GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

HEALTH REGULATION AND LICENSING ADMINISTRATION

Adverse Events in the District of Columbia

Annual Report
December
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FOR THE REPORTING PERIOD:

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Executive Summary

Improving Healthcare Delivery in the District of Columbia

In December 2006, the District of Columbia passed the Medical Malpractice Amendment Act of 2006. The Act requires that any licensed healthcare provider or medical facility must report adverse events, which include 28 Serious Reportable Events defined by the National Quality Forum (NQF) as events that are unambiguous (identifiable and measurable), serious (resulting in death or significant disability), and usually preventable. In 2009, the Act was amended to require that adverse event reports must be reported within 60 days of their occurrence. Adverse event reports submitted to the Department of Health (the Department) are confidential and patient information is de-identified. The Department analyzes these reports, identifies patterns or trends, recommends methods to reduce systematic adverse events, provides technical assistance to healthcare providers and medical facilities, and disseminates information and advice on best practices.

This second annual report provides an analysis of adverse event reports and describes the most important findings from the reporting period July 1, 2008, through September 30, 2009. The report covers 15 months of reported adverse events in order to standardize the reporting period to include a twelve month period beginning in October. The Department has focused on educating reporting facilities by providing individualized feedback on reported events. This initiative will continue with feedback to facilities on corrective action plans and evaluation of root cause analyses. The next step in the ongoing effort to improve healthcare delivery in the District of Columbia is the implementation of a web-based adverse event reporting system. The first phase of implementation, scheduled to begin in early 2010, will include hospitals and ambulatory surgical centers.

Data Collection—Patterns and Trends in Adverse Event Reports

Collecting and analyzing reports of adverse events is a vital component of the District of Columbia's goal to improve healthcare delivery. During the reporting period July 2008 through September 2009, the District's healthcare providers and medical facilities submitted a total of 706 adverse event reports. Twenty-eight (4%) of the reports involved a patient death. Acute care hospitals submitted 420 (59%) of the reports; 280 (40%) were submitted by long-term acute care or rehabilitation hospitals, and the remaining 6 (<1%) reports were submitted by a nursing home.

The Department has adopted NQF's list of 28 Serious Reportable Events as a classification system for reportable events. In addition to these, the Department collects one type of healthcare-associated infection (HAI): central-catheter-associated laboratory-confirmed primary bloodstream infection (CLABSI). The most commonly reported event types were CLABSIs, falls, pressure ulcers, and retained foreign objects, representing 674 (95%) of reports submitted.

Highlights of the data submitted to the Department for the reporting period July 2008 to September 2009 include the following:

- A total of 706 adverse event reports were received.
- Twenty-eight reports (4%) involved a patient death.
- The majority of reports, 420 (59%), were submitted by acute care hospitals.
- CLABSI 634 (90%) was the most frequently reported event.

- Of 64 non-CLABSI reports specifying an event type, 61 (95%) were substantially complete.
- Event descriptions were thorough in 39 (61%) of non-CLABSI reports specifying an event type and inadequate or missing in 4 (6%), compared to 13 (28%) and 12 (26%) respectively during the last reporting period.

The adverse event reports submitted by healthcare providers and medical facilities in the second year of the District's reporting program represent a sustained effort by District healthcare providers and medical facilities. Consistent and reliable data is needed to continue to obtain useful information. The goal is a decrease in the number of adverse events that accurately reflects an improvement in the safety of healthcare delivery in the District. In 2010, the District is launching a web-based adverse event reporting initiative to support the reporting efforts of healthcare providers and facilities. The initial stage of implementation will include hospitals and ambulatory surgical facilities.

Guidance for Healthcare Providers and Medical Facilities

One of the chief goals of any reporting program is to prevent the occurrence of similar adverse events in the future. By analyzing the causes of adverse events, we hope to find and repair the weaknesses in clinical processes in order to prevent the same events from happening to other patients or residents. At the facility or provider level, the analysis of an individual adverse event can uncover root causes and contributing factors underlying the event and provide the basis for development of strategies to prevent recurrence. However, at this level of analysis, it may be difficult to determine trends in the data related to the type or volume of adverse events experienced by a provider or facility. When a particular type of adverse event occurs rarely, a facility may view it as a random occurrence, and the potential to implement systems and processes for prevention may be lost.

Aggregating adverse event data gathered from facilities and providers throughout the District is a powerful tool in identifying trends undermining safe and effective healthcare. The introduction of a web-based adverse event reporting system providing access to aggregate data at the District and nationwide level strengthens this process. Analysis of the information received through the District's reporting program will serve as the basis for meaningful insights, lessons learned, and best practices that can improve patient safety. This report focuses on the most frequently reported events: Central-Catheter-Associated Laboratory-Confirmed Primary Bloodstream Infection (CLABSI), stage III or IV pressure ulcers, retained foreign objects after surgery, and falls. For each of these event types, this report discusses what we have learned about the causes of these events and presents strategies for helping to prevent these events from happening again.

Introduction

Adverse Event Reporting and Patient Safety

Medical errors and adverse events are a significant killer in the United States, and most are preventable. According to the Institute of Medicine (IOM), more than 1 million preventable adverse events occur each year in the United States, of which 44,000 to 98,000 are fatal.[1] Although the accuracy of these numbers has been questioned, there is general consensus throughout the healthcare community that safety is a significant problem in virtually all care settings and that the healthcare system frequently puts patients at unnecessary risk.

Since IOM published *To Err is Human*, both the healthcare community and the general public have become considerably more aware of and sensitive to the issues surrounding patient safety. One of the principal recommendations of the IOM report was to create a mandatory reporting system for the most serious events. In response, several healthcare error reporting systems have been launched by public and private entities. For example, the Joint Commission implemented its Sentinel Event Policy (SEP) following the publication of the IOM report. SEP instructs organizations to identify sentinel events, complete a thorough root cause analysis of those events, implement strategies to reduce their prevalence, track the effectiveness of those strategies, and share lessons learned.[2]

Reporting systems are an important mechanism for generating knowledge about errors and their underlying causes. They help healthcare providers learn from experience, share lessons learned, and monitor their progress over time. When reports are shared beyond the four walls of a healthcare facility to an external party that aggregates and analyzes the results, there is a remarkable opportunity to disseminate lessons more broadly. The National Academy for State Health Policy and others have identified many ways in which public reporting systems can stimulate improvements in the safety and quality of patient care.[3]

For example:

- Safety alerts about new hazards can be generated from just a few or even one significant report.
- Safety alerts about hazards can be generated from analysis across many reports that reveals patterns and trends.
- Best practices can be gleaned from data-driven analyses, particularly in trying to identify the performance factors that help some facilities prevent or recover from certain types of errors while other facilities do not.

