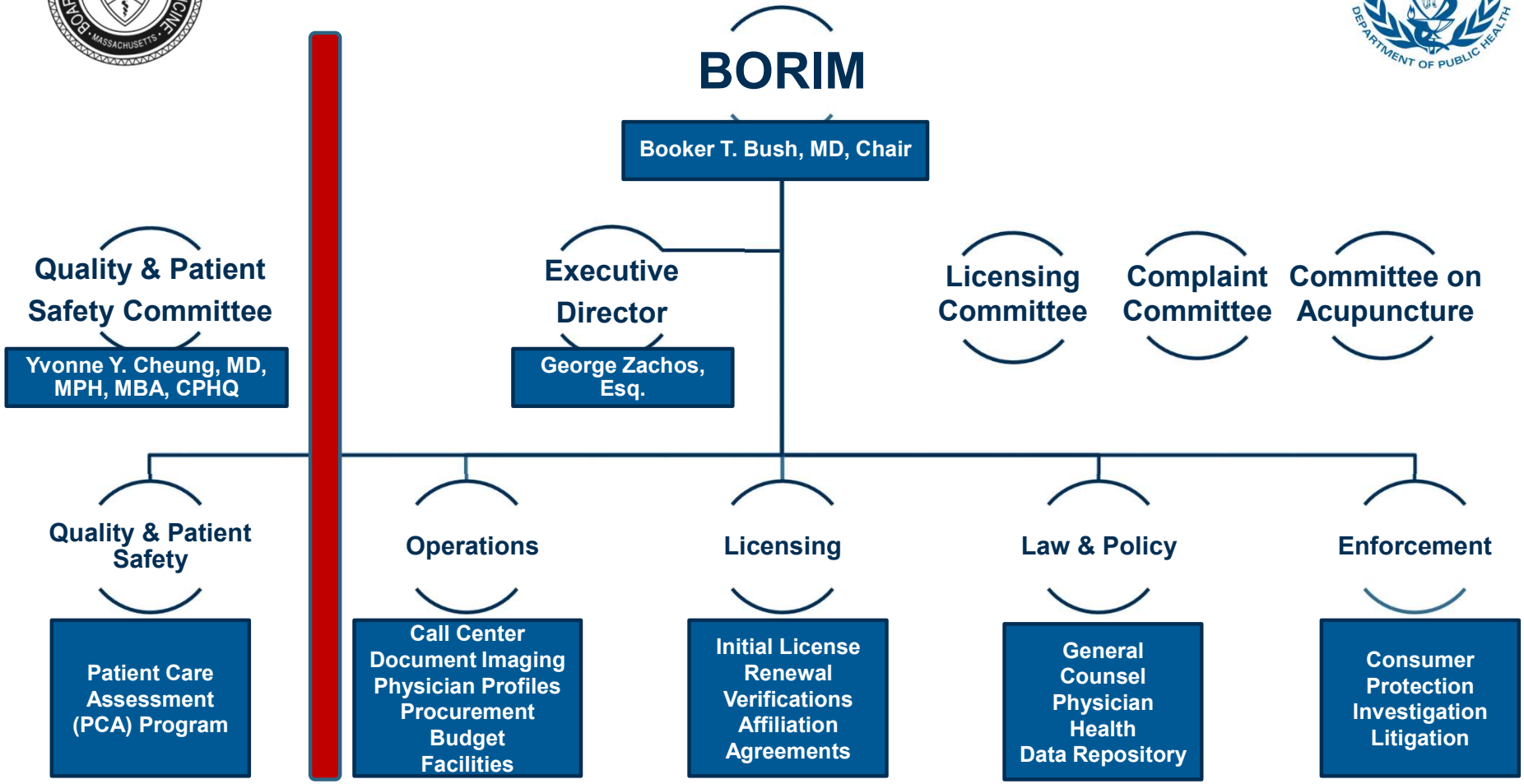
Massachusetts
Board of Registration in Medicine
Quality & Patient Safety Division

Massachusetts Society for Healthcare Risk Management

Trinh Ly-Lucas, MSN, AGNP-BC, Quality Analyst
Erin C. Long, MSN, RN, Quality Analyst
Daniela Brown, MSN, RN, CIC, Director

March 28, 2025

Committees & Divisions of BORIM



The Board of Registration in Medicine
Quality and Patient Safety Division (QPSD)

- As established by Massachusetts legislature (M.G.L. c. 111 § 203(d), § 204 & § 205), the QPSD oversees institutional Patient Care Assessment (PCA) programs.

- All hospitals, all ambulatory surgery centers, and certain ambulatory clinics must participate in a Patient Care Assessment (PCA) Program. PCA programs include:
  - ✓ quality assurance
  - ✓ risk management
  - ✓ peer review
  - ✓ credentialing

  - ✓ Safety & Quality Review (SQR) Reports are reports of unexpected patient outcomes, or
- Required reports are **afforded statutory confidentiality protections.** **(**M.G.L. c. 111, § 204(a) & 205(b))

Board of Registration in Medicine
Quality & Patient Safety Committee Members

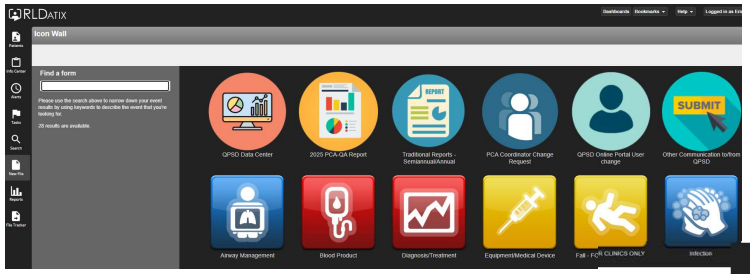
March 2025

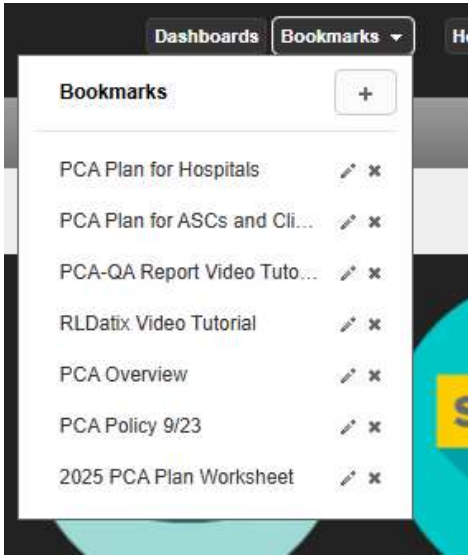
Member	Specialty
Yvonne Y. Cheung, MD, MPH, MBA, Chair	Anesthesiology
Booker T. Bush, MD	Internal Medicine
Michelle Chan, RPh	Board of Registration in Pharmacy
Sarah Rae Easter, MD	Obstetrics/Gynecology, Maternal Fetal Medicine, Critical Care Medicine
William G. Goodman, MD, MPH	Pulmonologist, Critical Care Medicine
Diane Hanley, MSN, RN-BC, EJD	Board of Registration in Nursing
Michael E. Henry, MD	Psychiatry
Karen M. Johnson, BSN, RN, CCMSCP	PCA Coordinator Representative
Pardon R. Kenney, MD, MMSc, FACS	General Surgery
Julian N. Robinson, MD	Obstetrics/Gynecology, Maternal Fetal Medicine
Marc S. Rubin, MD	General Surgery
Leslie G. Selbovitz, MD	Internal Medicine
Melissa Sundberg, MD, MPH	Pediatric Emergency Medicine
Meghna Trivedi, MD, FACP, FHM	Hospitalist Medicine
Pending	Emergency Medicine
Pending	Vascular Surgery
Open	Patient Advocate/Representative
Open	Radiology

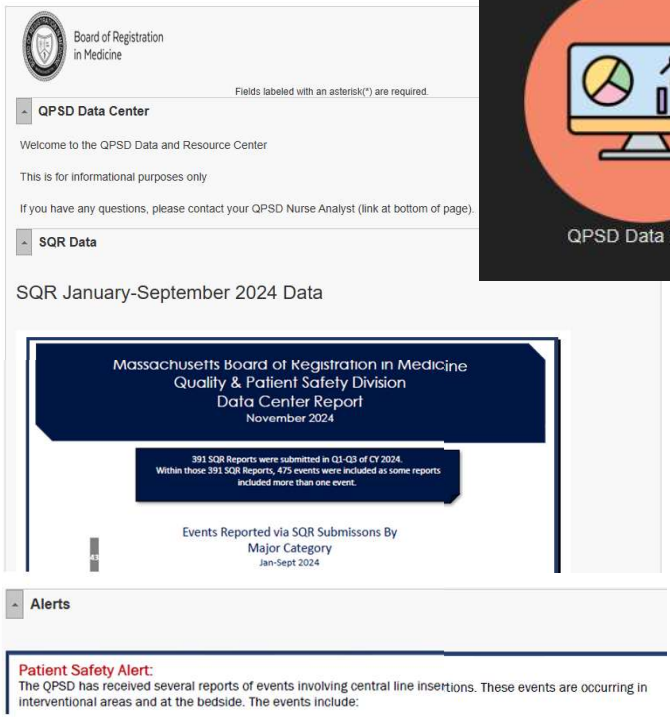
Launched QPSD Online Reporting Portal on September 1, 2023

