STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Bland Bryant Building ● Spring Grove Center
55 Wade Avenue ● Catonsville, Maryland 21228

Transmittal

TO: All Maryland Hospitals

From: Carol Benner

RE: Patient Safety Update

Date: February 24, 2005

COMAR 10.07.06 (Hospital Patient Safety Program) requires Maryland hospitals to carry out a number of activities, the purpose of which is to provide a safe environment for patients. As a result of these regulatory requirements, since March 15, 2004, the Office of Health Care Quality, Department of Health and Mental Hygiene (OHCQ) has been receiving root cause analyses (RCA) carried out by Maryland hospitals on level 1, as well as other adverse events as determined important by the hospital.

OHCQ has received a total of 115 adverse event reports from Maryland hospitals between 15 March, 2004 and 10 Feb, 2005.

OHCQ has been reviewing root cause analyses done on these events as they are submitted. An OHCQ nurse reviews each RCA to determine that the information required by regulation in section 10.07.06.06 has been provided. Where a hospital may not have fully complied with the provision of RCA information, the hospital is made aware of the perceived problem(s) and a dialogue between OHCQ and hospital staff will ensue.

With a significant number of cases now on hand, OHCQ staff, including two nurses, two physicians and an administrator, working as a quality improvement committee, have begun in-depth review of the individual RCAs, focusing on the clinical nature of the problem presented and the analysis and solution of the problem as carried out by the hospital through the RCA. As a result of this work, and preliminary analysis of the RCAs, two facts have become evident.

- The adverse events have begun to cluster into certain groupings, such as, among other:
    - Death or serious disability associated with anticoagulants (8 cases)
    - Death or serious disability associated with a fall (18 cases)
    - Death or serious disability associated with poor management of obese patients (3 cases).

- Many of the adverse outcomes could occur at almost any hospital in the state. Thus, educational feedback to the hospital community, by using relevant RCAs, would be beneficial in helping hospitals to focus on areas that might represent potential hazards to their patients. In each adverse outcome we see, we question if the adverse outcome could occur elsewhere. Often we suspect it could.

The Department is working with the reporting hospitals on a one-on-one basis through phone calls or visits when our review raises questions about the RCA itself or other issues arising from the adverse outcome. This is done in the spirit of the Patient Safety Program regulations; non-punitive, without assigning blame or attempting to sanction the hospital. So far, interactions have been professional and useful.

As we have done with long term care facilities, we will, from time to time, post on our web page, www.dhmh.state.md.us/ohcq, "Clinical Alerts" for hospitals. These will describe the adverse event briefly and then present the hospital's solution for preventing the problem from reoccurring. Reports will be done in such a way as to protect patients and hospitals. From time to time, we may ask the affected hospital if they would like to voluntarily post the event and discussion, with complete anonymity being assured. We encourage you to visit our website often to review this information.

All of this is to try to assist the good work done by Maryland hospitals in completing the RCAs and providing a higher level of safety to their patients.
Any suggestions that others may have as to how to use this invaluable data should be referred to OHCQ.

As always, thank you for your cooperation.

HO: 05-001