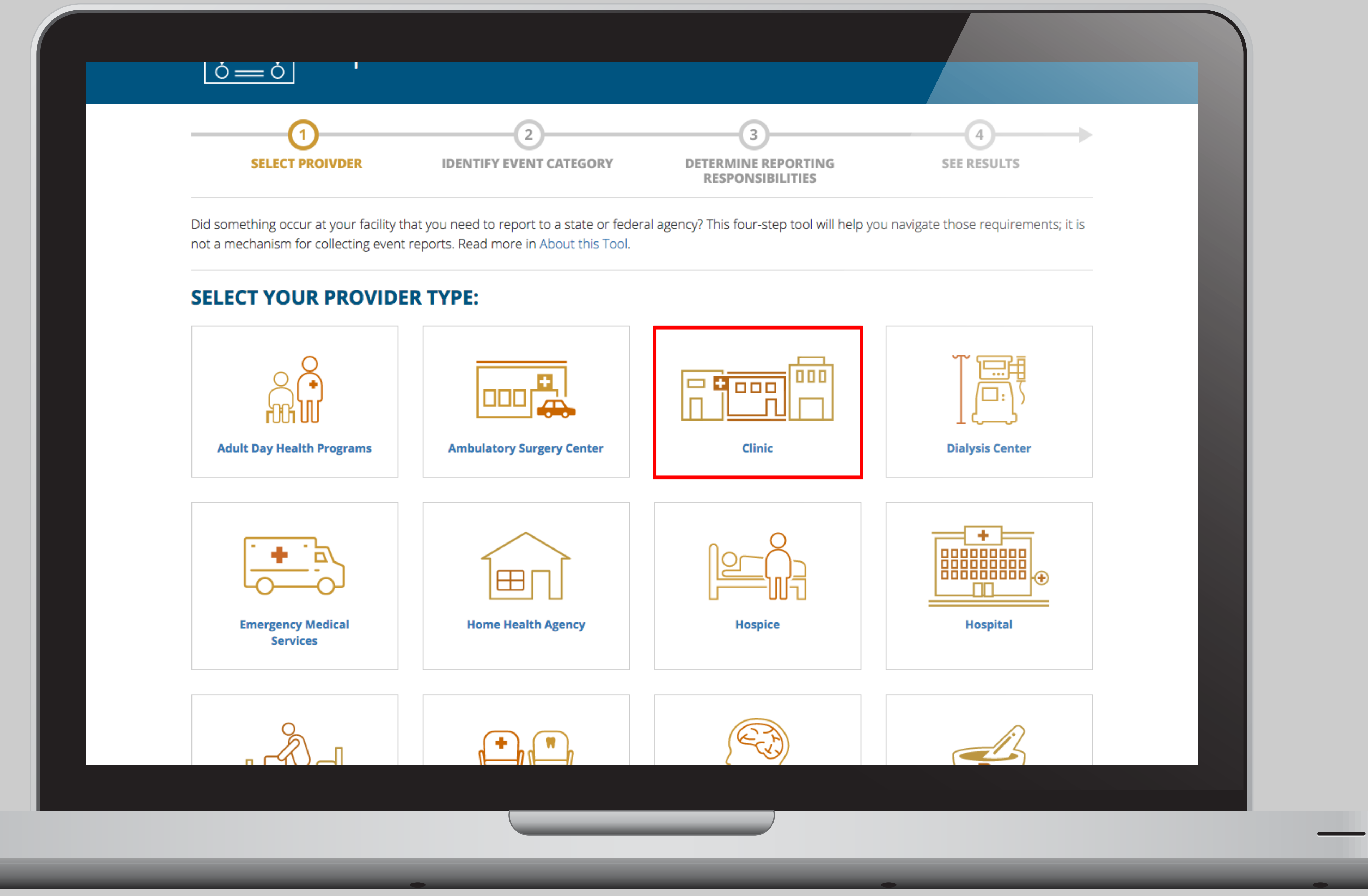

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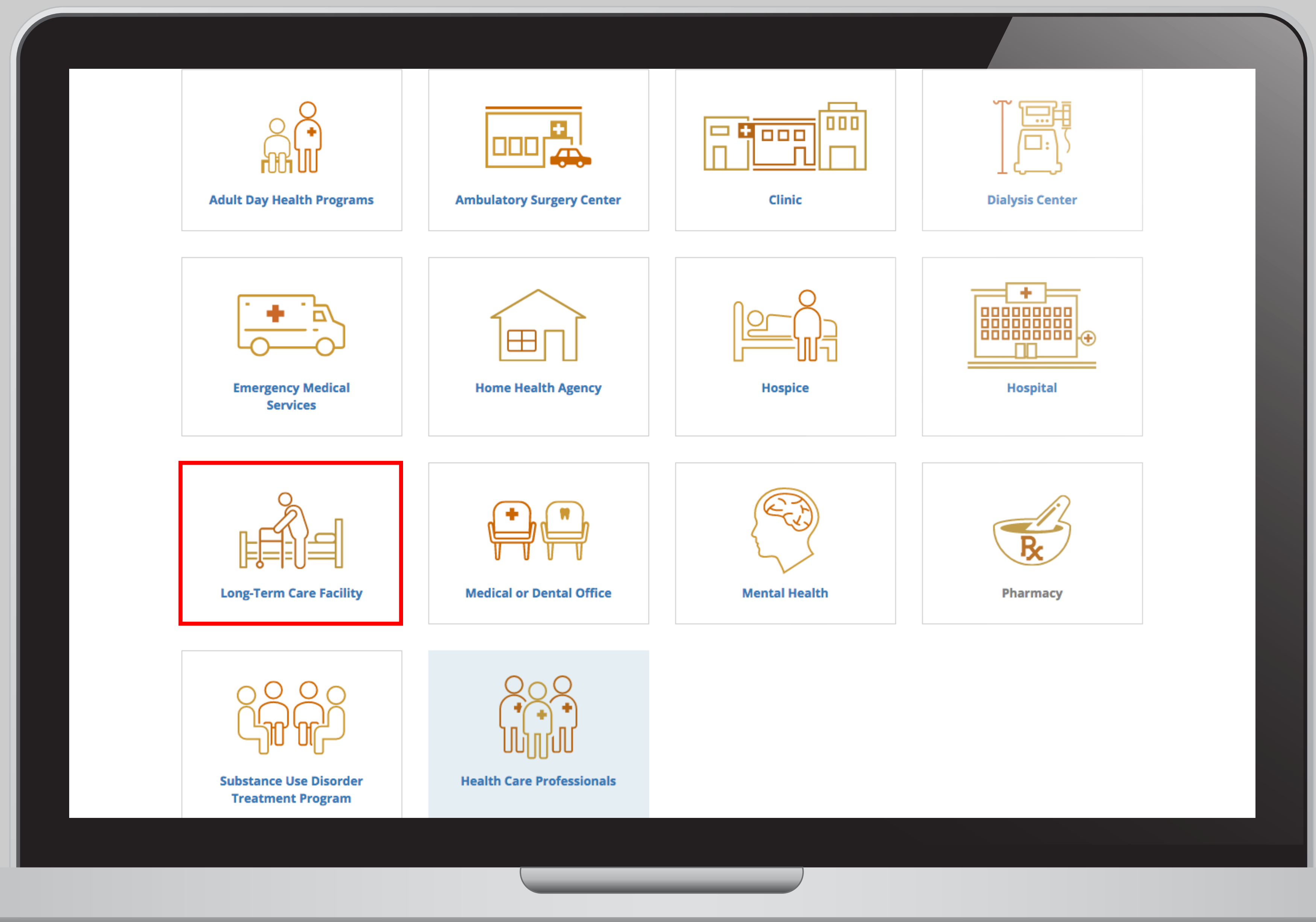

