DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
Patient Safety Reporting Program

Annual Report
Fiscal Year 2020

FOR THE REPORTING PERIOD OF:

OCTOBER 1, 2019, through SEPTEMBER 30, 2020

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 was implemented as part of the ongoing effort to improve healthcare delivery. The system is hosted by ECRI and the Institute for Safe Medication Practices (ISMP) Patient Safety Organization (PSO).

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 and 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 13th 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, 2019, and September 30, 2020, 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 2020 (FY 2020), the District's healthcare providers and medical facilities submitted a total of 335 events to DC Health (DC Health, 2020; ECRI and the ISMP PSO).

These reports consisted of 165 adverse event reports submitted to the District of Columbia Patient Safety Reporting System and 170 CLABSI reports (DC Health, 2020) 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 2020. The NQF events analysis is based on events submitted from October 2019 through September 2020, 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 (316 or 94% of reports submitted) were CLABSIs (170; 51%), pressure ulcers (98; 29%), and other events (48; 14%).

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 and the ISMP PSO). The adverse event reports submitted by healthcare providers and medical facilities in the 13th 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 2018–2020

	CLABSI	Pressure ulcer	Other	Retained foreign object	Fall	Neonatal event	Wrong-site procedure	Medication error	Air embolism	Assault	Wrong-patient procedure	Suicide or attempt	Wrong procedure
FY 2020 (n=335)	170	98	48	5	3	3	3	2	1	1	1	0	0
FY 2019 (n=198)	141	30	9	7	6	0	0	1	0	0	1	1	2
FY 2018 (n=228)	133	69	3	10	10	1	1	1	0	0	0	0	0

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 and the ISMP 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 NQF's top two event categories—pressure ulcers and other events—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.

In addition to the annual report, in FY 2020 the District's Patient Safety Reporting System offered facilities the following resources:

- Educational Webinars (Table 1, p. 7) are offered at least quarterly on patient safety topics.
- The Patient Safety Quarterly Review archive (Table 2, p.7) consists of the National and District PSO *Navigators*.
- Custom Feedback (Table 3, p. 7) on adverse events or topics provides resources and best practice information directly to facilities.
- Research Responses (Table 3, p. 7) are summaries of research requests received at a national level on various topics.
- *Patient Safety Briefs* (previously called *Compass Points*) (Table 4, p. 9) 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 and the ISMP PSO's root-cause analysis (RCA) review process. ECRI then provides the facility with a report to further assist providers and staff in improving their processes. See "Corrective Action Plans in Reports" (p. 17) for details.

TABLE 1. EDUCATIONAL WEBINARS (NUMBER OF LINES PARTICIPATING), FY 2020

Date	Title	Lines
November 2019	Safe Ambulatory Care Strategies for Patient Care and Risk Reduction – In Between the Lines	1
December 2019	The Federal Court Finally Speaks on Patient Safety Organization Privileges	0
January 2020	Integrated Model: Patient Safety and Staff Wellbeing	0
March 2020	Workplace Violence: Expecting the Unexpected	1
April 2020	COVID 19 Lab Webcasts	1
May 2020	Medication Safety Best Practices: How Are We Doing?	0
June 2020	Recent Contrasting and Conflicting Patient Safety Act Opinions and Lessons Learned	0
June 2020	ECRI's Top 10 Patient Safety Concerns 2020	0
July 2020	30 Minutes for Safety: Reducing Automated Dispensing Cabinet Overrides	11
September 2020	Postpartum Complications and Maternal Safety in the "Fourth Trimester"	2

TABLE 2. *NAVIGATOR* AND PATIENT SAFETY QUARTERLY REVIEW ARTICLES, FY 2020

National	Infection Control in Outpatient Settings
District	Don't Let the Bedbugs Bite: Manage Bedbug Presence Swiftly in Outpatient Settings

TABLE 3. CUSTOM FEEDBACK AND RESEARCH RESPONSES, FY 2020

Custom Feedback	Air Embolism
	Falls with Harm
	Mandatory Event Reporting and Engagement
	Normothermia

