Massachusetts Board of Registration in Medicine
Quality & Patient Safety Division
Spotlight on Quality & Patient Safety

Spring 2026

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Spotlight on Quality & Patient Safety

Spotlight is published by the **Massachusetts Board of Registration in Medicine**'s Quality & Patient Safety Division (QPSD). The Division, together with the Board's Quality & Patient Safety (QPS) Committee, oversees **Patient Care Assessment** (PCA) programs at hospitals, ambulatory surgery centers, and certain ambulatory clinics across the Commonwealth. PCA programs have four primary components: quality assurance, peer review, risk management, and credentialing.

This issue of *Spotlight* presents aggregate data from Safety & Quality Review (SQR) reports submitted during calendar year (CY) 2025. SQR reports document unexpected patient safety events.

In CY 2025, 583 SQR reports were submitted, describing a total of 692 events. Some reports included more than one event, which accounts for the difference between the number of reports and the total number of events.

The data continue to provide insight into patient safety events reported by health care facilities over the past year, supporting ongoing efforts to strengthen quality and safety across the Commonwealth of Massachusetts. Trends identified in SQR reports for CY 2025 are summarized on page seven. One notable trend this year involved events related to breakdowns in communication and coordination of care; additional information is provided in the **Patient Safety Alert** on page eight.

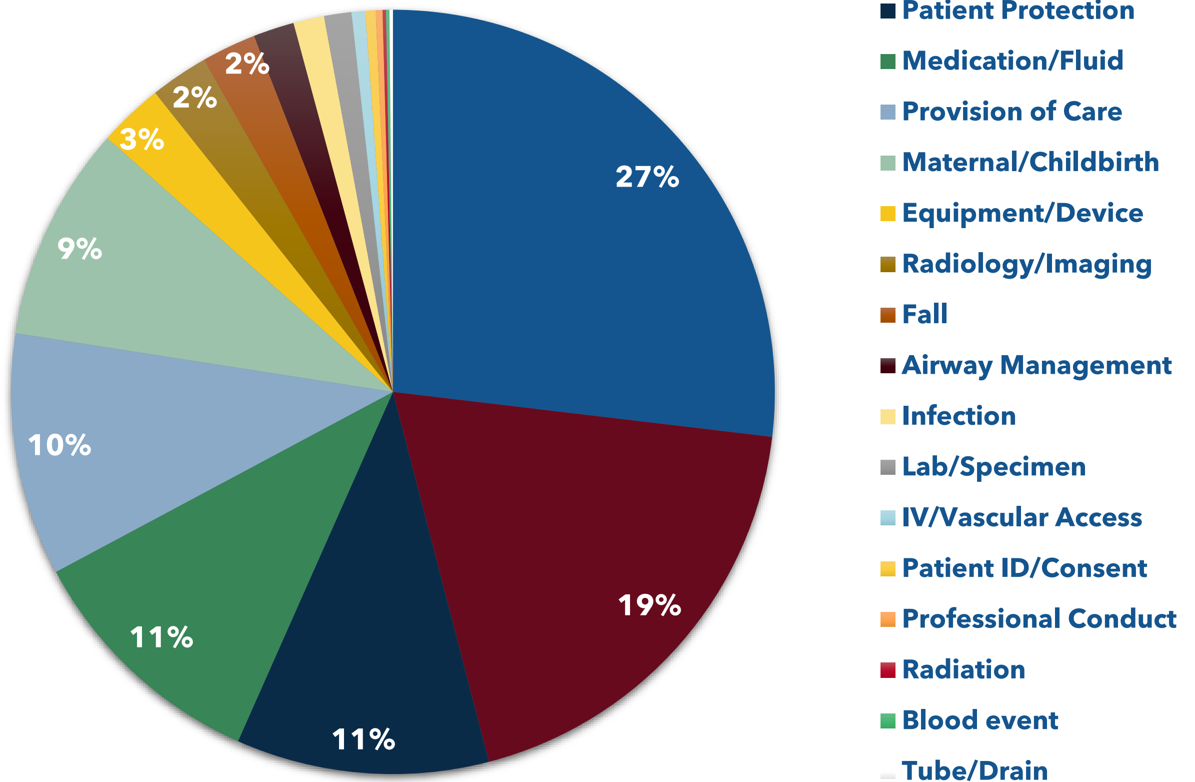
This issue of *Spotlight* also features an article from **Heywood Healthcare** addressing safety culture and transparency. The Quality & Patient Safety Division (QPSD) thanks Heywood Healthcare for its contribution to the spring edition of *Spotlight*. Health care organizations interested in being featured in a future issue are encouraged to contact the QPSD.