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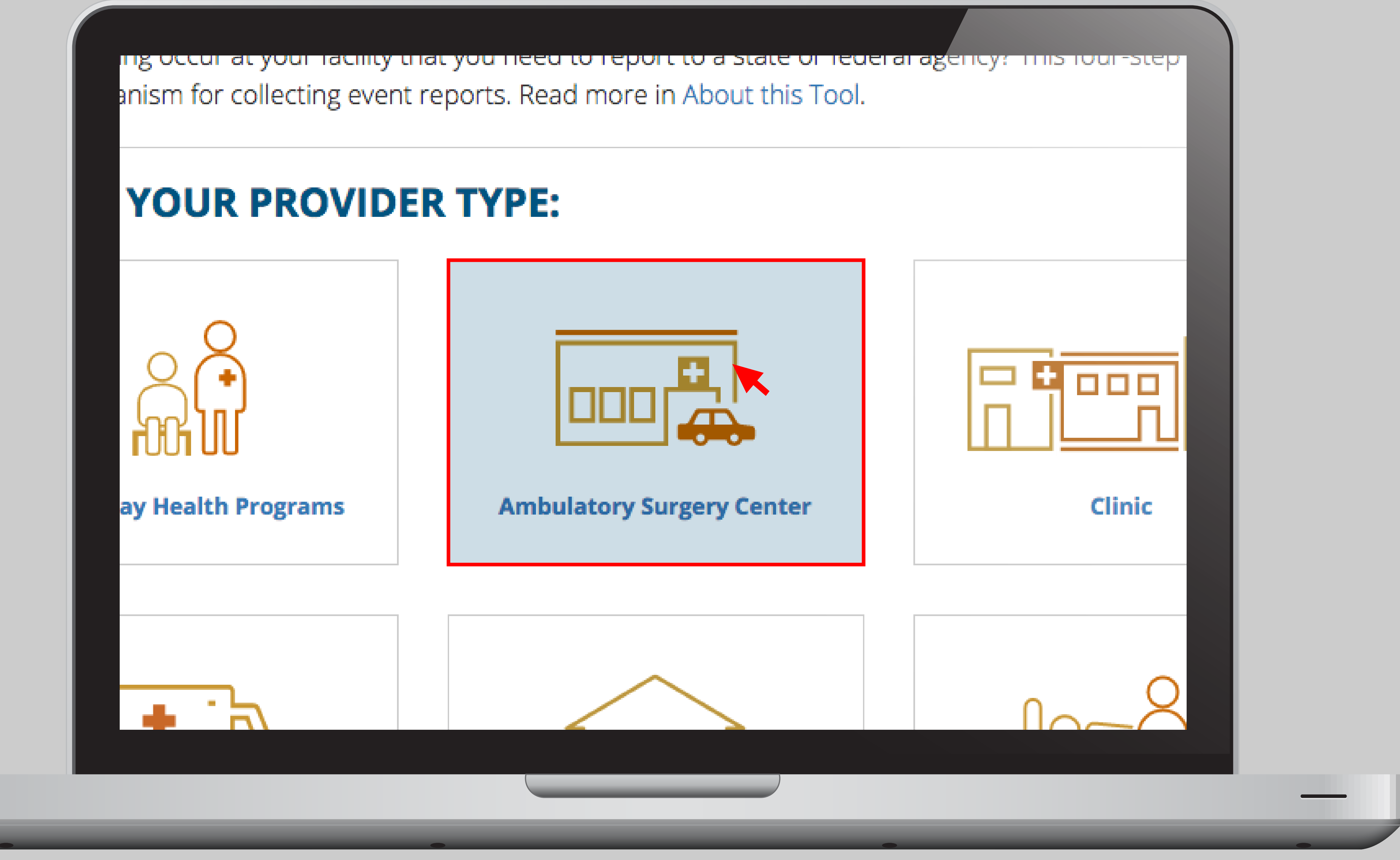
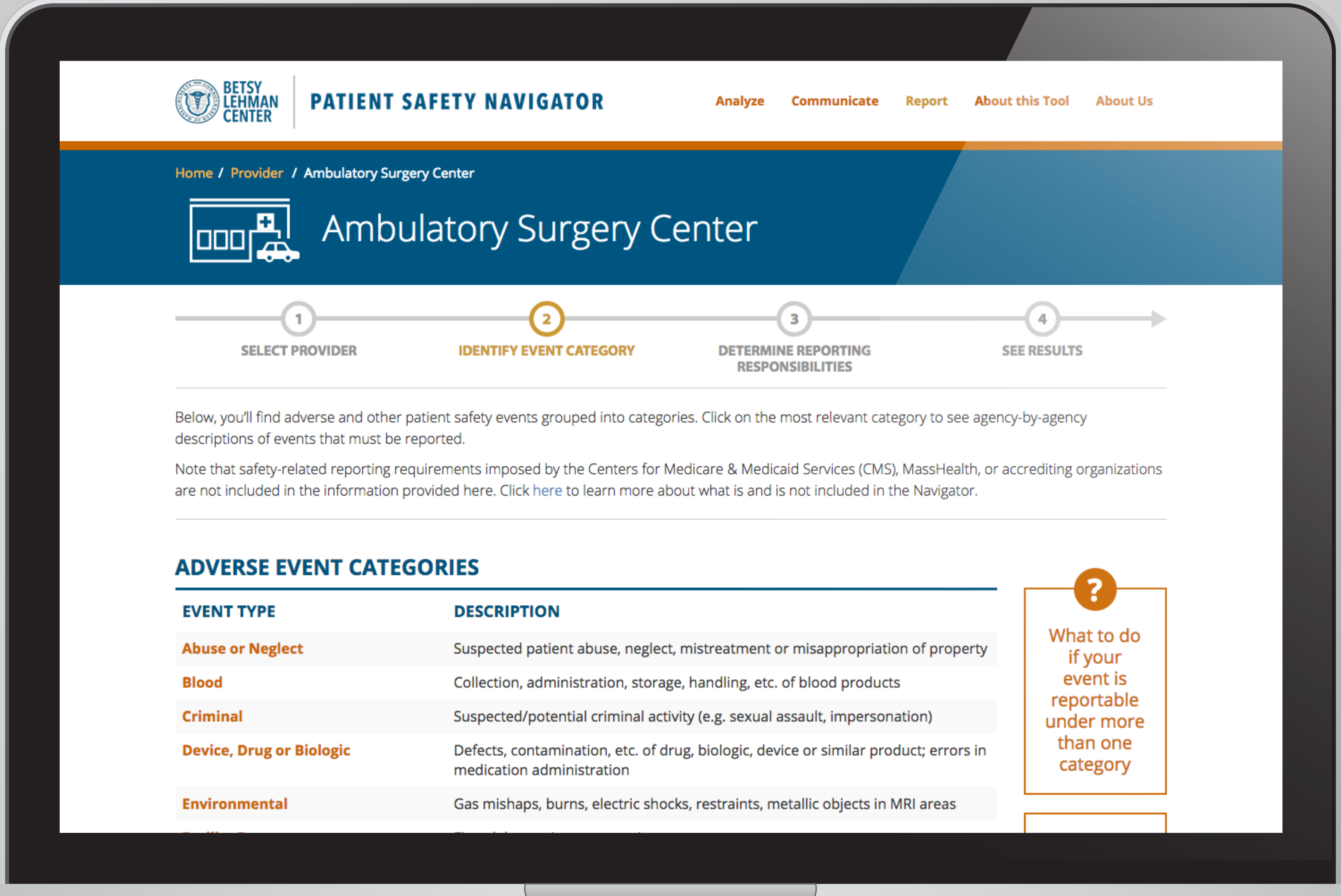
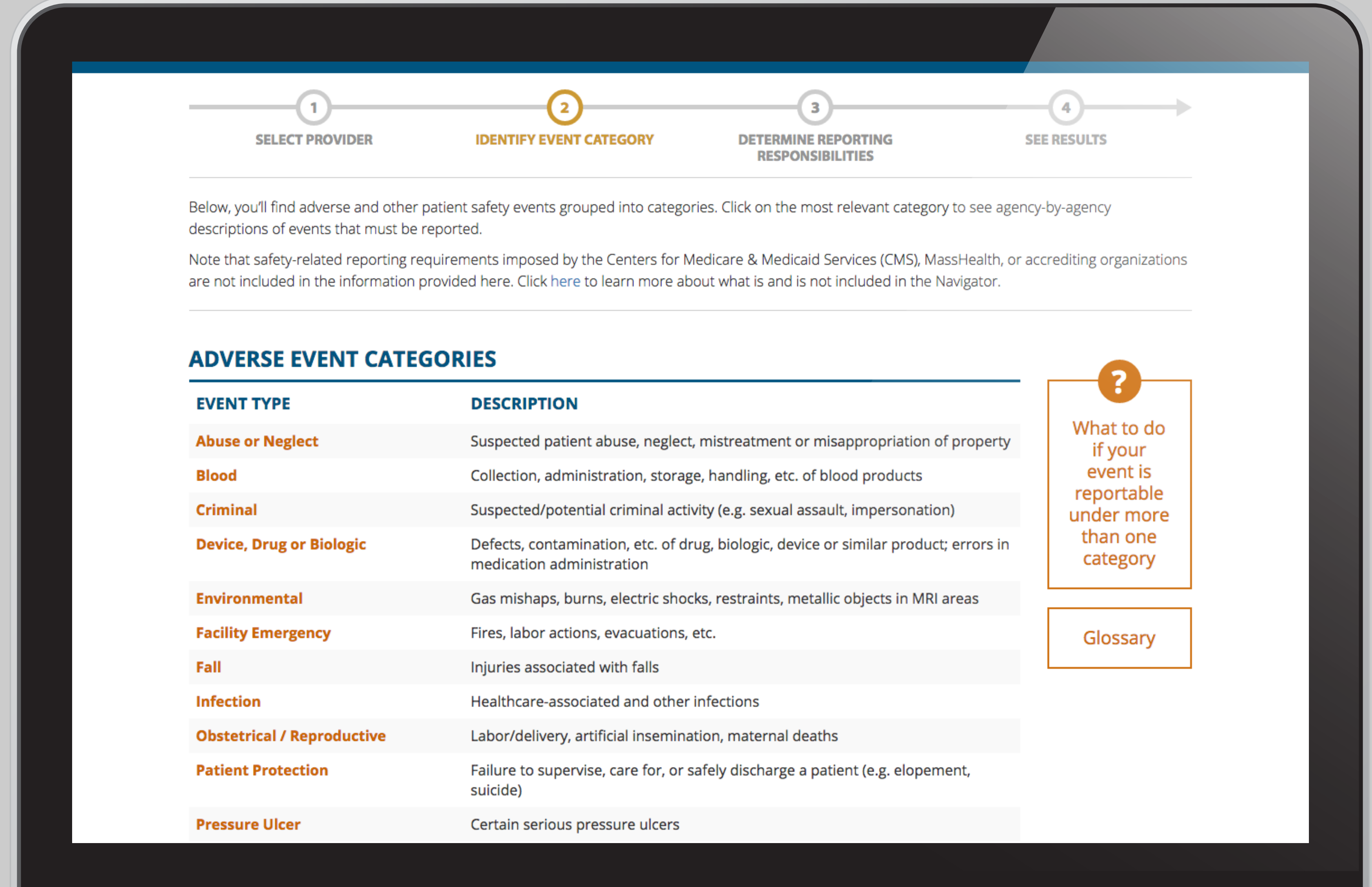


Let's take the example of an ambulatory surgery center where a patient was given the wrong dose of a medication during a procedure. Click the icon...



...and the next page shows categories of reportable patient safety events.



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Environmental	Gas mishaps, burns, electric shocks, restraints, metallic objects in MRI areas
Facility Emergency	Fires, labor actions, evacuations, etc.
Fall	Injuries associated with falls
Infection	Healthcare-associated and other infections
Obstetrical / Reproductive	Labor/delivery, artificial insemination, maternal deaths
Patient Protection	Failure to supervise, care for, or safely discharge a patient (e.g. elopement, suicide)
Pressure Ulcer	Certain serious pressure ulcers
Surgical or Invasive Procedure	Wrong patient, wrong site, wrong procedure, foreign object retention, etc.
Test Results	Failure to follow up with test results
Other	Choose this category if your event does not appear to fit elsewhere.

