The purpose of Healthcare Safety reporting is to enhance healthcare transparency in Texas and empower patients to make informed decisions about their healthcare.

Adverse Event: An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.
Objectives

1. Describe the current status and reporting environment in the US.
2. Review the PAE reporting requirements.
3. Correct common mistakes made by providers when entering PAE data.
4. Share the current status and findings of the Texas PAE reporting program.
5. Review the resources that are available on the PAE website.
6. Inform participants of upcoming training.
7. Give contact information and follow-up instructions.
Scope of the Problem

440,000 Deaths per Year in the US.

- **Falls**—
  - 700,000-1,000,000 falls annually\(^1\)
  - Leading cause injury-related death 65 & older
  - $30 billion by 2020\(^2,3\)

- **Pressure Ulcers**—
  - 257,412 Medicare patients 2007\(^1\)
  - 60,000 patients die annually from HA PUs
  - Average charge of $43,180\(^4\)

- **Medication Errors**—
  - 1000/day in hospitalized pts\(^5\)
  - 15/100 admissions—75% preventable\(^6\)

- **HAIs**—
  - 2 Million annually in US\(^7\) (200,000 in Texas\(^8\))
  - ~ 90,000 deaths (8-9000 Texas deaths)
  - ~ $5 billion - $ 31.5 billion\(^2\) healthcare costs
Joint Commission
Types of Sentinel Events

- Review of 2014 Events
- Voluntarily Reported N=764
  - 15% Unintended Retention of a Foreign Body
  - 12% Fall
  - 11% Suicide
  - 9% Delay in Treatment
  - 9% Wrong patient, Site, Procedure
  - 7% Operative/Post-op Complications
  - 37% Other

Joint Commission, SE Statistics as of: 1/14/2015
http://www.jointcommission.org/sentinel_event.aspx
Joint Commission
Root Causes of Sentinel Events

• Review of 2013 events
• Voluntarily reported N=887
  - 72% Human Factors
  - 63% Communication
  - 62% Leadership
  - 57% Assessment

Joint Commission, Office of Quality and Patient Safety
2013 Most Frequently Identified Root Causes of Sentinel Events
Reason's Swiss Cheese Model

Organization's layers of protection/defenses against hazards

Holes represent weaknesses/gaps

- **Hazards**
  - Med Adm

- **Organizational influences**
  - Low focus on safety

- **Unsafe supervision**
  - Less time for orientation

- **Precondition for unsafe act**
  - Look alike drugs on same shelf

- **Unsafe act**
  - Administering incorrect drug

- **Losses**
  - Med Error

State of the Nation Overview

• Reporting of Preventable Adverse Events
  - Internal reporting, formal & informal
    • Facilities are required to track events*
    • Facilities are required to*
      - Monitor effectiveness/safety of services
      - Analyze causes
      - Implement actions to prevent recurrence
  - External reporting to CMS, PSO’s, States
  - Public reporting by time period by event type, in the aggregate, and by facility

*42 CFR 482.21(a)(2)
Published by the National Academy for State Health Policy

Key Findings:
- Number of state reporting systems increased to 28 including Texas
- 27 Mandatory 1 Voluntary (Oregon)
- Wyoming ended
- New Hampshire started
Follow-up Processes

- Root Cause Analysis (20)
- Corrective Action Plan (19)
- Both RCA and CAP (15)
- Clinical review, On-Site investigation, Surveillance (16)
Between 2010 and 2013:

✓ *Patient Safety* improved
✓ 17% reduction in rates of hospital-acquired conditions.
✓ Half of *Patient Safety* measures improved
✓ 1.3 million fewer harms to patients
✓ 50,000 lives saved (est)
✓ $12 billion in cost savings (est)
Minnesota’s 10-Year Evaluation

- # of deaths from reportable adverse events overall from 2004 - 2013
- Serious disability slowly but steadily
- # of reported events remained ~ overall
- Surveyed facilities feeling significantly safer 4 X than in 2008
- Specific campaigns (retained foreign objects) resulted in of those events
- Submitted data more robust
- Time between occurrence and discovery
- 80% of facilities using shared learnings about adverse events.
Texas Health and Safety Code

- Senate Bill 203 of the 81st Legislature (2009) amended the Health and Safety Code, Chapter 98.102.a.2,4,5, to require:

  Healthcare facilities to report certain preventable adverse events to the DSHS,

  AND

  DSHS to make this data available to the public by facility, by type, and by number.
Who Must Report?

