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Texas Department of State Health Services

# Is This a Reportable PAE?

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September 20, 2018

# Objectives

Upon completion of this event, participants should be able to:

- Identify reportable PAEs in TxHSN
- Describe the reporting procedure for PAEs in TxHSN

Topics:

- Key aspects of TxHSN
- Reported PAEs 2015-2018
- Case scenarios

# Drug Diversion

# Injection Safety

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# Patient Safety Program

Texas Administrative Codes 133.48 and 135.27 for Hospital and 133.26 for ASC License:

1. Patient Safety Program--effective, ongoing, organization wide, data-driven
2. Focuses on prevention and reduction of medical errors and adverse events
3. In writing, approved by governing body
4. Available for review by the Regulatory Division

# Required Adverse Events

1. Medication Error—death or permanent loss of a bodily function
2. Suicide
3. Abduction of newborn or discharge to unauthorized person

# Required Adverse Events

4. Sexual Assault
5. Hemolytic transfusion reaction from wrong blood type
6. Surgery on Wrong patient, Wrong site
7. Retained Foreign object
8. Death or disability associated with use or function of device.

# Required action post event

Within 45 days of event, facility must:

1. Complete a Root Cause Analysis
2. Develop an Action Plan

These must be available for on-site review by Regulatory staff.

# Regulatory TAC 135.26

Written report to Facilities Licensing Group within 10 business days for:

1. Death of a patient
2. Transfer of patient to hospital
3. Admission to hospital within 24 hours for surgical complication
4. Patient stay exceeding 23 hours
5. Theft or diversion of drugs
6. Occurrence of fire

# Loretta Macpherson

- December 2014
- ER for anxiety and med concerns post recent brain surgery
- Fosphentoin (Cerebyx) ordered
- Rocuronium IV given (Zemuron/Esmuron)
- Respiratory/cardiac arrest
- Anoxic brain injury
- Death

# 2018 Top 10 Patient Safety Concerns

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1. Diagnostic errors
2. Opioid safety across the continuum of care
3. Internal care coordination
4. Workarounds
5. Incorporating health IT into patient safety programs
6. Management of behavioral health needs in acute care settings

Adapted from: *Top 10 Patient Safety Concerns for Healthcare Organizations 2018.* ©ECRI Institute | www.ecri.org.

# 2018 Top 10 Patient Safety Concerns

7. All-hazards emergency preparedness
8. Device cleaning, disinfection, and sterilization
9. Patient engagement and health literacy
10. Leadership engagement in patient safety

Adapted from: *Top 10 Patient Safety Concerns for Healthcare Organizations 2018.*

# 2018 Top 10 Health Technology Hazards

1. Ransomware and Other Cybersecurity Threats to Healthcare Delivery Can Endanger Patients
2. Endoscope Reprocessing Failures Continue to Expose Patients to Infection Risk
3. Mattresses and Covers May Be Infected by Body Fluids and Microbiological Contaminants

Adapted from: Executive Brief: *Top 10 Health Technology Hazards for 2018.*

# 2018 Top 10 Health Technology Hazards

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4. Missed Alarms May Result from Inappropriately Configured Secondary Notification Devices and Systems
5. Improper Cleaning May Cause Device Malfunctions, Equipment Failures, and Potential for Patient Injury
6. Unholstered Electrosurgical Active Electrodes Can Lead to Patient Burns

Adapted from: Executive Brief: *Top 10 Health Technology Hazards for 2018.*

# 2018 Top 10 Health Technology Hazards

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7. Inadequate Use of Digital Imaging Tools May Lead to Unnecessary Radiation Exposure
8. Workarounds Can Negate the Safety Advantages of Bar-Coded Medication Administration Systems
9. Flaws in Medical Device Networking Can Lead to Delayed or Inappropriate Care
10. Slow Adoption of Safer Enteral Feeding Connectors Leaves Patients at Risk

Adapted from: Executive Brief: *Top 10 Health Technology Hazards for 2018.*

# Spring 2018 Leapfrog Hospital Safety Scores

- Texas ranks 14th of 50 states
- 70 of 196 hospitals (35.71%) scored an "A"

1st Hawaii (72.73%) n=11
2nd Idaho (70%) n=10
3rd Rhode Island (62.50%) n=7
4th Mass (53.57%) n=56
14th Texas (35.71%) n=196
23rd Florida (30.64%) n=173
25th California (29.10%) n=244
48th New York (5.8%) n=137

| Rank | State | % A Hospitals |
|---|---|---|
| 1 | Hawaii | 72.73% |
| 2 | Idaho | 70.00% |
| 3 | Rhode Island | 62.50% |
| 4 | Massachusetts | 53.57% |
| 5 | Virginia | 51.67% |
| 6 | Colorado | 47.22% |
| 7 | Maine | 42.86% |
| 8 | Ohio | 42.45% |
| 9 | North Carolina | 41.89% |
| 10 | Wisconsin | 41.51% |
| 11 | Oregon | 41.38% |
| 12 | Utah | 40.91% |
| 13 | Missouri | 35.85% |
| 14 | Texas | 35.71% |
| 15 | Illinois | 34.58% |
| 16 | South Carolina | 34.15% |
| 17 | New Jersey | 33.85% |
| 18 | New Mexico | 33.33% |
| 18 | Minnesota | 33.33% |
| 20 | Tennessee | 32.79% |
| 21 | Indiana | 31.48% |
| 22 | Pennsylvania | 31.36% |
| 23 | Florida | 30.64% |
| 24 | Michigan | 30.25% |
| 25 | California | 29.10% |

| Rank | State | % A Hospitals |
|---|---|---|
| 26 | Mississippi | 29.03% |
| 27 | Kansas | 27.59% |
| 28 | Louisiana | 27.08% |
| 29 | Arizona | 26.19% |
| 30 | Montana | 25.00% |
| 30 | South Dakota | 25.00% |
| 32 | Washington | 24.44% |
| 33 | New Hampshire | 23.08% |
| 34 | Kentucky | 21.74% |
| 35 | Georgia | 21.13% |
| 36 | Vermont | 20.00% |
| 36 | Wyoming | 20.00% |
| 38 | Oklahoma | 19.44% |
| 39 | Iowa | 19.35% |
| 40 | Nevada | 16.67% |
| 40 | District of Columbia | 16.67% |
| 42 | Alabama | 15.22% |
| 43 | Nebraska | 12.50% |
| 44 | Arkansas | 12.00% |
| 45 | West Virginia | 9.09% |
| 46 | Connecticut | 8.33% |
| 47 | Maryland | 7.32% |
| 48 | New York | 5.84% |
| 49 | Alaska | 0.00% |
| 49 | Delaware | 0.00% |
| 49 | North Dakota | 0.00% |