Glossary

OTHER SAFETY REPORTING

EVENT TYPE	DESCRIPTION
Automated Data Collection	Quality indicators for care reimbursement and research
CMS and MassHealth	Broad overview and links to resources related to conditions of coverage and participation in these programs
Communicable Disease or Unusual Illness	Communicable disease, unusual illness, or other health condition of public concern
Disciplinary Action Taken Against a Physician	Professional review action, clinical privilege suspension, or other disciplinary action taken by a facility against a physician
Drug Diversion	Loss or theft of controlled substances
Influenza Vaccination Rate	Vaccination against influenza by health care personnel at your facility
Physician Misconduct	Fraudulent practice of medicine, prescription violations, gross negligence, sexual misconduct or other misconduct by a licensed physician

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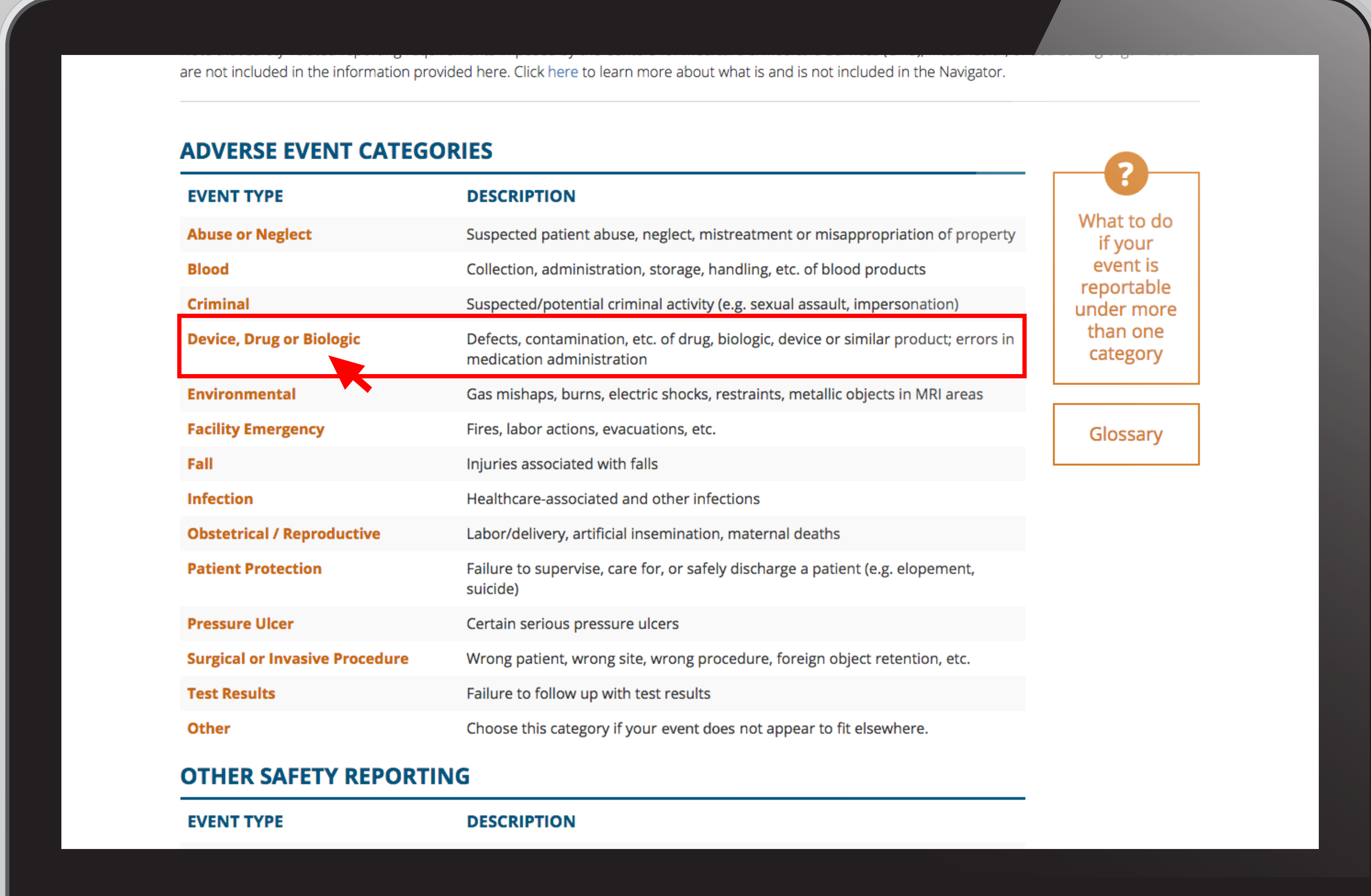
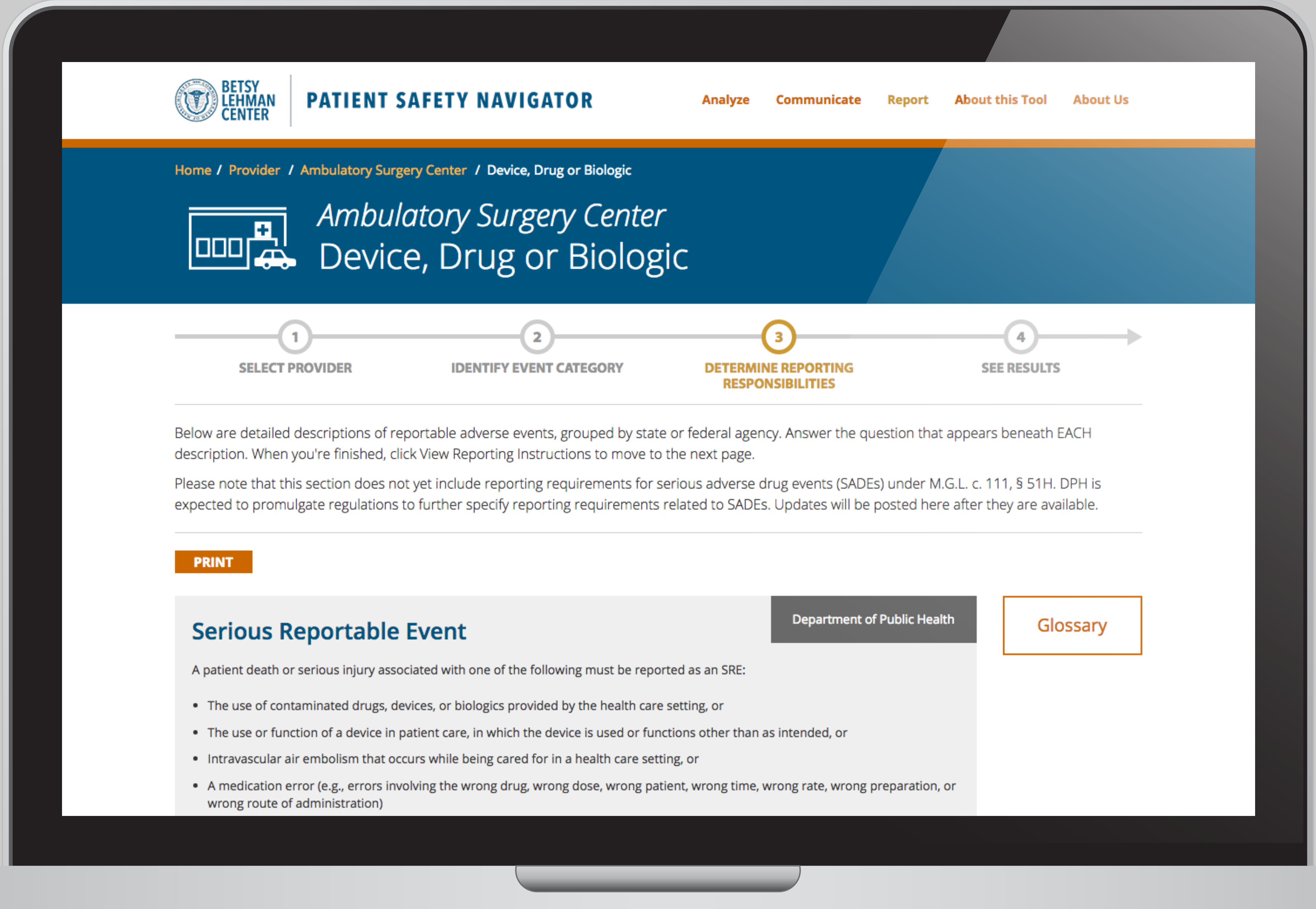
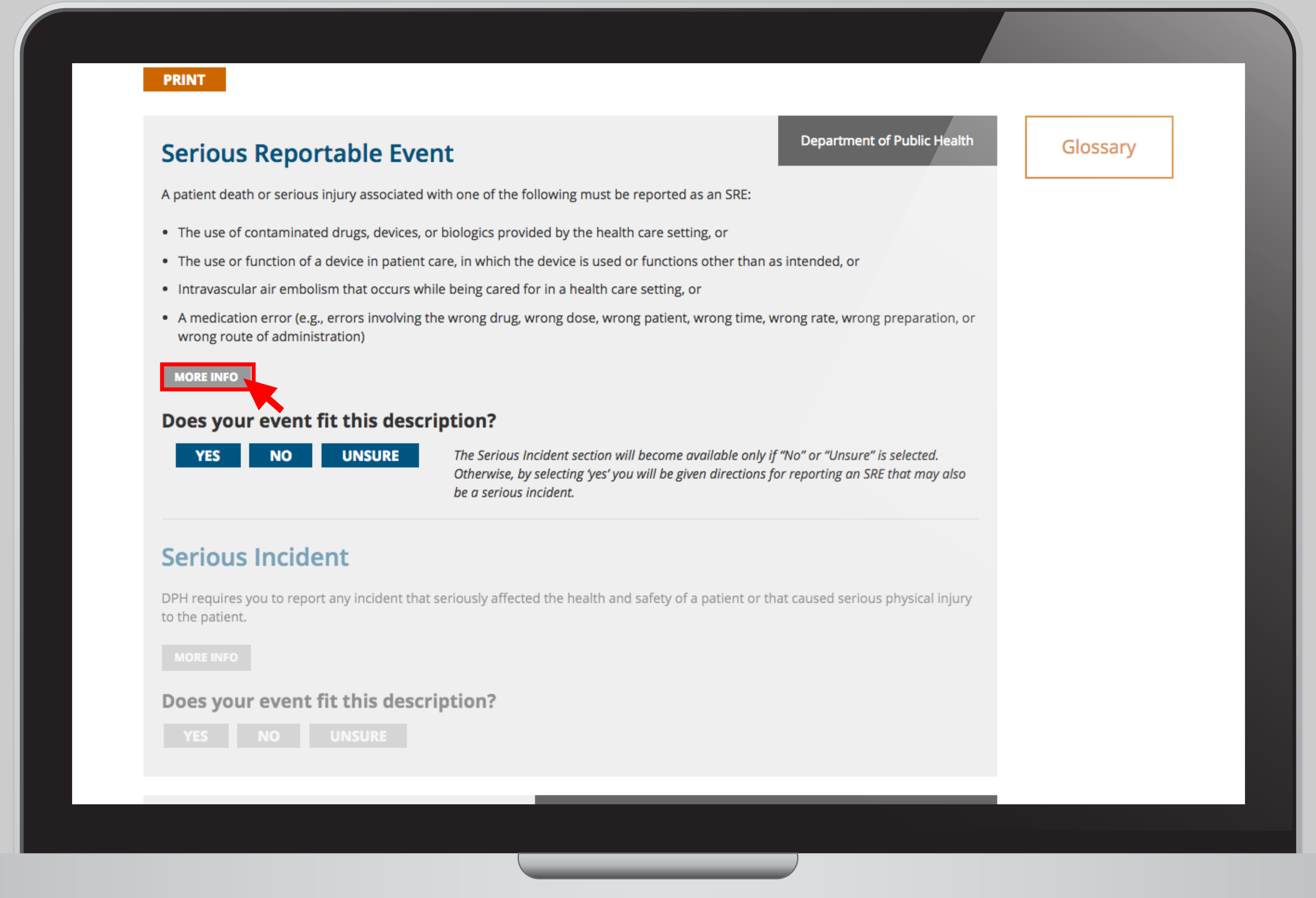