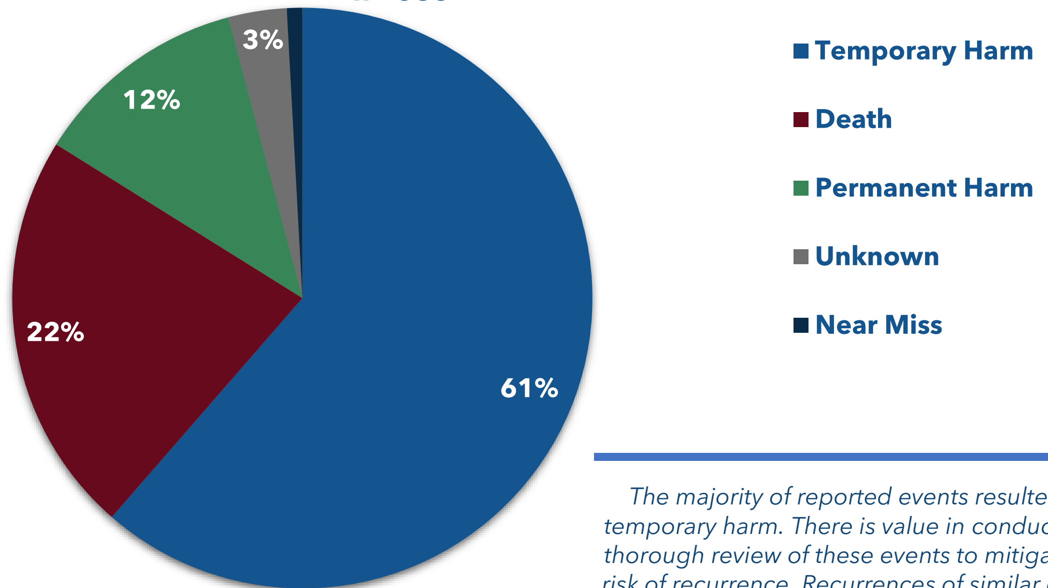
Safety & Quality Review CY 2025 Data

VOLUME OF SQR REPORT SUBMISSIONS
EXCLUDES AGGREGATE PATIENT FALLS AND PRESSURE INJURY REPORTS

QPSD Mission is to assist Massachusetts healthcare facilities in maintaining and improving systems for patient care that are evidence and team based, sustainable, safe, and inclusive. We achieve this by reviewing data, listening, collaborating, and educating teams in healthcare facilities throughout the state.

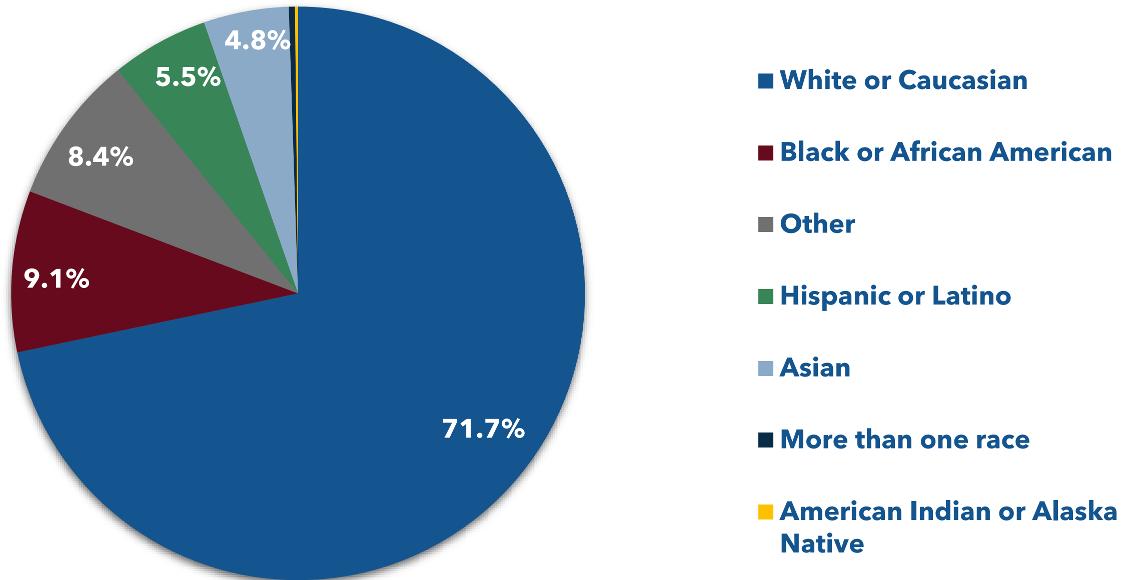
Spotlight on Quality & Patient Safety

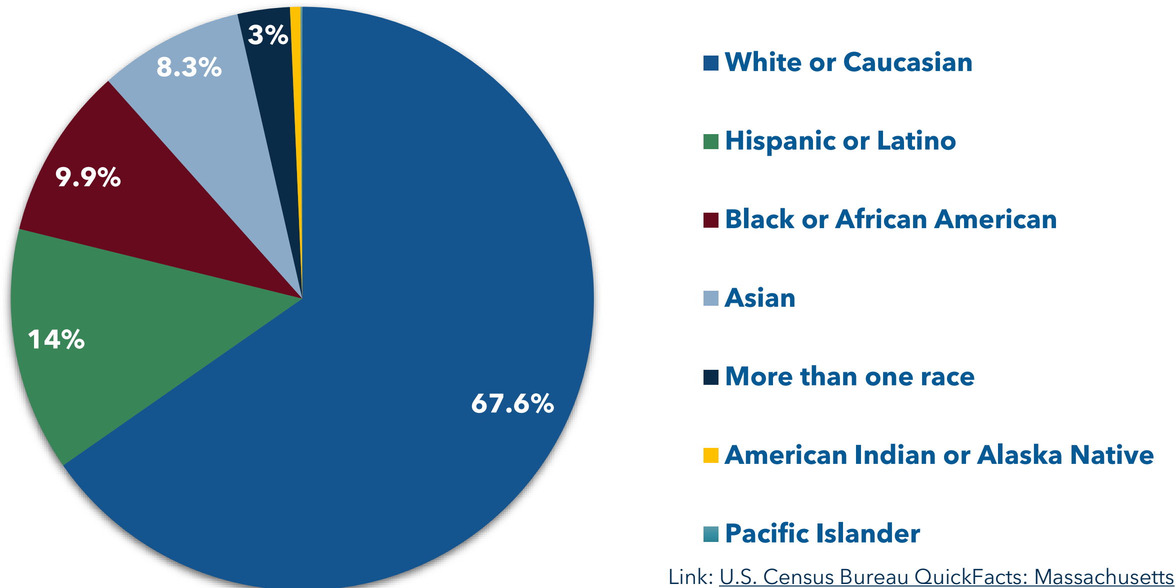




The majority of reported events resulted in temporary harm. There is value in conducting a thorough review of these events to mitigate the risk of recurrence. Recurrences of similar events may result in more serious harm.