The importance of collecting of data systematically was recognized at the federal level, leading to the establishment of the National Quality Forum (NQF), a voluntary consensus standards-setting organization. NQF has developed a list of serious reportable events in healthcare that are: (1) clearly identifiable and measurable; (2) of a nature such that the risk of occurrence is significantly influenced by

[1] Institute of Medicine Committee on Quality of Health Care in America. Kohn LT, Corrigan JM, Donaldson MS, eds. *To err is human: building a safer health system*. Washington (DC): National Academy Press; 1999 Nov 1:223 p.
[2] Sentinel Events. In: Joint Commission. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace (IL): Joint Commission Resources; 2006.

the policies and procedures of the healthcare facility; and (3) of concern to both healthcare providers and the public.[3]

In addition, to be considered a serious reportable event, an event must be unambiguous, usually preventable, serious, and one or more of the following:

- Adverse
- Indicative of a problem in a healthcare facility's safety systems
- Important for public credibility or public accountability

Requiring that an event be "usually preventable" acknowledges that some of these events are not always avoidable, given the complexity of the healthcare industry. The presence of an event on the list, therefore, is not an *a priori* judgment of either a systems failure or lack of due care. The ability to derive and disseminate good lessons from bad events is a hallmark of an effective reporting system. The primary goals are to prevent harm and enhance public trust. Through the establishment of an adverse event reporting program that encompasses standardized reporting requirements, the District has taken an important step in achieving this goal.

[3] National Quality Forum (NQF). *Serious reportable events in healthcare 2006 update: a consensus report*. Washington (DC): NQF; 2007.

Data Collection and Analysis

The Reporting Program

The District has mandated the reporting of adverse events by a broad range of healthcare providers and medical facilities. Adverse events that must be reported include the 28 NQF Serious Reportable Events and one healthcare-associated infection (HAI): central-line-associated bloodstream infection (CLABSI). Starting in January 2010, hospitals and ambulatory surgical centers will be required to report adverse events using a web-based reporting system. A standardized Adverse Event Reporting Form is available to all other medical facilities and healthcare providers for this purpose. Reports must be submitted within 60 days of the occurrence of an adverse event. A monetary penalty is imposed for failure to report. The Department collects and analyzes the reports, providing an annual report including summary data and recommendations. The Act contains well-defined confidentiality provisions related to reporters and information provided to the system administrator.

Reports by Event Type

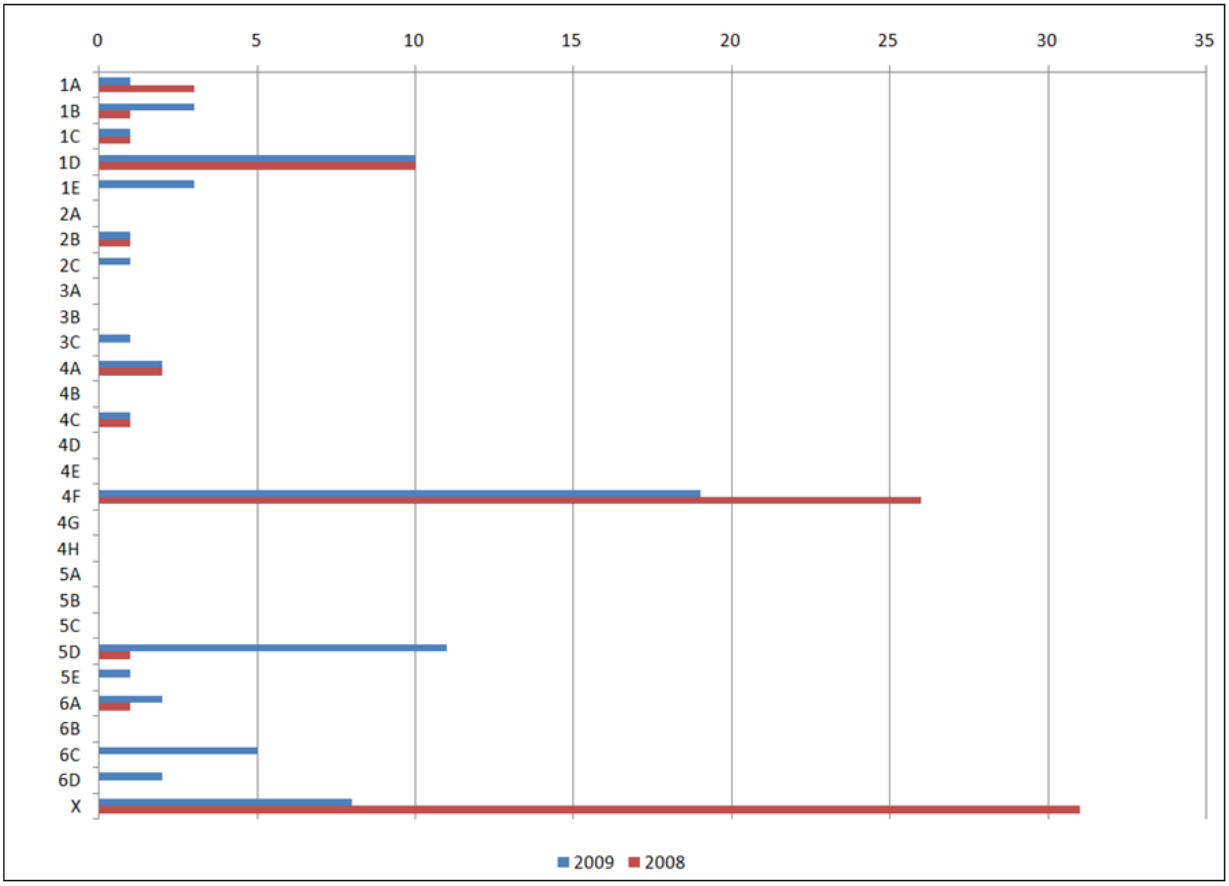
In the second reporting period, which covered events submitted between July 1, 2008, and September 30, 2009, District medical facilities and healthcare providers submitted 706 reports to the Department. The most frequently reported types of events were CLABSIs, stage III or IV pressure ulcers, falls, and retained foreign objects representing 674 (95%) of reports submitted. Eight (1%) of the reports did not specify the event type. Table 1 summarizes the reports submitted by event type. Table 2 provides a comparison between the number of events reported during this reporting period and the previous reporting period. Please note that the current reporting period includes reports submitted during a fifteen month period.