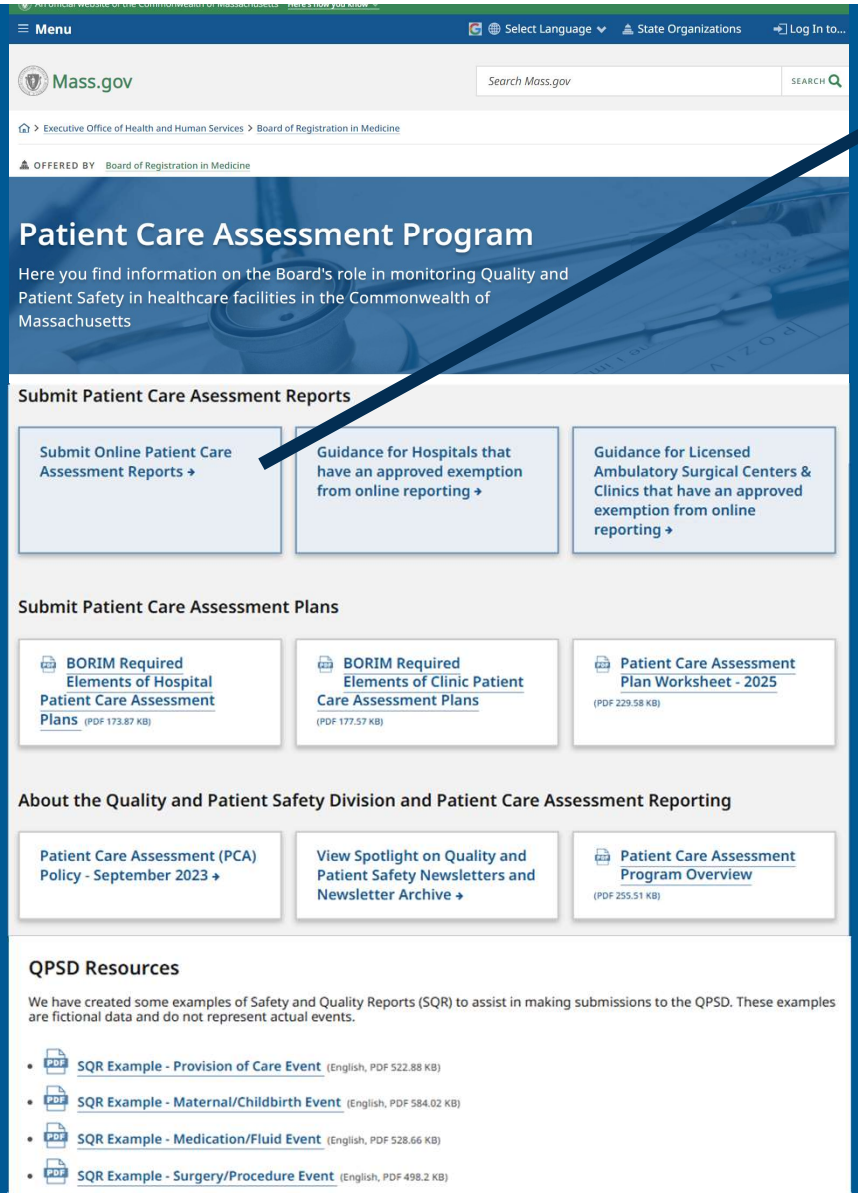
RLDatix

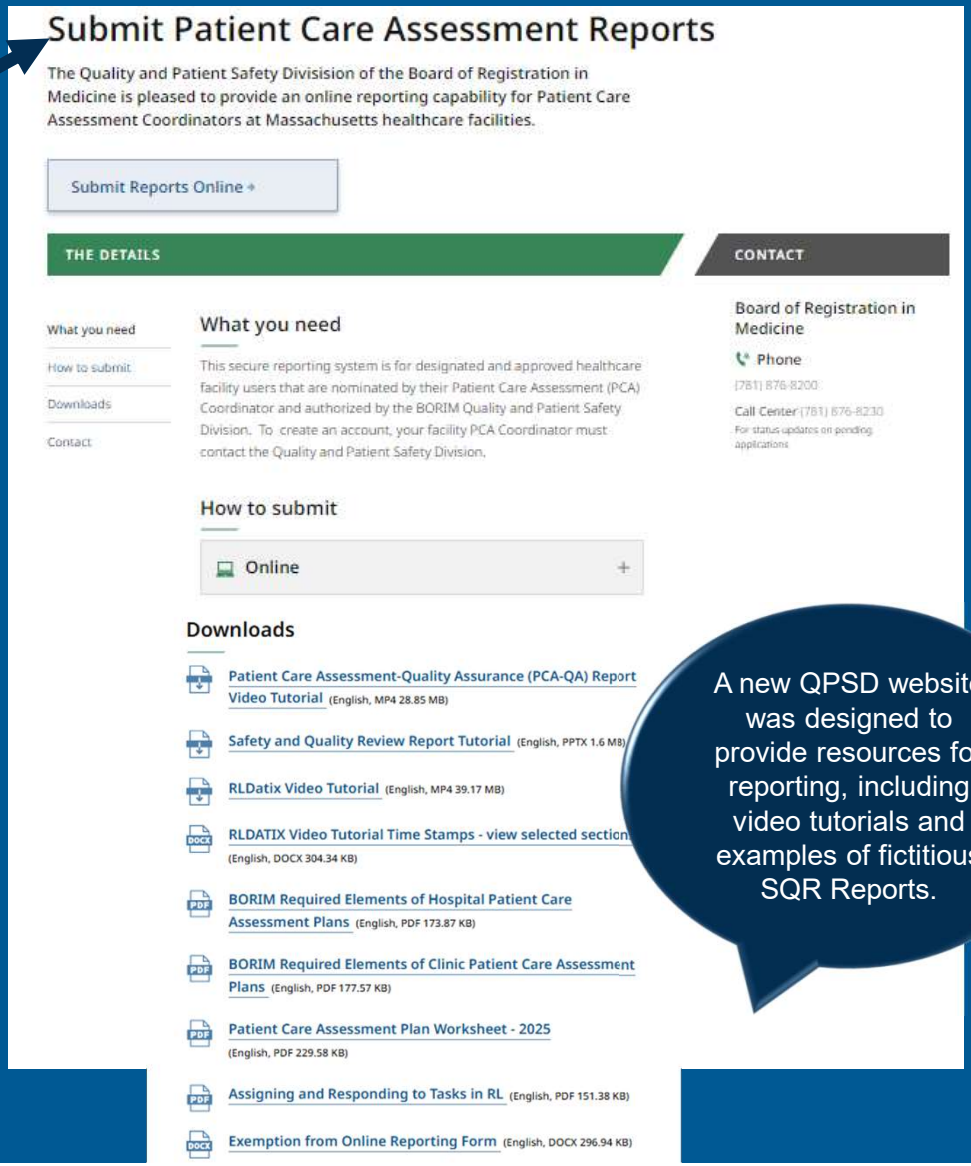
Launched 9/2023











A new QPSD website was designed to provide resources for reporting, including video tutorials and examples of fictitious SQR Reports.

Patient Care Assessment Programs 243 CMR 3.01-3.14

Require the submission of two types of reports:

Quality Assurance Reports (one of two options)

- PCA-QA Report (new)
- Annual and Semiannual Reports (traditional)

Safety & Quality Review (SQR) Reports

- Reports of unexpected patient outcomes with harm (adverse events)

These reports provide a window into your Patient Care Assessment Programs.

Safety and Quality Review (SQR) Reports
(unexpected patient outcomes)

01

TYPE 1

- Maternal deaths that are related to deliveryReview of any potential system-level concerns and opportunities for improvement.