	Patient Experience
	Pressure Ulcer Prevention
	Retained Foreign Object Prevention
	Suicide Attempt
	Timeout Process
Research Responses	Elopement Prevention on the Behavioral Health Unit
	Risk Management Strategies for Psychological Safety
	Placental Management: Indications for Pathological Examination
	Managing Risks Regarding Apparent Agency
	Improving the Patient Experience
	Preadmission Testing: Type and Screen
	Adjunct Technologies for Retained Surgical Items
	Retained Surgical Needles
	Risk Management Strategies for Small-Bore Feeding Tube: Dobhoff Tube Use Outside of Critical Care
	Vetting Community-Donated Supplies
	Best Prevention Practices for Warming Equipment-Related Burns

TABLE 4. PATIENT SAFETY BRIEFS, FY 2020

Diagnostic Testing: Match the Right Patient, Right Test, and Right Results
Supplemental Staff: Solution or Safety Risk? Answer Hinges on Organization Support
Reducing Risk of Spinal Surgical Site Infections with Pedicle Screws
Medication Administration Timing Errors and Health IT Systems: When CPOEs and EHRs Can Help or Hinder
Emergencies during Invasive Procedures and Surgeries: Complicated and Life-Threatening
Psychiatric Inpatient Falls: Assessment and Prevention for a High-Acuity Population
Don't Abandon Me: Close the Loop on Lab Specimens to Ensure Continuity of Care
Communicate Positive COVID-19 Findings across the Care Team
Ensure the Accuracy of Preliminary Teleradiology Diagnoses
Manage Patient Impatience: Reduce Wait Times and Implement Strategies to Decrease LWBS
Unintended Disclosures of Protected Health Information in Medical Offices

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 (42% of events reported in FY 2020 met this requirement, 35% did not meet this requirement, and 23% did not provide an event date). DC Health collects and analyzes the reports, to provide 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 through the web-based reporting system.

II. Reports by Event Type

In the 13th reporting period (October 1, 2019, to September 30, 2020), District medical facilities and healthcare providers submitted 335 reports to DC Health. The most frequently reported types of events were CLABSIs (170; 51%), pressure ulcers (98; 29%), and other events (48; 14%), representing 316 (94%) of the reports submitted. Table 5 (p. 11) summarizes the reports submitted by event type (DC Health, 2020; ECRI and the ISMP PSO; NQF, 2011). Figure 2 (p. 14) provides a graphic version.

TABLE 5. NUMBER AND PERCENTAGE OF NQF REPORTS BY EVENT TYPE, FY 2020

Category	Event Type	Reports	%
Surgical or invasive procedure events	1A - Surgery or other invasive procedure performed on the wrong site	3	0.9%
	1B - Surgery or other invasive procedure performed on the wrong patient	1	0.3%
	1C - Wrong surgical or other invasive procedure performed on a patient	0	0%
	1D - Unintended retention of a foreign object in a patient after surgery or other invasive procedure	5	1.5%
	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	1	0.3%
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	0	0%
Care management events	4A - Patient death or serious injury associated with a medication error	2	0.6%
	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	3	0.9%
	4E - Patient death or serious injury associated with a fall while being cared for in a healthcare setting	3	0.9%
	4F - Any stage 3, stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	98	29%
	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	0	0%

	laboratory, pathology, or radiology test results		
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%

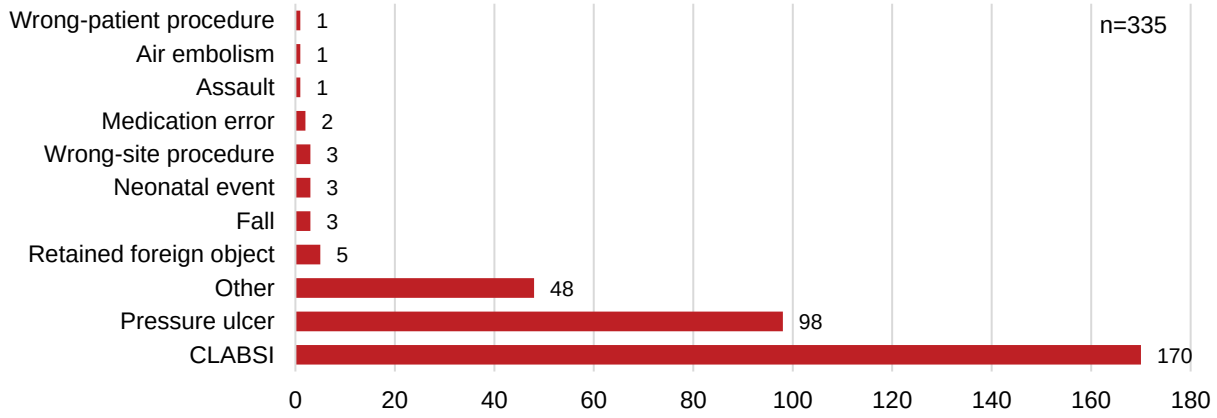
	7D - Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare setting	1	0.3%
CLABSIs	8 - Central-line-associated bloodstream infection (DC Health, 2020)	170	50.7%
"Other" event type reported	X - "Other" non-NQF type of event reported	48	14.3%
Total		**335**	**99.7%**