The Leapfrog Hospital Safety Grade

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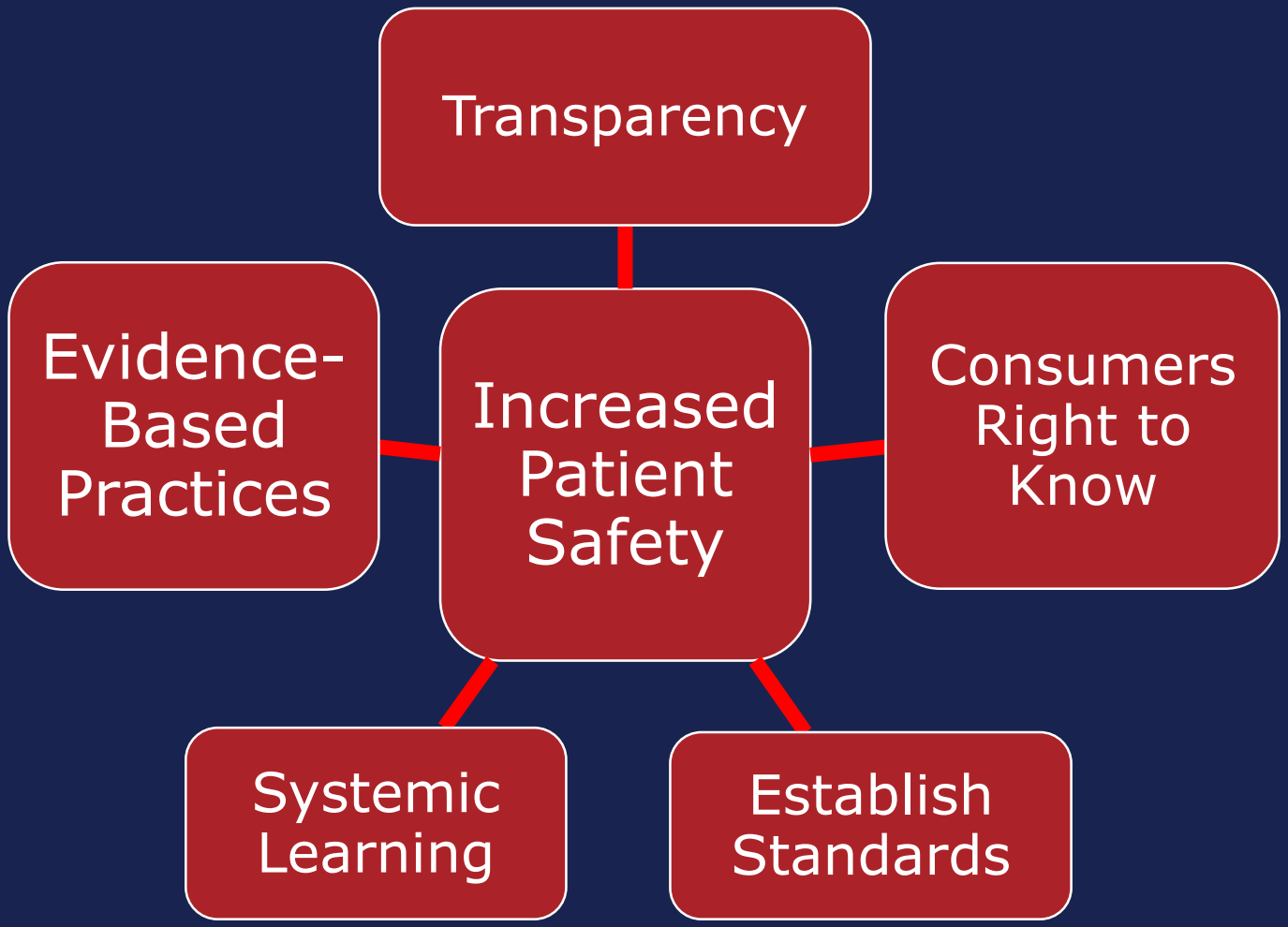
# Patient Safety Science

- Safety Culture
- Transparency
- Psychological Safety
- Human Factors Engineering
- High Reliability
- RCA2 / FMEA
- Communication
- Teamwork
- Transitions/Handoffs
- Checklists
- Forcing Functions
- Systems Thinking
- Nonpunitive Response to Mistakes vs Accountability
- Swiss Cheese Model
- Slips versus Mistakes
- Blunt vs Sharp End
- Complexity Theory
- Complex Adaptive Systems
- Adverse Event Reporting

# Impact of Adverse Event Reporting



# Texas Health and Safety Code

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

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

**AND**

**DSHS to make this data available to the public by facility, by type, and by number.**

# Chapter 98 Preventable Adverse Event Definition

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A healthcare-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid Services;

**and**

An event included in the list of adverse events identified by the National Quality Forum.

The executive commissioner may exclude an adverse event from the reporting requirement if the executive commissioner determines that the adverse event is not an appropriate indicator of a preventable adverse event.