Table 1. Number and Percentage of Reports by Event Type

Event Category	Event Type	No.	%
Surgical Events	1A - Surgery performed on the wrong body part	1	<1
	1B - Surgery performed on the wrong patient	3	<1
	1C - Wrong surgical procedure performed on a patient	1	<1
	1D - Unintended retention of a foreign object in a patient after surgery or other procedure	10	1
	1E - Intraoperative or immediately postoperative death in an ASA (American Society of Anesthesiologists) Class I patient	3	<1
Product or Device Events	2A - Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	0	0
	2B - Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	1	<1
	2C - Patient death or serious disability associated with intravascular air embolism that occurs while the patient is being cared for in a healthcare facility	1	<1
Patient Protection Events	3A - Infant discharged to the wrong person	0	0
	3B - Patient death or serious disability associated with patient leaving the facility without permission	0	0

Event Category	Event Type	No.	%
	3C - Patient suicide or attempted suicide resulting in serious disability while the patient is being cared for in a healthcare facility	1	<1
Care Management Events	4A - Patient death or serious disability associated with a medication error	2	<1
	4B - Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA-incompatible blood or blood products	0	0
	4C - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while the patient is being cared for in a healthcare facility	1	<1
	4D - Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	0	0
	4E - Death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns	0	0
	4F - Stage III or IV pressure ulcers acquired after admission to a healthcare facility	19	3
	4G - Patient death or serious disability due to spinal manipulative therapy	0	0
	4H - Artificial insemination with the wrong donor sperm or wrong egg	0	0
Environmental Events	5A - Patient death or serious disability associated with an electric shock while the patient is being cared for in a healthcare facility	0	0
	5B - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	0	0
	5C - Patient death or serious disability associated with a burn incurred from any source while the patient is being cared for in a healthcare facility	0	0
	5D - Patient death or serious disability associated with a fall while the patient is being cared for in a healthcare facility	11	2
	5E - Patient death or serious disability associated with the use of restraints or bedrails while the patient is being cared for in a healthcare facility	1	<1
Criminal Events	6A - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	2	<1
	6B - Abduction of a patient of any age	0	0
	6C - Sexual assault on a patient within or on the grounds of a healthcare facility	5	1
	6D - Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility	2	<1
Healthcare Associated Infections	7 – Central-catheter-associated bloodstream infection	634	90
No Event Type Reported	X - No event type reported	8	1
	Total	**706**	100

Table 2. Comparison of Number of Event Types (Non-CLABSI)



Overall, the most significant changes in the number of events reported occurred in the falls event type category. District facilities reported an almost 10 fold increase in falls events this reporting period. A change in the number of event reports may reflect increased reporting or a difference in the number of events that occurred. In addition, the reporting period this year includes fifteen months compared to a twelve month period last year. The number of non-CLABSI event reports that did not indicate an event type decreased, from 31 (40%) in 2008 to 8 (1%) in 2009. During the current reporting period there was also an increase in the total number of event types reported, from 11 event types in 2008 to 17 event types.

Reports by Level of Harm

The Department's use of NQF's list of Serious Reportable Events means that every report submitted represents an event that caused substantial harm to a patient. For example, the list does not require reporting of all patient falls or even all patient falls resulting in harm but only those resulting in "death or serious disability."[4] There is one question on the report form that explicitly addresses the degree of harm: "Did the patient expire?" This distinguishes only two categories of harm: death or a level of harm

[4]NQF defines the term "serious" as resulting "in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility."

less severe than death. Not all reportable events necessarily imply the same degree of harm, and it is often useful to distinguish among degrees of harm. To this end, a harm scale developed by the National Coordinating Council for Medication Error Reporting and Prevention was applied to non-CLABSI-related reports, 85% (61) could be categorized based on the information provided. Table 3 summarizes the level of harm among those reports. Table 4 provides a comparison of the percentage of the level of harm identified in reports.

Table 3. Level of Harm (Non-CLABSI Reports)

Harm Score	Reports	%
An event occurred that contributed to or resulted in temporary harm and required treatment or intervention	24	39
An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization	21	29
An event occurred that contributed to or resulted in permanent harm	2	3
An event occurred that resulted in a near-death event (e.g., required ICU care or other intervention necessary to sustain life)	2	3
An event occurred that contributed to or resulted in death*	12	17
Could not be determined from information provided	11	18

* (There were 28 total deaths—16 (57%) of those were potentially related to a CLABSI)

Table 4. Comparison of Level of Harm (Non-CLABSI Reports)

Harm Score	% (2009)	% (2008)
An event occurred that contributed to or resulted in temporary harm and required treatment or intervention	39	18
An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization	29	41
An event occurred that contributed to or resulted in permanent harm	3	10
An event occurred that resulted in a near-death event (e.g., required ICU care or other intervention necessary to sustain life)	3	3
An event occurred that contributed to or resulted in death	17	28

Report Quality

During the current reporting period, there was an increase in the overall quality of reports in terms overall completion of the event report form as well as the quality of the information provided. Table 5 summarized the number of substantially complete reports by event type as determined by over 50% completion of all fields in the event report form.

Table 5. Completion of Event Report Forms (excludes CLABSI and reports with no event type specified)

Event Type	Complete Reports	Incomplete Reports	Total
1A - Surgery performed on the wrong body part	1	0	1
1B - Surgery performed on the wrong patient	3	0	3
1C - Wrong surgical procedure performed on a patient	1	0	1
1D - Unintended retention of a foreign object in a patient after surgery or other procedure	10	0	10
1E - Intraoperative or immediately postoperative death in an ASA (American Society of Anesthesiologists) Class I patient	3	0	3
2A - Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	0	0	0
2B - Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	1	0	1
2C - Patient death or serious disability associated with intravascular air embolism that occurs while the patient is being cared for in a healthcare facility	1	0	1
3A - Infant discharged to the wrong person	0	0	0
3B - Patient death or serious disability associated with patient leaving the facility without permission	0	0	0
3C - Patient suicide or attempted suicide resulting in serious disability while the patient is being cared for in a healthcare facility	1	0	1
4A - Patient death or serious disability associated with a medication error	2	0	2
4B - Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA-incompatible blood or blood products	0	0	0
4C - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while the patient is being cared for in a healthcare facility	1	0	1
4D - Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	0	0	0
4E - Death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns	0	0	0
4F - Stage III or IV pressure ulcers acquired after admission to a healthcare facility	17	2	19