02

TYPE 2

- Death in the course of, or resulting from, elective ambulatory procedures

03

TYPE 3

- Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part

04

TYPE 4

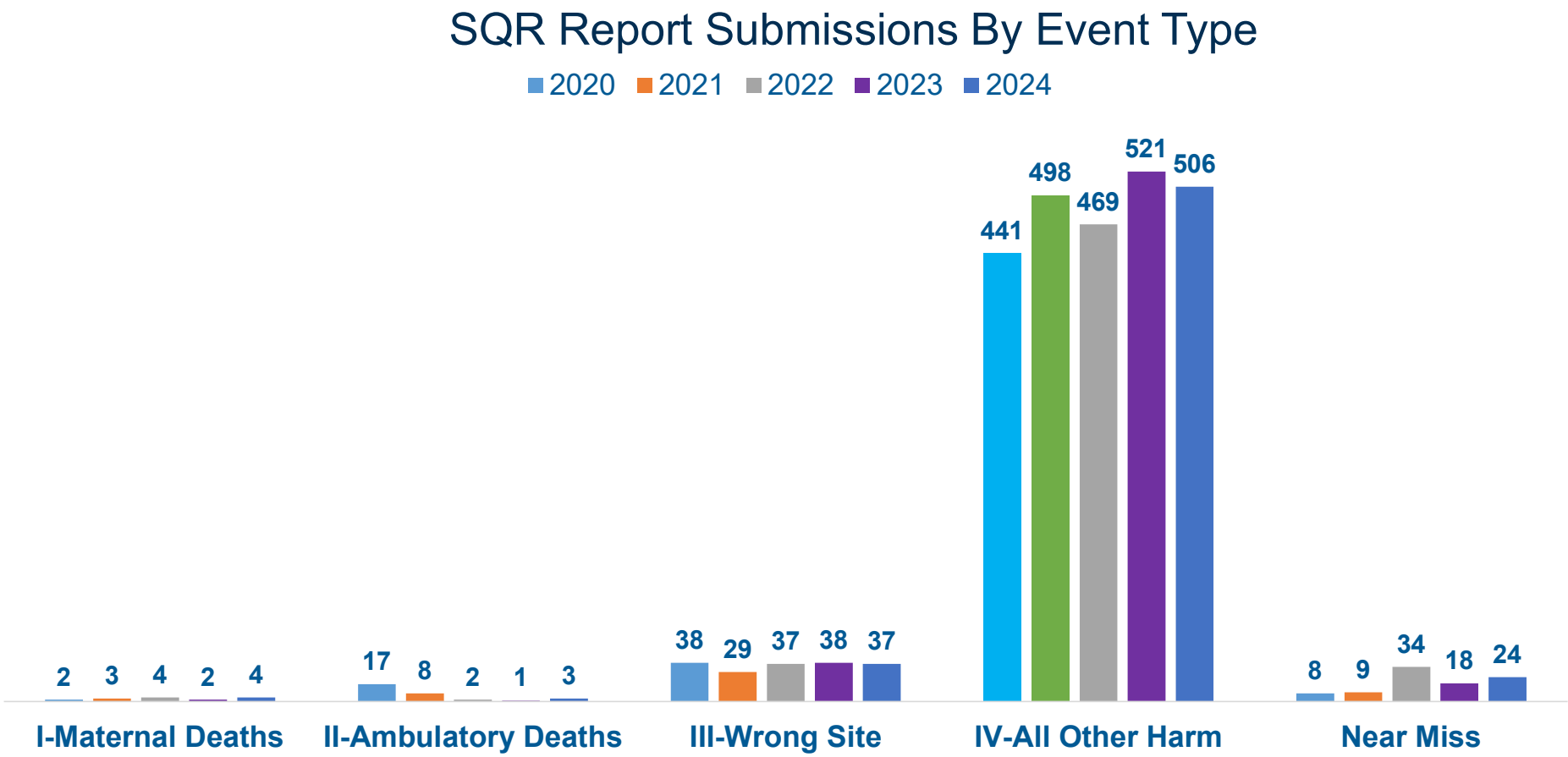
- All deaths or major or permanent impairments of bodily functions that are not ordinarily expected as a result of the patient's condition on presentation

Safety & Quality Review (SQR) Reporting

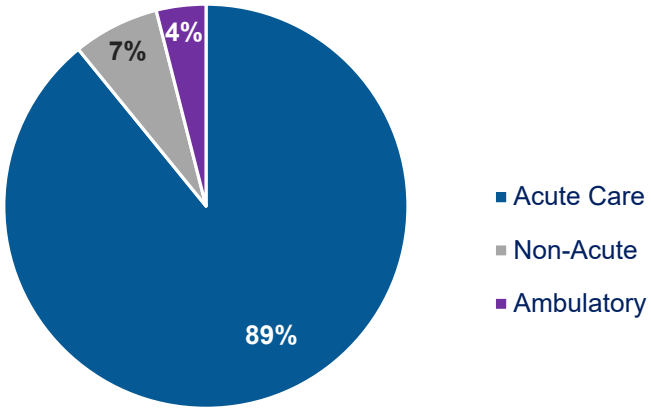
Safety & Quality Review (SQR) Reports are reports of unexpected patient outcomes, or adverse events. The submission of SQR Reports is a requirement of a healthcare facility's Patient Care Assessment (PCA) Program.

Safety & Quality Review (SQR) Report Data Summary

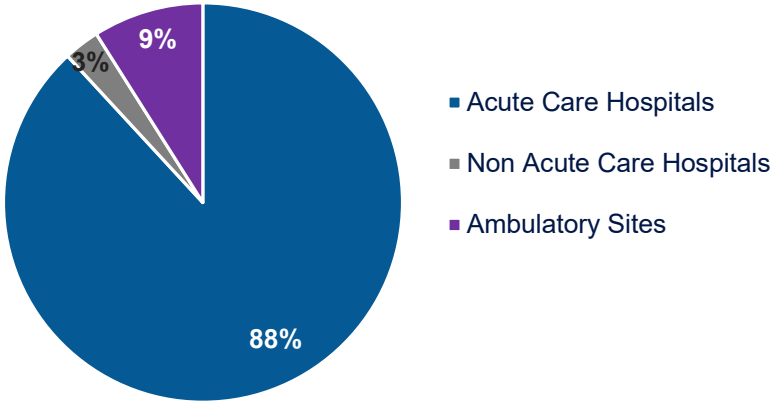
SQR Reports = Reports of Unexpected Patient Outcomes



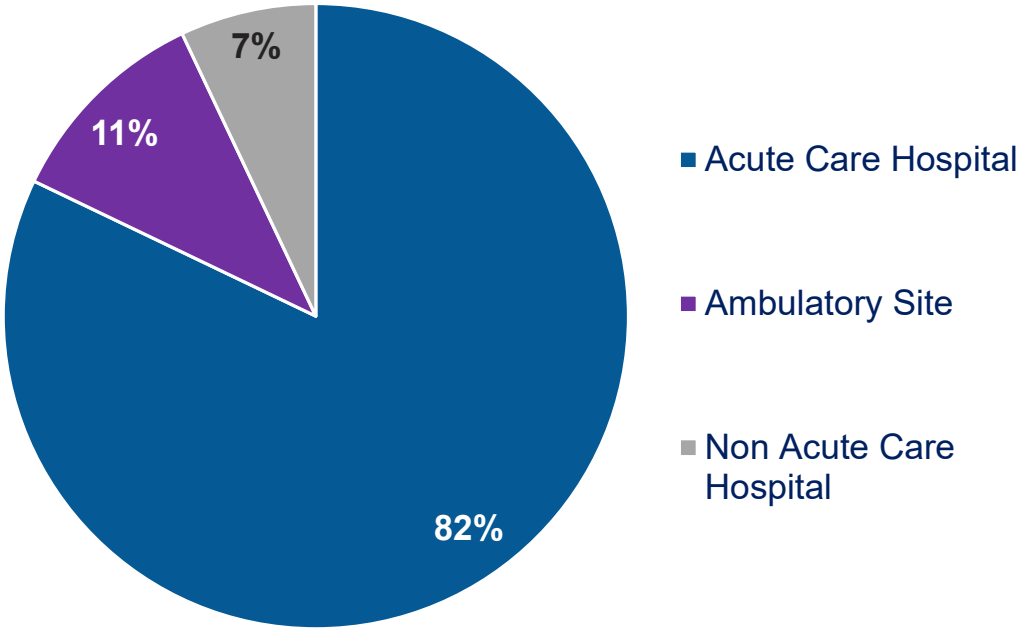
CY 2019 SQR Submissions By HCF Type
n=506



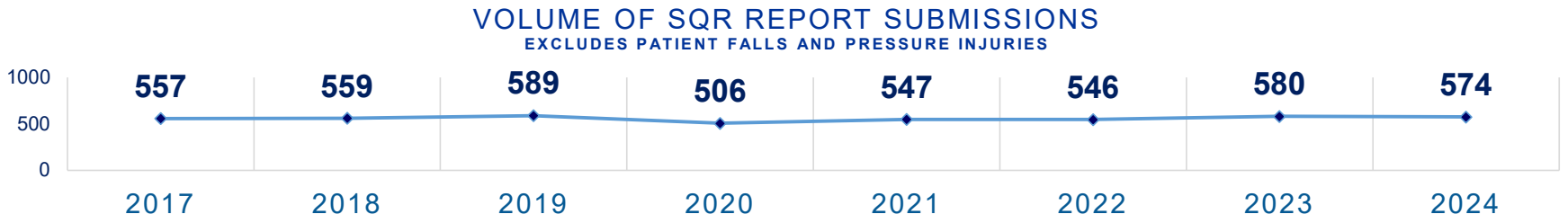
CY 2023 SQR Submissions By HCF Type
n=580