Spotlight on Quality & Patient Safety





Link: U.S. Census Bureau QuickFacts: Massachusetts

Black, Indigenous, and people of color (BIPOC) are more likely to experience adverse events but are less likely to have events reported.[1] The QPSD encourages healthcare organizations to review their internal incident demographic data and compare the data against the race and ethnicity data of the communities that they serve to assist in determining if an opportunity exist for improvement in awareness, education, and reporting of internal incidents (patient safety events).

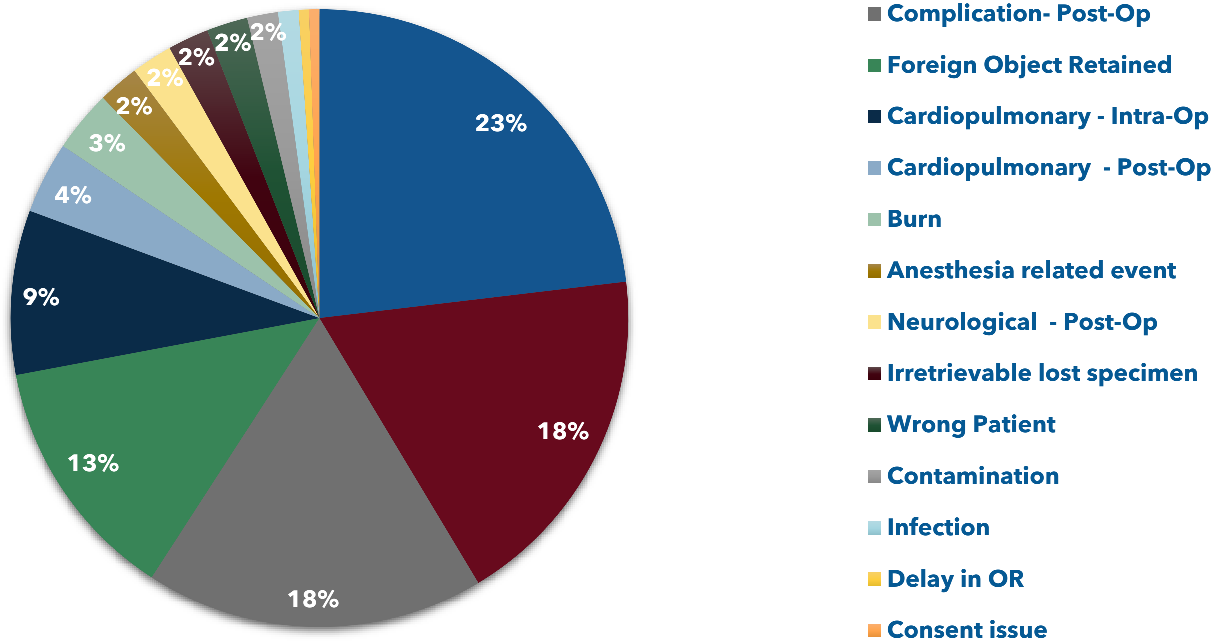
[1] Hoops K, Pittman E, Stockwell DC. Disparities in patient safety voluntary event reporting: a scoping review. Joint Comm Journal on Qual Patient Saf. 2024;50(1):41-48. doi:10.1016/j.jcjq.2023.10.009. Disparities in Patient Safety Voluntary Event Reporting: A Scoping Review - Joint Commission Journal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

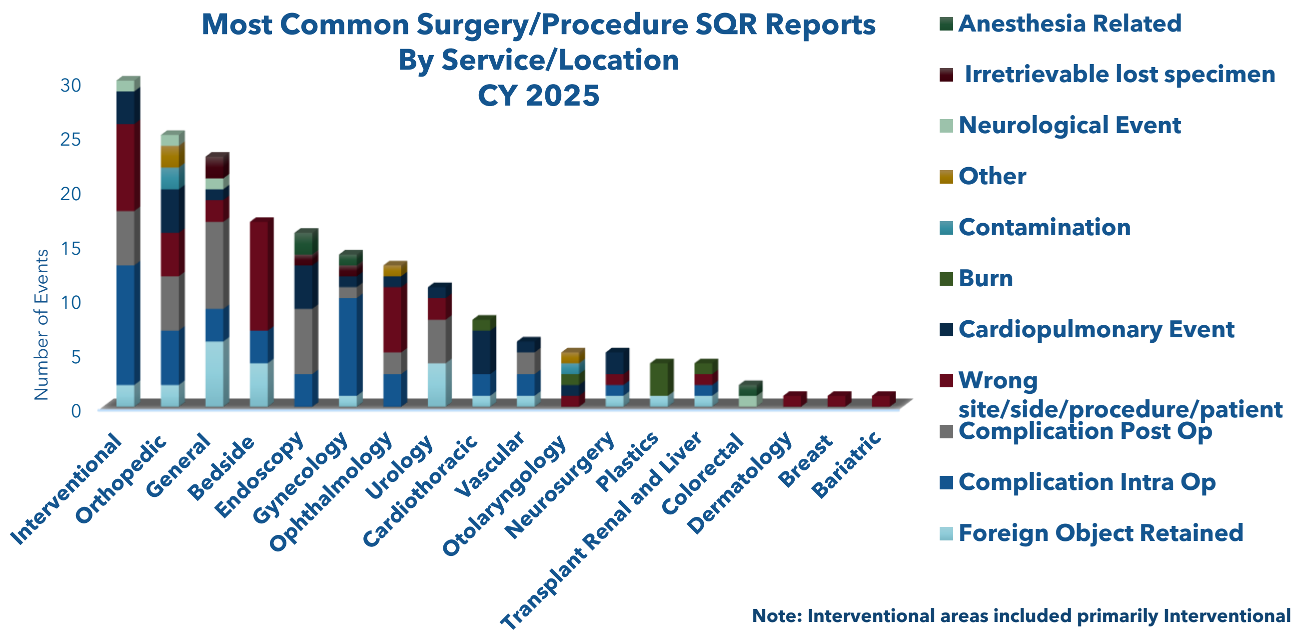
Spotlight on Quality & Patient Safety

Spotlight provides more detailed data regarding the most common subcategories of reported patient safety events in CY 2025:

- Surgery/Procedure
- Diagnosis/Treatment
- Patient Protection
- Medication/Fluid
- Provision of Care
- Maternal/Childbirth

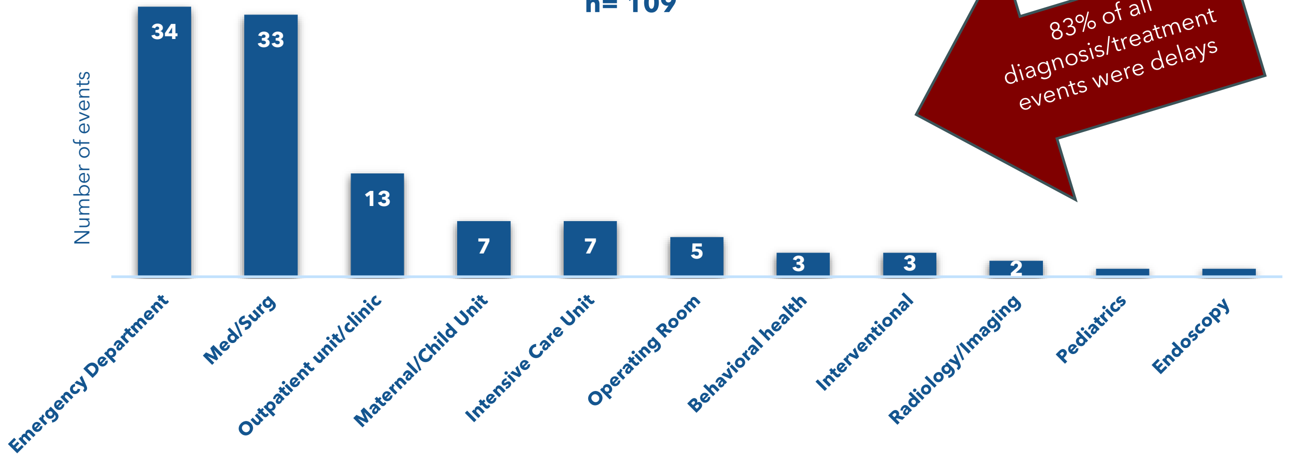
The trends noted regarding these events is summarized in a chart on page seven.

