Assurance of Safety through Monitoring and Prevention of Serious Safety Events

Methodist Hospital of Sacramento identifies, monitors and acts on to prevent serious safety events through various quality and safety interventions.

Table below shows how Methodist hospital is doing on the various serious safety events identified by the National Quality Forum.

Category	Event Name	2022	2023
Surgical or Invasive Procedure Events	Surgery or other invasive procedure performed on the wrong site	0	0
	Surgery or other invasive procedure performed on the wrong patient	0	0
	Wrong surgical or other invasive procedure performed on a patient	0	0
	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	1	0
	Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient	0	0
Product or Device Events	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	0	0
	Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended	0	0
	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	0	0
Patient Protection Events	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	0	0
	Patient death or serious injury associated with patient elopement (disappearance)	0	0
	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	0	0
Care Management Events	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	0	0
	Patient death or serious injury associated with unsafe administration of blood products	0	0
	Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	0	0
	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	0	0
	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	0	0
	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	1	2
	Artificial insemination with the wrong donor sperm or wrong egg	0	0
	Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen	0	0
	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	0	0

Reference: https://www.qualityforum.org

Environmental Events	Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	0	0
	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	0	0
	Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	0	0
	Patient death or serious injury associated with the use of physical restraints or bed rails while being cared for in a healthcare setting	0	0
Radiologic Events	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area	0	0
Potential Criminal Events	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	0
	Abduction of a patient/resident of any age	0	0
	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	0	0
	Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting	0	0

Summary of Data in the Table:

For Calendar Year 2023, Methodist Hospital sustained excellent results in the prevention of serious safety events as evident in the table above. There were no events that resulted in the death or serious disability of a patient.

Efforts Taken By Methodist Hospital to Improve Safety and Quality:

1. Identify these events through a robust surveillance program that includes self reporting, medical record reviews, and review of outcomes.
2. Review of each event by a multidisciplinary team to identify factors that led to occurrence of the event.
3. Evaluation of current prevention practices to identify any gaps in the system by conducting a comparison with evidence based practices.
4. Planning an implementation of action items to resolve all gaps in prevention practices that were identified.
5. Ongoing monitoring to ensure that the improvement activities are sustained.

Definitions:

Serious Safety Event: An event that is preventable, serious, adverse, indicative of a problem in a healthcare setting;s safety systems, and is important for public credibility or public accountability (1).

National Quality Forum (NQF): A not-for-profit organization that supports efforts to improve healthcare. The NQF publishes a list of harmful clinical events that are largely preventable. to help healthcare facilities assess, measure and report performance in providing safe care.