# Requirements of DSHS

- Establish Healthcare-Associated Infection (HAI) and Preventable Adverse Event (PAE) reporting system
- Compile and make available to the public a data summary, by health care facility, at least annually
- Allow health care facilities to submit concise written comments
- Provide education and training
- Ensure confidentiality & legal protections
- Verify the accuracy and completeness of the data reported
- Receive reports from the public

# Texas Healthcare Safety Network TxHSN

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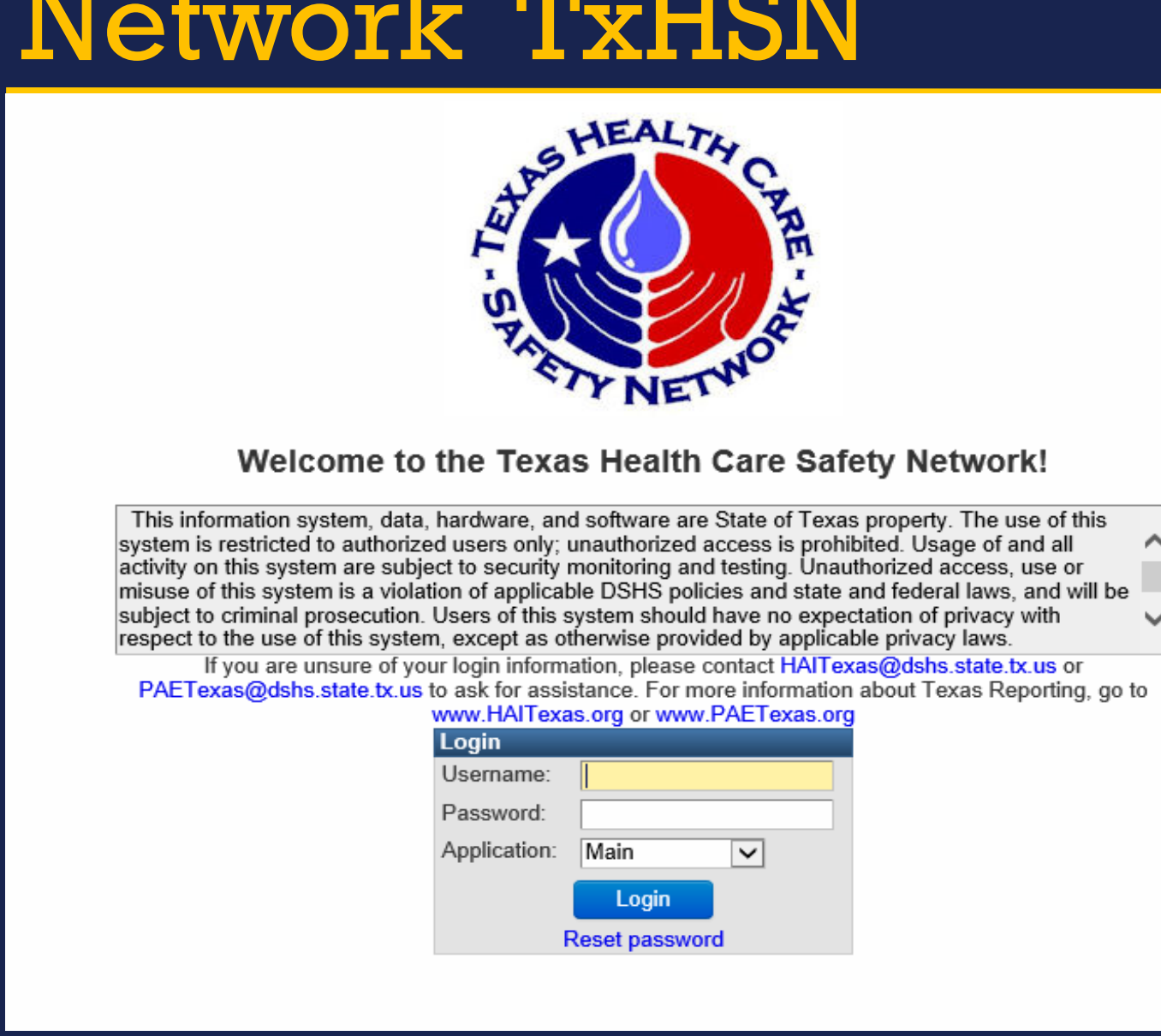


# Reportable PAEs

- Texas Administrative Code Chapter 200 lists the specific reportable PAEs.
- Listed on the PAE brochure by Tiers (years implemented)
- Categorized by:
  - Surgical or Invasive Procedure Events
  - Care Management Events
  - Patient Protection Events
  - Environmental Events
  - Potential Criminal Events
  - Product or Device Events
  - Radiological Events

# Texas Preventable Adverse Event Reporting 3 Tier Phase-In Implementation

## First Tier PAE Reporting Beginning January 1, 2015

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

## Second Tier PAE Reporting Beginning January 1, 2016

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

## Third Tier PAE Reporting Beginning January 1, 2017

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

Published 11/14

# Texas Preventable Adverse Events by Category

## Surgical or Invasive Procedure Events

1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
2. Foreign object retained after surgery.
3. Post-operative death of an ASA Class 1 Patient.
4. Surgical site infections following a spinal procedure, shoulder procedure, elbow procedure, laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.
5. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
6. Iatrogenic Pneumothorax with venous catheterization.
7. Patient death or severe harm associated with intravascular air embolism that occurs while being cared for in a health care facility

## Patient Protection Events

1. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
2. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
3. Patient death or severe harm associated with patient elopement.

**Find information, news, resources and training info at www.PAETexas.org**

**For questions email us at PAETexas@dshs.state.tx.us**

Sign Up for E-mail Updates

## Environmental Events

1. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.
2. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.
3. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
4. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.

## Potential Criminal Events

1. Abduction of a patient of any age.
2. Sexual abuse or assault of a patient within or on the grounds of a health care facility.
3. Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a health care facility.
4. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.

## Product or Device Events

1. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.
2. Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.

## Care Management Events

1. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
2. Patient death or severe harm associated with unsafe administration of blood or blood products.
3. Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
4. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
5. Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.
6. Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.
7. Artificial insemination with the wrong donor sperm or wrong egg.
8. Poor glycemic control: hypoglycemic coma.
9. Poor glycemic control: diabetic ketoacidosis.
10. Poor glycemic control: nonketotic hyperosmolar coma.
11. Poor glycemic control: secondary diabetes with ketoacidosis.
12. Poor glycemic control: secondary diabetes with hyperosmolarity.
13. Patient death or severe harm associated with a medication error.

