DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
Patient Safety Reporting Program

Annual Report
Fiscal Year 2019

FOR THE REPORTING PERIOD OF:

OCTOBER 1, 2018, through SEPTEMBER 30, 2019

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

ECRI

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EXECUTIVE SUMMARY

I. Background

In December 2006, the District of Columbia passed the Medical Malpractice Amendment Act of 2006. The Act requires that all licensed healthcare providers or medical facilities in the District of Columbia report adverse events, which include the 29 serious reportable events defined by the National Quality Forum (NQF) as events that are unambiguous (identifiable and measurable), serious (resulting in death or significant injury), and usually preventable.

In 2009, the Act was amended to require that adverse events be reported within 60 days of their occurrence. In January 2010, the web-based District of Columbia Department of Health (DC Health) - Health Regulation and Licensing Administration Patient Safety Reporting System, hosted by ECRI's Patient Safety Organization (PSO), was implemented as part of the ongoing effort to improve healthcare delivery.

Current users of the web-based adverse event reporting system include acute care and long-term acute care hospitals, rehabilitation facilities, and ambulatory surgical centers.

Adverse event reports are submitted to DC Health through its subcontractor, ECRI. These reports are confidential.

The web-based reports are analyzed to identify patterns, trends, and to recommend methods to reduce systematic adverse events, and they serve as the basis for the information disseminated to ensure best practices. In addition, technical assistance is provided to healthcare providers and medical facilities. All other facilities and providers can submit adverse event reports using the original paper-based form.

Starting in 2010, District facilities were required to report central-line-associated bloodstream infections (CLABSIs) in intensive care units (ICUs) through the National Healthcare Safety Network (NHSN) system, allowing epidemiologists at DC Health to monitor and validate infection rates for District facilities and contribute District information to the Centers for Disease Control and Prevention's (CDC) national database.

The DC Health Center for Policy, Planning and Evaluation's Division of Epidemiology Disease Surveillance and Investigation (CPPE DE-DSI) provides CLABSI data from CDC's NHSN to ECRI to include in the annual report.

This 12th annual report provides an update on the District of Columbia Patient Safety Reporting System. The report presents an overview of the program's offerings, analysis of adverse event reports, and descriptions of the most significant findings from events submitted between October 1, 2018, and September 30, 2019, as well as comparisons with data from previous years.

II. Data Collection—Patterns and Trends in Adverse Event Reports

Collecting and analyzing reports of adverse events is a vital component of the District's goal to improve the quality of healthcare delivery. During the reporting period of fiscal year 2019 (FY 2019), the District's healthcare providers and medical facilities submitted a total of 198 events to DC Health (DC Health, 2019; ECRI PSO).

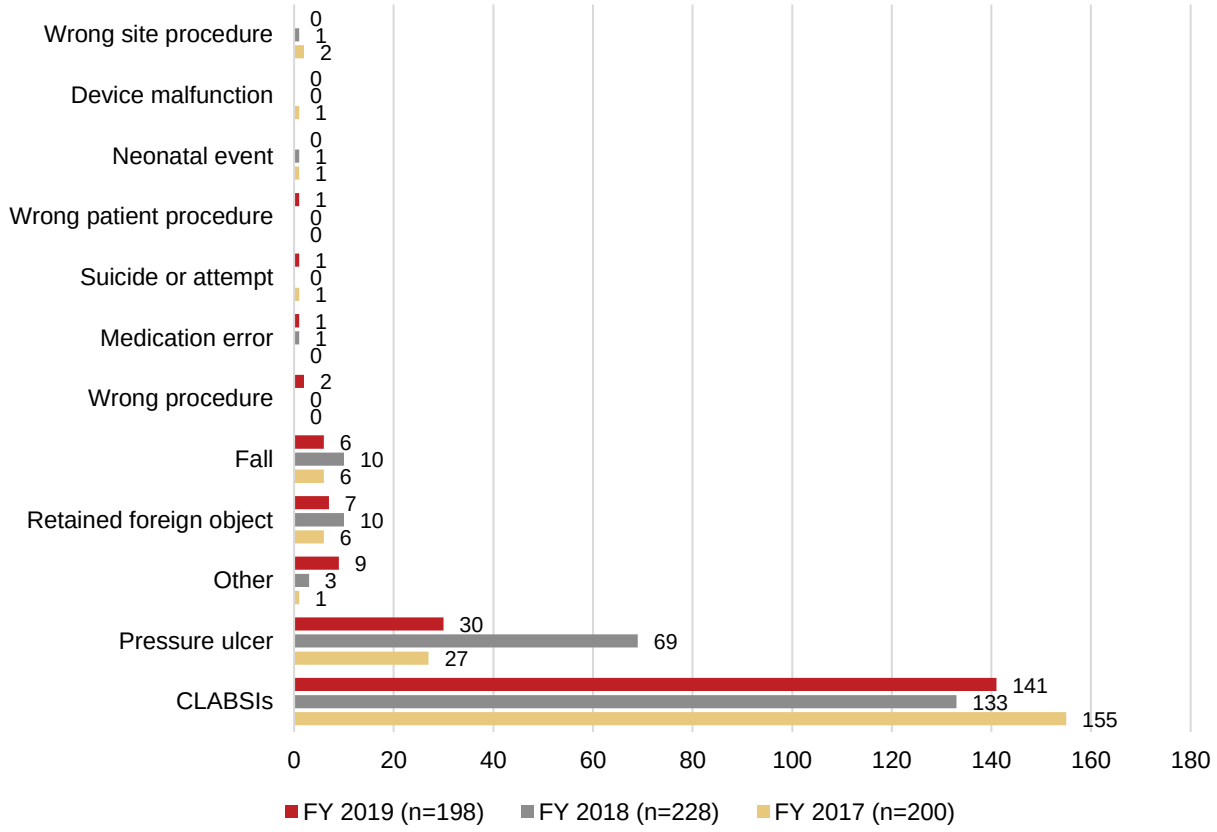
Fifty-seven (57) adverse event reports were submitted to the District of Columbia Patient Safety Reporting System, and 141 CLABSI reports (DC Health, 2019) were submitted to CDC's NHSN. These events are reported to and validated by DC Health's CPPE DE-DSI.