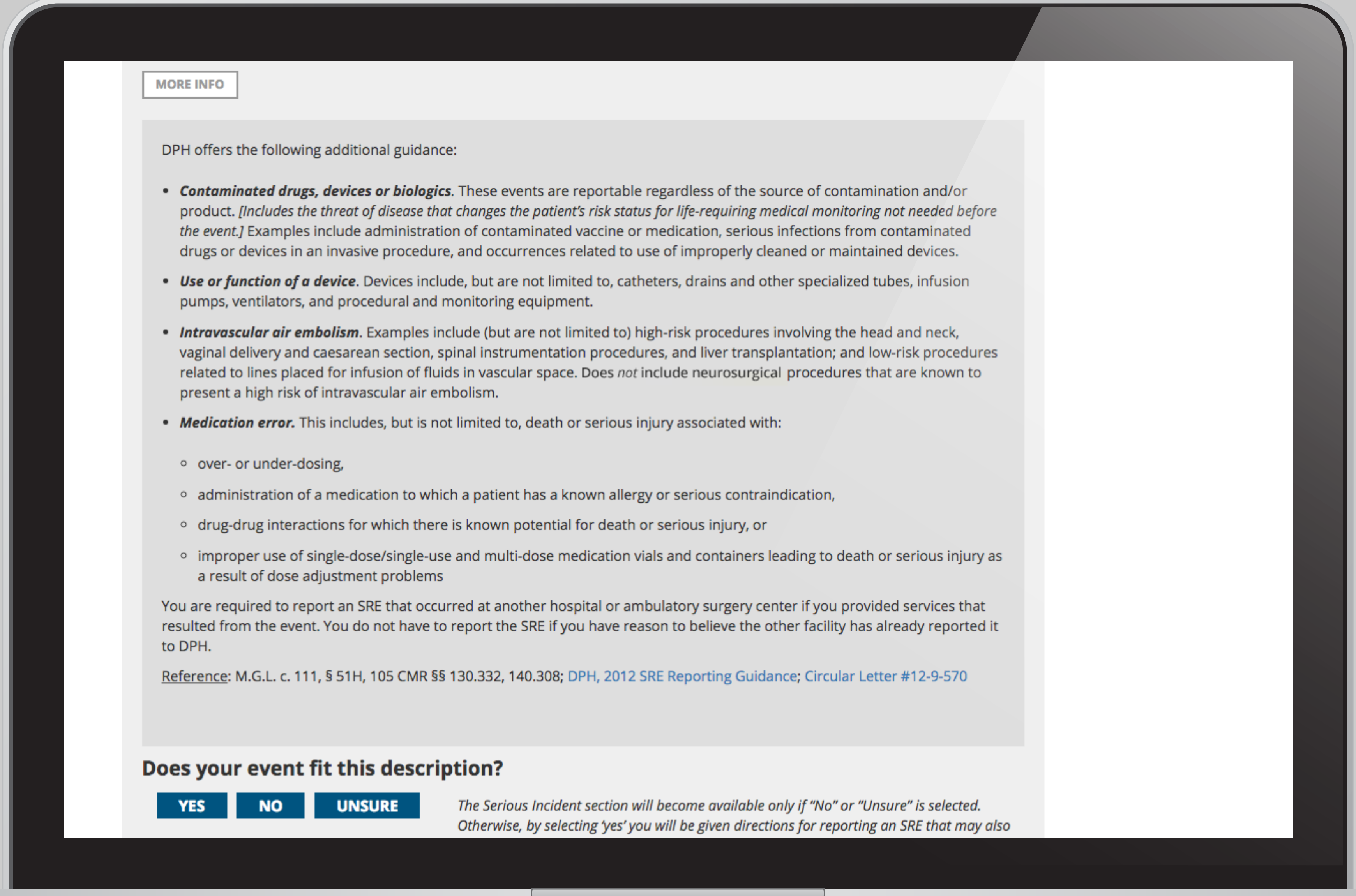
For this example of a medication error, you would select “Device, Drug or Biologic.”



The next step helps you determine if and what you need to report based on descriptions of patient safety events from the Department of Public Health and other agencies.



The tool provides additional information drawn from relevant laws and regulations to help you make decisions.



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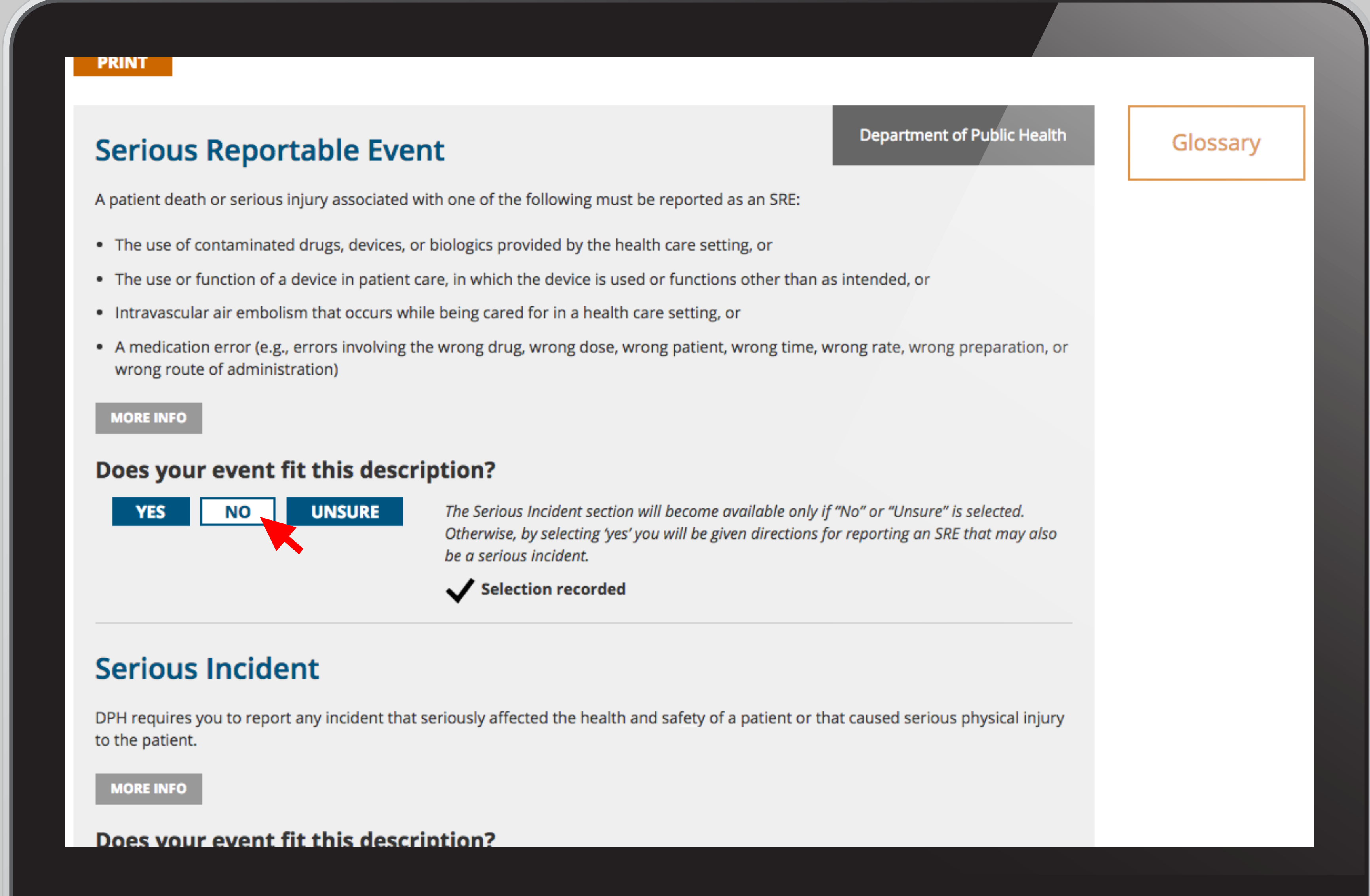
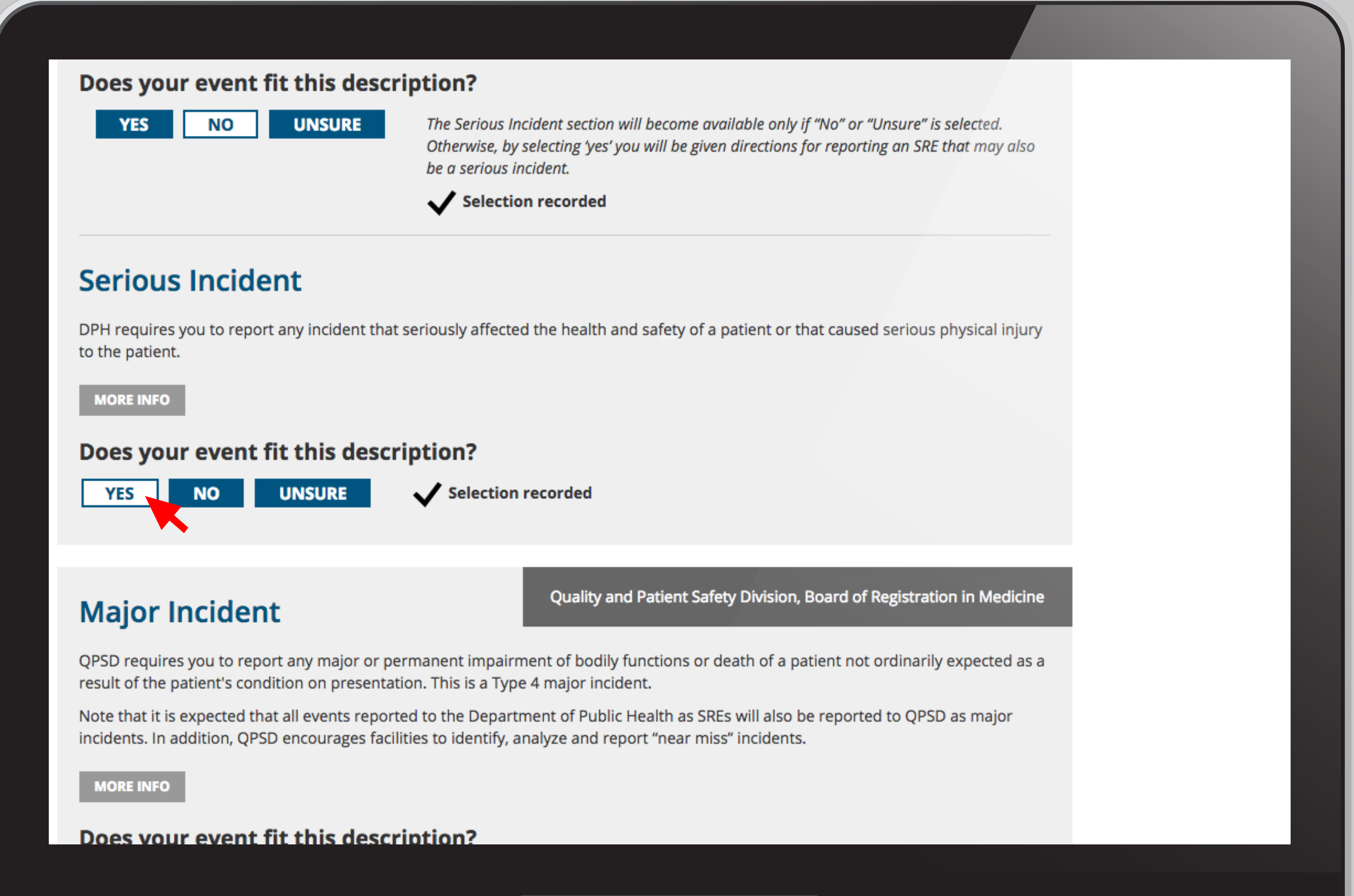


Answer each question, clicking the response that applies to your situation.