## Radiological Event

1. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.

# What Data is Required?

- The following are required:
  - Category of Event
  - Type of Event
  - Date of Event
  - Medical Record/Patient ID#
  - Level of Harm
  - Do you want to delete this record?

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

# PAEs Reportable in Texas--SREs

- Serious Reportable Events (SREs)-- "Never Events"
  - ✓List of 29 events developed by the National Quality Forum (2002)
- Most begin with "Death or Severe Harm".
- Some SREs are also HACs.
- There is not a list of associated ICD-10 codes for the SREs.

# PAEs Reportable in Texas--HACs

- Hospital-Acquired Conditions (HACs)
  - List of 14 Events/Event categories for which Medicare will not provide additional payment to the facility
- Condition not present on admission but is present on discharge
- PAE events that are only HACs are to be reported if they would meet HAC ICD-10 Coding.

# Where are the HAC codes?

- The HAC ICD-10 code list is accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html
- HAC coding is completed in your coding and/or billing department.
- Some facilities notify key personnel when a HAC is identified.
- The occurrence of these events could be identified by direct care, patient safety, quality, risk management or IC professionals.

# HACS Currently Reported to NHSN for Texas Reporting

- CAUTIs in ICUs
- CLABSIs in ICUs/NICUs (VCAIs)
- SSIs following CABG
- SSIs following CIED in Children's hospitals
- SSIs following spinal fusion in Children's hospitals

# HACS Currently Reported to TxHSN as PAEs

- Events that are only HACs are to be reported as PAEs if they meet or would meet the HAC ICD-10 Codes:
  - DVT/PE after hip/knee surgery (2016)
  - Iatrogenic Pneumothorax with Venous Catheterization (2016)
  - Poor Glycemic Control (2017)
  - SSIs for certain events (2017)

# HAC SSIs for PAE Reporting

- Certain spinal, shoulder, elbow procedures
- Laparoscopic gastric bypass
- Gastroenterostomy
- Laparoscopic gastric restrictive surgery
- Cardiac Implantable Electronic Device (exception Childrens Hospitals)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

# SSI's for PAE Reporting in TxHSN

- A surgical site infection that occurs during the episode of care during which the surgery was performed are reportable as a PAE.
- Reporting of PAE SSIs is completed in TxHSN—NOT in NHSN.
- These infections do not have to meet NHSN criteria.
- The PAE SSIs are Healthcare Acquired Conditions or "HACs". If an infection occurs that would meet the HAC coding, then it is reportable.

# ICD-10 Codes for Surgical Orthopedic HACs

| | |
|---|---|
| 0RQJXZZ | Repair Right Shoulder Joint, External Approach |
| 0RQK0ZZ | Repair Left Shoulder Joint, Open Approach |
| 0RGJ04Z | Fusion of Right Shoulder Joint with Int Fix, Open Approach |
| 0RGJ07Z | Fusion of Right Shoulder Joint with Autol Sub, Open Approach |
| 0RGJ0JZ | Fusion of Right Shoulder Joint with Synth Sub, Open Approach |
| 0RGJ0KZ | Fusion of R Shoulder Jt with Nonaut Sub, Open Approach |
| 0RGJ0ZZ | Fusion of Right Shoulder Joint, Open Approach |
| 0RGJ34Z | Fusion of Right Shoulder Joint with Int Fix, Perc Approach |
| 0RGJ37Z | Fusion of Right Shoulder Joint with Autol Sub, Perc Approach |
| AND | |
| K6811 | Postprocedural retroperitoneal abscess |
| T814XXA | Infection following a procedure, initial encounter |
| T8460XA | Infect/inflm reaction due to int fix of unsp site, init |
| T84610A | Infect/inflm reaction due to int fix of right humerus, init |
| T84611A | Infect/inflm reaction due to int fix of left humerus, init |

# Poor Glycemic Control

See ICD-10 codes for these:

- Hypoglycemic coma
- Diabetic ketoacidosis
- Nonketonic hyperosmolar coma
- Secondary diabetes  with ketoacidosis
- Secondary diabetes with hyperosmolarity

# Poor Glycemic Control Crosswalk

| HAC 09 - Manifestations of Poor Glycemic Control CROSSWALK | | |
|---|---|---|
| **Code** | **Long Description** | **TxHSN PAE POOR GLYCEMIC CATEGORIES** |
| **E0800** | Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) | Poor Glycemic Control – Secondary diabetes with hyperosmolarity |
| **E0801*** | Diabetes mellitus due to underlying condition with hyperosmolarity with coma | Poor Glycemic Control – Nonketotic Hyperosmolar coma |
| | | Poor Glycemic Control – Secondary diabetes with hyperosmolarity |
| **E0810** | Diabetes mellitus due to underlying condition with ketoacidosis without coma | Poor Glycemic Control – Secondary diabetes with ketoacidosis |
| **E0900** | Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) | Poor Glycemic Control – Secondary diabetes with hyperosmolarity |
| **E0901*** | Drug or chemical induced diabetes mellitus with hyperosmolarity with coma | Poor Glycemic Control – Nonketotic Hyperosmolar coma |
| | | Poor Glycemic Control – Secondary diabetes with hyperosmolarity |
| **E0910** | Drug or chemical induced diabetes mellitus with ketoacidosis without coma | Poor Glycemic Control – Secondary diabetes with ketoacidosis |
| **E1010** | Type 1 diabetes mellitus with ketoacidosis without coma | Poor Glycemic Control – Diabetic ketoacidosis |
| **E1100** | Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) | Poor Glycemic Control - Diabetic Ketoacidosis |
| **E1101** | Type 2 diabetes mellitus with hyperosmolarity with coma | Poor Glycemic Control – Nonketotic Hyperosmolar coma |
| **E1300** | Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) | Poor Glycemic Control – Secondary diabetes with hyperosmolarity |
| **E1301*** | Other specified diabetes mellitus with hyperosmolarity with | Poor Glycemic Control – Nonketotic |