DC Health continued to use NQF's updated 2011 list of 29 serious reportable events as a classification system for reportable events during FY 2019. The NQF events analysis is based on events submitted from October 2018 through September 2019, regardless of event occurrence date. The lag time in reporting is due to the time lag established within the reporting requirement.

Similar to past years, the most commonly reported event types, representing 193 (98%) of reports submitted, were CLABSIs (71%), pressure ulcers (15%), other events (5%), retained foreign objects (4%) and falls (3%).

Figure 1 (p. 5) provides an overview of the number of serious reportable events, by event type, that have been reported over the past three fiscal years (ECRI PSO). The adverse event reports submitted by healthcare providers and medical facilities in the 12th year of the District's reporting program represent a continued effort by the District to contribute to the Patient Safety Reporting System.

FIGURE 1. NUMBER OF EVENTS BY TYPE, FY 2017-2019



INTRODUCTION

I. The District's Patient Safety Reporting System

Goals of the District's Patient Safety Reporting System:

- Promote patient safety
- Improve the culture of safety
- Learn from and prevent the reoccurrence of similar adverse events
- Provide feedback and information on best practices to District facilities

Aggregation of adverse event data gathered from facilities and providers throughout the District is a powerful tool for identifying trends in reported events that challenge safe and effective healthcare. Aggregation helps achieve the primary goal of the reporting program, which is to prevent the reoccurrence of similar adverse events. The web-based adverse event reporting system provides access to aggregate data at the District level and, through ECRI PSO, at the national level. Analysis of the information received through the District's reporting program serves as the basis for meaningful insights, lessons learned, and the development of best practices that can improve patient safety.

For the top three event categories—retained foreign objects, falls, and pressure ulcers—this report provides an overview of data from the fiscal year and presents guidance and recommendations to help look further into the practices surrounding these adverse events.

Aside from the annual report, in FY 2019, the District's Patient Safety Reporting System offered facilities the following resources:

- Webinars (Table 1, p. 7) are offered at least quarterly on patient safety topics.
- Patient safety advisory articles (Table 2, p. 7) are offered quarterly in the publications *National Navigator* and *District Navigator.*
- Custom feedback (Table 3, p. 8) on adverse events or topics provides resources and best practice information directly to facilities.
- Research responses (Table 3, p. 8) are summaries of research requests received at a national level on various topics.
- *Patient Safety Compass Points and E-lerts* (Table 4, p. 10) are unscheduled special notices on major patient safety issues that have occurred at a national level.
- *Patient Safety Membership Update* is a twice-monthly electronic newsletter that compiles updated patient safety news.

If a thorough corrective action plan (CAP) is submitted along with an event, it is analyzed through ECRI PSO's root-cause analysis (RCA) review process. The facility can then be provided with a report to further assist providers and staff in improving their processes. See "Corrective Action Plans in Reports" (p. 18) for details.

TABLE 1. EDUCATIONAL WEBINARS (NUMBER OF LINES PARTICIPATING), FY 2019

Date	Title	Lines
October 2018	Coordination: The Key to Providing Quality Primary Care	0
November 2018	Meeting Patients' Behavioral Health Needs in Acute Care	2
December 2018	Putting ECRI's Top 10 Health Technology Hazards List into Action	0
January 2019	Transgender Patient Safety: Advanced Concepts	1
January 2019	Electrosurgical Safety: Don't Get Burned by These Common Mistakes	0
March 2019	Leveraging the EMR to Improve Sepsis Outcomes	3
April 2019	A Multidisciplinary Perspective on Optimizing Safe Implementation and Use of Infusion Pumps	0
April 2019	Driven by Data: Don't Leave ADC Override Safety Outside the Drawer	0
May 2019	When Words and Actions Matter Most: Responding to Patient Harm: The Case for CANDOR	1
June 2019	ECRI's Top Ten Patient Safety Concerns	2
September 2019	Bridging the Gap Between Implementation Science and Integration of Best Practice: A Practical Approach	0
September 2019	Safe Practices for Drug Allergies – Using CDS and Health IT	0