• **General Hospitals** licensed under Chapter 241 or a hospital that provides surgeries or obstetrical services and is maintained or operated by this State.
  - All General Hospitals provide OB and/or Surgery.
  - Comprehensive Medical Rehabilitation Hospitals do not have to report.
  - LTAC’s must report if they are licensed as a General Hospital (provide OB and/or Surgery).
  - It does not include a LTAC licensed as a Special Hospital.

• **Ambulatory Surgery Centers** licensed under Chapter 243.
Texas Preventable Adverse Event Reporting 3 Tier Phase-In Implementation

Second Tier PAE Reporting Beginning January 1, 2016

1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
2. Iatrogenic Pneumothorax with venous catheterization.
3. Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.
4. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
5. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
6. Patient death or severe harm associated with patient elopement.
7. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
8. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.
9. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.

Third Tier PAE Reporting Beginning January 1, 2017

1. Surgical site infections following a spinal procedure, shoulder procedure, elbow procedure, laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.
2. Artificial insemination with the wrong donor sperm or wrong egg.
3. Poor glycemic control: hypoglycemic coma.
4. Poor glycemic control: diabetic ketoacidosis.
5. Poor glycemic control: nonketotic hyperosmolar coma.
7. Poor glycemic control: secondary diabetes with hyperosmolarity.
8. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.
9. Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
10. Patient death or severe harm associated with intravascular air embolism that occurs while being cared for in a health care facility.
11. Patient death or severe harm associated with a medication error.

First Tier PAE Reporting Beginning January 1, 2015

1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
2. Foreign object retained after surgery.
3. Post-operative death of an ASA Class 1 Patient.
4. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
5. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.
7. Sexual abuse or assault of a patient within or on the grounds of a health care facility.
8. Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a health care facility.
9. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
10. Patient death or severe harm associated with unsafe administration of blood or blood products.
11. Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
12. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
13. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.
14. Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.
SURGICAL OR INVASIVE PROCEDURE EVENTS
1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
2. Foreign object retained after surgery.
3. Post-operative death of an ASA Class 1 Patient.

PATIENT PROTECTION EVENTS
1. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
ENVIRONMENTAL EVENTS

1. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.

2. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.

POTENTIAL CRIMINAL EVENTS


2. Sexual abuse or assault of a patient within or on the grounds of a health care facility.

3. Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a health care facility.
1. Patient death or severe harm associated with unsafe administration of blood or blood products.
2. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
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5. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
SURGICAL OR INVASIVE PROCEDURE EVENTS
1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
2. Iatrogenic Pneumothorax with venous catheterization.

PATIENT PROTECTION EVENTS
1. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
2. Patient death or severe harm associated with patient elopement.
ENVIRONMENTAL EVENTS
1. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
2. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.

POTENTIAL CRIMINAL EVENTS
1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
CARE MANAGEMENT EVENT
1. Any Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.

RADIOLOGICAL EVENT
1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
What to Report?

- We are using modified AHRQ Common Formats for the reporting formats.
- All questions from the Common Formats will be presented but only the following are required:
  - Category of Event
  - Type of Event
  - Date of Event
  - MR/Patient ID#
  - Degree of Harm
  - Do you want to delete this record?
- Facilities are NOT required to:
  - Report or identify unsafe conditions or near misses—ONLY actual events
Assessment of Harm

- PAE’s that start with the words Patient Death or Severe Harm are reportable if the assessed level of residual harm is Patient Death or Severe Harm.

- PAE’s that do not start with those words, e.g. Foreign object retained after surgery, are all reportable regardless of the assessed level of residual harm.

- There are 3 choices for the level of harm question:
  - Death
  - Severe harm
  - Other (includes Moderate harm, Mild harm, No harm, Unknown harm)
**Basic Information**

- **Record ID:** 300000868
- **Record Type:** PAE - Care Management Event
- **Person:** ()
- **Investigation Status:** Active Record - Reported
- **Linked Records(s):** 0 linked records(s) ([View])
- **Attachments:** 0 attachment(s) ([Add])
- **Facility Links:** This PAE is only reportable if the Degree of Harm is Death or Severe Harm. Change Degree of Harm to Death or Severe Harm OR request to delete record. Record is in workflows ([View List]).

---

**General QP**

- After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?

Other (includes No harm, Moderate harm, Mild harm or Unknown Harm)

---

“This PAE is only reportable if the Degree of Harm is Death or Severe Harm. Change Degree of Harm to Death or Severe Harm OR request to delete record.”
Concern displayed if choice is other than Death

Record Dashboard

This PAE is only reportable if the Degree of Harm is Death. Change Degree of Harm to Death OR request to delete record.

General QP
How to Report?