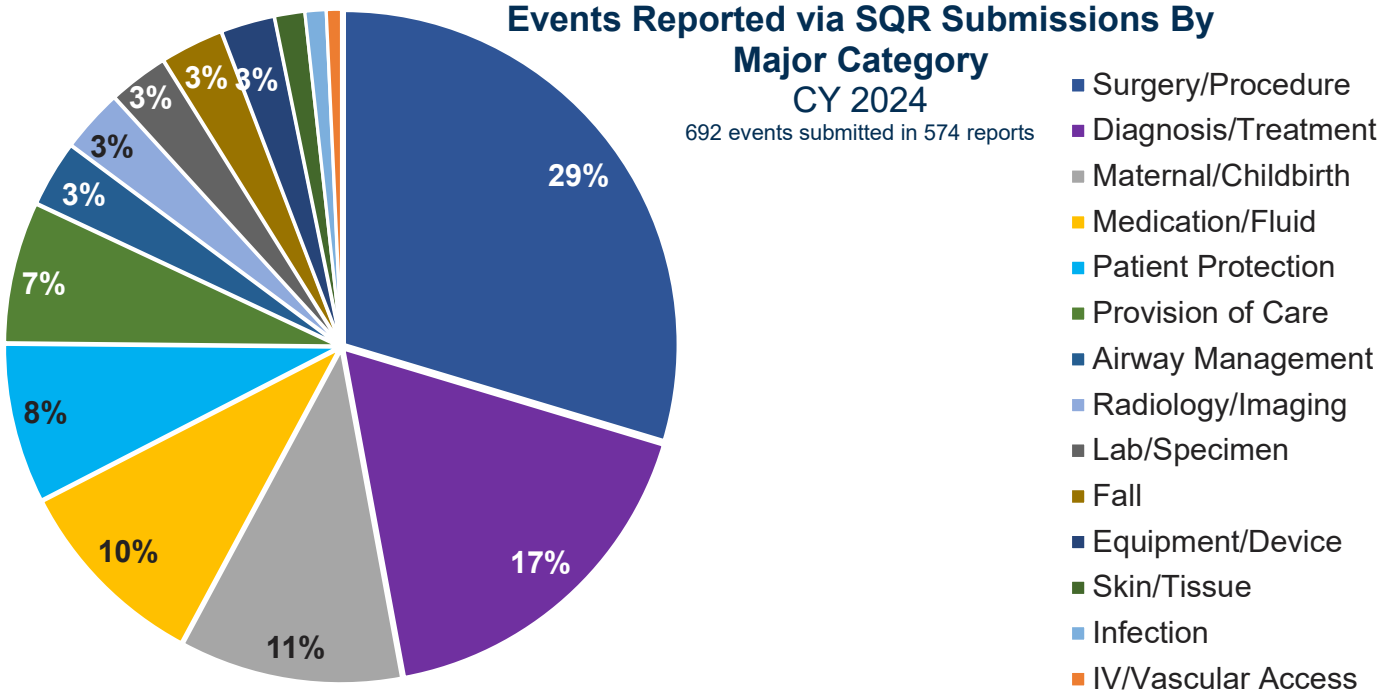


SQR Reports By HCF Type
CY 2024
n=574



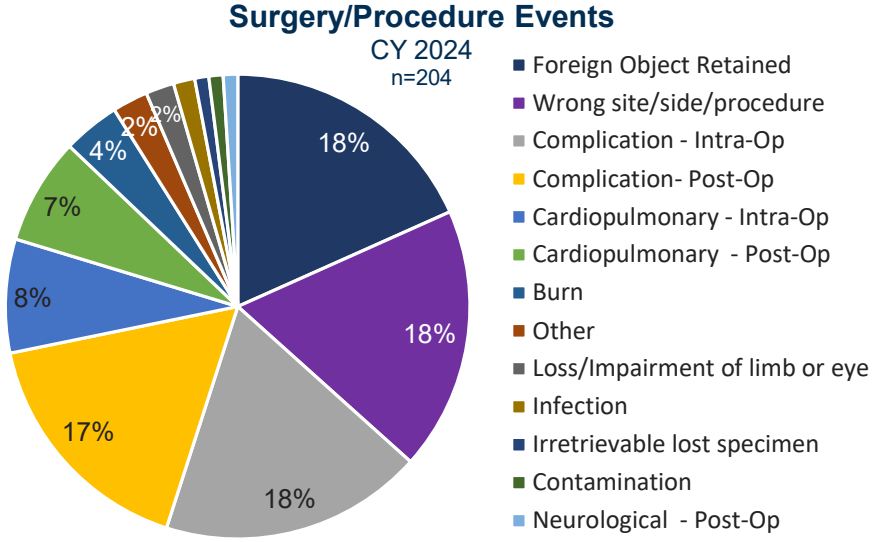
Safety & Quality Review (SQR) Report Data Summary

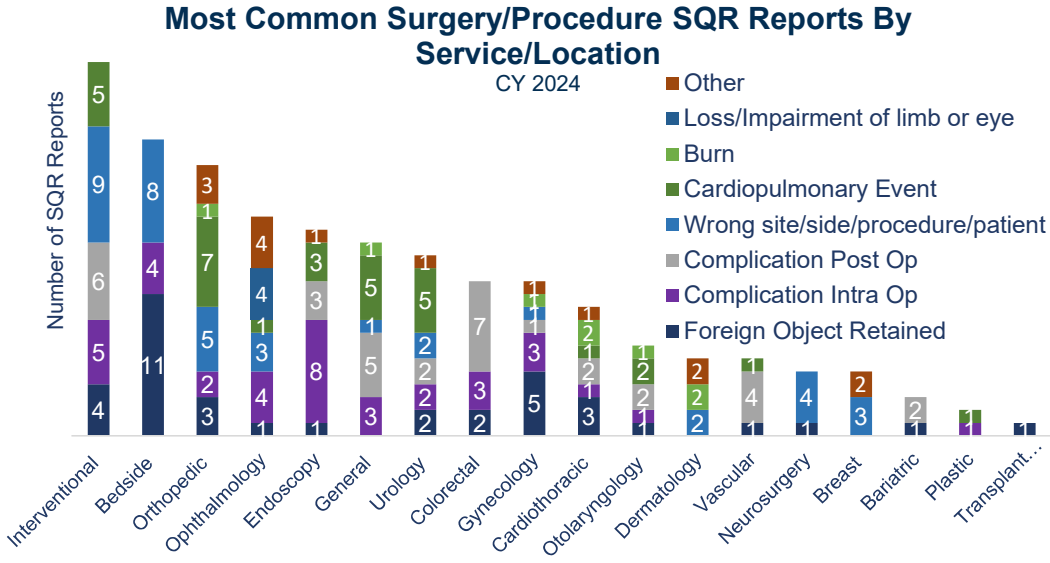


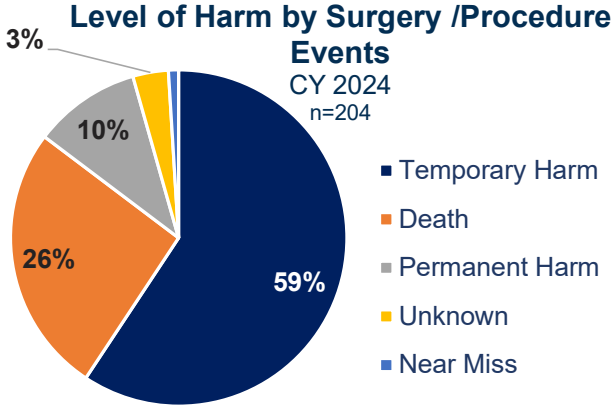


75% of all SQR Reports are in the top 5 categories of events

Surgery/Procedure Reported Events







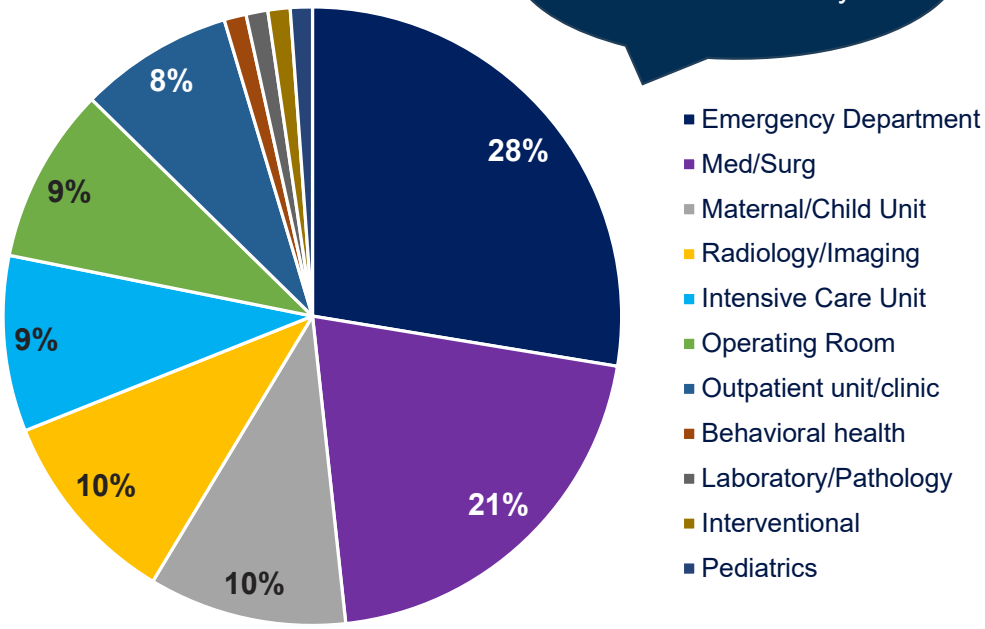
Noted

- Opportunity to improve supervision of trainees
- Central line insertion- wrong site and RFO (guidewires)
- Central line complications with guidewires (perforations)
- Spinal level and joint injections-wrong site
- Dobhoff feed tube wrong site (no Xray confirmation or incorrect reading)
- Complications-hemorrhage/perforation (interventional, endoscopic, and bedside)
- Complications involving anastomotic leaks with abscess
- Device malfunction (balloon rupture, cautery burns)
- Contamination/ use of kits not sterilized