TABLE 2. NAVIGATOR AND PATIENT SAFETY ADVISORY ARTICLES, FY 2019

National	ECRI PSO Annual Meeting: Building a Patient Safety Infrastructure
	Hands-On Learning for Health Profession Trainees: Minimize Error-Prone Conditions
	Perinatal Safety: Attention to Care Bundles to Prevent Adverse Events
	Device Dislodgement: Common but Sometimes Harmful Event
District	Patients' Behavioral Needs Going Unmet in Non-Behavioral Settings: Resources and Support Systems Lacking
	When Students Make the Catch: Opportunities for Learning All Around

	Postpartum Hemorrhage: Identify Risk Factors and Implement Supportive Systems Solutions
	Keep Calm and Manage Expectations: Reducing Agitation's Effects in Intubated Patients

TABLE 3. CUSTOM FEEDBACK AND RESEARCH RESPONSES, FY 2019

Custom Feedback	Alarm Management
	Retained Guidewires
	Wrong Site Surgery
	Fall Prevention
	Medical Devices and Pressure Ulcers
	Pediatric Falls
	Pressure Ulcer Prevention
	Retained Foreign Objects
	Tubing Misconnections
	Risk Management Plan
	Pressure Ulcer Benchmarking Rates
	HIT Workflow Issues
	Endotracheal Tube Alerts
	Deep Tissue Injury
	Medication Packaging Labels
	Patient Experience
Research Responses	Recommended Intervals for Vital Sign Monitoring
	Early Warning Systems to Identify Patients at Risk of Deterioration
	Video Laryngoscopes: Best Practices for Use and Injury Prevention
	Imaging Contrast Injection Extravasation
	Screening ED Patients for Concealed Weapons
	Shoulder Dystocia Detection and Prevention
	Ensuring Emergency Access to a Backup Defibrillator

	Mobile Mammography
	Managing Incidental Findings on Imaging
	Risk Management Strategies for Safe Use of IV Contrast for Emergency CT Studies

TABLE 4. PATIENT SAFETY COMPASS POINTS AND E-LERTS, FY 2019

One Last Request: Improving Documentation and Communication of End-of-Life Treatment Choices
Security in the Ambulatory Setting: Dealing with Disruptive Patients and Visitors
Don't Be Left Out of the Loop—Use Technology to Close It Instead
When a Spoonful of Sugar Won't Help: Pediatric Prescribing Risks
Agitation in Hemodialysis Settings: Be Ready to Manage the Unexpected
A Ripple Effect: Slow Care Transitions, Unclear Communication, and Delays in Care
Unsafe Sharps Practices Put Patients and Clinicians at Risk
Pediatric Patients in Distress: Clear Communication Supports Proper Response
Insulin and Insurance: Coverage and Care
Leave Me Alone: Isolation Failures and Infection Risk
Say My Name: Address Patients by Preferred Names and Pronouns
Diagnostic Errors in Ambulatory Care Settings: Laboratory
Diagnostic Errors in Ambulatory Care Settings: Imaging
Say What: Dictation-Related Transcription Errors
Alarms: Don't Disconnect the Human Element from Patient Care
Medication Safety in Outpatient Settings Needs Systemic Support Too
Be Wary During Changes in Care When Managing Patients with Methotrexate
Infection Control in Behavioral Health: Turn Obstacles into Opportunities
As IR Capabilities Expand, So Does the Need for Safety Focus
Are You Positive: Pregnancy Testing Complications
Falls in Outpatient Settings: Different Location, Similar Risk Factors
Nursing Students: Supervision and Support Key to Success
U-500 Insulin: Concentration Causes Confusion
Promethazine: Wrong Route Leads to Poor Outcomes
Equipment Maintenance: An Ounce of Prevention
Uterine Rupture: More than VBAC Is at Risk

DATA COLLECTION AND ANALYSIS

I. Reportable Events

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 29 NQF serious reportable events listed in 2011. During this past fiscal year, CLABSI events reported to CDC's NHSN were validated by DC Health's CPPE DE-DSI.

Since 2010, hospitals and ambulatory surgical centers have been required to report adverse events and CAPs using the web-based reporting system. A standardized adverse event reporting form is available to all other medical facilities and healthcare providers for this purpose. Reports of an adverse event must be submitted within 60 days of the occurrence of the event (58% of events reported met this requirement and 1% did not provide an event date). DC Health collects and analyzes the reports, providing an annual report that includes summary data and recommendations. The Medical Malpractice Amendment Act of 2006 contains well-defined confidentiality provisions related to reporters and information provided to the system administrator. This annual report compiles and provides analysis on both the CLABSI data from NHSN and the NQF events submitted to the web-based reporting system.

II. Reports by Event Type

In the 12th reporting period (October 1, 2018, to September 30, 2019), District medical facilities and healthcare providers submitted 198 reports to DC Health. The most frequently reported types of events were CLABSIs (71%), pressure ulcers (15%), other events (5%), retained foreign objects (4%) and falls (3%), representing 193 (98%) of the reports submitted. Table 5 (p. 12) summarizes the reports submitted by event type (DC Health, 2019; ECRI PSO; National Quality Forum, 2011). Figure 2 (p. 15) provides a graphic version.