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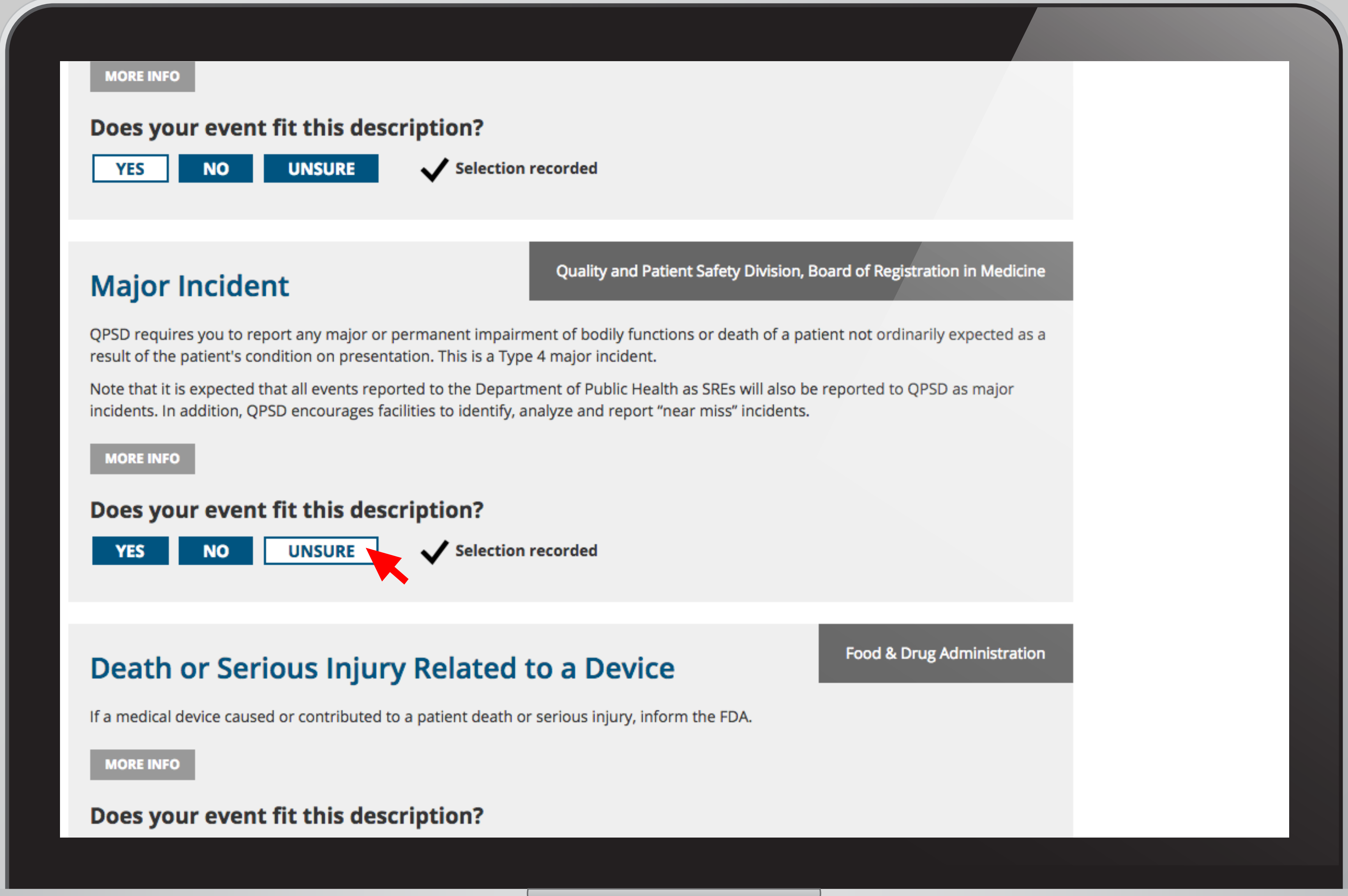

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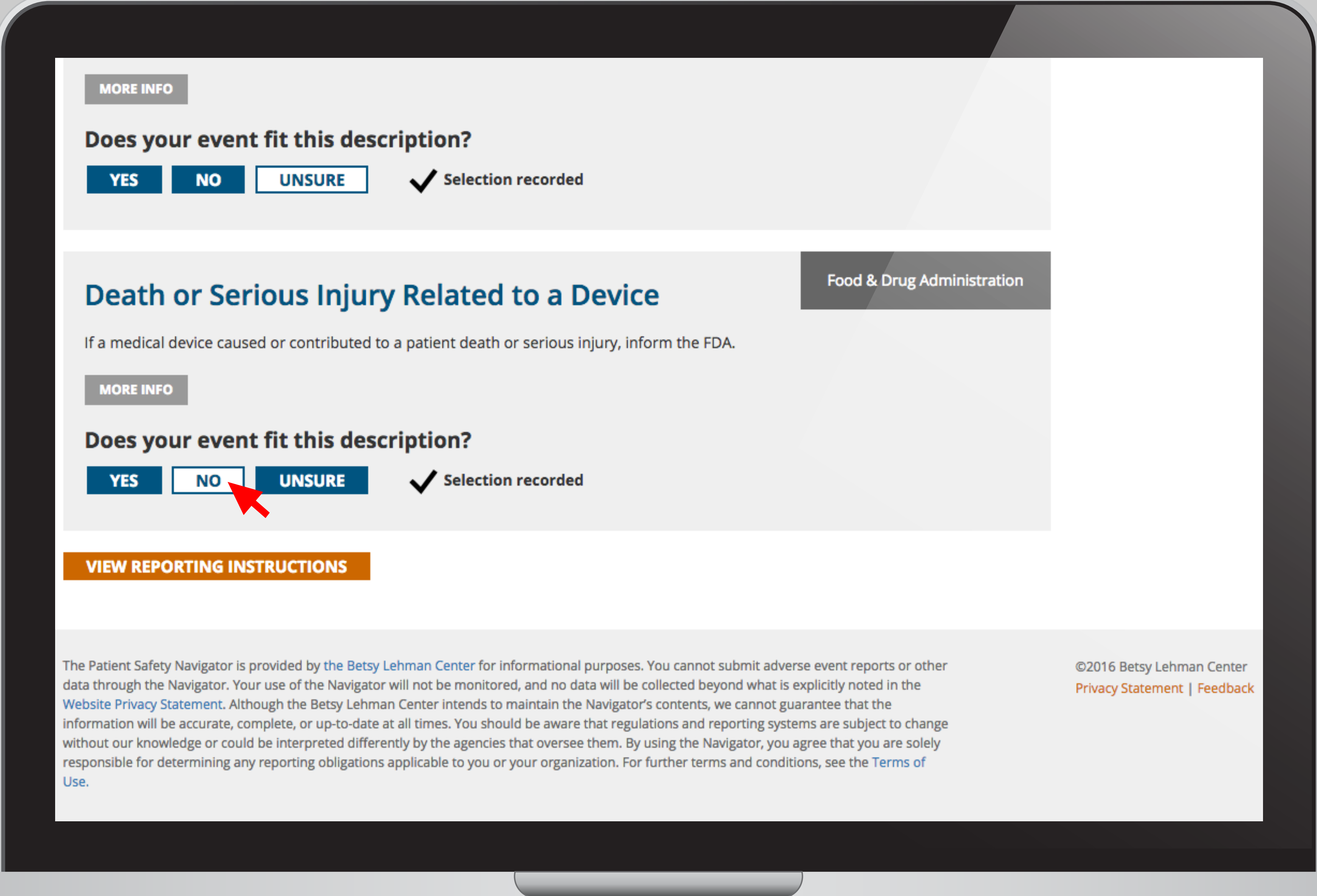