Diagnosis/Treatment Events

Location of Reported Delays in Diagnosis/Treatment
CY 2024
n=87

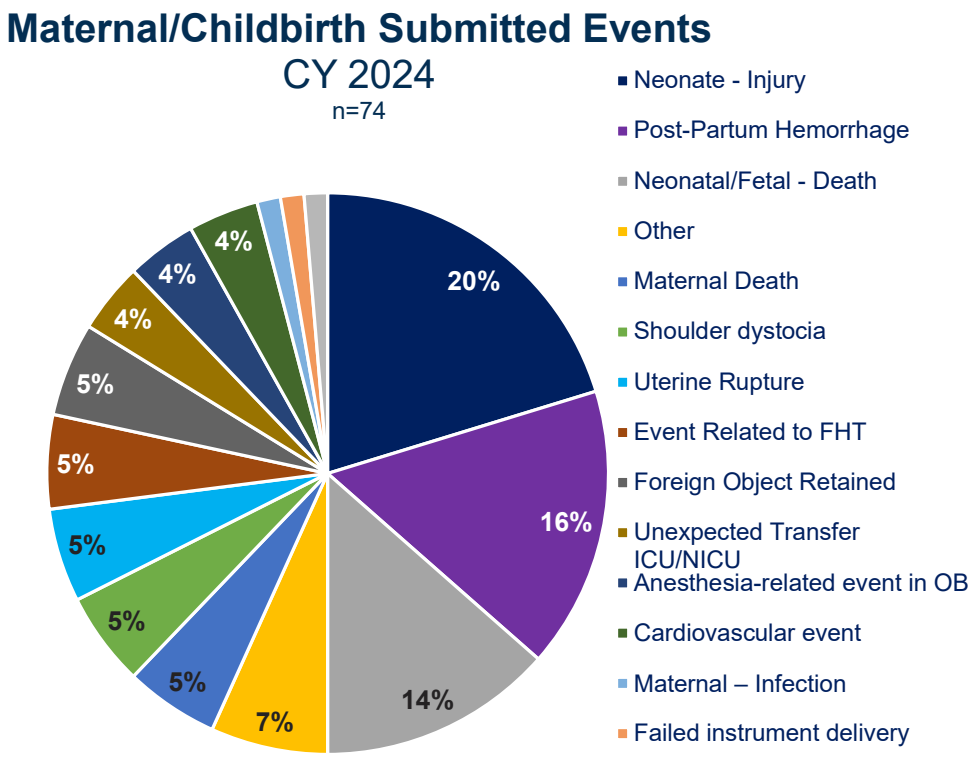
73% of all diagnosis/treatment events were delays



Noted

- Gaps in COMMUNICATION
  - Among specialist consulted
  - Imaging/Lab result not communicated
  - Coordination of Care
- ED Boarders
- EKG readings not appreciated (ED)
- Identification of compartment syndrome (ED)
- Left without being seen, returned with cardiac issues
- Transfers (internal and external)
- Calling RRT
- Incidental findings (breast, colon) not communication with delays in treatment
- Arrythmias not noted while on telemetry

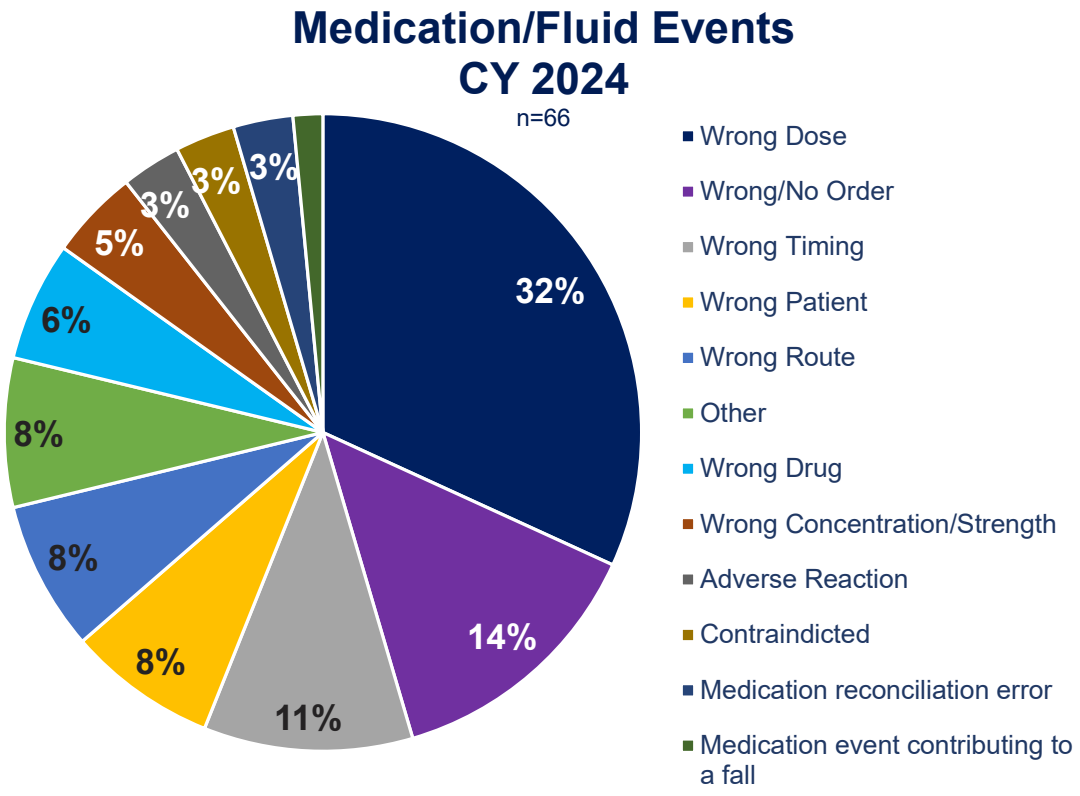
Maternal/Childbirth Events

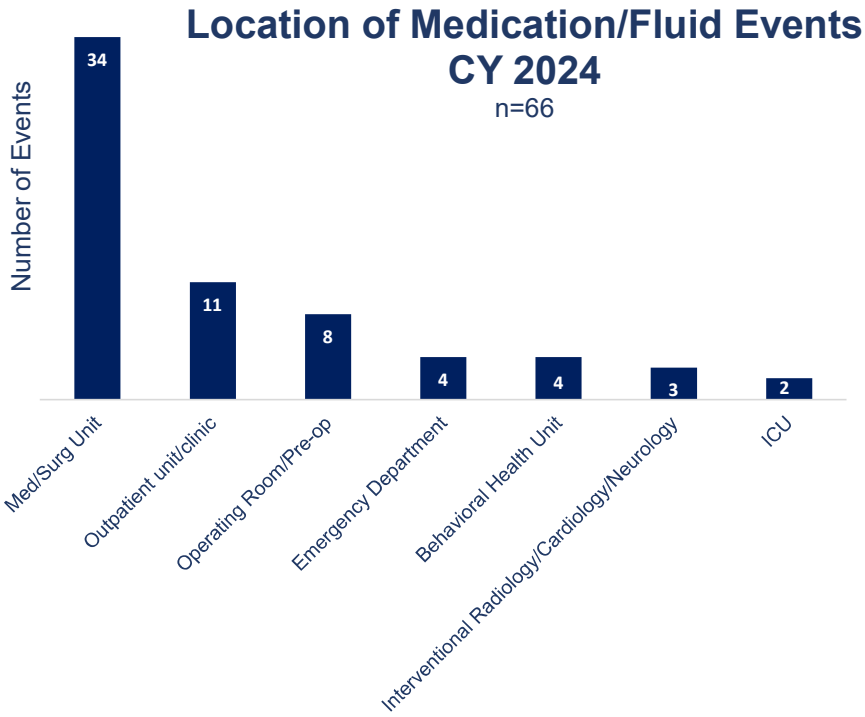


Noted

- Neonatal Injury
  - Neurological injury
  - Skull fracture
  - Hematoma
  - Laceration
  - Circumcision injury
  - Clavicle fracture/arm injury
- Post-Partum Hemorrhage
  - Abruption
  - Uterine rupture/TOLAC
  - Unplanned HYST reported
  - Use of EBL vs. QBL
  - Calling for MTP
- Neonatal/Fetal Death
  - Prolonged Category II with worsening features
  - Inadvertently tracing maternal heart rate
  - Delay in NST/induction (no room) returning with demise
  - Sepsis
  - Unexpected congenital diagnosis
- Other
  - Delay in treatment/transfer
  - Maternal Morbidity (neuro)
  - Unexpected change in condition
- Maternal - Death
  - Sepsis
  - Cardiovascular
  - Covid