TABLE 5. NUMBER AND PERCENTAGE OF NQF REPORTS BY EVENT TYPE, FY 2019

Category	Event Type	Reports	%
Surgical or invasive procedure events	1A - Surgery or other invasive procedure performed on the wrong site	0	0%
	1B - Surgery or other invasive procedure performed on the wrong patient	1	<1%
	1C - Wrong surgical or other invasive procedure performed on a patient	2	1%
	1D - Unintended retention of a foreign object in a patient after surgery or other invasive procedure	7	4%
	1E - Intraoperative or immediately postoperative/postprocedure death in an ASA class 1 patient	0	0%
Product or device events	2A - Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	0	0%
	2B - Patient death or serious injury 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	0%
	2C - Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	0	0%
Patient protection events	3A - Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	0	0%
	3B - Patient death or serious injury associated with patient elopement	0	0%
	3C - Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	1	<1%
	4A - Patient death or serious injury associated with a medication error	1	<1%

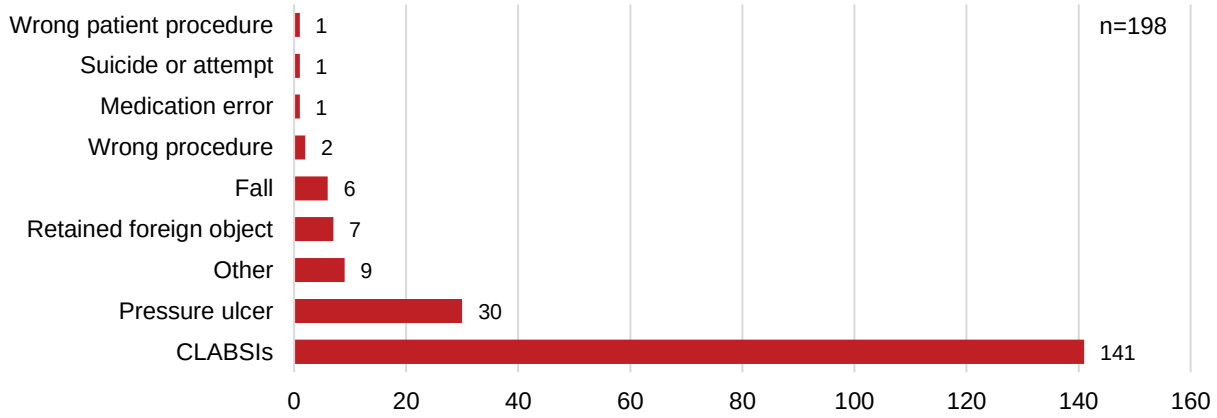
Care management events	4B - Patient death or serious injury associated with unsafe administration of blood products	0	0%
	4C - Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	0	0%
	4D - Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	0	0%
	4E - Patient death or serious injury associated with a fall while being cared for in a healthcare setting	6	3%
	4F - Any stage 3, stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	30	15%
	4G - Artificial insemination with the wrong donor sperm or wrong egg	0	0%
	4H - Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen	0	0%
	4I - Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	0	0%
Environmental events	5A - Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	0	0%
	5B - Any incident in which systems designated for oxygen or other gas to be delivered to a patient contain no gas, the wrong gas, or are contaminated by toxic substances	0	0%
	5C - Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	0	0%
	5D - Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting	0	0%

Radiologic events	6A - Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area	0	0%
Potential criminal events	7A - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	0%
	7B - Abduction of a patient/resident of any age	0	0%
	7C - Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	0	0%
	7D - Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare setting	0	0%
CLABSIs	8 - Central-line-associated bloodstream infection (DC Health, 2019)	141	71%
"Other" event type reported	X - "Other" non-NQF type of event reported	9	5%
Total		**198**	**102%**

Note: Total does not equal 100% because of rounding.
ASA: American Society of Anesthesiologists
MRI: Magnetic Resonance Imaging
NQF: National Quality Forum

Figure 2 (p. 15) details the event types for which one or more events were reported during the FY 2019 reporting period; 141 CLABSIs and 57 total NQF event types were reported including 9 "Other" events (ECRI PSO).