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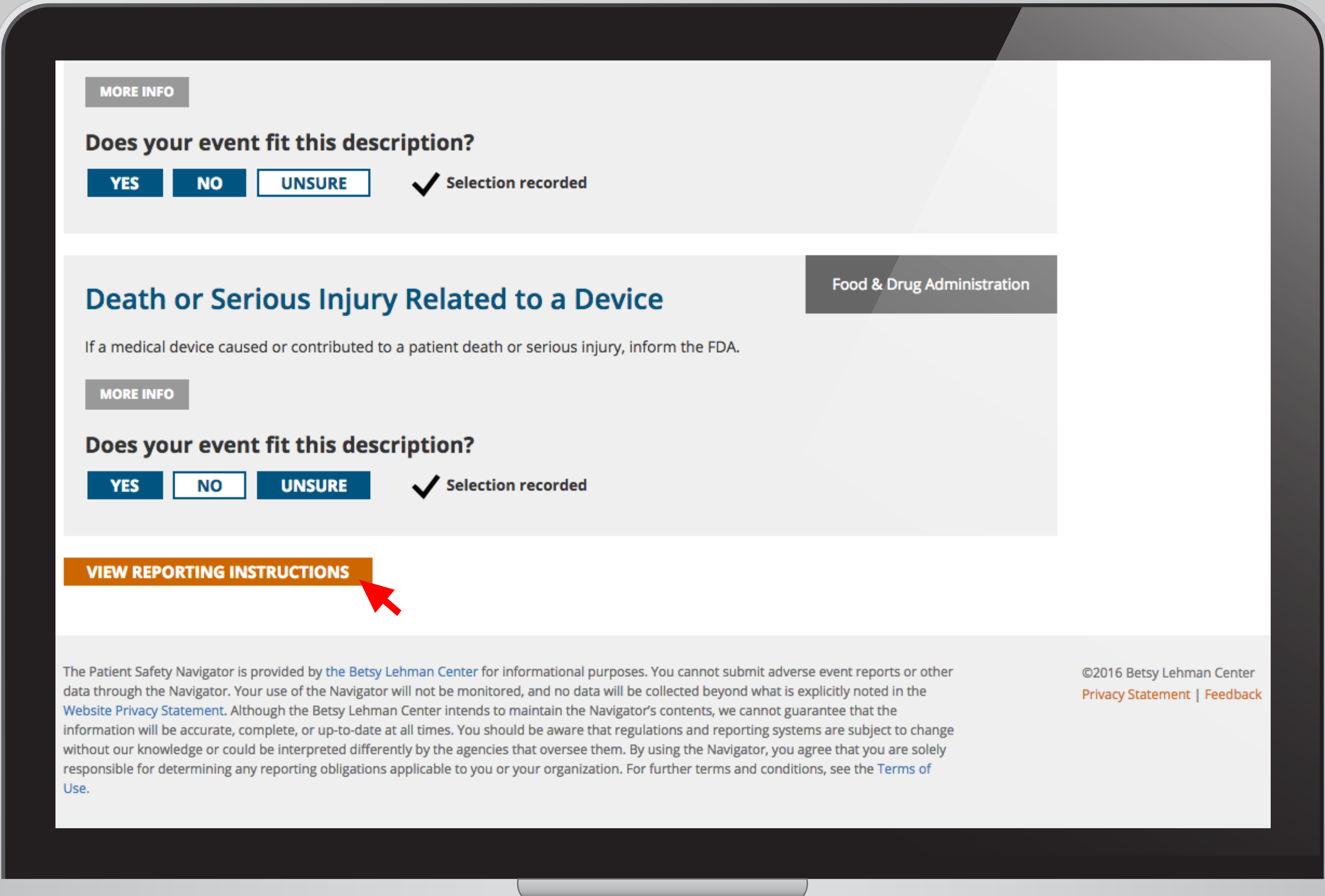
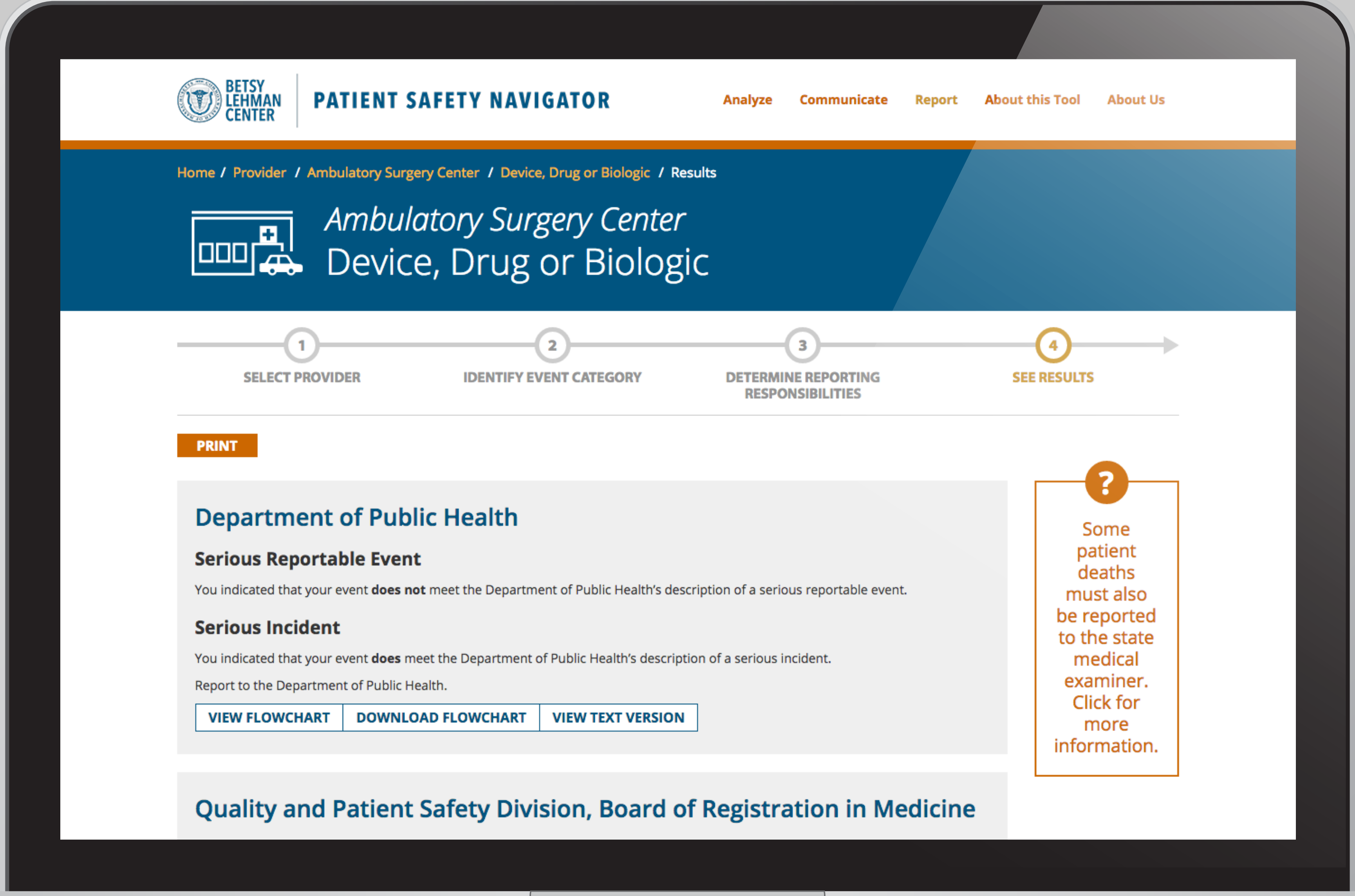


Then click to see a results page with reporting instructions for that event.



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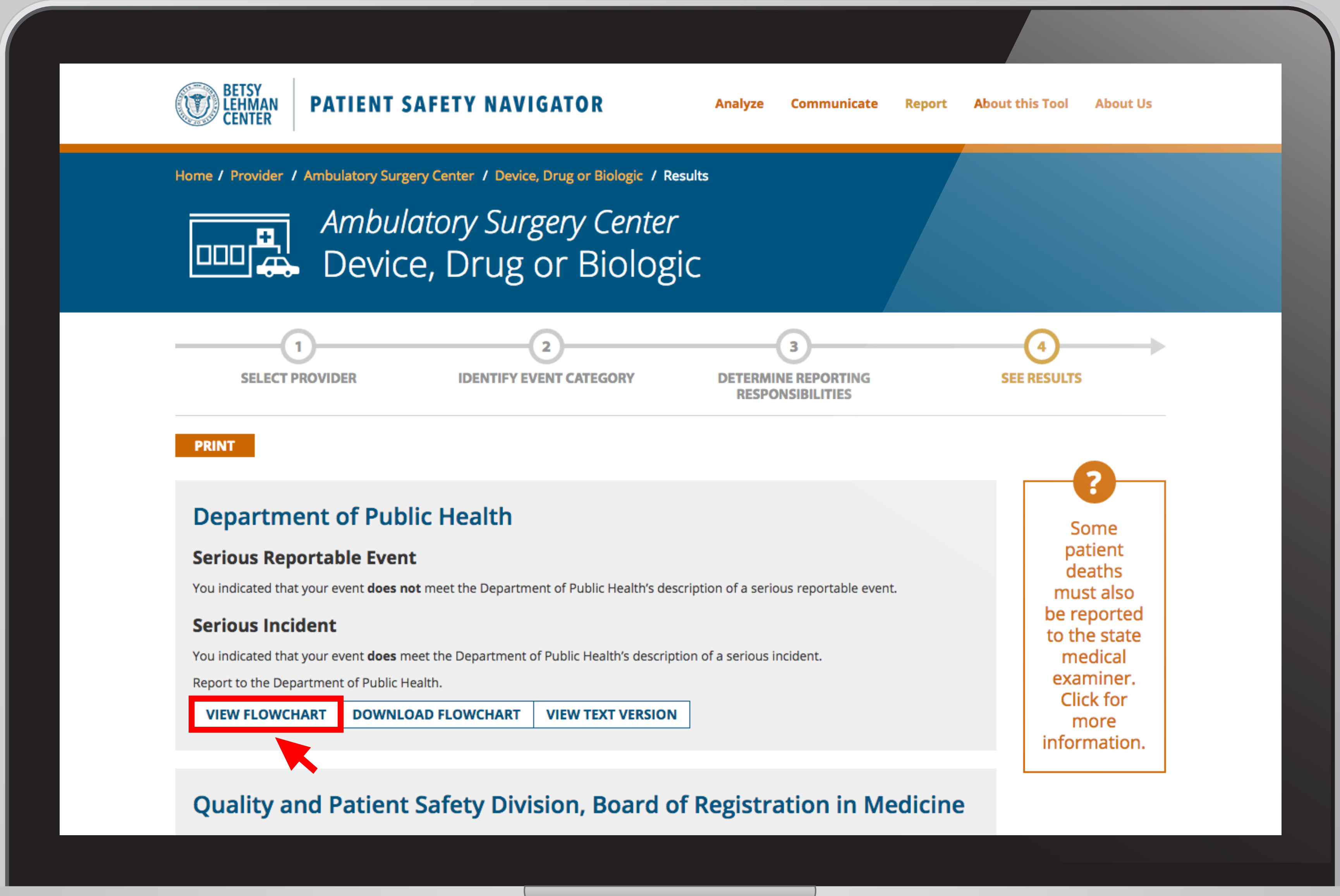

View or download the instructions as a flowchart…

How to report SREs to the Department of Public Health

Follow the steps below to report an SRE that occurred at ***your*** facility. If it occurred at ***another*** hospital or ambulatory surgery center, you must report the event by fax instead of electronically (use this form) within 7 days; you do not need to provide a 30-day follow-up report.

IMMEDIATELY

Call DPH at the number below if the SRE involved any of the following,* and complete steps 2 and 3:

- Unanticipated death,
- Suicide, or
- A serious criminal act

If not, go directly to step 2.

* Partial list of immediately reportable events that could overlap with SREs.