Event Type	Complete Reports	Incomplete Reports	Total
4G - Patient death or serious disability due to spinal manipulative therapy	0	0	0
4H - Artificial insemination with the wrong donor sperm or wrong egg	0	0	0
5A - Patient death or serious disability associated with an electric shock while the patient is being cared for in a healthcare facility	0	0	0
5B - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	0	0	0
5C - Patient death or serious disability associated with a burn incurred from any source while the patient is being cared for in a healthcare facility	0	0	0
5D - Patient death or serious disability associated with a fall while the patient is being cared for in a healthcare facility	11	0	11
5E - Patient death or serious disability associated with the use of restraints or bedrails while the patient is being cared for in a healthcare facility	1	0	1
6A - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	2	0	2
6B - Abduction of a patient of any age	0	0	0
6C - Sexual assault on a patient within or on the grounds of a healthcare facility	4	1	5
6D - Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility	2	0	2
Total	61	3	64

During the previous reporting period, 40 (85%) of event reports were substantially completed, compared to 61 (95%) during the current reporting period. In 2008, event descriptions were thorough in 13 (28%) of non-CLABSI reports specifying an event type, compared to 39 (61%) during the current reporting period. Six hundred and thirty four CLABSI reports were submitted. CLABSI reports were submitted in a variety of forms that included the District's adverse event forms, by tables of line listings used in hospitals for infection surveillance, and by submitting National Health Safety Network (NHSN) forms as represented in Table 6.

Table 6. Methods of CLABSI Event Reporting

CLABSI Report	Total
Line Listings	282
NHSN report forms	31
Adverse Event Report Form	321
Total	634

Root Causes and Corrective Action Plans in Reports

The Department of Health Adverse Event Reporting Form requires submission of a Corrective Action Plan (CAP). A CAP describes how the facility or provider plans to prevent or reduce the risk of similar events in the future. Any CAP should be based in part on the root cause or causes of the event, defined as the most basic factor or factors that, if corrected or removed, will reduce the risk or prevent recurrence of a situation.[2] The provision of healthcare involves complex systems of people and technology and presents virtually unlimited opportunities for errors with many possible causes and contributing factors. Without a structured way to approach the investigation of errors, it would be easy to overlook important causative factors and miss the opportunity to put systems in place to eliminate error. Analysis of the cause or causes of an event helps ensure that all possible causes of medical error are considered and that appropriate, effective, CAPs are developed and implemented.

Failure in the performance of any one physician, nurse, or other practitioner is seldom the sole cause of an adverse event. The investigation of an event must look beyond the direct patient care provider to identify causes embedded in the system. Of the non-CLABSI-related reports submitted that specified an event type, 45 (70%) explicitly identified a cause, an improvement since the last reporting period (in which 31% of reports identified a cause). Table 7 indicates reports by event type that identify a root cause or a contributing factor. Of the 45 reports identifying a cause, 34 (76%) went beyond individual performance and cited one or more system-related causes for the event. Two reports cited individual performance as a possible cause of the event. Four reports of a fall cited patient related factors, either the patient or family was non-compliant with instructions. Of the 634 CLABSI-related reports submitted, one report explicitly identified that the patient's co-morbidities were a contributing factor. Table 8 indicates whether a Corrective Action Plan (CAP) was submitted and the quality of the CAP. A generic CAP refers to corrective actions in the plan that is facility-wide and/or not specific to the reported event.

Table 7. Number of Reports by Event Type and Identification of Root Causes/Contributing Factor
(excludes CLABSI reports and reports not specifying an event type)

Event Type	Reports Identifying Causes/Contributing Factors	Reports With No Causes or Contributing Factors Identified	Total
1A - Surgery performed on the wrong body part	1	0	1
1B - Surgery performed on the wrong patient	3	0	3
1C - Wrong surgical procedure performed on a patient	1	0	1
1D - Unintended retention of a foreign object in a patient after surgery or other procedure	9	1	10
1E - Intraoperative or immediately postoperative death in an ASA (American Society of Anesthesiologists) Class I patient	3	0	3
2A - Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	0	0	0
2B - Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	1	0	1
2C - Patient death or serious disability associated with intravascular air embolism that occurs while the patient is being cared for in a healthcare facility	1	0	1
3A - Infant discharged to the wrong person	0	0	0
3B - Patient death or serious disability associated with patient leaving the facility without permission	0	0	0
3C - Patient suicide or attempted suicide resulting in serious disability while the patient is being cared for in a healthcare facility	1	0	1
4A - Patient death or serious disability associated with a medication error	2	0	2
4B - Patient death or serious disability associated with a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA-incompatible blood or blood products	0	0	0
4C - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while the patient is being cared for in a healthcare facility	1	0	1
4D - Patient death or serious disability associated	0	0	0

Event Type	Reports Identifying Causes/Contributing Factors	Reports With No Causes or Contributing Factors Identified	Total
with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility			
4E - Death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns	0	0	0
4F - Stage III or IV pressure ulcers acquired after admission to a healthcare facility	11	8	19
4G - Patient death or serious disability due to spinal manipulative therapy	0	0	0
4H - Artificial insemination with the wrong donor sperm or wrong egg	0	0	0
5A - Patient death or serious disability associated with an electric shock while the patient is being cared for in a healthcare facility	0	0	0
5B - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	0	0	0
5C - Patient death or serious disability associated with a burn incurred from any source while the patient is being cared for in a healthcare facility	0	0	0
5D - Patient death or serious disability associated with a fall while the patient is being cared for in a healthcare facility	7	4	11
5E - Patient death or serious disability associated with the use of restraints or bedrails while the patient is being cared for in a healthcare facility	0	1	1
6A - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	2	0	2
6B - Abduction of a patient of any age	0	0	0
6C - Sexual assault on a patient within or on the grounds of a healthcare facility	2	3	5
6D - Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility	0	2	2
Total	45	19	64

Table 8. Corrective Action Plans (excludes CLABSI reports and reports not specifying an event type)