FIGURE 2. NUMBER OF NQF EVENTS BY EVENT TYPE, FY 2019

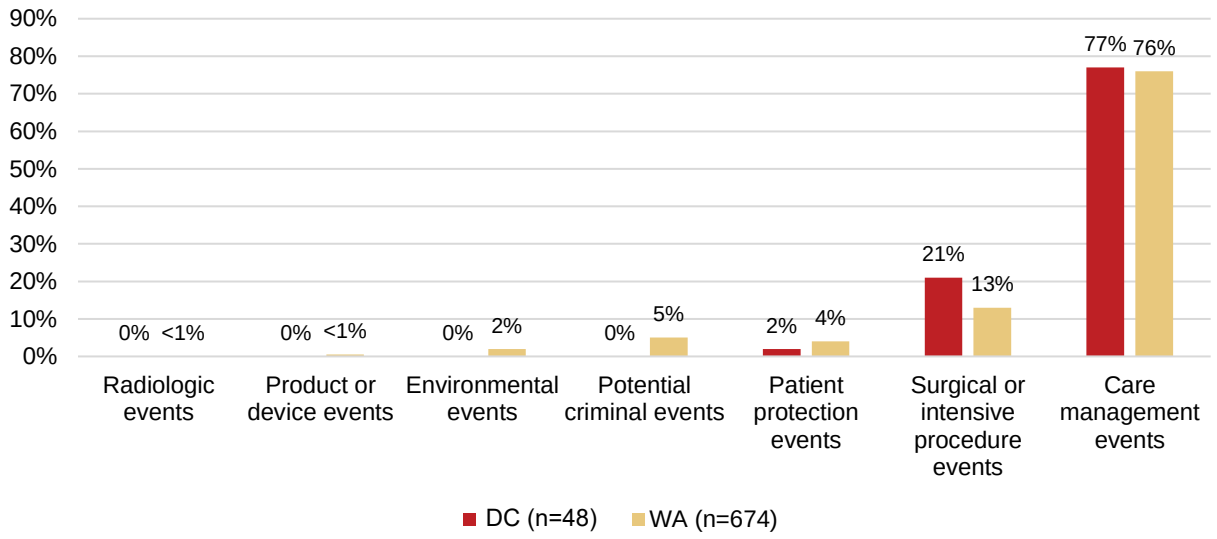


Comparison with other mandatory reporting systems may also be valuable (see Figure 3, p. 16) (ECRI PSO; Washington State Department of Health, 2020; National Quality Forum, 2011). For example, the Washington State Department of Health's *Serious Reportable Events* Table *2006-2020* noted 674 NQF events reported.

Washington State Department of Health adverse health events are also based on NQF's list of serious reportable events, updated in 2011. Although Washington's system includes many more facilities that are required to report, when broken down by event category percentages, its most frequently reported events were similar to those reported by DC Health in that they included pressure ulcers (47%), falls (21%) and retained foreign objects (7%). The Washington state system also includes additional event categories for which the District did not receive reports (e.g., loss of an irreplaceable specimen and lack of test result follow-up).

Figure 3 (p. 16) shows the NQF event-report category frequency from the District of Columbia for FY 2019 and from the Washington State Department of Health's 2019 reporting year; the percentages are based on the total number of NQF events (ECRI PSO; Washington State Department of Health, 2020). Upon examination, the reporting from both DC Health and Washington State reveal that pressure ulcer reports occur more frequently than falls or medication errors in the care management category.

FIGURE 3. COMPARISON OF NQF EVENT CATEGORY FREQUENCY (DISTRICT OF COLUMBIA AND WASHINGTON STATE), FY 2019



Note: Total does not equal 100% because of rounding.

III. Reports by Level of Harm

The 2011 list of NQF serious reportable events changed the language from "serious disability" to "serious injury" in applicable event types (National Quality Forum, 2011). Not all reportable events imply the same degree of harm, and it is often useful to distinguish among degrees of harm. To this end, the harm scale developed by the National Coordinating Council for Medication Error Reporting and Prevention continues to be applied to the event reporting system, and the 57 NQF events could be categorized based on the information provided.

Table 6 summarizes the level of harm among the 57 reports, and Figure 4 (p. 17) shows the percentages of the levels of harm identified (ECRI PSO).

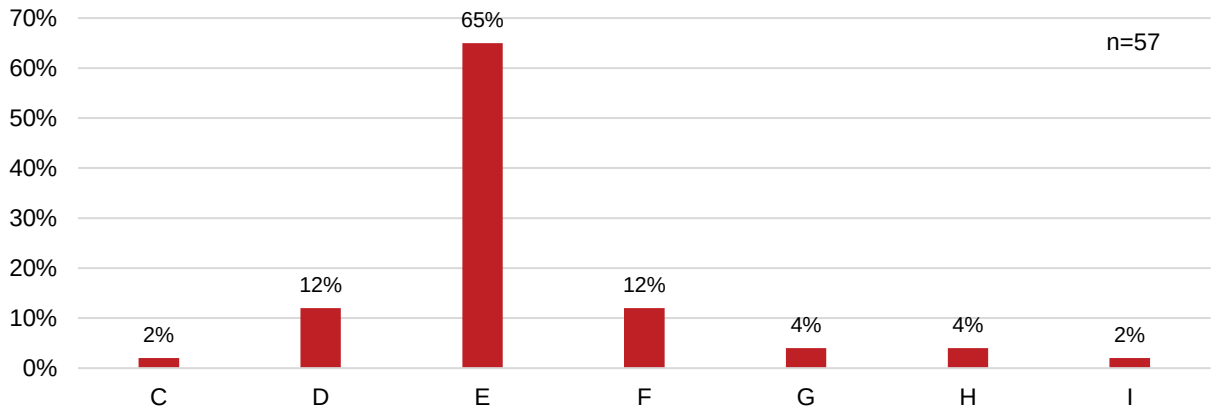
TABLE 6. NUMBER AND PERCENTAGE OF NQF REPORTS BY LEVEL OF HARM, FY 2019

Harm Score	Description	Reports	%
A	Circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment)	0	0%
B1	An event occurred but did not reach the individual ("near miss" or "close call") because of chance alone	0	0%
B2	An event occurred but did not reach the individual ("near miss" or "close call") because of active recovery efforts by caregivers	0	0%