# Pressure Ulcers (SRE and HAC)

- Stage III, Stage IV or Unstageable Pressure Ulcer Acquired after admission/presentation to a healthcare facility.
- Stage II on admission that progresses to Stage III or IV or Unstageable is reportable.
- Deep Tissue Injuries (DTIs) present on admission do not have to be reported.
- DTIs that progress or are assessed as Stage III, IV or Unstageable are reportable.
- Refer to Pressure Ulcers Reporting Guidance

# Pressure Ulcers Reporting Guidance

| On Admission and Documented | Progresses to | Reportable? |
|---|---|---|
| Skin intact | Stage 3, 4, Unstageable | Yes |
| Stage 1 | Stage 3, 4, Unstageable | Yes |
| Stage 2 | Stage 3 | No |
| Stage 2 | Stage 4, Unstageable | Yes |
| Stage 3 | Stage 3, 4, Unstageable | No |
| Stage 4 | Stage 4, Unstageable | No |
| Unstageable | Stage 3, 4, Unstageable | No |
| DTI | Stage 3, 4, Unstageable | No |

| Occurring During Episode of Care | Progresses to | Reportable? |
|---|---|---|
| Skin intact | Stage 3, 4, Unstageable | Yes |
| Stage 1, 2 | Stage 3, 4, Unstageable | Yes |
| Stage 3, 4, Unstageable | Stage 3, 4, Unstageable | Yes |
| DTI | Stage 1, 2 | No |
| DTI | Stage 3, 4, Unstageable | Yes |

# TxHSN Reporting Schedule

| Reporting Quarter | Q1: Jan 1 – Mar 31 | H1: Jan 1 – June 30 | Q3: July 1 – Sept 30 | H2: July 1 – Dec 31 |
|---|---|---|---|---|
| Facility data submission deadline | Within 60 days of end of reporting quarter | | | |
| DSHS takes preliminary data snapshot | 1-Jun | 1-Sept | 1-Dec | 1-Mar |
| DSHS sends email to facility users review data | ~15-Jun | ~15-Sep | ~15-Dec | ~15-Mar |
| Facility data corrections due<br>✶ Last day to verify no PAEs to report for half year | 30-Jun | 30-Sep✶ | 31-Dec | 31-Mar✶ |
| DSHS takes final data snapshot | 1-July | 1-Oct | 1-Jan | 1-Apr |
| DSHS sends email to facility to review data summary and make comments | NA | 15-Oct | NA | 15-Apr |
| Facility comment period deadline | NA | 30-Oct | NA | 30-Apr |
| DSHS reviews comments | NA | 15-Nov | NA | 15-May |
| Public posting of data summary with approved comments | NA | 1-Dec | NA | 1-Jun |

# Suspension of PAE Reporting Requirement

- September 2017—Governor's suspension of reporting to TxHSN due to Hurricane Harvey.
- TxHSN January 2018--suspension extended
- Reporting for Jan-June 2018 is optional and encouraged.
- Reports from this time period will not be published.
- The reporting site Texas Healthcare Safety Network (TxHSN) remains open.
- Facilities have been and will continue to be able to login and report events.

# PAE Website

## www.paetexas.org

# Data Website

## http://txhsn.dshs.gov/HCSreports

# Healthcare Safety Consumer Report

# of Hospital Beds: 60
# Patient Admissions per year: 2702
# Patient-Days per year: 12507

Facility-Specific Health Care Safety Report - Consumer Version

Reported by the Texas Department of State Health Services
Time Period: January - June 2015
Report current as of: 09/01/2015 09:31 AM

Data shown in this report came from two different sources: the National Healthcare Safety Network (NHSN) was the source for CLABSI, CAUTI and SSI tables and the Texas Health Care Safety Network (TxHSN) was the source for the PAE table.

| Preventable Adverse Events (PAEs) | |
|---|---|
| **Type of Event** | **Total Number** |
| **Events related to patient care** | |
| Patient death or severe harm resulting from test results that were not communicated or followed up on. | 1 |
| **Events related to the patient's setting** | |
| Any event where a medical gas was not given to a patient correctly (no gas, wrong gas or toxic gas). | 2 |