WITHIN 7 DAYS OF DISCOVERING THE EVENT

TIPS

Not familiar with DPH's online reporting system? You can get enrollment help, training materials, and more from DPH.

Remember that there are also specific requirements to notify patients and third-party payers about the event.

When filing the 30-day report, include any updates to the incident narrative. Also provide an analysis of the event's root cause(s) and preventability -- Was it: preventable? within the facility's control? unambiguously attributable to a

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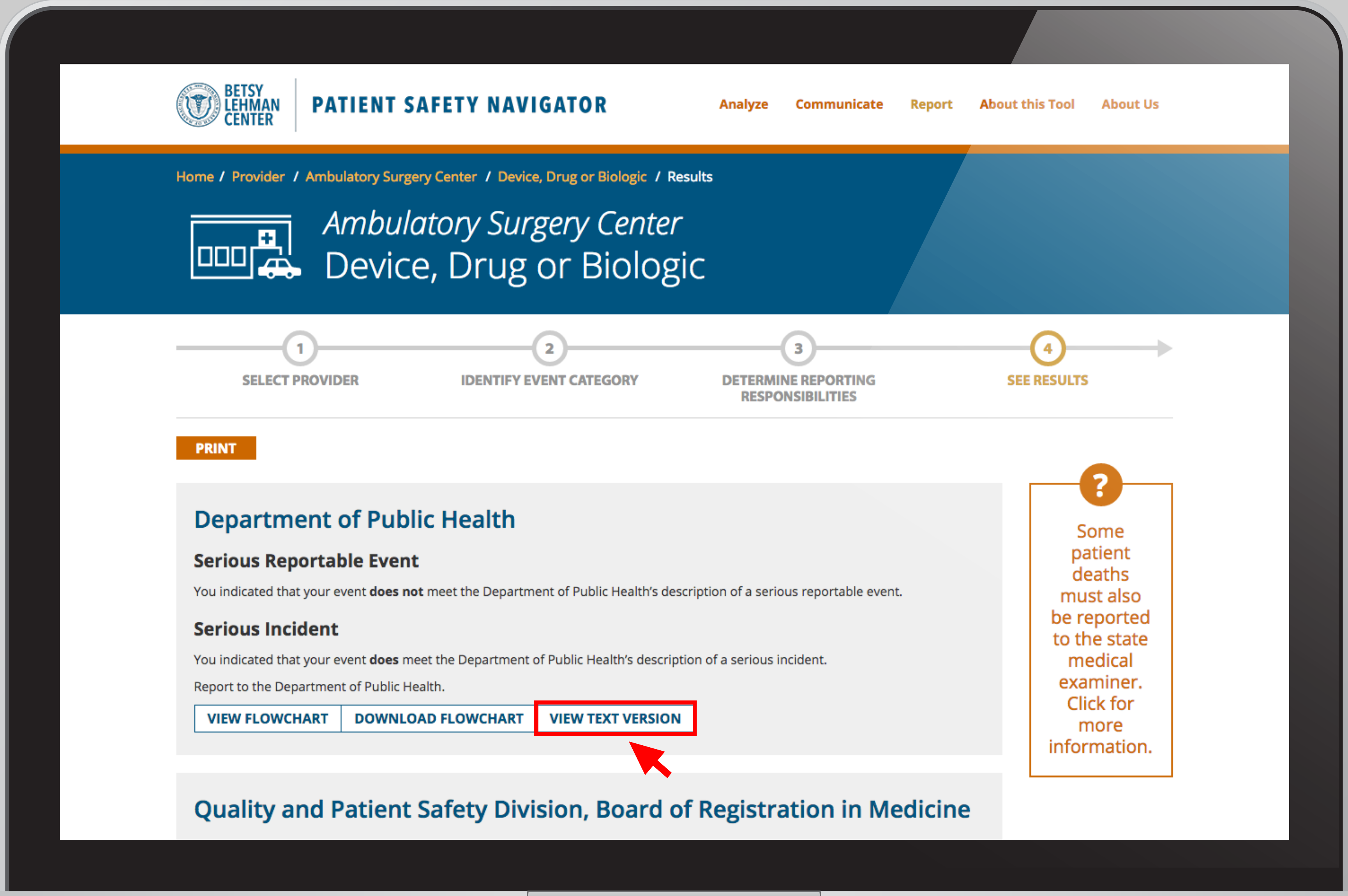

…or in text form.

BETSY LEHMAN CENTER | PATIENT SAFETY NAVIGATOR

Analyze Communicate Report About this Tool About Us

Home / Provider / Ambulatory Surgery Center / DPH: SREs [Text-based]

How to report SREs to the Department of Public Health

PRINT

Note: If the SRE occurred at another hospital or ambulatory surgery center, use this form to report by fax within 7 days, instead of electronically. You would not need to provide a 30-day follow-up report.

1. Immediately

If the SRE involved any of the following*, call DPH and complete steps 2 and 3:

- Unanticipated death,
- Suicide, or
- A serious criminal act

(See contact information below).

If not, skip this step and go to step 2

2. Within 7 days [of discovering the event]

Submit an initial report using the Virtual Gateway - Healthcare Facility Reporting System (HCFRS)

3. Within 30 days [of making the initial electronic report]

Submit a follow-up report through HCFRS that reflects the findings of your investigation of the event.

*This is a partial list of immediately reportable events. For the full list, see 105 CMR § 130.331(A) or § 140.307.

Tips:

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Tips:

Not familiar with DPH's online reporting system? You can get enrollment help, training materials, and more from DPH.

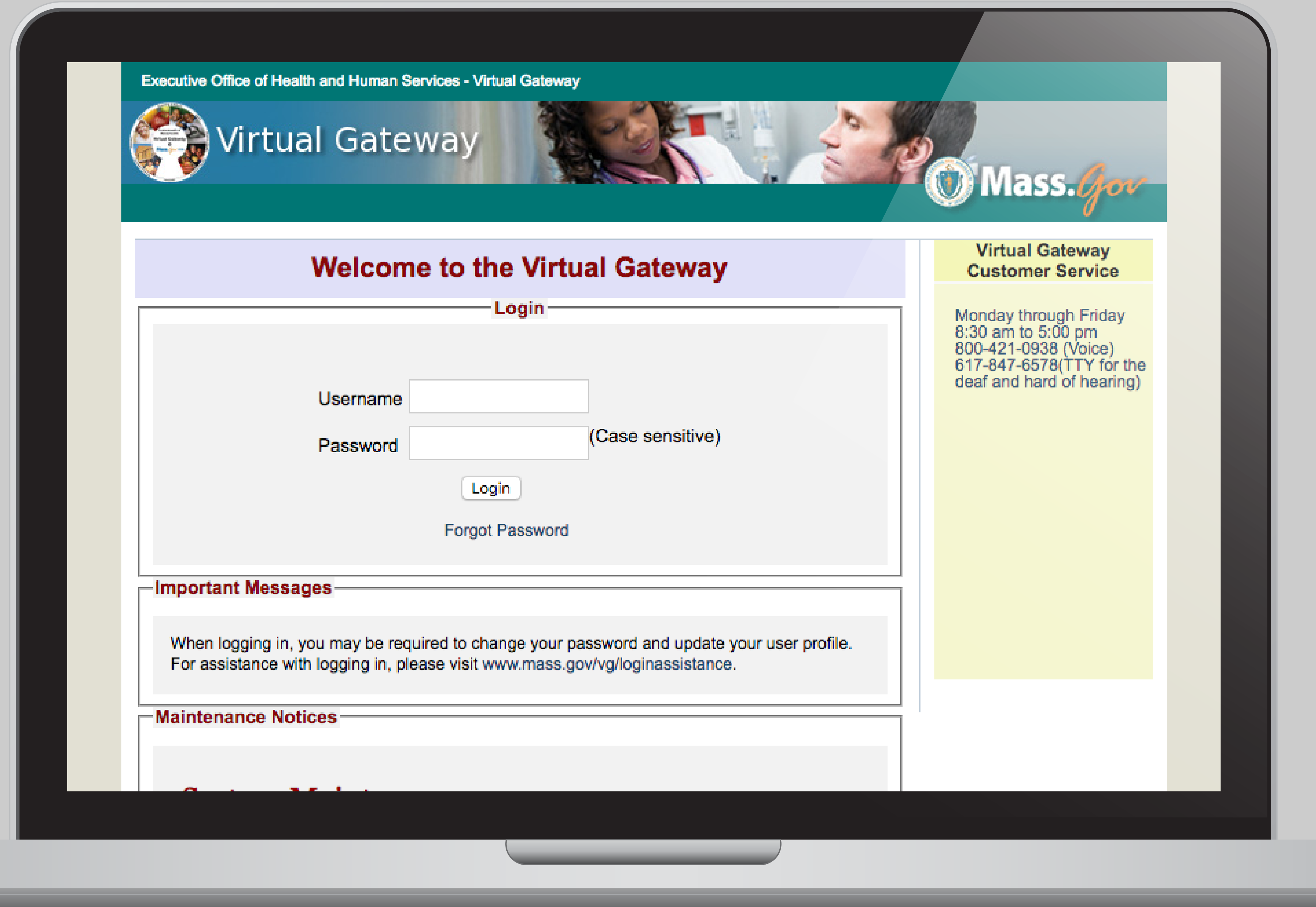
Remember that there are also specific requirements to notify patients and third-party payers about the event.

When filling your 30-day report be sure to include in your preventability determination narrative: identification and analysis of root causes; any updates to the incident narrative; and description of any corrective measures taken.

Resources:

Related DPH forms and instructions

The tool provides links to the correct forms and websites of government agencies that collect patient safety event information.