C	An event occurred that reached the individual but did not cause harm and did not require increased monitoring (an error of omission, such as a missed medication dose, does reach the individual)	1	2%
D	An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm	7	12%
E	An event occurred that contributed to or resulted in temporary harm and required treatment or intervention	37	65%
F	An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization	7	12%
G	An event occurred that contributed to or resulted in permanent harm	2	4%
H	An event occurred that resulted in a near-death event (e.g., required ICU care or other intervention necessary to sustain life)	2	4%
I	An event occurred that contributed to or resulted in death	1	2%
	Harm score not provided	0	0%
Total		**57**	**101%**

Note: Total does not equal 100% because of rounding.
ICU: intensive care unit
NQF: National Quality Forum

FIGURE 4. PERCENTAGE OF NQF REPORTS BY HARM SCORE, FY 2019



Note: Total does not equal 100% because of rounding.

Harm scores classified by the reporting facility and associated with the reports submitted ranged from category C ("An event occurred that reached the individual but did not cause harm and did not require increased monitoring"),1 event (2%); to category I ("An event occurred that contributed to or resulted in death"), 1 (2%). When investigating these events of serious harm or death, an organization may benefit from submitting an RCA with CAP for review and analysis (see section V).

The majority of the events (37, or 65%), were categorized as having a harm score of E ("An event occurred that contributed to or resulted in temporary harm and required treatment or intervention"), which is consistent with the minimal harm score severity level described in the NQF events.

Near-miss reporting can be valuable in providing lessons learned from "good catches." District facilities continue to voluntarily report events that did not cause patient harm. Harm scores reported during FY 2019 included harm score C; NQF serious reportable events typically have a harm score of E or higher.

IV. Report Quality

During FY 2019, 44% of the 57 NQF events reported to the District of Columbia Patient Safety Reporting System had thorough event descriptions, and 56% had minimal event descriptions. The "Event Description" field is a free-text field on the web-based form; when reporters complete it, this field can capture the most important details of the event. This area of reporting has remained consistent and coincides with the implementation of the electronic reporting system.

V. Corrective Action Plans in Reports

The District requires the submission of a CAP as a follow-up to a reported adverse event. This procedure allows the facility to receive a review of its CAP. The goals of the program include responding to an adverse event with the following steps:

1. Adverse event occurs; report submitted.
2. RCA and CAP completed and submitted.
3. RCA and CAP analyzed; feedback provided.
4. Facility implements CAP.
5. Adverse events decrease.

A CAP describes how the facility or provider plans to prevent or reduce the risk of similar events in the future and should be based on the findings from the event investigation. The investigation of an event must look beyond the direct patient-care provider to identify system failures. Of the 57 NQF reports submitted in FY 2019, there were a few that alluded to corrective action(s), which is consistent with the previous fiscal year, but no official CAP submissions were received for review. Although some reports identified contributing factors or root causes, no complete RCAs were submitted for review during FY 2019.

Some facilities have used an additional field within the reporting system labeled "Supplemental Information" and found it to be an easy way to incorporate their CAPs. This also allows the event details and the action plans to be stored in the same location. Facilities have the ability to update an event report after the event has been submitted if the RCA and CAP have not been completed at the time of the event submission.

Contributing factors were cited within some reports; however, no trends were seen. Some of those cited include:

- Retained surgical items
  - Environment: culture of safety, management
  - Communication: among staff
  - Shift change
- Pressure Ulcers
  - Equipment/device: function
  - Patient/resident factor: unresponsive
- Other Events
  - Data: accuracy
  - Adherence to policy
  - Workflow completion of patient/resident assessment
- Falls
  - Other factors: patient's medical condition

The following ECRI resources are available to District facilities (access required) on these topics:

- Retained Surgical Items: What the Data is Telling Us (2018 Feb 15).
- The Ins and Outs of Tracheostomy Care and Maintenance (2020 Jan 2).
- Don't Fall Behind in Falls Prevention: Reducing Falls Risk in the Emergency Department (2018 Aug 28).
- Antibiotic Stewardship: Engaging Physician Compliance (2017 Dec 20).

Facility staff can obtain access to the DC Patient Safety Reporting System web portal by contacting the liaison in their facilities.

VI. Central-Line-Associated Bloodstream Infections (CLABSIs)

Facilities in the District of Columbia are required by law to report CLABSIs to CDC's NHSN. NHSN is an online tracking system that provides a reporting mechanism for the District and eight short-term acute care and two long-term acute care facilities covered by the mandate. Epidemiologists at DC Health's CPPE DE-DSI perform validation studies on CLABSIs reported to NHSN.

The following data were provided by DC Health's CPPE DE-DSI in advance of publication by CDC, from the reports submitted to CDC's NHSN. During FY 2019, units from all 10 acute care facilities reported a total of 141 CLABSIs and 153,245 central-line-days, for a CLABSI rate of 0.92 infections per 1,000 central-line days. Data viewed in this way represent a different mix of hospitals and units for each year. This raw, unadjusted rate provides the actual number of events over a specified time. This rate is useful in assessing the overall burden of healthcare-associated infections (HAIs) in the healthcare system (DC Health, 2019).