Event Type	Reports with CAP		No CAP	Total
	Generic	Non-generic		
1A - Surgery performed on the wrong body part	0	1	0	1
1B - Surgery performed on the wrong patient	1	2	0	3
1C - Wrong surgical procedure performed on a patient	0	1	0	1
1D - Unintended retention of a foreign object in a patient after surgery or other procedure	0	10	0	10
1E - Intraoperative or immediately postoperative death in an ASA (American Society of Anesthesiologists) Class I patient	0	1	2	3
2B - Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	0	1	0	1
2C - Patient death or serious disability associated with intravascular air embolism that occurs while the patient is being cared for in a healthcare facility	0	1	0	1
3C - Patient suicide or attempted suicide resulting in serious disability while the patient is being cared for in a healthcare facility	0	1	0	1
4A - Patient death or serious disability associated with a medication error	0	2	0	2
4C - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while the patient is being cared for in a healthcare facility	0	1	0	1
4F - Stage III or IV pressure ulcers acquired after admission to a healthcare facility	11	7	1	19
5D - Patient death or serious disability associated with a fall while the patient is being cared for in a healthcare facility	5	5	1	11
5E - Patient death or serious disability associated with the use of restraints or bedrails while the patient is being cared for in a healthcare facility	0	0	1	1
6A - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	2	0	2
6C - Sexual assault on a patient within or on the grounds of a healthcare facility	0	4	1	5
6D - Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility	1	0	1	2
Total	18	39	7	64

Guidance and Recommendations

The Department is charged with providing facilities and providers with recommended methods to reduce systematic adverse events and disseminating information and advice on best practices. During this reporting period, in order to provide meaningful feedback to facilities, each reporting facility received an individualized report analyzing the quantity and quality of its reporting. Where possible while preserving a facility's confidentiality, a comparison was provided to the corrective action plans submitted by other facilities. Examples of retrospective and/or proactive event investigation techniques were presented.

The following is a summary of the most commonly reported event types. As required by the Act, the information is de-identified and anonymous with regard to the facility, provider, and patient. Root causes/contributing factors and preventive strategies identified by healthcare facilities and providers are shared. Finally, recommended best practices are provided to further assist facilities and providers in improving healthcare delivery in the District.

Retention of a Foreign Object

Foreign objects can be left behind following a surgical procedure in any part of the body—most frequently in the abdominal cavity and thorax—although no body cavity is invulnerable.[5] Sponges are the items most frequently reported as retained, followed by instruments.[5] Retention of a foreign object (RFO) may lead to serious complications, such as sepsis, fistula or small bowel obstruction, or visceral perforation.[5] RFO is considered a serious preventable event by NQF.[6] The Centers for Medicare & Medicaid Services (CMS) includes RFO in its list of hospital-acquired conditions for which reimbursement will not be provided.[7]

Estimates of the incidence of RFOs vary. It may be difficult to arrive at a true estimate of the incidence of RFOs since an RFO can remain undetected for years. RFOs are rare, occurring at a rate of 1 in 5,500 to 1 in 8,801 inpatient operations.[8,9] During the current reporting period, 10 total RFO events were reported by District facilities. Of the 10 reports, 1 death was reported, although the death was attributed to multiple medical complications, not directly to the RFO. Six (60%) reports indicated that the patient required an additional operative procedure. All events involved patients aged 55 or younger. Retained objects identified in the reports were as follows:

- Sponges 3(30%)
- Screw/screw tab 2(20%)

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[5]Gawande AA, Studdert DM, Orav EJ, et al. Risk factors for retained foreign bodies after surgery. *N Eng J Med* 2003 Jan 16;348(3):229-35.

[6] National Quality Forum. Serious reportable events in healthcare- 2006 update: A consensus report. Washington, DC: National Quality Forum;2007.

[7] Centers for Medicare & Medicaid Services. Hospital-acquired condition (present on admission indicator) [online]. 2009 Feb 19 [cited 2009 Mar 11]. Available from Internet: http://www.cms.hhs.gov/HospitalAcqCond/ 06_Hospital-Acquired_Conditions.asp.

[8] Egorova NN, Moskowitz A, Gelijns A, et al. Managing the prevention of retained surgical instruments. What is the value of counting? *Ann of Surg* 2008 Jan;247(1):13-8.

[9]Cima RR, Kollengode A, Garnatz J, et al. Incidence and characteristics of potential and actual retained foreign object events in surgical patients. *J Am Coll Surg* 2008 Jul;207(1):80-7.

- Surgical tubing 1(10%)
- Balloon fragment 1(10%)
- Catheter tip 1(10%)
- Pin tip 1(10%)
- Retractor 1(10%)

Of the 10 reports, 2 RFO reports indicated that the count was correct. In these events, the RFO was discovered after the patient was discharged. Two facilities reported that the count was incorrect. Both reports indicate that an x-ray was performed. In one event, the RFO was not detected on the x-ray (a false negative); in the other event the film was taken after the patient's incision was closed. In two other reports, one facility reported a broken drill bit, and another reported a broken pin. In both cases, the RFO was not retrievable. None of the 10 reports indicates that the facility used routine postoperative screening x-rays for RFOs. Finally, four reports of RFOs involved objects that are not generally counted, including surgical tubing, catheter balloons, central-line catheters, and screw tabs.

Prevention of Retained Foreign Objects

The causes of RFOs were most often related to communication breakdown and/or the lack of an element of evidence based recommended counting procedures. Facilities reported the following root causes/contributing factors to the events:

- An incorrect count was announced after the patient's incision was closed
- Screws were not routinely included in the surgical count.
- X-rays to rule out the retention of a foreign object were not reviewed by a radiologist.
- Nursing staff reported a correct instrument count; surgeons failed to confirm that all instruments were removed prior to final closure.
- Hospital policy did not include a sponge count at the end of each procedure when multiple bilateral procedures were performed.

All RFO reports included a corrective action plan, which includes actions that the healthcare facility will implement to prevent the event from happening again. In RFO reports involving incorrect surgical counts corrective actions included:

- Revision of counting policies to follow Association of PeriOperative Registered Nurses (AORN) guidelines.
- Radiology department will write a policy to address steps to follow when an x-ray is obtained for the evaluation of an RFO.
- Indications for and results of x-rays will be discussed directly between radiologist and surgeon.
- In-servicing will be conducted with staff to reinforce the proper procedure when a count is incorrect.

CAPS submitted where the surgical count was thought to be correct included the following corrective actions:

- Use sponge count bags.
- Use radiopaque sponges to increase visualization of sponges on x-rays.
- Obtain postoperative x-rays for surgeries longer than eight hours or when two or more body cavities and/or are multiple teams are involved.