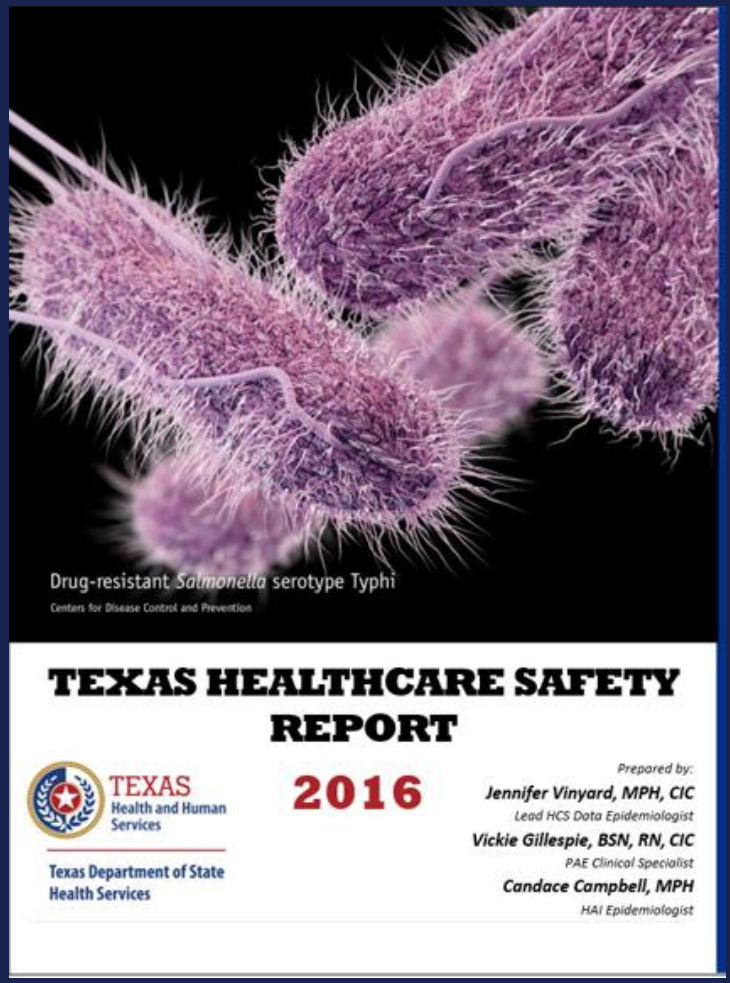
**Facility Comments on NHSN data:**

**Facility Comments on PAE data:**

| Catheter-Associated Urinary Tract Infection (CAUTI)** | | | | |
|---|---|---|---|---|
| Hospital Unit | Number of Infections | | National Comparison | No. of CAUTIs that Contributed to the Patient's Death |
| | Actual | Predicted | | |
| Intensive Care Unit | 0 | 3.86 | Better — Fewer infections (better) than the national baseline. | 0 |
| ** NOTE: CAUTIs are Urinary Tract Infections (UTIs) that happen after a urinary catheter is placed in a patient. The facility is responsible for providing any additional explanation regarding deaths and if provided, can be found below in the Facility Comments Section. | | | | |
| **Coronary artery bypass graft with both chest and donor site incisions** | | | | |
| Inpatient | 5 | 1.641 | Worse — More infections (worse) than the national baseline. | 0 |

| Preventable Adverse Events (PAEs) | |
|---|---|
| Type of Event | Total Number |
| **Events related to patient care** | |
| Patient death or severe harm associated with a fall in a health care facility that caused a broken bone. | 1 |
| **Events related to surgery** | |
| Object left in patient after surgery. | 1 |

# Annual Healthcare Safety Report




2016 DSHS Healthcare Safety Report

# Reported PAEs

| Reported PAEs | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|
| Total | 545 | 1,396 | 1,120 | 480 |

| Reported Deaths | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|
| Total | 25 | 43 | 27 | 7 |

*Preliminary numbers and these have not been validated. PAE reporting for 2017 and January – June 2018 events was not required due to Hurricane Harvey/the Governor's suspension of PAE reporting rules (Texas Administrative Code 200.1 – 200.10) and likely does not represent all events that occurred.

NA: PAE not required to be reported in that time period

| | Preventable Adverse Events | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 1 | Stage III, IV, or Unstageable Pressure Ulcer Acquired After Admission | NA | 642 | 479 | 214 |
| 2 | Patient Death or Severe Harm Associated with a Fall Resulting in a Fracture | 202 | 185 | 146 | 74 |
| 3 | Foreign Object Retained After Surgery or Invasive Procedure | 121 | 129 | 71 | 25 |
| 4 | Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) After Total Knee Replacement | NA | 86 | 54 | 23 |
| 5 | Iatrogenic Pneumothorax with Venous Catheterization | NA | 53 | 54 | 27 |
| 6 | Wrong Site Surgery or Invasive Procedure | 66 | 73 | 22 | 13 |
| 7 | Patient Death or Severe Harm Associated with a Fall Resulting in an Intracranial Injury | 43 | 57 | 28 | 11 |
| 8 | DVT/PE After Hip Replacement | NA | 37 | 16 | 15 |
| 9 | Wrong Surgery/Procedure | 29 | 30 | 19 | 7 |
| 10 | Patient Death or Severe Harm Associated with a Fall Resulting in Other Injury | 17 | 24 | 24 | 10 |
| 11 | Patient Death or Severe Harm Resulting from Failure to Follow Up or Communicate Laboratory, Pathology, or Radiology Test Results | 11 | 14 | 4 | 1 |

| | Preventable Adverse Events | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 12 | Perinatal Death or Severe Harm (Maternal or Neonate) Associated with Labor or Delivery in a Low-Risk Pregnancy | 17 | 13 | 16 | 4 |
| 13 | Patient Suicide, Attempted Suicide, or Self-Harm That Results in Severe Harm | NA | 11 | 10 | 4 |
| 14 | Patient Death or Severe Harm Associated with a Burn Incurred From Any Source | NA | 9 | 8 | 7 |
| 15 | Surgery or Invasive Procedure on Wrong Patient | 7 | 7 | 7 | 5 |
| 16 | Any Incident in Which Systems for O2 or Other Gas Contains No Gas, Wrong Gas, or Are Contaminated by Toxic Substances | 8 | 5 | 3 | 4 |
| 17 | Patient Death or Severe Harm Associated with Patient Elopement | NA | 4 | 0 | 0 |
| 18 | Patient Death or Severe Harm Resulting from the Irretrievable Loss of an Irreplaceable Biological Specimen | 1 | 3 | 1 | 1 |
| 19 | Patient Death or Severe Harm Associated with Use of Physical Restraints or Bedrails | 2 | 3 | 0 | 1 |
| 20 | Sexual Abuse or Assault | 8 | 3 | 2 | 2 |

| | Preventable Adverse Events | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 21 | Patient Death or Severe Harm Resulting from a Physical Assault that Occurs within or on the Grounds of a Health Care Facility | 3 | 2 | 0 | 0 |
| 22 | Intra-Operative or Immediately Post-Operative Death of an ASA Class 1 Patient | 2 | 2 | 0 | 0 |
| 23 | Patient Death or Severe Harm Associated with a Fall Resulting in a Dislocation | 6 | 2 | 3 | 1 |
| 24 | Any Instance of Care Ordered or Provided by Someone Impersonating a Physician, Nurse, Pharmacist, or Other Licensed Health Care Provider | NA | 1 | 0 | 1 |
| 25 | Discharge/Release of Patient of Any Age Who is Unable to Make Decisions, to Someone Other than an Authorized Person | 1 | 1 | 1 | 0 |
| 26 | Patient Death or Severe Harm Associated with Unsafe Administration of Blood or Blood Products | 1 | 0 | 1 | 2 |
| 27 | Abduction of a Patient of any Age | 0 | 0 | 1 | 0 |
| 28 | Patient Death or Severe Harm Associated with Intravascular Air Embolism that occurs While Being Cared for in a Health Care Facility | NA | NA | 6 | 3 |