To take these data one step further, a standardized infection ratio (SIR) was calculated for eight of the short-term acute care facilities that submitted data in the District. The SIR is an indirect standardization method that is used to summarize the HAI experience across any number of stratified groups (DC Health, 2019).

The SIR allows for comparison of data across risk groups, procedures, and hospital characteristics to gain a better understanding of the incidence, trends, and patterns of HAIs while adjusting for underlying patient or hospital factors that may affect the occurrence of HAIs (DC Health, 2019).

The SIR is calculated by dividing the number of observed CLABSIs by the number of statistically predicted CLABSIs based on the national baseline data and provides a basis for comparison between how many CLABSIs occurred and how many were expected to occur based on the national experience. A SIR of 1.0 means the observed number of infections is similar, or equal, to the number of predicted infections. A SIR higher than 1.0 means that there were a greater number of infections than predicted, and a SIR of less than 1.0 means that there were fewer infections than predicted. For FY 2019, the overall SIR for the eight short-term acute care facilities was 0.748 (95% confidence interval: 0.632, 0.891) (DC Health, 2019).

Additional Resource

National and State Healthcare Associated Infections Progress Report: D.C. Acute Care Hospitals.
Centers for Disease Control and Prevention (2016).

VII. Patient Safety Webinars and Training

Webinars are provided on patient safety topics and are also used to train users of the reporting system. For the 12 webinars offered in FY 2019, and the number of lines that called in for each presentation, see Table 1 (p. 7) (note that information about the number of participants on each line is unavailable). After the presentation, webinar recordings and handouts are posted to the web portal for future viewing.

GUIDANCE AND RECOMMENDATIONS

DC Health is charged with providing facilities and providers with recommended methods to reduce systematic adverse events and with disseminating information and advice on best practices. The following is a summary of three important topic categories and a discussion of lessons learned and strategies to help prevent reoccurrence of these event types.

The three NQF event types are as follows:

I. Retained foreign objects
II. Pressure ulcers
III. Falls

As required by the Medical Malpractice Amendment Act of 2006, the information is deidentified and anonymized with regard to facility, provider, and patient. Root causes, contributing factors, and prevention strategies identified by healthcare facilities and providers are shared, if available. Finally, recommended best practices are provided to further assist facilities and providers in improving healthcare delivery in the District.

I. Retained Foreign Objects

Surgical events reported included the following event category:

- Unintended retention of a foreign object in a patient after surgery or other procedure

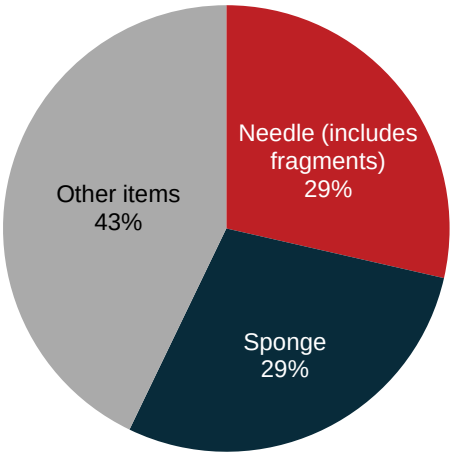
DC Health Findings

A review of the seven retained foreign object events submitted over the past fiscal year (Figure 5, p. 22) (ECRI PSO), between October 2018 and September 2019, revealed the following findings:

- Twenty-nine percent (29%) of retained foreign objects were sponges or gauze.
- Twenty-nine percent (29%) were needles or pieces of needles.
- Forty-three percent (43%) were other items.
- There were no trends with patient characteristics, care location, or harm level.
- All but one was reported as preventable (ECRI PSO).

FIGURE 5. RETAINED FOREIGN OBJECTS, FY 2019

n = 7



Note: Total does not equal 100% because of rounding.

Recommendations

- Consider adding technological solutions to the manual count such as radio-frequency identification, bar-coding, or other technology. (ECRI Guidance: Unintentionally Retained Surgical Items)
- Establish policies and procedures outlining standardized practices to prevent retained surgical items and count discrepancies. (ECRI Guidance: Unintentionally Retained Surgical Items)
- Count individual needles of all sizes for all surgical procedures. (ECRI Guidance: Retained Surgical Needles)

Additional Resources

- Best practices for prevention of retained surgical items. Association of periOperative Registered Nurses [webinar].
- Retained sponges persist as a surgical complication despite manual counts. ECRI (2018 Sep 26).
- Retained surgical items. Association of periOperative Registered Nurses (2016 Jan).
- Retained surgical items: what the data is telling us. ECRI PSO (2018 Feb 15). [webinar].