- Revise the count sheet to provide more specific documentation /tracking of instruments.

Other CAPS included the following corrective actions:

- Policy updated to require counting of screw tabs.
- Vendor contacted to promote safety with device (surgical drain).
- Warning sheet included with instrumentation to count screw tabs with surgical count.
- Documentation of event to support transparency.

Additional Resources

Counting procedures to prevent RFOs are in place in most hospitals. However, regulations do not prescribe how counts should be performed, who should perform them, and when they should be performed. American College of Surgeons (ACS), AORN, and Joint Commission guidelines recommend counting all sponges, sharps, and instruments at the following times:

- Before the procedure, to establish a baseline
- Before the closure of a cavity within a cavity
- Before wound closure begins
- At skin closure
- At the time of permanent relief of either the scrub person or circulating nurse

Adding to the count sheet any sponge, sharp, or instrument subsequently introduced to the operative field and performing counts to coincide with personnel handoffs is also recommended. In July 2006, AORN, with the support of ACS, published the following best practices for preventing the retention of a foreign object:[10,11,12]

- Consistently perform surgical counts according to national standards and facility policy.
- Promote an environment that is focused on, and attentive to, the patient's perioperative care.
- Use only x-ray-detectable sponges, towels, miscellaneous items, and instruments in the surgical wound.
- Conduct a methodical wound exploration before wound closure and whenever a count discrepancy is noted.
- Employ radiographic or other technology as needed to ensure that all potential foreign objects have been removed from the surgical site.
- Document the outcomes of the surgical count, items intentionally used for packing, and actions taken to rectify a count discrepancy.
- Provide resources to support safe practices to prevent RFOs.
- Develop and review count policies and procedures though a collaborative process to promote consistency in practice across disciplines.

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[10] Association of periOperative Nurses (AORN). Best practices for preventing a retained foreign body. *AORN J* 2006 Jul;84(1 Supp 1):S30-6.
[11] American College of Surgeons. Statement on the prevention of retained foreign bodies after surgery. *Bull Am Coll Surg* 2005 Oct;90(10):15-6.
[12] Joint Commission. Foreign objects retained after surgery [online]. 2009 Jan [cited 2009 Jul 30]. Available from Internet: http://www.jcrinc.com/Foreign-Objects-Retained-After-Surgery.

- Make count policies and procedures readily available in the practice setting.

Stage III & IV Pressure Ulcers Acquired after Admission to a Healthcare Facility

Stage III and IV pressure ulcers are considered Serious Reportable Events and have been added to the list of hospital-acquired conditions whose treatment will no longer be reimbursed by Medicare. Pressure ulcer incidence rates vary considerably by clinical setting—ranging from 0.4% to 38% in acute care, from 2.2% to 23.9% in long-term care, and from 0% to 17% in home care.[13] Stage III and IV pressure ulcers include pressure ulcers with full thickness tissue loss and full thickness tissue loss with exposed muscle, tendon or bone. The Department received 19 reports of stage III or IV pressure ulcers acquired after admission. The majority of these reports (17 [89%]) were submitted by hospitals. Three reports involved patients age 65 or older. The most frequently cited co-morbidities in patients who developed stage III or IV pressure ulcers were poor nutritional status, anemia, and immobility.

Prevention of Stage III and IV Pressure Ulcers

Facilities reported the following root causes/contributing factors to the events:

- The patient has atypical skin breakdown
- Failure to identify early signs of skin breakdown
- Staff education required updating
- Skin care assessment protocols not updated
- Patient was non-compliant with instructions or refused to change position

CAPS were submitted with 18 (95%) reports; of these, 11 (61%) were facility-wide CAPs. Corrective actions submitted included the following:

- Staff soliciting improved family participation in care planning
- Plan of care modified to prompt patient to change position in chair
- Skin resource group meets monthly to improve PU prevention
- Nursing staff re-educated about skin assessment, wound identification and wound care
- Improve communication during hand-off with transfer from the unit:
    - Review wound care worksheet with receiving RN
    - Assess skin/pressure points together
    - Track wounds as required
- Handoff to include nurse to nurse bedside assessment for patients with a Braden score of ≥18
- Wound resource nurse program implemented with representative on each unit
- Revised wound care protocols to include all phases of skin breakdown
- Automatically place high-risk patients in specialty beds
- Skin breakdown prevention order set developed for computerized physician order entry system
- Wound & skin consults added to computerized system so the Wound Care Specialist will receive rapid notification and consult information to eliminate phone call/faxes and improve communication

[13] Lyder CH. Pressure ulcer prevention and management. *JAMA* 2003;289(2):223-6.

- Braden Q Skin Assessment Tool will be enhanced with better definitions to assist staff in scoring accuracy

Additional Resources

As part of its 5 Million Lives campaign, the Institute for Healthcare Improvement (IHI) recommends that the following elements be included in a comprehensive prevention program:[14]

- Conduct a pressure ulcer admission assessment for all patients
- Reassess the pressure risk for all patients daily
- Inspect each patient's skin daily
- Manage patient moisture; keep the patient dry, and moisturize skin
- Optimize patient nutrition and hydration
- Minimize pressure to the patient's body, especially to areas of bony prominences

Details of each element of prevention are available on the IHI Web site. A number of clinical practice guidelines have been developed in the area of pressure ulcer prevention and treatment. The following is a summary of the National Quality Forum's Safe Practices for Pressure Ulcer Prevention:[15]

- Evaluate each patient on admission and regularly thereafter for the risk of developing pressure ulcers.
- Implement explicit organizational policies regarding the prevention of pressure ulcers, including the following:
    - Identify individuals at risk of developing pressure ulcers
    - Document the pressure ulcer risk assessment and prevention plan
    - Assess and periodically reassess each patient's risk, and act on the assessment
    - Perform quarterly prevalence studies to evaluate the effectiveness of the pressure ulcer prevention program
- Performance improvement initiatives should include the following elements:
    - Education regarding the pertinent pressure ulcer frequency and severity
    - Skill building in use of pressure ulcer prevention interventions
    - Implementation of process improvement interventions
    - Measurement of process or outcome indicators
    - Reporting of performance outcomes

NQF also endorses the use of implementation approaches, as follows:[15]

- Use of preventive fire-code-compliant pads or plastic polymer pressure-relieving pads on pressure points

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[14] Institute for Healthcare Improvement. Getting started kit: Prevent pressure ulcers. How to guide [online]. 2008 Mar 27 [cited 2009 Jul 28]. Available from Internet: https://www.ihi.org/users/login.aspx?returnURL=http%3a%2f%2fwww.ihi.org%2fihi%2fdownload.aspx%3ffile%3d%2fNR%2frdonlyres%2f5ABABB51-93B3-4D88-AE19-BE88B7D96858%2f0%2fPressureUlcerHowtoGuide.doc

[15] National Quality Forum (NFQ). Safe practices for better healthcare 2006 update [online]. [cited 2009 Sept 15]. Available from Internet: http://www.qualityforum.org/Publications/2007/03Safe_Practices_for_Better_Healthcare-2006.aspx.