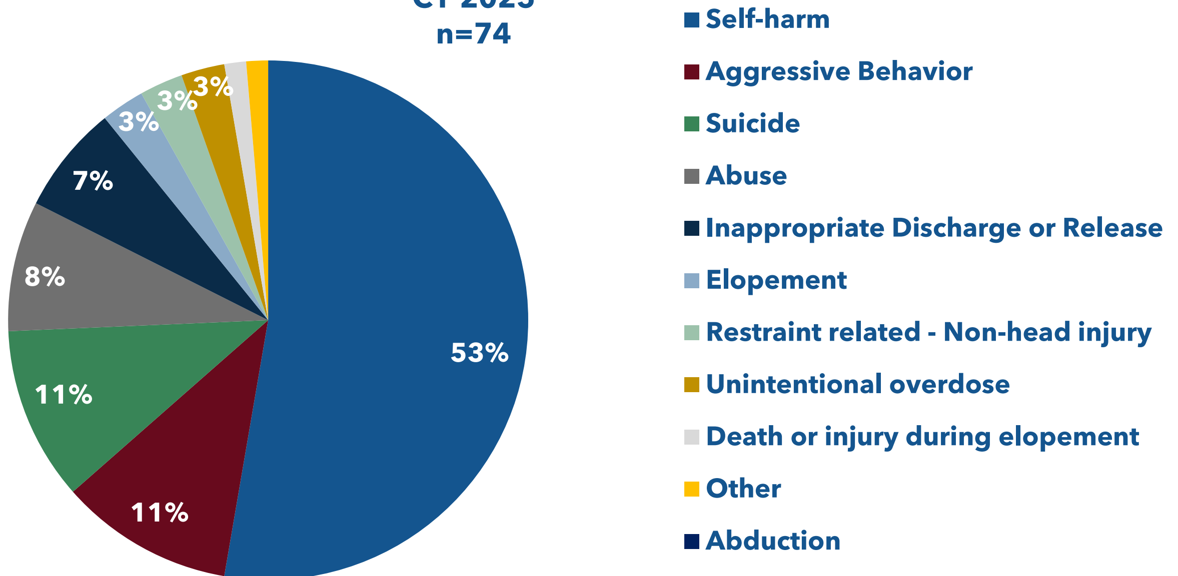


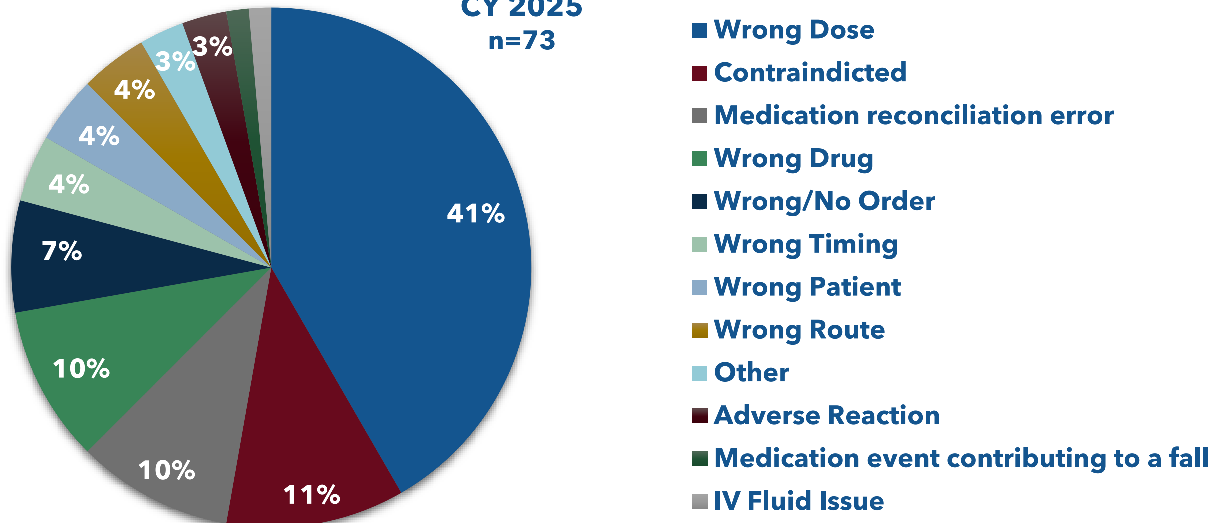


Note: Interventional areas included primarily Interventional Radiology (69%), but also included Interventional Cardiology (21%), and Interventional Pain Clinics (1%).

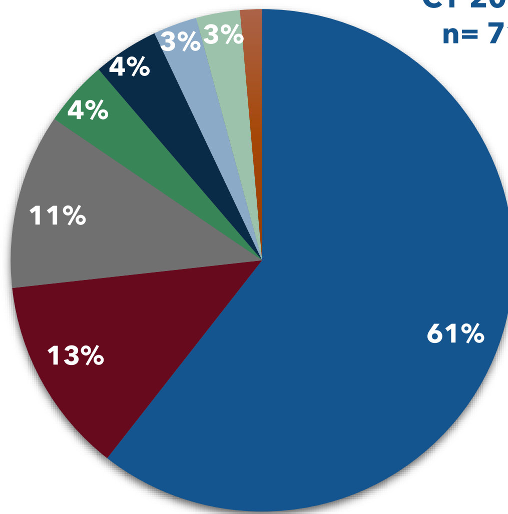
Spotlight on Quality & Patient Safety





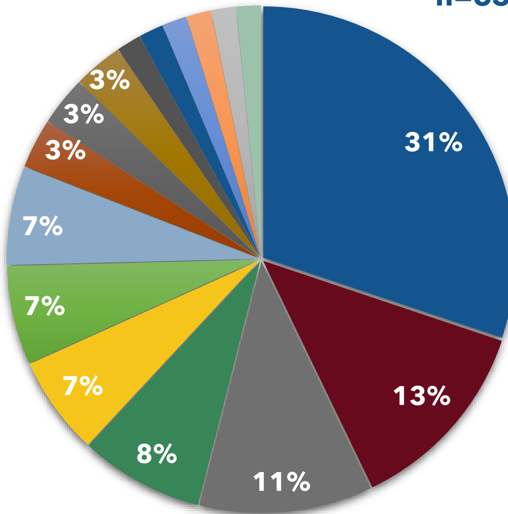


Provision of Care Events
CY 2025
n= 71



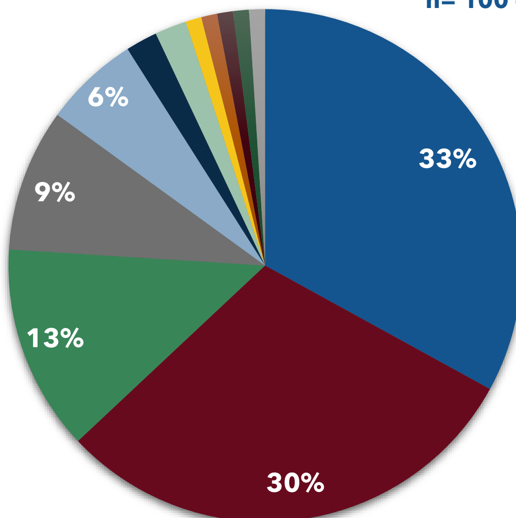
- Unanticipated transfer to higher level of care
- Patient Death (Unexpected)
- Other
- Burn
- Skin Injury (not pressure)
- Referral Issue
- Left Against Medical Advice
- Dietary Issue

Maternal/Childbirth Events
CY 2025
n=63



- Post-Partum Hemorrhage
- Neonatal - Death
- Neonate - Injury
- Fetal - Death
- Event Related to Fetal Heart Tracing
- Foreign Object Retained
- Shoulder Dystocia
- Unexpected Transfer ICU/NICU
- Amniotic Fluid/Pulmonary Embolism
- Wrong Patient Breastmilk
- Magnesium Toxicity
- Maternal - Injury to Body Part or Organ
- Maternal Death
- Cardiovascular event
- Maternal - Infection
- Complication cesarean section

SQR Report Event Categories:
Ambulatory Surgery Centers and Select Ambulatory Clinics CY 2025
n= 100 events in 85 SQR Reports



- Provision of Care
- Surgery/Procedure
- Patient Protection
- Fall
- Diagnosis/Treatment
- Airway Management
- Maternal/Childbirth
- Medication/Fluid
- Infection
- Lab/Specimen
- Radiology/Imaging
- Equipment/Device

Trends Noted in SQR Reporting

Surgery/Procedure

The most common events were complications, retained foreign objects, and wrong site/side/procedure surgeries.

Complications:
- Perforations
- Transection of organs and adjacent structures
- Hemorrhage

Retained Foreign Objects (RFO):
- Guidewires during central line insertion and Dobhoff insertion are the most common RFOs.
- Lap sponges in abdomen
- Fragments of needles and drill bits
- Tips on scopes
- Introducer needle sheath

Wrong site/side surgery:

Refer to page 10

- Central line in artery
- Dobhoff in lung
- Wrong side anesthetic block
- Wrong spinal level
- Wrong side/site joint injections

Diagnosis/Treatment

83% of all diagnosis/treatment events were delays. Many of the delays took place in the Emergency Department and Medical/Surgical units.