| | Preventable Adverse Events | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 29 | Patient Death or Severe Harm Associated with the Use or Function of a Device in Patient Care, in Which the Device is Used or Functions Other Than as Intended | NA | NA | 4 | 2 |
| 30 | Patient Death or Severe Harm Associated with a Medication Error | NA | NA | 13 | 3 |
| 31 | Poor Glycemic Control: Diabetic Ketoacidosis | NA | NA | 55 | 9 |
| 32 | Poor Glycemic Control: Secondary Diabetes with Ketoacidosis | NA | NA | 28 | 2 |
| 33 | Poor Glycemic Control: Hypoglycemic Coma | NA | NA | 3 | 2 |
| 34 | Poor Glycemic Control: Nonketotic Hyperosmolar Coma | NA | NA | 1 | 0 |
| 35 | Poor Glycemic Control: Secondary Diabetes with Hyperosmolarity | NA | NA | 1 | 1 |
| 36 | Surgical Site Infection Following a Spinal Procedure | NA | NA | 27 | 6 |
| 37 | Surgical Site Infection Following a Shoulder Procedure | NA | NA | 1 | 0 |

| | Preventable Adverse Events | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 38 | Surgical Site Infection Following a Cardiac Implantable Electronic Device | NA | NA | 2 | 0 |
| 39 | Surgical Site Infection Following a Gastroenterostomy | NA | NA | 2 | 0 |
| 40 | Surgical Site Infection Following a Laparoscopic Gastric Restrictive Surgery | NA | NA | 1 | 0 |
| 41 | Patient Death or Severe Harm Associated with the Introduction of a Metallic Object into the MRI Area. | NA | 0 | 1 | 0 |
| | TOTAL | 545 | 1,396 | 1,120 | 480 |

*Preliminary numbers and these have not been validated. PAE reporting for 2017 and January – June 2018 events was not required due to Hurricane Harvey/the Governor's suspension of PAE reporting rules (Texas Administrative Code 200.1 – 200.10) and likely does not represent all events that occurred.

NA: PAE not required to be reported in that time period

| | Reported Preventable Adverse Events Associated with Patient Deaths | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 1 | Perinatal Death | 11 | 6 | 3 | 2 |
| 2 | Fall Resulting in an Intracranial Injury | 5 | 11 | 1 | 0 |
| 3 | Fall Resulting in Other Injury | 3 | 2 | 2 | 2 |
| 4 | Failure to Follow Up or Communicate Results | 2 | 5 | 1 | 0 |
| 5 | Death of an ASA Class 1 Patient | 2 | 2 | 0 | 0 |
| 6 | Fall Resulting in a Fracture | 1 | 3 | 0 | 0 |
| 7 | Foreign Object Retained | 1 | 0 | 0 | 0 |
| 8 | O2 or Other Gas | 0 | 2 | 0 | 0 |
| 9 | Unsafe Administration of Blood or Blood Products | 0 | 0 | 1 | 0 |
| 10 | Physical Restraints or Bedrails | 0 | 1 | 0 | 0 |
| 11 | DVT/PE After Hip Replacement | NA | 4 | 2 | 0 |
| 12 | Patient Suicide | NA | 3 | 1 | 1 |
| 13 | Patient Elopement | NA | 3 | 0 | 0 |

| | Reported Preventable Adverse Events Associated with Patient Deaths | 2015 | 2016 | 2017* | 2018* Jan - June |
|---|---|---|---|---|---|
| 14 | Stage III, IV, or Unstageable Pressure Ulcer | NA | 2 | 4 | 1 |
| 15 | DVT/PE After Total Knee Replacement | NA | 2 | 0 | 0 |
| 16 | Iatrogenic Pneumothorax with Venous Catheterization | NA | 1 | 0 | 0 |
| 17 | Introduction of Metal into the MRI Area | NA | 0 | 1 | 0 |
| 18 | Unintended Use or Function of a Device | NA | NA | 3 | 1 |
| 19 | Intravascular Air Embolism | NA | NA | 3 | 0 |
| 20 | Medication Error | NA | NA | 3 | 1 |
| | | | | | |
| | Total | 25 | 47 | 23 | 7 |

*Preliminary numbers and these have not been validated. PAE reporting for 2017 and January – June 2018 events was not required due to Hurricane Harvey/the Governor's suspension of PAE reporting rules (Texas Administrative Code 200.1 – 200.10) and likely does not represent all events that occurred.

NA: PAE not required to be reported in that time period

# 1. Injection Error

- Nurse in OK (true story)
- Injected medication using same medication vial and same syringe into multiple patients IV Bags/tubings
- 186 patients potentially exposed to HIV and Hepatitis C.

## Is this a reportable PAE?

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Texas Department of State Health Services

# 2. OP Falls Outside

- Outpatient falls outside of healthcare facility awaiting an appointment for the day.
- Sustained a shoulder fracture requiring surgery.

## Is this a reportable PAE?

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# 3. Fall

- Patient falls in the valet area in front of an ASC.
- Fractures a hip requiring surgery.
- The fall was unwitnessed, but was about to enter the ASC.

## Is this a reportable PAE?

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# 4. DVT/PE

- Patient had a total knee replacement.
- The patient did not receive anticoagulant because the physician felt patient to be high risk for bleeding.
- Pt. developed a PE post operatively.

## Is this a reportable PAE?

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# 5. Unanticipated Fall

- Fall due to new onset seizure.
- Patient sustained a small intracranial hemorrhage.

Is this a reportable PAE?

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# 6. Vaginal Packing

- Patient had GU surgery, with vaginal packing left in place to be removed prior to discharge.
- Patient exam in physician's office on Post Op Day 1
- Vaginal packing found in place and removed without incident

## Is this a reportable PAE?

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# 7. Pneumothorax

- Central line placed today
- No pneumothorax confirmed by x-ray post placement
- Tomorrow patient develops a pneumothorax

## Is this a reportable PAE?

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# 8. Foreign Object Retained

- Gastrectomy Sleeve procedure for weight loss.
- Sleeve gastrectomy specimen was not removed from the surgical field.
- Patient returned to facility with intra-abdominal abscess.