II. Pressure Ulcers

Pressure ulcer events are defined as follows:

- Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting

DC Health Findings

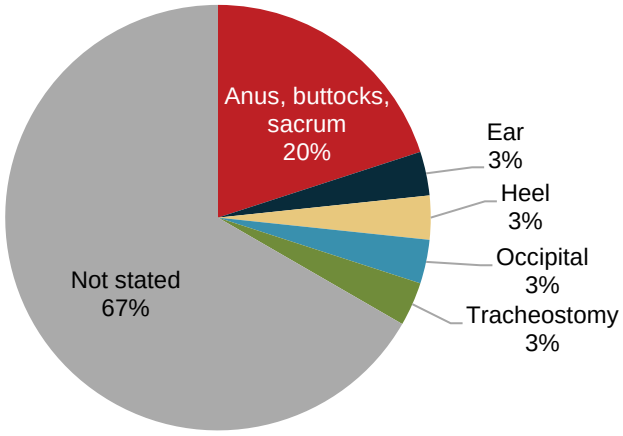
A review of 30 pressure ulcer events submitted over the past fiscal year between October 2018 and September 2019 revealed the following (ECRI PSO):

- Treatment location (unit) was indicated in only two of the reports submitted.
- Thirty-three percent (33%) of the events reported the pressure ulcer locations on the body:
  - Twenty percent (20%) were located in the area of the sacrum, buttocks and anus
  - The remaining (13%) were single cases at the heel, ear, tracheostomy, and head (Figure 6). (ECRI PSO Database)
- The majority of the reports had a harm score of E. The following shows the breakdown of harm scores:
  - Harm Score D = 3%
  - Harm Score E = 80%
  - Harm Score F = 13%
  - Harm Score G = 3%

More than 50% of the reports did not have a detailed event description stating either "hospital acquired pressure ulcer" or "HAPI."

FIGURE 6. PRESSURE ULCER INJURY LOCATION, FY 2019

n = 30



Note: Total does not equal 100% because of rounding.

Recommendations

- Consider new technology to monitor correct positioning and to prompt nursing to turn the patient. (ECRI PSO Navigator, 2018)
- Ensure that policies and guidelines that describe the prevention, identification, and treatment of pressure injuries are consistent with current federal and state regulations, as well as evidence-based standards, guidelines, and appropriate case law. (ECRI, 2018)
- Ensure that each patient assessed to be at risk for pressure injuries has an individualized plan of care. (ECRI, 2018)

Additional Resources

- Preventing pressure ulcers in hospitals: a toolkit for improving quality of care. Agency for Healthcare Research and Quality (2014).
- Unavoidable pressure injury: state of the science and consensus outcomes. Journal of wound, ostomy, and continence nursing (2014). (login required)
- Prevention and treatment of pressure ulcers/injuries: clinical practice guideline. National Pressure Injury Advisory Panel (2019). (available for purchase)

III. Falls

Serious reportable falls are defined as:

- Patient death or serious injury associated with a fall while being cared for in a healthcare setting

DC Health Findings

- There were six falls reported. This probably reflects a better reporting culture at some facilities; however, it likely also reflects under- or nonreporting by the other facilities (both submitting and nonsubmitting).
- Fifty percent (50%) of the reports provided an event summary while the others provided no information.
- No RCAs or CAPs were submitted.

Recommendations

- Update falls prevention programs to include tools that focus on your patient population.
- Proactively involve and educate patients and family members on fall risks to assist in fall prevention.
- Perform post fall huddles to debrief, determine process barriers, and discuss possible resolutions.
- Compare patients identified as at risk against patients who have fallen to identify gaps in your current falls risk assessment process. (ECRI *Compass Points*, 2018)

Additional Resources

- Transforming care at the bedside how-to guide: reducing patient injuries from falls. Institute for Healthcare Improvement (2012).
- A toolkit for improving quality of care. Agency for Health Research and Quality (2018).
- Prevention of chair falls. ECRI (2017). (login required)

CONCLUSION

Medical facilities and providers in the District of Columbia continue to take important steps to improve patient safety by submitting adverse event reports in accordance with the Medical Malpractice Amendment Act of 2006. The success of the reporting program continues to rely on the willingness of healthcare facilities and providers to disclose NQF events and submit meaningful reports. The focus of the District's Patient Safety Reporting System is to analyze events to better understand how and why adverse events occur and to prevent the reoccurrence of similar events. The vision for the reporting system is to provide a tool for quality improvement and education. Disseminating lessons learned and best practices facilitates system changes that consistently promote the delivery of safe patient care. In 2020, the District will have continued opportunities to benefit from custom feedback as well as the ability to submit research requests to support this objective, with the delivery of safe patient care as the ongoing goal.

Technical Credits

This report was prepared by ECRI in collaboration with DC Health. ECRI, a nonprofit organization, dedicates itself to bringing the discipline of applied scientific research in healthcare to discover the best approaches to improving patient care. As pioneers in this science for more than 50 years, ECRI marries experience and independence with the objectivity of evidence-based research. More than 5,000 healthcare organizations worldwide rely on ECRI's expertise in patient safety improvement; risk and quality management; healthcare processes, devices, and procedures; and drug technologies.

Acronyms and Abbreviations

- BSI: bloodstream infection
- CAP: corrective action plan
- CDC: Centers for Disease Control and Prevention
- CLABSI: central-line-associated bloodstream infection
- CPPE DE-DSI: Center for Policy, Planning and Evaluation's Division of Epidemiology Disease Surveillance and Investigation
- DC Health: District of Columbia Department of Health
- FY: fiscal year
- HAI: healthcare-associated infection
- ICU: intensive care unit
- NHSN: National Healthcare Safety Network
- NQF: National Quality Forum
- PSO: patient safety organization
- RCA: root-cause analysis
- RSI: retained surgical item
- SIR: standardized infection ratio

Figures

Tables

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