- Sepsis (neonatal, infant, and adult) not recognized in a timely manner
- Triage incorrectly (STEMI, Trauma)
- Medical diagnosis is not considered in patients with substance use disorder
- Unable to transfer due to weather
- Management of necrotizing fasciitis
- Testicular and ovarian torsion
- Recognizing acute-intra-abdominal processes
- Missed retroperitoneal bleeding in patient on anticoagulation
- New onset atrial fibrillation, no anticoagulation >>>DVT/PE
- Vascular ischemia
- Telemetry monitoring -unrecognized arrhythmia or loss of signal
- Ineffective communication and coordination of care

Medication/Fluid

41% of all medication events involved the wrong dose being given.

- Anticoagulation events often related to EMR data entry error (weight and/or default issue), trainees ordering incorrect dose, Heparin infusion exceeding recommended max
- Wrong dose-bar scanning, override, and/or verbal orders not verified
- Epinephrine IV instead of IM for anaphylaxis with wrong dose
- Vanco protocol not followed
- Insulin doses incorrect
- Default doses not adjusted
- Lack of labeling syringe leading to wrong drug (Anesthesia)
- Patients given roommate's/other patient's meds
- Events related to Ketamine (poor communication, no pediatric dosing)
- Pump programming errors (concentration and dose)

Patient Protection

Most common in this category were self-harm events.

- Ingestion:
  Wires in mask, button batteries, hand sanitizer, outside meds hidden in compartment of bag, overdose in waiting room while waiting for bed, make up, O2 probes, cables
- Ligature: Clothing tied together, telemetry cords and cables
- Laceration: razor hidden in body cavity, outlet cover, phone
- Insertion of FO in body cavities such as IV catheters and other objects in urethra, nail glue in body cavities, make up
- Other: Jumping through glass walls, doors, and windows occurred in several reported events during attempts at elopement

Provision of Care

Most common types included unanticipated transfers to higher levels of care.

CY 2025 saw an increase in Ambulatory Surgical Centers reporting this event.

ASCs were assessing their internal processes for:

- Patient selection appropriateness
- Pre-procedure optimization of patient's clinical status
- Pre-procedure education
- Pre-procedure assessments
- Emergency readiness and opportunities for improvement
- Transfer process

Several Provision of Care reports involved interruptions and errors related to communication and the coordination of care.

Refer to Patient Safety Alert on page 8

Maternal/Childbirth

Most common event was post-partum hemorrhage (PPH).

Maternal events
- PPH with/without hysterectomy
- Late hemorrhage
- Delayed recognition Magnesium toxicity
- Not appropriately referred to MFM
- Cardiovascular event /Amniotic Fluid Embolism
- Retained vaginal packs and sponges
- Low incision with bladder injury
- Lack of assessment prior to termination

Neonatal events
- Skull fracture and/or hematoma (vacuum, forceps)
- Shoulder dystocia (may involve fracture)
- Newborn falls with injury
- Wrong breast milk
- Infection
- Unrecognized and/or prolonged Category II/III tracing with unknown neurological status or demise

Spotlight on Quality & Patient Safety

Patient Safety Alert: Communication/Coordination of Care Events

The Quality & Patient Safety Division (QPSD) has received multiple Safety & Quality Review (SQR) reports in which breakdowns in communication and care coordination were identified as contributing factors in patient safety events.

In these cases, there were opportunities to improve communication and teamwork among attending physicians, consulting physicians, nursing staff, ancillary staff, trainees, and other members of the care team.

Examples Identified in SQR Reports:

- Failure to communicate changes in patient status to anesthesia prior to surgery, including new cardiac ischemia, electrolyte abnormalities, medication changes, or suspected bowel obstruction, contributing to cardiopulmonary and airway complications.
- Lack of notification regarding clinical deterioration, resulting in delays in diagnosis and/or treatment—most commonly during transitions of care.
- Wrong site/side surgery when discrepancies among the consent, procedure order, requisition, history and physical, or operating room schedule were identified but not fully reconciled prior to proceeding.
- Unclear responsibility for boarded patients in the emergency department, particularly when it was uncertain whether Emergency Medicine or Hospitalist Medicine was managing the patient, resulting in missed orders or lack of follow-up on diagnostic results.
- Medication dosing errors during verbal orders, particularly involving high-risk medications such as sedatives and narcotics in the ICU, ED, and OR settings.
- Anticoagulation management errors, including failure to hold or delayed re-initiation of anticoagulation therapy due to lack of clear communication or order entry, leading to bleeding complications. In some cases, recommendations from consulting physicians were not converted into actionable orders.
- Laboratory and radiology results not communicated or acted upon, particularly in outpatient settings, resulting in delayed follow-up that was sometimes identified only at the next patient encounter or hospital admission.
- Suboptimal communication between trainees and attending physicians, leading to delays or gaps in care.
- Inadequate triage of STEMI and obstetrical patients during high-volume periods, contributing to adverse outcomes.
- Delayed recognition of the need for transfer to a higher level of care, particularly for patients with surgical, neurological, or obstetrical complications.
- Inadequate discharge communication and coordination, including insufficient follow-up planning for patients requiring anticoagulation management or treatment for conditions such as tuberculosis.
- Failure to communicate or document DNR/MOLST status during transitions of care.