- Repositioning of any patient at risk for the development of a pressure ulcer at least every two hours
- Nutrition assessment and supplements when indicated
- Instituting a protocol incorporating specific risk assessment scores, and empowering nurses to initiate prevention interventions without a physician's order

A summary of pressure ulcer prevention guidelines may be found at the National Guideline Clearinghouse (www.guideline.gov). In addition, National Pressure Ulcer Advisory Panel NPUAP provides a list of pressure ulcer prevention points at http://www.npuap.org/PU_Prev_Points.pdf.

Patient Death or Serious Disability Associated with a Fall

More than 1.8 million falls occur nationally every year; the most common injury is a hip fracture.[16] Falls are most common in older adults across healthcare settings. The Centers for Disease Control and Prevention (CDC) estimates that one in three U.S. adults age 65 or older falls each year.[17] Between 2% and 10% of hospital inpatients fall during a hospital stay.[18] Within nursing homes, an estimated 3% to 4% of residents fall each year.[19] During the current reporting period, District facilities reported eleven falls-related events. The number of event reports including common risk factors recognized to contribute to patient falls included the following:[20]

- Age >80—5 (45%)
- Cognitive impairment—4 (36%)
- Mobility/gait impairment—4 (36%)

Three of the reports (27%) involved patient deaths. The patient sustained a head injury in four (36%) of the events. Three (27%) events resulted in a fracture.

Prevention of Falls

Two event reports indicated that a Root Cause Analysis of the event was performed. Both of these reports indicated that a breakdown in the consistency of application of risk reduction interventions was a potential contributing factor. Facilities reported the following root causes/contributing factors to the events:

- Use of subjective decision-making instead of objective criteria (safety score) to evaluate fall risk
- Patient and family not compliant with instructions to contact nurse prior to going to the bathroom

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[16] ECRI Institute. *Falls Prevention Strategies in Healthcare Settings.* Plymouth Meeting (PA): ECRI Institute; 2006 Oct.
[17] Centers for Disease Control and Prevention. Falls among older adults; an overview [online]. 2008 Apr 25 [cited 2009 Aug 2]. Available from Internet: http://www.cdc.gov/ncipc/factsheets/adultfalls.htm.
[18] Hendrich A, Bender P, Nyhuis A. Validation of the Hendrich II fall risk model: a large concurrent case/control study of hospitalized patients. *Appl Nurs Res* 2003 Feb;16(1):9-21.
[19] Centers for Disease Control and Prevention. Falls in nursing homes [online]. 2008 Jun 10 [cited 2009 Aug 2]. Available from Internet: http://www.cdc.gov/ncipc/factsheets/nursing.htm.
[20] Bunting RF, Schukman J, Wong WB. The impact of preventable adverse events and ways to reduce them. Chapter 5. In: *A comprehensive guide to managing never events and hospital acquired conditions*. Marietta, GA. Lionhart Publishing, Inc.; 2009:5:19.

- Patient's daughter insisted that the patient use a bedside commode when the patient could not bear weight
- Patient instructed to call but did not wait for nurse
- Patient non-compliant with weight bearing restrictions

Four (36%) of the reports of falls indicated that the patient and/or family member was instructed that the patient was not to get out of bed or a chair unassisted but did not comply. Two (18%) reports indicated that the patient was sitting on the side of the bed while a caregiver was in the room; both of these events occurred in patients with risk factors for a fall.

Ten of the falls-related event reports submitted by District facilities contained a CAP. Half of these referred to a facility-wide falls prevention program that was not described. Additional corrective actions in plans included:

- Fall prevention education to be added to agency staff orientation
- Fall debriefing on all patient falls with monthly review of all falls at staff meetings
- Institute walking rounds at shift change to enhance compliance
- Review of use of chairs with footrests in elderly patients
- Assess area around bedside commode for items a patient could fall on (e.g., trashcan)

Additional Resources

Since 2005, the Joint Commission's National Patient Safety Goals for accredited organizations have included the implementation of a program aimed at reducing the risk of injury from falls. To meet the requirements for this goal, accredited facilities must implement falls reduction programs and conduct ongoing assessment of the efficacy of the program. The key components of a program aimed at addressing the persistent problem of falls in healthcare facilities include assessment for falls risk, action-based interventions, postfalls assessment and data collection, and use of falls reduction program tools.[21,22] When developing or revising fall prevention policies and protocols, it is important to consider that the risk factors for falls are complex and that no single type of intervention will succeed in eliminating the risk of falling.

Major areas that should be addressed in a falls prevention policy include the following:[21,22,23,24]

- Composition, responsibilities, and goals of a falls prevention team
- Definition of a fall
- Falls risk assessment requirements for inpatients, residents, outpatients, visitors, and employees

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[21] ECRI Institute. Falls. *Healthc Risk Control* 2005 Sep;2:Safety and Security 2:4-6.
[22] Pennsylvania Patient Safety Authority. Medication assessment: one determinant of fall risk. *PA PSRS Patient Saf Advis* 2008 Mar;5(1):16-8.
[23] Joint Commission. Root causes: tips and strategies for addressing the top three root causes of falls. *Jt Comm Perspect Patient Saf* 2003 Jun:5.
[24] Association for Healthcare Research and Quality (AHRQ). National Guideline Clearinghouse: Fall prevention in older adults [online]. 2004 Feb
[cited 2008 Sep 19]. Available from Internet:
http://www.guideline.gov/summary/summary.aspx?doc_id=4833&nbr=003480&string=fall+AND+prevention.