- PAEs are entered by the reporting facility into the Texas Healthcare Safety Network (TxHSN).
  - Manual entry online
  - XML Upload per TxHSN webservices

- PAE reporting deadlines, comment period and public posting of data follows the established HAI schedule.
## TxHSN Reporting Schedule

<table>
<thead>
<tr>
<th>Reporting Quarter</th>
<th>Q1: Jan 1 – Mar 31</th>
<th>H1: Jan 1 – June 30</th>
<th>Q3: July 1 – Sept 30</th>
<th>H2: July 1 – Dec 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility data submission deadline</td>
<td>Within 60 days of end of reporting quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSHS takes preliminary data snapshot</td>
<td>1-Jun</td>
<td>1-Sept</td>
<td>1-Dec</td>
<td>1-Mar</td>
</tr>
<tr>
<td>DSHS sends email to facility users review data</td>
<td>~15-Jun</td>
<td>~15-Sep</td>
<td>~15-Dec</td>
<td>~15-Mar</td>
</tr>
<tr>
<td>Facility data corrections due</td>
<td>30-Jun</td>
<td>30-Sep</td>
<td>31-Dec</td>
<td>31-Mar</td>
</tr>
<tr>
<td>Last day to verify no PAEs to report for half year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSHS takes final data snapshot</td>
<td>1-July</td>
<td>1-Oct</td>
<td>1-Jan</td>
<td>1-Apr</td>
</tr>
<tr>
<td>DSHS sends email to facility to review data summary and make comments</td>
<td>NA</td>
<td>15-Oct</td>
<td>NA</td>
<td>15-Apr</td>
</tr>
<tr>
<td>Facility comment period deadline</td>
<td>NA</td>
<td>30-Oct</td>
<td>NA</td>
<td>30-Apr</td>
</tr>
<tr>
<td>DSHS reviews comments</td>
<td>NA</td>
<td>15-Nov</td>
<td>NA</td>
<td>15-May</td>
</tr>
<tr>
<td>Public posting of data summary with approved comments</td>
<td>NA</td>
<td>1-Dec</td>
<td>NA</td>
<td>1-Jun</td>
</tr>
</tbody>
</table>
Facilities report directly into TxHSN via TDSHS website portal. Facility-specific reports are then generated.
HAI Reporting

DSHS exports HAI data from NHSN and stores it in TxHSN. Facility-specific reports are then generated.
Internal Data Review Report Notification: Four times a year, in mid June, September, December and March, TxHSN users will receive an email instructing them to login to TxHSN and review their facility’s Internal Data Review Report to make sure PAE data look correct and to make corrections if needed.
Comments Notification: Then, twice a year (for the half year time periods) in October and April, TxHSN users will receive another email with instructions to login to TxHSN and preview their Health Care Safety Reports. Users will be able to submit a comment for DSHS approval that will be posted on their reports.
PAE Reporting Overview

After comments are approved, the final Health Care Safety Reports for each half year are posted in June and December for the public to view at

http://txhsn.dshs.texas.gov/hai/

Alerts regarding data & reports

View reports & make comments
What will be posted?

- The PAE results will be included in the HAI public report.
- PAEs will be reported by facility, by name and by number.
- Example:

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death or severe harm associated with unsafe administration of blood or blood products</td>
<td>1</td>
</tr>
<tr>
<td>Foreign object retained after surgery</td>
<td>1</td>
</tr>
<tr>
<td>Type of Event</td>
<td>Total Number</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in a Fracture</td>
<td>75</td>
</tr>
<tr>
<td>Foreign Object Retained After Surgery or Invasive Procedure</td>
<td>44</td>
</tr>
<tr>
<td>Wrong Site Surgery or Invasive Procedure</td>
<td>21</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in an Intracranial Injury</td>
<td>13</td>
</tr>
<tr>
<td>Wrong Surgery/Procedure</td>
<td>11</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in Other Injury</td>
<td>8</td>
</tr>
<tr>
<td>Perinatal Death or Severe Harm (maternal or neonate) Associated with Labor or Delivery in a Low-Risk Pregnancy while being cared for in a health care facility</td>
<td>6</td>
</tr>
<tr>
<td>Any Incident in which Systems for O2 or Other Gas Contains No Gas, Wrong Gas, or are Contaminated by Toxic Substances</td>
<td>4</td>
</tr>
<tr>
<td>Type of Event</td>
<td>Total Number</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results</td>
<td>3</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with Use of Physical Restraints or Bedrails</td>
<td>2</td>
</tr>
<tr>
<td>Intra-operative or Immediately Post-operative Death of an ASA Class 1 Patient</td>
<td>2</td>
</tr>
<tr>
<td>Wrong Patient Surgery or Invasive Procedure</td>
<td>2</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in a Dislocation</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Abuse or Assault of a Patient within or on the Grounds of a Health Care Facility</td>
<td>1</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Resulting from a Physical Assault that Occurs within or on the Grounds of a Health Care Facility</td>
<td>1</td>
</tr>
</tbody>
</table>
Infectious Disease Control