Recommendations to Strengthen Communication and Care Coordination

Effective communication and care coordination are essential to ensuring safe, continuous, and comprehensive care. To reduce fragmented care and prevent adverse outcomes, facilities may consider the following strategies:

Recommendations to avoid fragmented care include:

- Standardize communication practices, including the use of structured tools such as SBAR, I-PASS, and CUSP Teamwork and Communication and TeamSTEPPS. These tools are particularly valuable during hand-offs and transitions of care. Facilities may also define criteria for when a warm hand-off is required.
- Identify complex patients early and implement multidisciplinary team meetings when appropriate. Standardized agendas and clear processes for tracking and closing action items can improve follow-through.
- Ensure a centralized and accessible electronic health record (EHR) system. Patient data, progress notes, and consultation documentation should be current and readily available to all members of the care team.
- Consider implementing an early-warning system within the EHR to alert the care team to patient deterioration.
- Engage patients and designated health care proxies in care planning and shared decision-making whenever possible.
- Provide detailed discharge plans in plain language, in the patient's preferred language.
- Use standardized discharge and transfer checklists to ensure follow-up appointments are arranged, patient and family education is completed (with written materials provided), medication management is addressed, and all necessary documentation accompanies patients transferred to another facility.

Resources:

Advance Alert Monitor Program: An Automated Early Warning System for Adults At Risk for In-Hospital Clinical Deterioration. U.S. Department of Health and Human Services. Patient Safety Network. 2023. https://psnet.ahrq.gov/innovation/advance-alert-monitor-program-automated-early-warning-system-adults-risk-hospital#

Clinical Checklists. World Health Organization. Accessed February 4, 2026. Clinical checklists

Implement Teamwork and Communication. Agency for Healthcare Research and Quality. 2018. Accessed February 2, 2026. https://www.ahrq.gov/hai/cusp/modules/implement/index.html

Montori VM, Ruissen MM, Hargraves IG, Brito JP, Kunneman M. Shared decision-making as a method of care. BMJ Evid Based Med. 2023 Aug;28(4):213-217. doi: 10.1136/bmjebm-2022-112068. Epub 2022 Dec 2. PMID: 36460328; PMCID: PMC10423463. https://pmc.ncbi.nlm.nih.gov/articles/PMC10423463/

Plain Language Materials & Resources. Centers for Disease Control and Prevention. Accessed February 4, 2026. Plain Language Materials & Resources | Health Literacy | CDC

SBAR Tool: Situation-Background-Assessment-Recommendation. Institute for Healthcare Improvement. Accessed February 10, 2026. SBAR Tool: Situation-Background-Assessment-Recommendation | Institute for Healthcare Improvement

Starmer AJ, Spector ND, Srivastava R, Allen AD, Landrigan CP, Sectish TC; I-PASS Study Group. I-pass, a mnemonic to standardize verbal handoffs. Pediatrics. 2012 Feb;129(2):201-4. doi: 10.1542/peds.2011-2966. Epub 2012 Jan 9. PMID: 22232313; PMCID: PMC9923540. https://pmc.ncbi.nlm.nih.gov/articles/PMC9923540/

Taberna M, Gil Moncayo F, Jané-Salas E, Antonio M, Arribas L, Vilajosana E, Peralvez Torres E, Mesía R. The Multidisciplinary Team (MDT) Approach and Quality of Care. Front Oncol. 2020 Mar 20;10:85. doi: 10.3389/fonc.2020.00085. PMID: 32266126; PMCID: PMC7100151. https://pmc.ncbi.nlm.nih.gov/articles/PMC7100151/

TeamSTEPPS Module 1: Communication. Agency for Healthcare Research and Quality. Accessed Jan 30, 2026. https://www.ahrq.gov/teamstepps-program/curriculum/communication/index.html

Tool: Handoff. 2023. Agency for Healthcare Research and Quality. https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/handoff.html

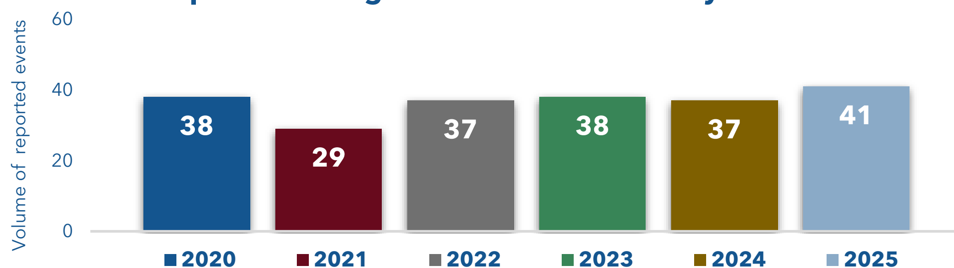
Warm Handoff Intervention: Patient and Family Engagement. AHRQ Patient Safety May 18, 2017. https://www.bing.com/videos/riverview/relatedvideo?q=warm+hand-off+ihi&mid=8505B4FD115B1E4D673C8505B4FD115B1E4D673C&FORM=VIRE

Spotlight on Quality & Patient Safety

Spotlight on Health Care Facilities in the Commonwealth: Wrong Site/Side/Procedure Events

In response to wrong site, wrong side, and wrong procedure events, hospitals and ambulatory surgery centers across the Commonwealth have implemented the following actions:

- Standardizing and clearly designating roles within the time-out process, including verification that the procedure order aligns with the booking schedule and the consent form.
- Updating the time-out process to require review of relevant imaging prior to the procedure.
- Providing surgical services nurses with access to PACS (Picture Archiving and Communication System).
- Revising time-out documentation to prominently display the intended site and laterality at the top of the form.
- Implementing mandatory site marking for regional block procedures performed by anesthesiologists.
- Requiring at least two staff members, including the proceduralist, to be present for every time-out conducted prior to nerve blocks.
- Standardizing the time-out workflow across all procedural areas to eliminate variation.
- Requiring surgeons to circle the appropriate intraocular lens (IOL) type and diopter on the IOL master sheet, with the date and surgeon's initials.
- Implementing policies and processes regarding the use of ultrasound for confirmation of proper guidewire placement in the jugular vein during central line insertions.
- Sharing events at department meetings, M&Ms, and staff meeting to share key teaching points and increase awareness among clinicians.
- Ensuring a culture of safety whereby staff are able to stop the line whenever a concern or discrepancy exists. Some have created a specific "awareness pause" during the time out process where the attending surgeon asks, "Does anyone have any concerns?"