Is this a reportable PAE?

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Health and Human Services

Texas Department of State Health Services

# 9. Wrong IOL

- Patient received a standard IOL instead of a premium IOL.
- Surgery had to be redone.

Is this a reportable PAE?

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# 10. Surgical Site Infection

- An SSI occurred for a surgical procedure code 0D160ZB, Bypass Stomach to Ileum, Open Approach (HAC Code)
- Reason for surgery--cancerous tumor resection procedure and not bariatric surgery.

## Is this a reportable PAE?

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# 11. Drain Broke Off

- A surgical drain is removed on the 2nd post op day as ordered.
- Upon removal the drain catheter broke off unbeknownst to staff.
- 5th post op day, an I&D of drain site was needed and the remaining part of drain was found.

## Is This a Reportable PAE?

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# 12. Pediatric SSIs

- A patient in a children's hospital developed an SSI following a spinal procedure ( XX )
- This SSI will be reported to NHSN.
- This SSI/procedure is also a PAE (HAC ICD-10 list).

Is this a reportable PAE?

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Health and Human Services

Texas Department of State Health Services

# 13. Foreign Object Retained

- Patient 2 years status post knee replacement and needed a revision.
- During surgery a screw fell into fatty tissue. Surgeon knew but forgot to retrieve at end of case.
- One month post op, screw found in fatty tissue of knee and second surgery required to remove it.

## Is this a reportable PAE?

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# 14. Fall/Rib Fracture

- 25 year old male in ER threatening harm and acting out.
- Patient stuck an EMT.
- Security guard took patient down to the ground.
- Patient sustained rib fracture and pneumothorax with transfer to ICU.

Is this a reportable PAE?

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# 15. Pressure Ulcer

- Patient admitted with intact skin.
- On day 3 a Stage II pressure ulcer was found on heel.
- On day 6, the Stage II ulcer progressed to a Stage III pressure ulcer.

## Is this a reportable PAE?

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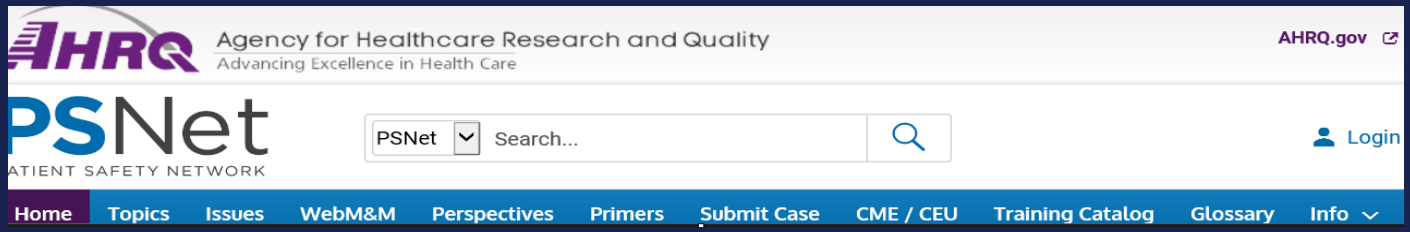
# Key Resources

- https://psnet.ahrq.gov/




- www.qualityforum.org

NATIONAL QUALITY FORUM

- https://www.cdc.gov/nhsn/

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
National Healthcare Safety Network (NHSN)

- www.paetexas.org

# AHRQ Patient Safety Primers

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**Approach to Improving Safety** —

- Communication Improvement 7
- Culture of Safety 7
- Education and Training 3
- Error Reporting and Analysis 13
- Human Factors Engineering 5
- Legal and Policy Approaches 1
- Logistical Approaches 4
- Quality Improvement Strategies 7
- Specialization of Care 1
- Teamwork 1
- Technologic Approaches 4

**Safety Target** —

- Alert fatigue 1
- Diagnostic Errors 2
- Discontinuities, Gaps, and Hand-Off Problems 3
- Failure to rescue 1
- Fatigue and Sleep Deprivation 1
- Identification Errors 1
- Inpatient suicide 1
- Interruptions and distractions 2
- Medical Complications 2
- Medication Safety 3
- Nonsurgical Procedural Complications 1
- Psychological and Social Complications 1
- Second victims 2
- Surgical Complications 2

https://psnet.ahrq.gov/primers

# References


1. *Top 10 Patient Safety Concerns for Healthcare Organizations 2018.* ©ECRI Institute | www.ecri.org www.ecri.org/patientsafetytop10
2. Executive Brief: *Top 10 Health Technology Hazards for 2018.* ©ECRI Institute | www.ecri.org www.ecri.org/2018hazards
3. The Leapfrog Hospital Safety Grade Spring 2018 http://www.hospitalsafetygrade.org/about-us/newsroom/display/663012
4. Texas Health and Safety Code, Title 2. Health, Subtitle D. Prevention, Control and Reports of Diseases, Chapter 98. Reporting of Health Care-Associated Infections and Preventable Adverse Events, Section 98.102 and Section 98.1045
5. Texas Administrative Code, Title 25 Health Services, Part 1 Department of State Health Services, Chapter 200 Reporting of Healthcare Associated Infections and Preventable Adverse Events Subchapter A Control of Communicable Diseases, Rule 200.7 Schedule of HAI and PAE Reporting
6. FY 2018 CMS Hospital Acquired Conditions (HACS) ICD-10 List https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html
7. Summary Data of Sentinel Events Reviewed by The Joint Commission as of 1/23/18 https://www.jointcommission.org/sentinel_event_statistics_quarterly/
8. Texas Reportable Preventable Adverse Events Definitions and Guidance v1.7 (04/01/18) http://www.dshs.texas.gov/IDCU/health/preventable-adverse-events/PAE-Resources.aspx


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# Thank you!

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