- Requirements for reassessment of risk
- Environmental rounds
- Responsibilities of staff
- Initial and ongoing education of staff
- Intervention strategies
- Appropriate responses to falls, including protocols for investigation
- Event documentation and reporting requirements
- Collection and analysis of data for trends
- Revision of intervention strategies based on data
- Falls rates reporting within a quality improvement plan
- Promotion of the falls reduction program and risk awareness
- Reeducation of caregivers who are noncompliant with falls policies, procedures, and protocols, as well as counseling or remediation should noncompliance persist

A number of falls prevention tools can be accessed at:

- AHRQ's Quality Tools Web site at http://www.qualitytools.arhq.gov.
- IHI at http://www.ihi.org/IHI/Topics/PatientSafety/ReducingHarmfromFalls
- The National Guideline Clearinghouse at: http://www.guideline.gov/summary/summary.aspx?doc_id=9743&nbr=005216&string=falls
- Healthcare Quality Improvement Community (MedQIC) at: http://www.medqic.org

Central-Catheter-Associated Laboratory-Confirmed Primary Bloodstream Infection

Nationally, the incidence (or infection rate) of CLABSI in hospitals ranges from 1.5 to 6.8 infections per 1,000 central-line days, depending on the type of hospital unit.[25] To compare the CLABSI rate in District of Columbia hospitals with national figures requires collecting data not only on the infections, but also on the number of patients in each facility that have central line catheters during the same time period. During the second annual reporting period the Department did not require facilities to report this information. Some institutions are conducting house-wide surveillance, while other medical centers are only collecting data from the ICU. Three different methods are currently used by facilities to report CLABSI events, demonstrating the disparity in reporting. The Department is planning a standardized method to collect CLABSI.

Prevention of CLABSI

One of 634 CLABSI reports included a contributing factor, significant patient co-morbidities. Other contributing factor/root causes were not specified in the reports; however, known contributing factors to CLABSI are poor catheter handling techniques, unsanitary treatment areas, and lack of proper hand washing.

Seventy-seven (12%) reports did not include a CAP. Facilities reported the following corrective actions:

- Checklist for central catheter insertion

[25] Edwards JR, Peterson KD, Andrus ML, et al. National Healthcare Surveillance Network (NHSN) Report, data summary for 2006, issued June 2007. Am J Infect Control. 2007 Jun;35(5):290-301.

- Antimicrobial coated catheters
- Site care following CDC guidelines
- Daily assessment of the need for catheter
- Introduce the use of biopatch around insertion of central line

Additional Resources

CLABSI safe practices based on both CDC and IHI recommendations are summarized below:[26,27]

- Perform hand washing using an alcohol-based hand rub before and after central-catheter insertion and during catheter care.
- Use maximal barrier precautions in preparation for central-catheter insertion.
    - Cover the patient from head to toe with a sterile drape with an opening for the insertion site and using a cap, mask, sterile gown, and sterile gloves.
- Perform skin antisepsis using a 2% chlorhexidine-based preparation before catheter insertion.
    - Apply chlorhexidine solution using a back-and-forth friction scrub for at least 30 seconds.
    - Allow antiseptic solution time to dry completely before puncturing the site.
    - Chlorhexidine products are not approved by FDA for children two months of age or younger but are used at some institutions for cleaning central venous catheter (CVC) insertion sites or as a sponge dressing for children in this age group.[28]
    - A povidone-iodine preparation should be used to clean CVC insertion sites for children 2 months of age or younger, especially low-birth-weight neonates.[28]
- Select the optimal site for catheter insertion.
    - A subclavian line is the preferred site for nontunneled central catheters in adults.
- Review line necessity daily, and remove unnecessary lines promptly.
- Replace catheter-site dressings according to CDC guidelines, as follows:[26]
    - Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the catheter site. Tunneled CVC sites that are well healed might not require dressings.
    - If the patient is diaphoretic, or if the site is bleeding or oozing, a gauze dressing is preferable to a transparent, semipermeable dressing.
    - Replace catheter-site dressing if the dressing becomes damp, loosened, or visibly soiled.
    - Change dressings at least weekly for adult and adolescent patients, depending on individual patient circumstances.
    - Do not use topical antibiotic ointments or creams on insertion sites (except when using dialysis catheters) because of their potential to promote fungal infections and antimicrobial resistance.

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[26] O'Grady NP, Alexander M, Dellinger EP, et al. Guidelines for the prevention of intravascular catheter-related infections. Centers for Disease Control and Prevention. *MMWR Recomm Rep* 2002 Aug 9;51(RR10):1-26. Also available: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5110a1.htm.

[27] Institute for Healthcare Improvement (IHI). Prevent central line infections. Getting started kit. Updated how-to guide [online]. 2008 Jun [cited 2009 Sept 17]. Available from Internet: http://www.ihi.org/IHI/Programs/Campaign/CentralLineInfection.htm.

[28] Bleasdale SC, Trick WE, Gonzalez IM, et al. Effectiveness of chlorhexidine bathing to reduce catheter-associated bloodstream infections in medical intensive care unit patients. *Arch Intern Med* 2007 Oct 22;167(19):2073-9.

- Do not submerge the catheter in water. Showering should be permitted when precautions can be taken to reduce the likelihood of introducing organisms into the catheter.

The National Guideline Clearinghouse provides a summary of CLABSI prevention guidelines, available online at:
http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=13395&nbr=006806&string=CLABSI

Also refer to the Society for Healthcare Epidemiology of America/Infectious Diseases Society of America "Compendium of Strategies to Prevent Healthcare-Associated Infections" for practical recommendations about implementation of CLABSI prevention efforts available online at: http://www.shea-online.org/about/compendium.cfm

The Joint Commission (JCAHO) – 2009 National Patient Safety Goals (NPSG 07.04.01) This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

Conclusion

Medical facilities and providers in the District continue to take important steps in reducing the number of adverse events by submitting adverse event reports under the Medical Malpractice Amendment Act of 2006. Facilities have processes for addressing intentional or reckless provider behavior that may place patients at risk. Remedial or disciplinary action is an option in those cases. However, the focus of the reporting system is on using analysis of events to better understand how and why adverse events occur. Dissemination of lessons learned and best practices will facilitate system changes that consistently promote the delivery of safe patient care. The success of the reporting program continues to rely on the willingness of healthcare facilities and providers to submit meaningful reports. In 2010, the District will implement an electronic reporting system that will support this objective. The vision for the reporting system is to provide a tool for quality improvement and education. In addition, CLABSI-related reporting is currently undergoing development with the goal of a uniform method of reporting CLABSI rates. The delivery of safe patient care is the ongoing goal of the program and 2010 will usher in the next phase of this important effort.

Technical Credits

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