ASA: American Society of Anesthesiologists
MRI: magnetic resonance imaging
NQF: National Quality Forum

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

Figure 2 details the event types for which one or more events were reported during the FY 2020 reporting period; 170 CLABSIs and 165 total NQF event types were reported, including 48 "Other" events (ECRI and the ISMP PSO).

FIGURE 2. NUMBER OF NQF EVENTS BY EVENT TYPE, FY 2020



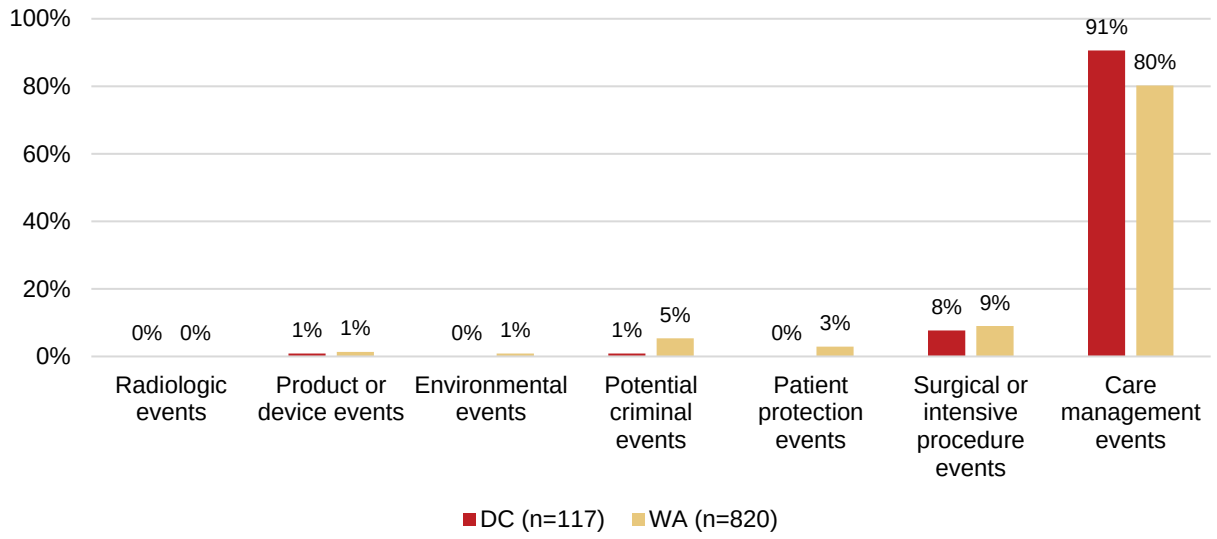
Comparison with other mandatory reporting systems may also be valuable (see Figure 3, p. 15) (ECRI and the ISMP PSO; Washington State Department of Health, 2020; NQF, 2011). For example, the Washington State Department of Health's Serious Reportable Events Table for 2020 noted 820 NQF events reported.

Washington State Department of Health adverse health events are also based on NQF's list of serious reportable events, updated in 2011. Although Washington State's system includes many more facilities that are required to report, when events are broken down by event category percentages, Washington State's most frequently reported events were similar to those reported by DC Health in that they included pressure ulcers (59%) and falls (17%), but they also included medication errors (3%) as well as retained

foreign objects (3%). The Washington State system also includes event categories for which the District did not receive reports (e.g., impersonating a healthcare provider and patient abduction).