Medication/Fluid Events

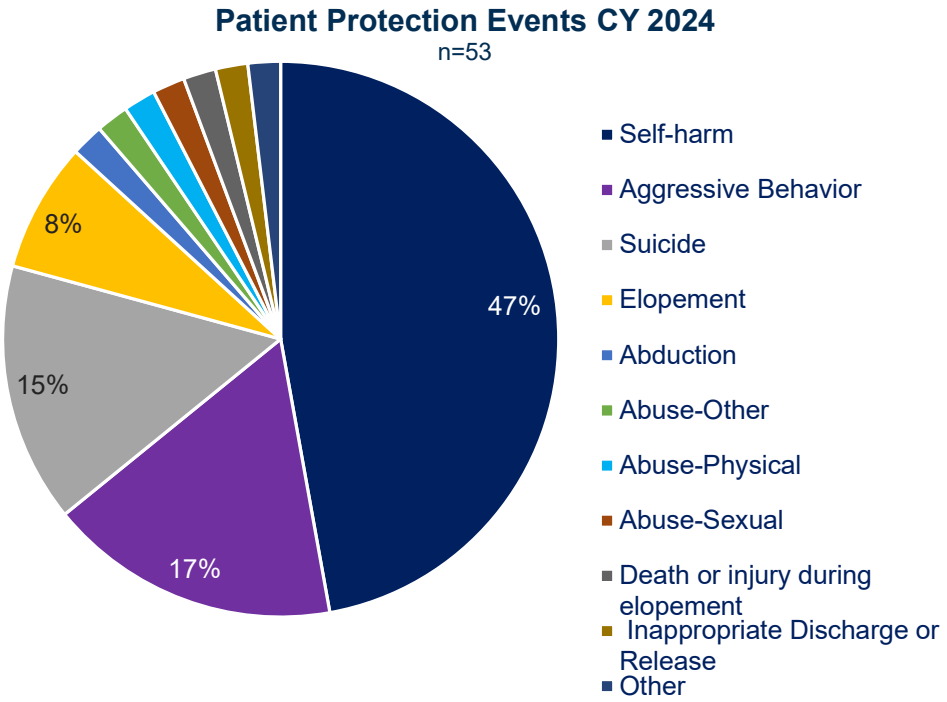


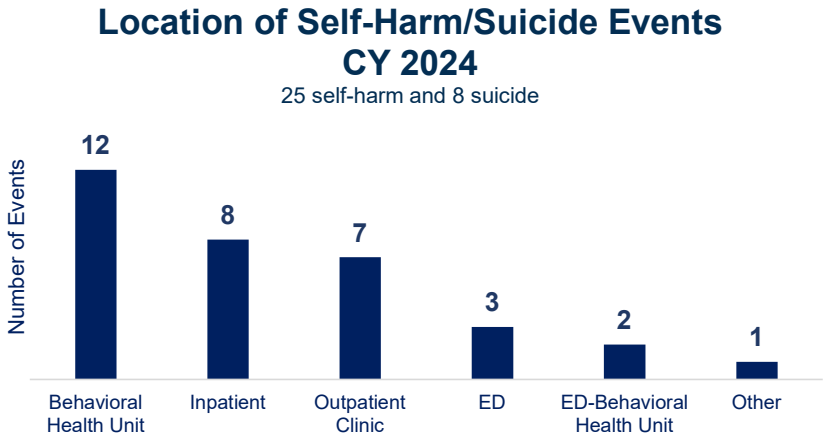


Notes

- Anticoagulation order issues (especially after transitions in care-most often reported in post-op period)
- Medications not reconciled appropriately on admission (change of dose)
- Paralytic administered inadvertently in pre-op/PACU setting
- IV Pumps Concentration incorrect programing with incorrect dose
- Infusion of entire bag at once due to other programming error
- Fall with medication error/issue as possible contributing factor
- Verbal order (order to “give 5”, 5mL given instead of 5mg)

Patient Protection Events



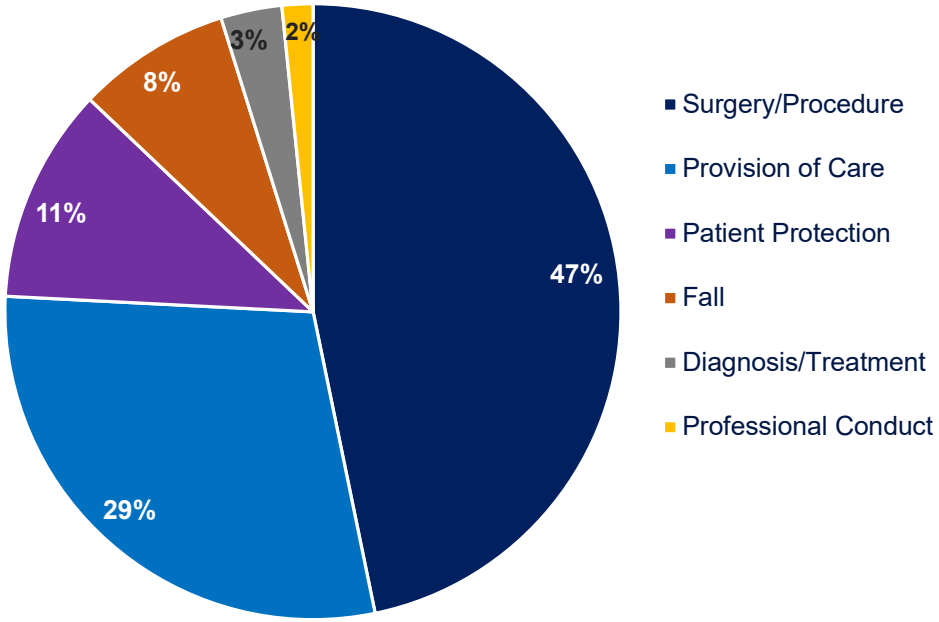


Noted

- Self-harm events
  - Ingestion
  - Laceration
  - Intentional water intoxification
  - Ligature
- Aggressive behavior (adolescent, ED boarders)
- Suicide
  - Six reports (5 outpatient, 1 inpatient)
  - Ingestion most common
  - Cords of medical devices (CPAP, Oxygen
- 1:1 monitoring whereby face and hands of patient are not observed at all times

Events Reported by Ambulatory Surgery Centers and Ambulatory Clinics

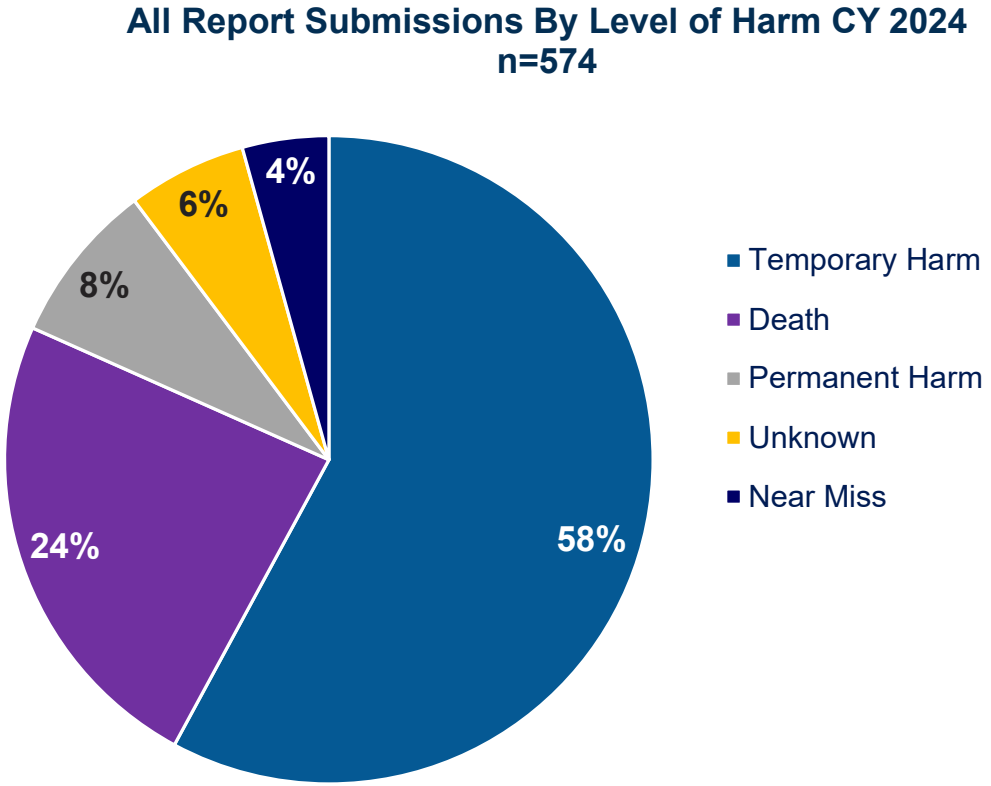
SQR Report Event Categories Submitted by Clinics CY 2024
n=62