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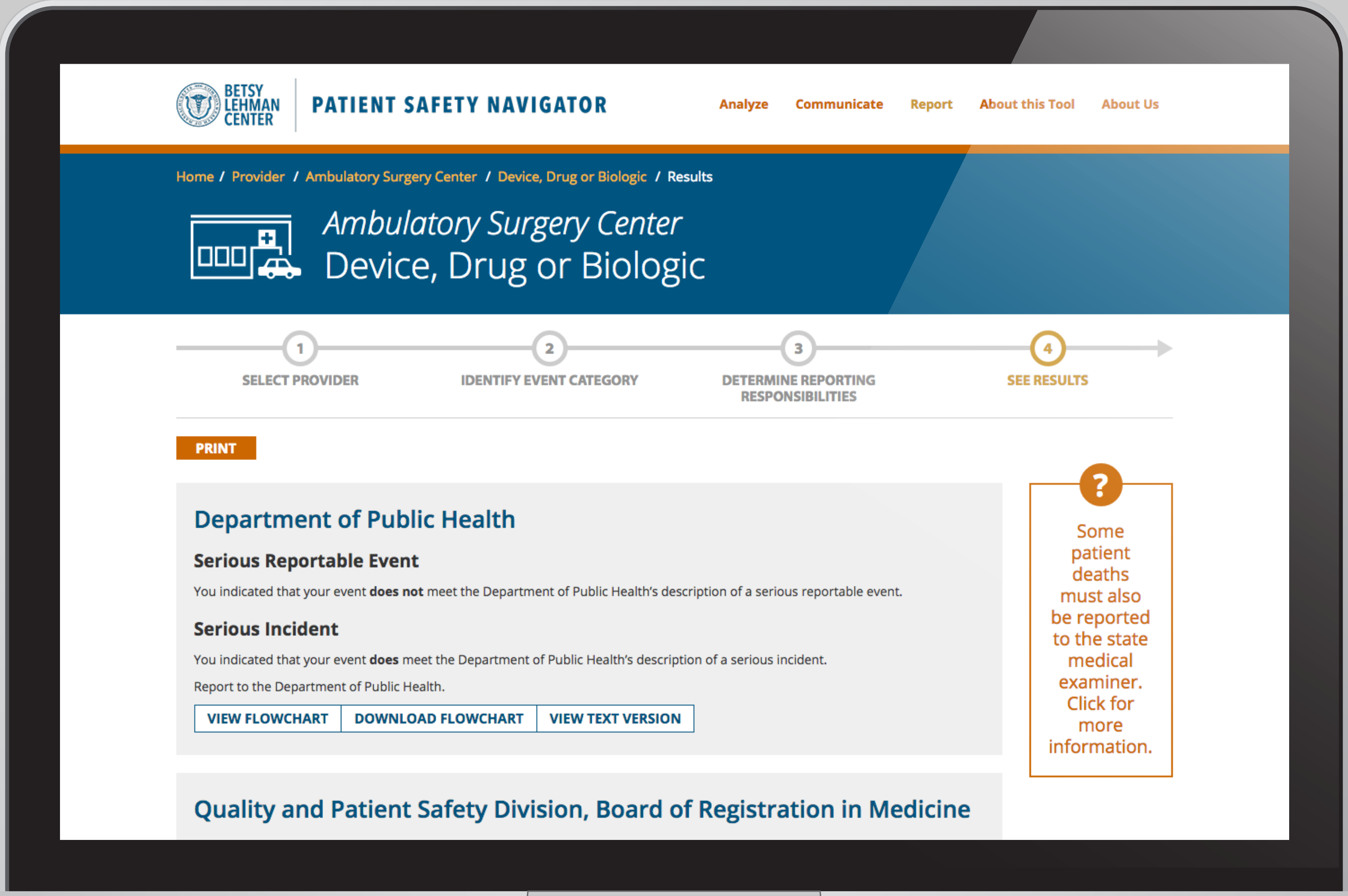

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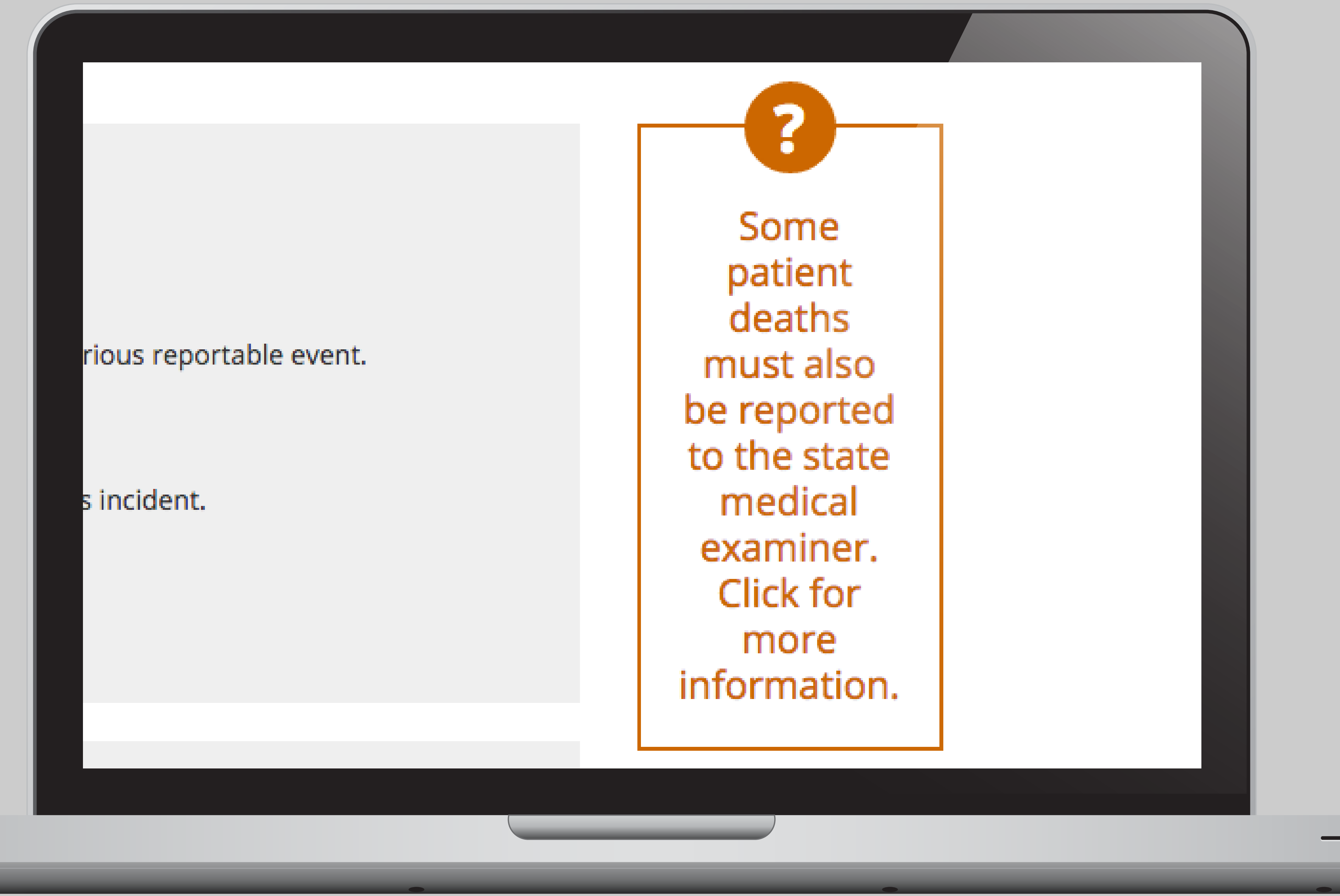

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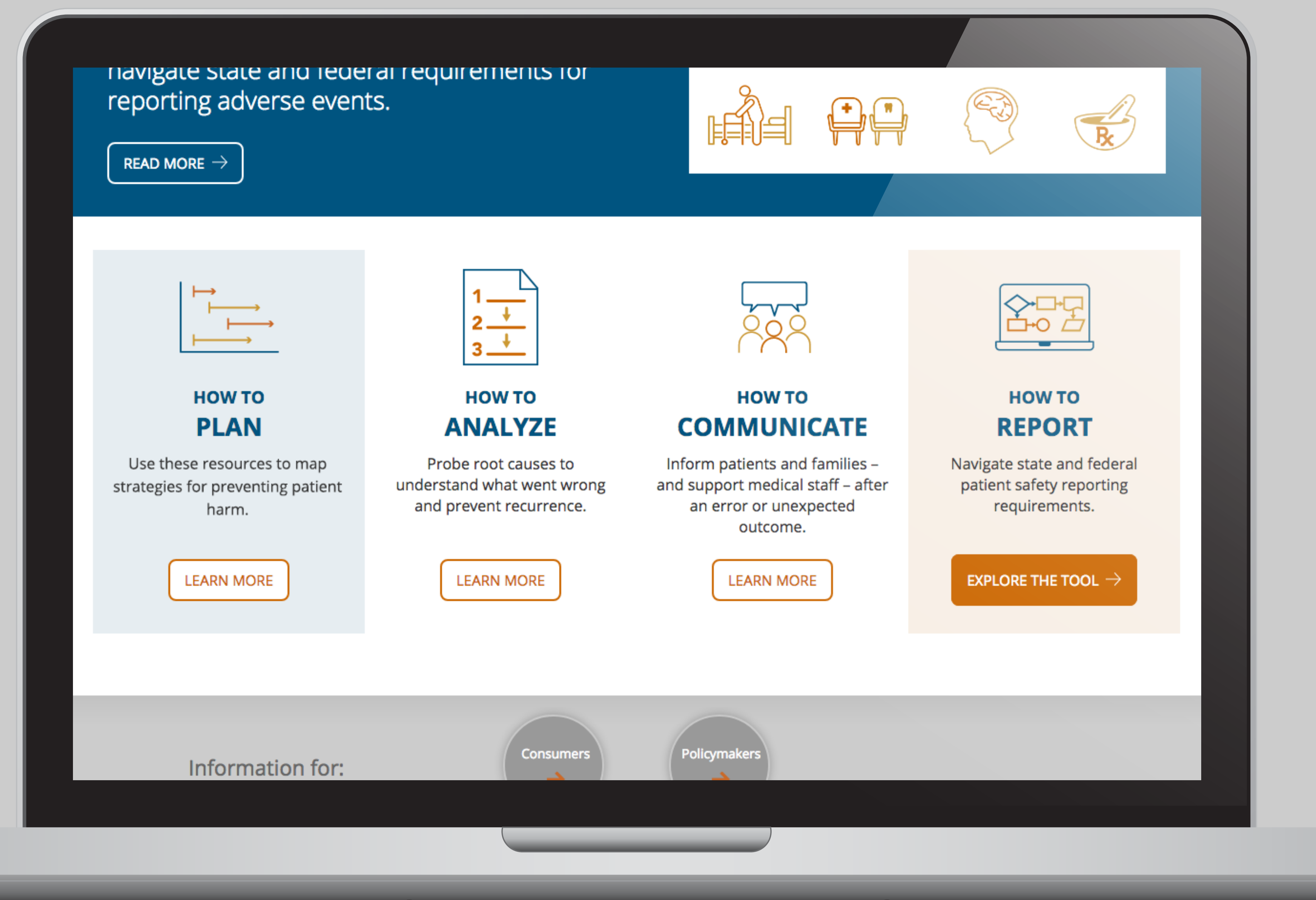

The Patient Safety Navigator shows you how to report and, more importantly, helps you learn from harmful events so you can improve the quality of care for your patients.

To learn more, visit navigator.BetsyLehmanCenterMA.gov.

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