Figure 3 shows the NQF event-report category frequency from the District of Columbia for FY 2020, not including the "Other" event category, and from the Washington State Department of Health's 2020 reporting year; the percentages are based on the total number of NQF events (ECRI and the ISMP PSO; Washington State Department of Health, 2020). Data from both DC Health and Washington State reveal that pressure ulcers continue to be reported 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 2020



Note: Totals do 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 (NQF, 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 165 NQF events could be categorized based on the information provided.

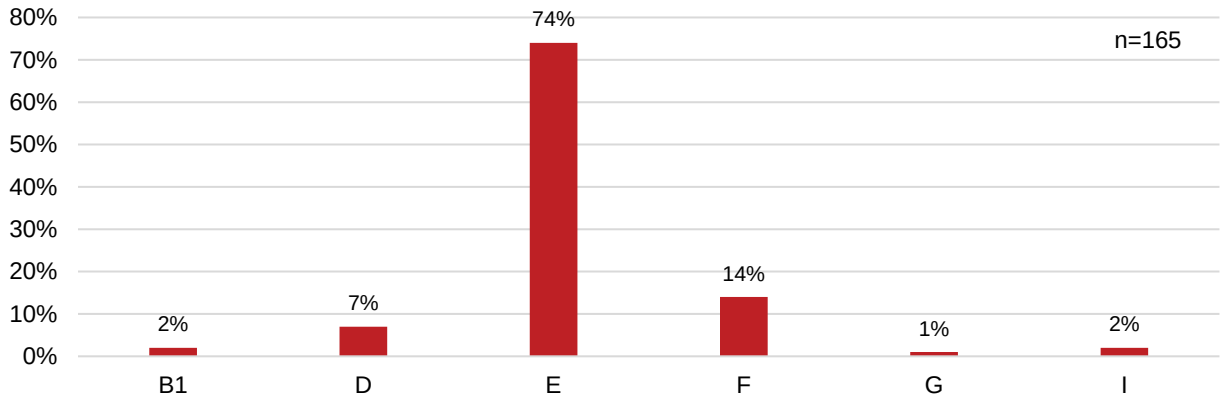
Table 6 (p.16) summarizes the level of harm among the 165 reports, and Figure 4 (p. 17) shows the percentages of the levels of harm identified (ECRI and the ISMP PSO).

TABLE 6. NUMBER AND PERCENTAGE OF NQF REPORTS BY LEVEL OF HARM, FY 2020

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	3	2%
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)	0	0%
D	An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm	12	7%
E	An event occurred that contributed to or resulted in temporary harm and required treatment or intervention	122	74%
F	An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization	23	14%
G	An event occurred that contributed to or resulted in permanent harm	2	1%
H	An event occurred that resulted in a near-death event (e.g., required ICU care or other intervention necessary to sustain life)	0	0%
I	An event occurred that contributed to or resulted in death	3	2%
Total		**165**	**100%**

ICU: intensive care unit
NQF: National Quality Forum

FIGURE 4. PERCENTAGE OF NQF REPORTS BY HARM SCORE, FY 2020



Harm scores classified by the reporting facility and associated with the reports submitted ranged from 3 events (2%) in category B1, "An event occurred but it did not reach the individual ('near miss' or 'close call') because of chance alone," to 3 events (2%) in category I, "An event occurred that contributed to or resulted in death." 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 (122; 74%), 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 2020 included harm score B1 and higher; NQF serious reportable events typically have a harm score of E or higher.

IV. Report Quality

During FY 2020, 78% of the 165 NQF events reported to the District of Columbia Patient Safety Reporting System had thorough event descriptions, and 22% 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 165 NQF reports submitted in FY 2020, a few 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 2020.

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. Some factors cited include the following:

- Human factors: health issues
- Supervision/support: clinical supervision
- Equipment/device: design
- Human factors: inattention
- Staff qualifications: competence

The following resources are about human factors in healthcare and relate to these topics:

- The Human Factors Analysis Classification System (HFACS) applied to health care. American Journal of Medical Quality (2014).
- Using HFACS-Healthcare to Identify Systemic Vulnerabilities During Surgery. American Journal of Medical Quality (2018).

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. However, data updates may be delayed due to COVID-19. During FY 2020, units from all 10 acute care facilities reported a total of 170 CLABSIs and 148,708 central-line-days, for a CLABSI rate of 1.14 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, 2020).

To take these data one step further, a standardized infection ratio (SIR) was calculated for the eight 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, 2020).