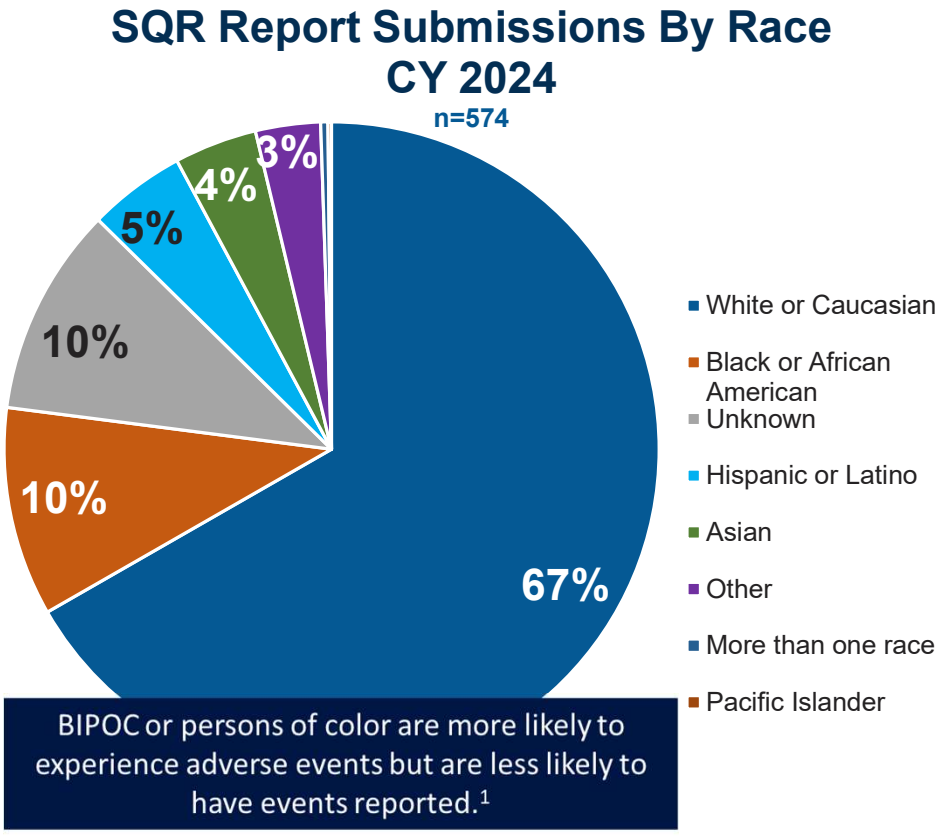
Noted

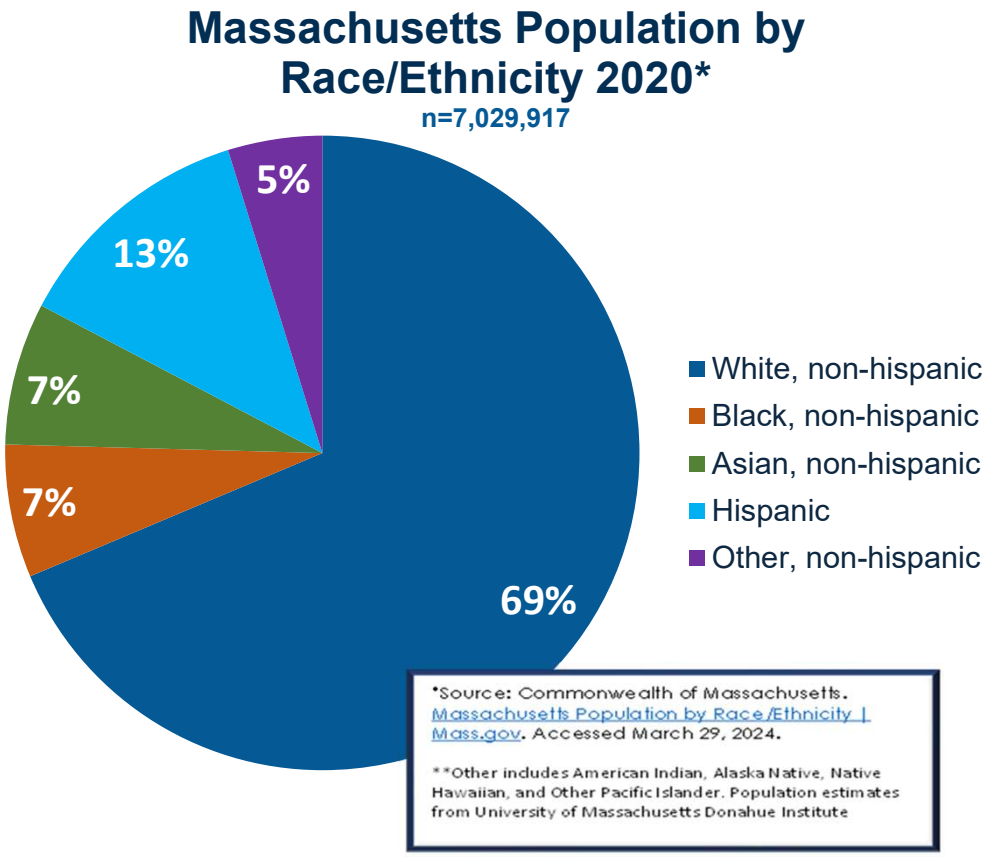
- Intra and post-operative complications
  - Perforation (endoscopic)
  - Cardiovascular complications
  - Injury to eye
  - Burns
- Wrong site/side surgery
  - Joint injections
  - Skin lesions
- Provision of care events
  - Primarily transfers to a higher level of care (cardiac issues)
- Issues with “add-on” patients
- Patient Protection events included:
  - 3 reports of suicide and
  - 4 reports of self-harm events

SQR Report CY 2024 Data By Level of Harm



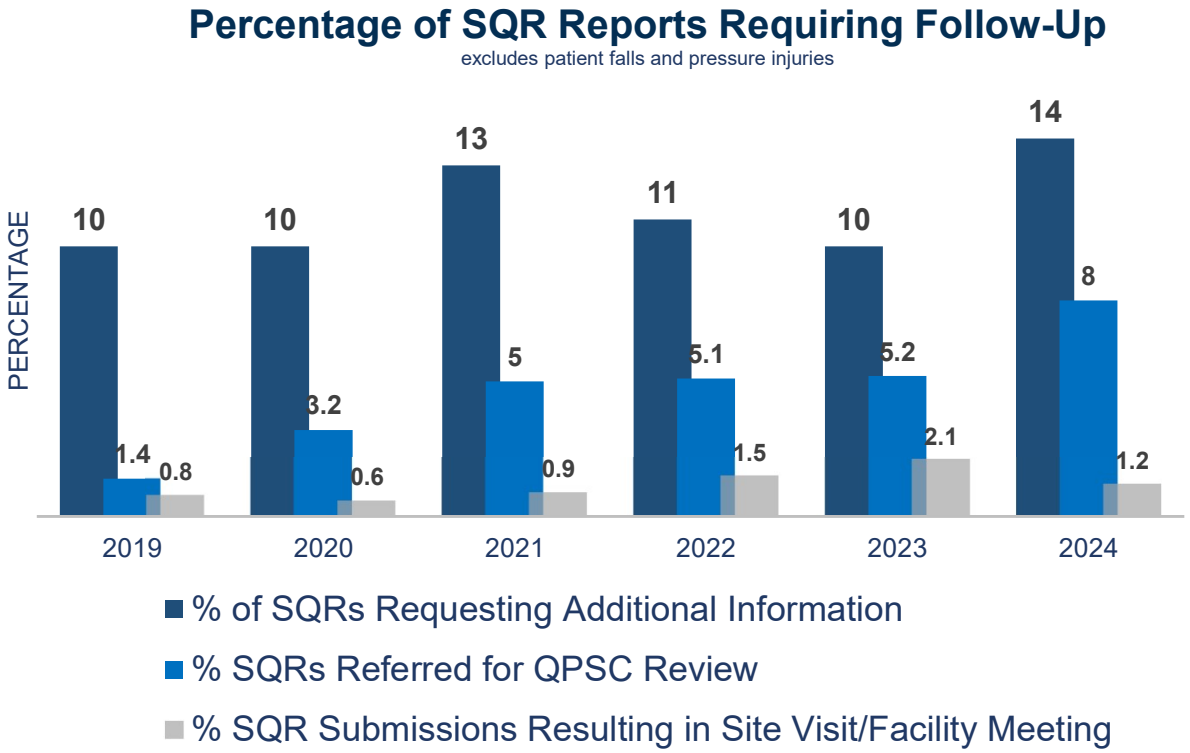
SQR Report CY 2024 Data By Race

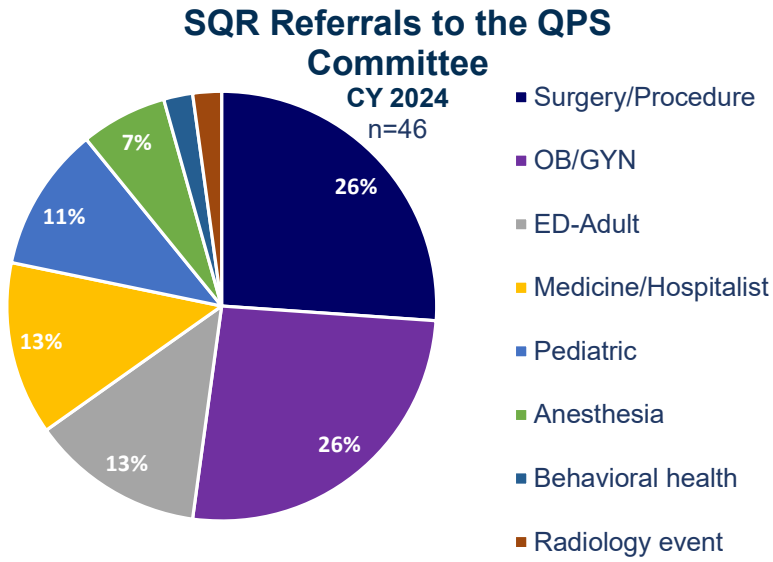




[1] Hoops K, Pittman E, Stockwell DC. Disparities in patient safety voluntary event reporting: a scoping review. Joint Comm Journal on Qual Patient Saf. 2024;50(1):41-48. doi:10.1016/j.jcjq.2023.10.009.

Safety & Quality Review (SQR) Report Follow-Up Data





Year	2022	2023	2024
QPSD Average Response Time	21 days	16 days	10 days

Quality Assurance Reports

The PCA-QA Report must be submitted annually on or before the following due dates:

March 30th for ambulatory surgical centers, and ambulatory clinics.

April 30th for hospitals.

The reporting period is the calendar year prior to the report due date.

Example: Report due March 30, 2024. The reporting period is CY 2023 (12 months).