QPSD REPORTING REMINDERS

Ambulatory Surgery Centers and Ambulatory Clinics
PCA-QA Reports
(or Annual & Semiannual Reports)
Due by March 30, 2026

Hospitals
PCA-QA Reports
(or Annual & Semiannual Reports)
Due by April 30, 2026

Heywood Healthcare

From Compliance to Learning: Strengthening Safety through Transparency

Jody Langlois, CRHCP, CPPS, System Director Risk Management, Patient Safety, & Regulatory Affairs
Laura Sims, RN, BSN, MBA, Senior Director of Quality and Risk, Corporate Compliance Officer
Dayna Stahl, DNP, MSN/ED, RN, VP of Patient Care Services and Chief Nursing Officer
Frank Sweeney, MD, Chief Medical Officer

In healthcare, some of the most meaningful safety improvements begin not with policy change, but with a shared understanding of why transparency matters. Safety work is rarely comfortable, and reporting safety events can feel deeply uncomfortable. Over time, our organization has come to appreciate that reporting is not simply a regulatory obligation, but a powerful tool for learning.

Figure 1.

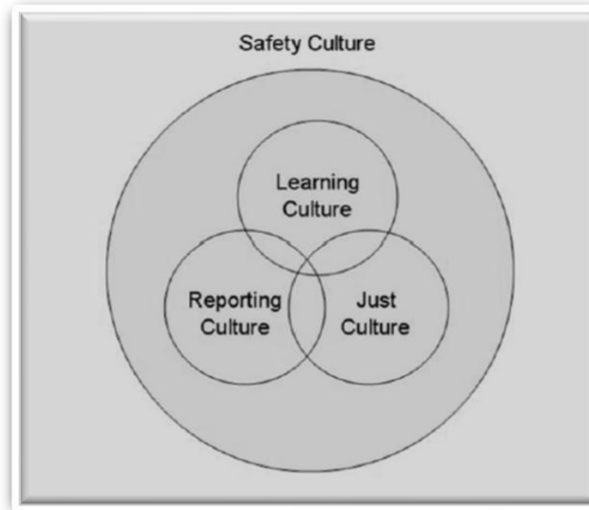


Figure 1. Reporting, learning, and just culture are interconnected elements of a strong safety culture.

While we consistently reinforced the importance of reporting and how it supports collective learning, another organization's experience helped further clarify and strengthen our "why." Learning about an experience at Virginia Mason Medical Center reinforced how transparency following a preventable event can extend learning far beyond a single organization. Open disclosure prompted other hospitals to recognize similar risks and change their processes. Perhaps most impactful was the recognition that earlier sharing of a similar event elsewhere might have prevented harm altogether. This experience deepened our understanding of how transparency transforms individual events into system-wide prevention.

Internal reporting supports local learning; external reporting extends that learning beyond our walls and helps prevent harm elsewhere.

This reflection also strengthened our understanding of the intent behind National Patient Safety Goals, reinforcing how standards, while sometimes perceived as burdensome, are grounded in real events and shared learning intended to prevent harm. Understanding the context behind these expectations helped shift conversations from "what is required" to "why it matters."

With this understanding, our organization intentionally evolved how we approach safety event review and learning. We shifted away from viewing reporting solely through a compliance lens and toward a culture that emphasizes fairness, learning, and shared responsibility. Central to this work has been the integration of the Just Culture Decision Tool into root cause analyses, peer learning discussions, and event review processes. By using a consistent, non-punitive framework, conversations-particularly those that explore questions such as whether staff performed as expected, have become more productive and less defensive, allowing teams to focus on system factors and improvement opportunities.

What we learned along the way is that leading with Just Culture required more than applying a framework- it required us, as leaders, to shift our own thinking first. We could not ask leaders and staff to approach events with curiosity, fairness, and accountability if we were not consistently modeling those behaviors ourselves. Our credibility depended on examining our own assumptions about error, risk, and responsibility before expecting others to do the same.

In parallel, we have seen increased engagement at the departmental level through the use of structured quality assurance processes to initiate case reviews and peer learning discussions. These mechanisms have complemented traditional incident reporting and expanded the ways safety signals are identified, discussed, and addressed. Together, these approaches reinforce that learning can occur through multiple pathways and that responsibility for safety is shared across the organization.

Culture change rarely happens all at once. Often, it begins by planting small seeds-leaning into discomfort, sharing stories, and applying consistent frameworks that support learning. Over time, those efforts take root, strengthening trust, learning, and collaboration. By embracing transparency and collective learning, organizations can move beyond individual experiences and contribute to safer care for patients across the broader healthcare community.

Massachusetts Board of Registration in Medicine Quality & Patient Safety Division

Please contact the QPSD with any questions, comments, or future potential contributions to the Spotlight:

Trinh Ly-Lucas, MSN, NP-BC
Quality Nurse Analyst

trinh.ly-lucas@mass.gov

Patient Care Assessment (PCA) program and online reporting guidance including video tutorials, examples of fictitious SQR reports, and an overview of Patient Care Assessment may be found at:

Patient Care Assessment Program | Mass.gov

This issue is provided by the Board of Registration in Medicine (BORIM), Division of Quality and Patient Safety (QPSD). This issue allows BORIM to share the practices and experiences of the healthcare clinicians and facilities that report to the QPSD. It does not necessarily include a comprehensive review of literature. Publication of this issue does not constitute an endorsement by the BORIM of any practices described in this issue and none should be inferred.