

Children's Hospital Boston: Serious Reportable Events and Improvement Plans
Organized by Category
(2008 Events Reported to Department of Public Health)

Category	MDPH/NQF Listing Of Serious Reportable Events	Key Findings Contributing to Event	Lessons Learned/Actions to Prevent Future Events
1 Surgery	Wrong site surgery	A tongue-tie release (lingual frenulectomy) was performed instead of a lip-tie release (labial frenulectomy) in outpatient surgery. The consent used the term frenulectomy and did not distinguish between the lip and tongue, the team used the term frenulectomy in discussion and did not distinguish between the lip or tongue and rarity of a lip-tie release were identified as contributing factors. The patient was discharged the same day without problems. Children's Hospital Boston performed 24,460 surgical cases in fiscal year 2008.	Staff education, policy and practice changes implemented including incorporation of the World Health Organization Surgical Safety Checklist into Universal Protocol.
1 Surgery	Wrong site surgery - Specifically, an additional biopsy procedure was performed during a scheduled fluid drainage procedure.	The procedure transcribed to the working schedule did not coincide with the procedure ordered. The discrepancy was not verified with the ordering physician and as a result an additional biopsy was performed along with a scheduled fluid drainage procedure. Since the biopsy had been performed it was appropriately processed and clinically relevant information was obtained that was used in the ongoing management of the patient. There have been no patient complications related to the biopsy. Children's Hospital Boston performed 3,339 vascular/interventional procedures in fiscal year 2008.	The Universal Protocol verification practice was changed and staff education implemented. The ordering physician is contacted to verify the procedure whenever a discrepancy is noted. The World Health Organization (WHO) surgical/procedural checklist has since been implemented at the hospital as an additional safety precaution.
1 Surgery	Retained foreign object: Specifically, sections of vessel loops used to temporarily tie off a blood vessel were retained unintentionally in the patient after	Elastic-like loops were used to tie off a blood vessel during cardiac surgery. The loops were placed and the excess material was trimmed. Not all members of the team were fully aware the loops and been placed and were not	New protocol restricting trimming of vessel loops unless absolutely necessary for exposure in the operative field. Enhanced policy requiring active communication at the time potentially alterable items are placed in a body cavity. Now providing

	the chest was closed	removed in their entirety. During a subsequent procedure the remnant loops were identified and removed. Also contributing was the complexity of the patient's anatomy due to congenital abnormalities that required a less frequently performed operative approach. There was no patient harm. Children's Hospital Boston performed 24,460 surgical cases in fiscal year 2008.	vessel loops in colors other than red.
1 Surgery	Retained foreign object: The patient was undergoing elective removal of two pieces of surgical hardware. One piece of hardware was removed and the patient's skin was closed. The team then identified the presence of a second piece of hardware that was not visible in the operative field and required reoperation to remove	Two bars were intentionally placed one aligned below the other to support bone remodeling in order to correct an anatomic defect consisting of a concave anterior chest. It is more typical to place a single bar but due to this patient's size and age the decision was made to support the chest with two bars. Months later, after correction of the defect, a procedure was performed to remove the bars. The second bar was encased in dense, fibrous tissue and was not visible or palpable when the chest was opened. The presence of the second bar was identified in a postoperative chest x-ray performed while the patient was in the Post Anesthesia Recovery Unit. The patient returned to the OR and the second bar was removed without complication. There was no patient harm. Children's Hospital Boston performed 24,460 surgical cases in fiscal year 2008.	Practice change requiring labeling of operative notes and office charts to indicate atypical procedure/operative variance
2 Product or Device Event	Device failure in which the device functions other as intended.	A microcatheter was used as intended to inject material to block very small arteries feeding a large tumor. This was done in order to prevent hemorrhage during surgery to remove the tumor. The flexible tip of the microcatheter did not release from the material, and the flexible end of the catheter stretched out. Catheter tip retention and breaking is a rare but known complication. The patient was taken to surgery to remove the catheter and recovered without problems or disability. Children's Hospital	Notified device manufacturer and FDA. Device manufacturer analysis completed. Manufacturer is evaluating a new device design.

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2 Product or Device Event			
3 Patient Protection Event	NA		
4 Care Management Event	NA		
5 Environmental Event	NA		
6 Criminal Event	NA		