Example: Report due April 30, 2024. The reporting period is CY 2023 (12 months).

Elements of the PCA-QA Report

PCA Plan

1- A copy of the facility's Patient Care Assessment Plan, which shall be reviewed, updated, and submitted annually.

Data and Analysis

2- Patient complaint data:

Total volume of patient and family complaints for the reporting period, with the total volume of complaints in each of the top three categories of patient and family complaints.

Analysis, recommendations, and plans for corrective measures for any trends indicated by data.

Actions To Improve

3- Performance Improvement Activities (Major Tasks Completed).

Data and Analysis

4- Internal Reporting and Screening Systems:

Focused Occurrence Screening Criteria data, analysis, and recommendations.

Focused Occurrence Reporting Criteria data, analysis, and recommendations.

Internal Incident Reporting System Data.

Attestation

5- Attestation that the following elements are in place and available upon request:

Information regarding the distribution of **written instructions** regarding operational procedures relevant to patient care assessment and compliance with 243 CMR 3.00.

Policy/protocol regarding the **handling of impaired physicians**.

There is a 20-minute instructional video on our website

Patient Care Assessment-Quality Assurance
(PCA QA) Report

New report
New policy
New online submission

100% Compliance

- ✓ Acute-care hospitals
- ✓ Non-acute care hospitals
- ✓ Ambulatory Surgery Centers
- ✓ Ambulatory Clinics (select)

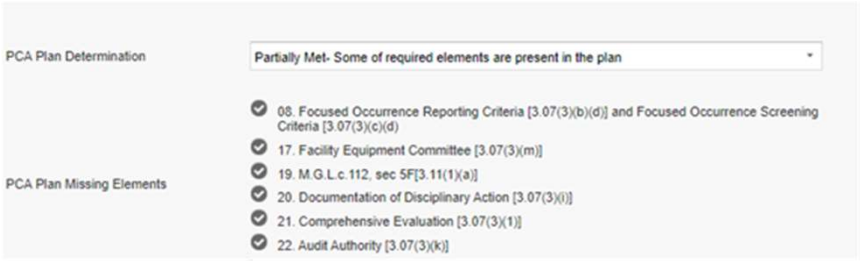
Patient Care Assessment-Quality Assurance (PCA QA) Report

Patient Care Assessment Plan Elements

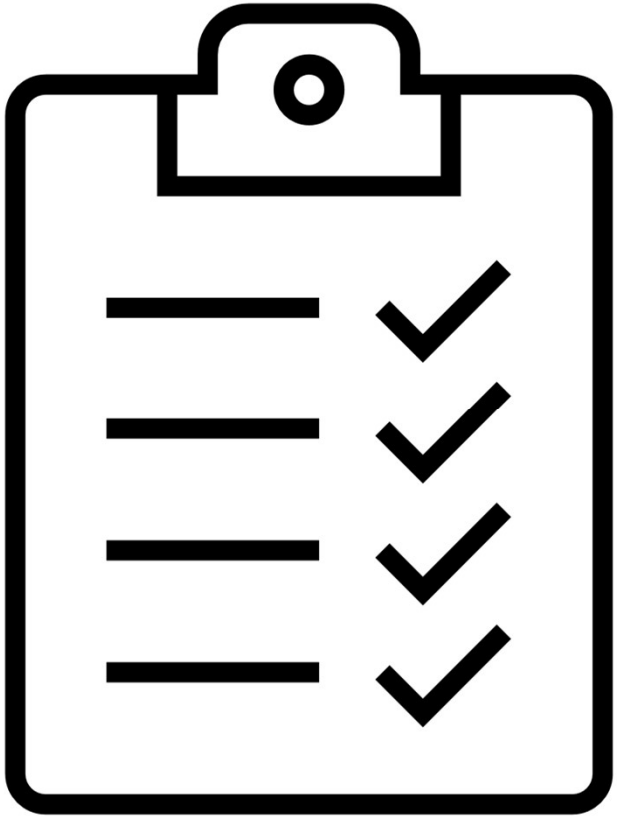
- o Facility and medical staff bylaws authorize elements of PCA Plan
- o Governing body, PCA Committee & Coordinator
- o Policies governing responsibilities of PCA Committee/Coordinator
- o Credentialing
- o Internal incident reporting
- o Focused occurrence reporting/screening criteria
- o Major incident reporting
- o Maintenance of reports
- o Patient complaint process
- o Informed consent policy
- o Impaired provider provision
- o Prescription practice and medication Errors
- o Medical records
- o Guidelines in specialties (Anesthesiology)
- o Facility equipment committee
- o Summary suspension/Disciplinary action documentation process
- o Annual written notice of requirements/rights in M.G.L. c. 112, sec. 5F.
- o Comprehensive evaluation
- o Audit authority to DPH and BORIM
- o Patient rights written notice

A gap analysis was performed of every healthcare facility PCA Plan with feedback provided.

Resources including templates and worksheets were provided to assist healthcare facilities in updating or creating PCA Plans that met regulatory requirements.



Quality & Patient Safety Division Activities



2024 QPSC Fall Conference
September 27th at UMass Memorial Medical Center
250 registered participants
Topic: Peer Review

Spotlight Newsletter

Inaugural Issue Winter 2024

Three issues distributed in 2024

Quality & Patient Safety Division

Winter 2

Welcome to the inaugural issue of Spotlight on Quality & Patient Safety. Spotlight is issued by the Massachusetts Board of Registration in Medicine Quality & Patient Safety Division (QPSD) to share aggregate Safety and Quality Review (SQR) report data and to share some of the good work being done by the hospitals, ambulatory surgery centers, and some ambulatory clinics in the Commonwealth. The QPSD would like to thank Tufts Medical Center and Emerson Hospital for sharing some performance improvement initiatives being undertaken at their respective facilities. If your organization would like to be featured in a future issue of Spotlight, please contact Trinh Ly-Lucas. Trinh's contact information and information regarding the upcoming Patient Care Assessment virtual Boot Camp may be found on the final page.

Hospitals, ambulatory surgery centers, and certain ambulatory clinics are required to submit events of unexpected patient outcomes (SQR reports) to the QPSD. In this issue, the QPSD is providing data regarding the major categories of SQR reports submitted in the first three quarters of 2023. We are highlighting the most reported category of events: Surgery/Procedure. Some resources are included on page two.

2025 Spring Spotlight Newsletter

2025 QPSC Fall Conference on October 17, 2025

Trends Noted in 2024 SQR Reporting

Surgery/Procedure Events	Diagnosis/Treatment Events	Maternal/Childbirth Events	Medication/Fluid Events	Patient Protection Events	Events Reported by ASCs & Ambulatory Clinics
• Opportunity to improve supervision of trainees • Central line insertion- wrong site and RFO (guidewires) • Central line complications with guidewires (perforations) • Spinal level and joint injections-wrong site • Dobhoff feed tube wrong site (no Xray confirmation or incorrect reading) • Complications- hemorrhage/perforation (interventional, endoscopic, and bedside) • Complications involving anastomotic leaks with abscess • Device malfunction (balloon rupture, cautery burns) • Contamination/ use of kits not sterilized	• Gaps in COMMUNICATION ○ Among specialist consulted ○ Imaging/Lab result not communicated ○ Coordination of Care • ED Boarders • EKG readings not appreciated (ED) • Identification of compartment syndrome (ED) • Left without being seen, returned with cardiac issues • Transfers (internal and external) • Calling RRT • Incidental findings (breast, colon) not communication with delays in treatment • Arrythmias not noted while on telemetry	• Neonatal Injury ○ Neurological injury ○ Skull fracture ○ Hematoma ○ Laceration ○ Circumcision injury ○ Clavicle fracture/arm injury • Post-Partum Hemorrhage ○ Abruption ○ Uterine rupture/TOLAC ○ Unplanned HYST reported ○ Use of EBL vs. QBL ○ Calling for MTP • Neonatal/Fetal Death ○ Prolonged Category II with worsening features ○ Inadvertently tracing maternal heart rate ○ Delay in NST/induction (no room) returning with demise ○ Sepsis ○ Unexpected congenital diagnosis • Maternal - Death ○ Sepsis ○ Cardiovascular ○ Covid	• Anticoagulation order issues (especially after transitions in care-most often reported in post-op period) • Medications not reconciled appropriately on admission (change of dose) • Paralytic administered inadvertently in pre-op/PACU setting • IV Pumps Concentration incorrect programing with incorrect dose • Infusion of entire bag at once due to other programming error • Fall with medication error/issue as possible contributing factor • Verbal order (order to “give 5”, 5mL given instead of 5mg)	• Self-harm events ○ Ingestion ○ Laceration ○ Intentional water intoxification ○ Ligature • Aggressive behavior (adolescent, ED boarders) • Suicide ○ Six reports (5 outpatient, 1 inpatient) ○ Ingestion most common ○ Cords of medical devices (CPAP, Oxygen • Lapses in 1:1 monitoring whereby face and hands of patient are not observed at all times	• Intra and post-operative complications ○ Perforation (endoscopic) ○ Cardiovascular complications ○ Injury to eye ○ Burns • Wrong site/side surgery ○ Joint injections ○ Skin lesions • Provision of care events ○ Primarily transfers to a higher level of care (cardiac issues) • Issues with “add-on” patients • Patient Protection events included: ○ 3 reports of suicide and ○ 4 reports of self-harm events

Questions