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, 2020).

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 2020, the overall SIR for the eight short-term acute care facilities was 0.858 (95% confidence interval: 0.722, 1.013) (DC Health, 2020).

Additional Resource

Current HAI Progress Report: 2019 National and State Healthcare-Associated Infections Progress Report. CDC (2019).

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 10 webinars offered in FY 2020, 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 two important topic categories and a discussion of lessons learned and strategies to help prevent reoccurrence of these event types.

The two event categories are as follows:

i. Retained foreign objects

ii. Pressure ulcers

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.

Some of the additional resources listed in this section are available through the ECRI web portal; facility staff can obtain access to the DC Patient Safety Reporting System web portal by contacting the liaison in their facilities.

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

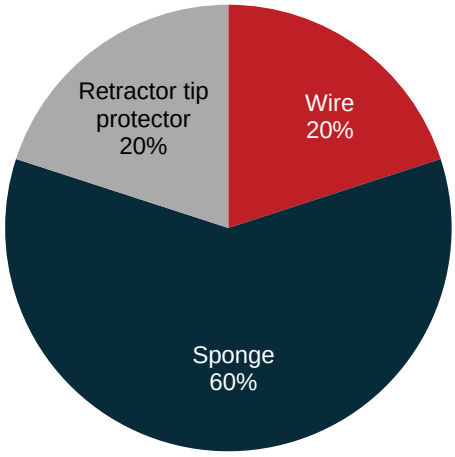
DC Health Findings

A review of the five retained foreign object events submitted over the past fiscal year (Figure 5, p. 21) (ECRI and the ISMP PSO), between October 2019 and September 2020, revealed the following findings:

- Sixty percent of retained foreign objects were sponges or gauze.
- Twenty percent involved a retained wire.
- Twenty percent involved a retractor tip protector.
- These events occurred within the following surgical specialties: obstetrics, thoracic surgery, and orthopedic surgery (ECRI and the ISMP PSO).

FIGURE 5. RETAINED FOREIGN OBJECTS, FY 2020

n=5



Recommendations

- Minimize distractions in the operating room while surgical counts are being performed (ECRI and the ISMP PSO, 2020).
- Consider adding technological solutions to the manual count of surgical sponges and other soft items (ECRI and the ISMP PSO, 2020).
- Establish standardized surgical count policies and procedures and train staff on these policies through a well-developed education program (ECRI and the ISMP PSO, 2020).

Additional Resources

- 2019 Top 10 Health Technology Hazards: Retained Sponges Persist as a Surgical Complication Despite Manual Counts. ECRI (2018).
- Retained Surgical Items: What the Data Is Telling Us [webinar]. ECRI and the ISMP PSO (2018).
- Adjunct Technologies for Retained Surgical Items. ECRI and the ISMP PSO (2020).

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

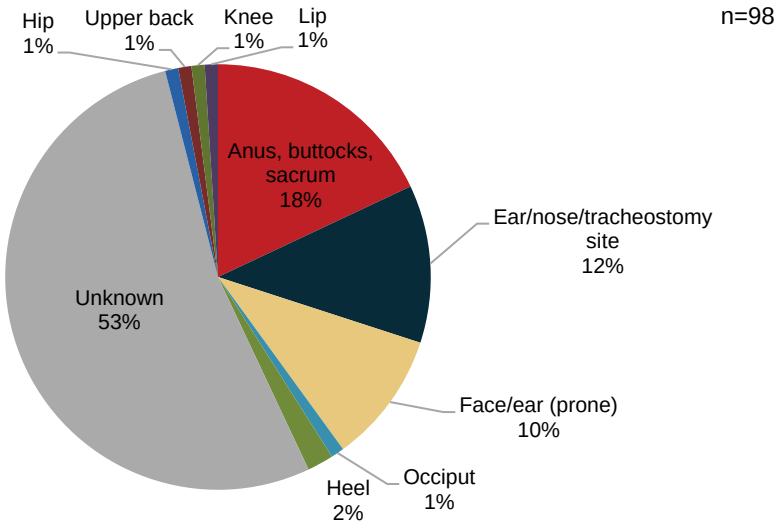
DC Health Findings

A review of 98 pressure ulcer events submitted between October 2019 and September 2020 revealed the following (ECRI and the ISMP PSO):