HEALTH CARE-ASSOCIATED INFECTIONS

People can get infections from hospitals, surgery centers or other places that offer health care. This is a big public health problem. A recent survey showed that 722,000 infections (HAIs) occurred in 2011 in the United States. This means that about 4% of hospital patients ended up with at least one infection.

All hospitals, clinics and other health care facilities know that stopping HAIs is vital. These HAIs are still a major cause of disease, loss of life and high medical costs. So, laws were put in place to report these infections to the public. There are ways to help manage and prevent them. DSHS created a system to track HAIs. General hospitals and surgery centers are required to report the following HAIs:

- Central line associated bloodstream infections (CLABSIs): These are infections in the blood that happen when a central line (tube that carries medicine and other treatments into a patient’s body) is used in a patient.
- Catheter associated urinary tract infections (CAUTIs): These are infections in a patient’s urinary tract (often referred to as a urinary tract infection or UTI) after a tube is placed in a patient that allows urine to pass out of the patient.
- Surgical Site Infections (SSIs): These infections happen in a patient’s body after the patient has surgery.

To see hospital and surgery center reports, please search HAI Data. Each healthcare facility reports their own cases and are not confirmed by DSHS.)
Data Website:
http://txhsn.dshs.texas.gov/hai/
How to get started?

- Complete and submit a PAE Contact Form. Each facility can have up to 2 designated contacts. These persons will be given access to enter data.
- Contacts then receive the website, log-in and temporary password information via email.
- Log-in and change your password.
- Review the TxHSN orientation slides.
- Contacts can then enter PAE data.
- Review resources on the PAE website.
Sign up for e-mail updates

Email quick link

www.paetexas.org
Click on FAQs and Resources

Infectious Disease Control

Preventable Adverse Events (PAEs)

PAE Training Materials for Texas Reporting

- Introduction to TxHSN PAE Users Guide (PDF PowerPoint) March 2015
- Introduction to TxHSN PAE HAI User Guide (PDF PowerPoint) March 2015
- PAE Reporting 101 (01/16/2015) Recorded webinar
- PAE Reporting 101 (01/16/2015) (PowerPoint, with notes)
- PAE Data Reporting (12/22/14, Recorded webinar)

PAE Tool Kit

- Definitions and Guidance PDF, 523 KB Revised 4/1/2015
- Perinatal Algorithm 01/01/2015
- PAE Categories and Tiers 120214
- Current PAE Brochure Sept 2014 PDF, 567 KB
- PAF Alert for ASC's Word, 49.6 KB
- TxHSN PAE Questions Worksheet PDF, 594 KB, Revised 04/01
- PAE Contact Change Form 11_12_2014
Resource Websites

- NQF  www.qualityforum.org
- AHRQ  www.ahrq.org
- PSO  www.pso.ahrq.org
- PSOPPC  https://psoppc.org/web/patientsafety/commonformats
- PSNET  http://www.psnet.ahrq.gov
- NHSN  www.cdc.gov/nhsn
- NPSF  www.nhsf.org
- IHI  www.ihi.org
- TCQPS  www.texashospitalquality.org
- TAHQ  www.txquality.org
- TMF  www.tmf.org
- TxChapter 98  www.statutes.legis.state.tx.us
- TxAdmCode  http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac
- PAETexas  www.PAETexas.org
A Third TxHSN Users Training will be given in September on the following topics:

- **TxHSN Reports:**
  - Review of TxHSN Healthcare Safety Reports (public)
  - Submitting comments—you won’t be able to do this until October—for the first half 2015
  - Printing event records
  - ???

- Dates/times/registration on the PAE website under Education-Training
Contact Information

*Help Desk Email*

PAETexas@dshs.state.tx.us
HAITexas@dshs.state.tx.us
512-776-7676

Emily Engelhardt, TxHSN Administrator
emily.engelhardt@dshs.state.tx.us
512-776-7676

Vickie Gillespie, PAE Clinical Specialist
vickie.gillespie@dshs.state.tx.us
512-776-7676

THE HELP DESK EMAIL IS THE BEST FIRST PLACE TO CONTACT AS IT IS MONITORED BY THREE PERSONS.
Questions?

Thank you!