- Treatment location (unit) was indicated in only two of the reports submitted.
- Pressure ulcer location was indicated in 47% of the reports submitted:
  - Sacrum, buttocks, and anus: 18%
  - Ear/nose/tracheostomy site (medical-device-related pressure injuries secondary to oxygen delivery devices): 12%
  - Face/ears (related to prone positioning): 10%
  - Single cases at the hip, heel, upper back, knee, lip, or occiput: 7% (Figure 6)
- The majority of the reports had a harm score of E. The following shows the breakdown of harm scores:
  - B1 = 1%
  - D = 2%
  - E = 80%
  - F = 17%

More than 34% of the reports did not have a detailed event description stating either "hospital-acquired pressure injury" or "HAPI."

FIGURE 6. PRESSURE ULCER INJURY LOCATION, FY 2020



Twenty-seven of the "Other" events included one stage 2 pressure injury and 26 deep tissue injuries. One of the deep tissue injuries was medical device related. Although these types of pressure injuries are not classified as serious reportable events, efforts should still be made to prevent them from occurring or from evolving into more serious injuries.

Recommendations

- Consider evaluation of processes for prone patients. Ensure "swimmer's position" changes are made every two hours. Ensure endotracheal tube holders with hard plastic are not used during periods of prone positioning. (NPIAP, 2020)
- Consider application of pressure injury risk scores. Ensure that appropriate interventions (turning schedules, use of weight-offloading devices, use of protective creams and foam barriers) are in place for high-risk patients (ECRI, 2017).
- Ensure that four-eyes skin assessments are taking place at admission and at any transfer of care. Evaluate the process for documentation of preexisting skin injuries (HQI, 2021).
- Ensure that frequent assessment of skin underneath medical devices is taking place. Consider protective gel barriers under continuous positive airway pressure (CPAP) masks and foam skin protection around oxygen tubing (NPIAP, 2020).

Additional Resources

- Root Cause Analysis for Hospital-Acquired Pressure Injury. Journal of Wound, Ostomy and Continence Nursing (2019).
- Preventing Pressure Ulcers in Hospitals Toolkit: A Toolkit for Improving Quality of Care. Agency for Healthcare Research and Quality (2014 Oct).
- Pressure Injury Prevention – PIP Tips for Prone Positioning. NPIAP (2020).

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. Throughout FY 2021, 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

- CAP: corrective action plan
- CDC: Centers for Disease Control and Prevention
- CLABSI: central-line-associated bloodstream infection
- CPAP: continuous positive airway pressure
- 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
- DTI: deep tissue injury
- FY: fiscal year
- HAI: healthcare-associated infection
- HAPI: hospital-acquired pressure injury
- ICU: intensive care unit
- NHSN: National Healthcare Safety Network
- NQF: National Quality Forum
- PSO: patient safety organization
- RCA: root-cause analysis
- SIR: standardized infection ratio

Figures

Tables

REFERENCES

DC Health. (2020). CLABSI data.

ECRI and the ISMP PSO. ECRI and the ISMP PSO Database. Plymouth Meeting (PA).

ECRI and the ISMP PSO. (2017). Pressure Ulcers Toolkit. Retrieved from https://www.ecri.org/components/PSOPlus/Pages/PU.aspx?tab=2

ECRI and the ISMP PSO. (2020). Retained Surgical Items. In: ECRI and the ISMP PSO Deep Dive: Strategies for Surgical Patient Safety. Retrieved from https://www.ecri.org/components/PSOCore/Pages/DeepDive2020_RetainedItems.aspx?tab=1

Hospital Quality Institute (HQI). (2021). Eliminating HAPU: HQI Toolkit. Retrieved from https://www.hqinstitute.org/hqi-toolkit/eliminating-hapu

National Pressure Injury Advisory Panel (NPIAP). (2020). Pressure Injury Prevention: PIP Tips for Prone Positioning. Retrieved from npiap_pip_tips_-_proning_202.pdf (ymaws.com)

National Quality Forum (NQF). (2011). Serious Reportable Events in Healthcare 2011. Retrieved from http://www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx

Washington State Department of Health. (2020). Adverse Events: Serious Reportable Events Table 2006-2020. Retrieved from https://www.doh.wa.gov/Portals/1/Documents/2900/689010.pdf