• Healthcare Associated Infections
  – Central line-associated bloodstream infections in certain special care settings (ICUs & CCUs, NICUs)
  – Catheter associated urinary tract infections in ICUs & CCUs (NICUs excluded)
  – Surgical site infections
• Multi-drug Resistant Organism Reporting
• Preventable Adverse Events (PAE)
Objectives

1. Discuss key aspects of the Texas DSHS Preventable Adverse Event (PAE) Reporting Program.
2. Explain the PAE reporting requirements for SSIs.
3. Identify at least 2 available resources.
“Medical errors now third leading cause of death in the United States”

- Recent study published in the BMJ analyzed 4 large studies dating 2000-2008
- Estimated 251,000 deaths/year in US—685/day
- 700 per day or 9.5% of all deaths
- 3rd leading cause after heart disease and cancer

Makary, Martin and Daniel, Micheal; Johns Hopkins University School of Medicine
December 2014
ER for anxiety and med concerns post recent brain surgery
Fosphenotoin (Cerebyx) ordered
Rocuronium IV given (Zemuron/Esmuron)
Respiratory/cardiac arrest
Anoxic brain injury
Death
Scope of the Problem

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

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

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

• HAIs—1 out of every 25 patients\(^9\)
  – 2 Million annually in US\(^7\) (200,000 in Texas\(^8\)) 722,000 in US acute hospitals\(^7\)
  – ~90,000 deaths (8-9000 Texas deaths) 75,000 during hospitalizations\(^7\)
  – ~$5 billion - $31.5 billion\(^2\) healthcare costs
Mortality and Morbidity

• 1 in 10 hospitalized patients develops an adverse event (AHRQ 2014)
• 1/3 of Medicare beneficiaries in SNF have an adverse event—half of which are deemed preventable (OIG 2014)
• 1 in 20 perioperative med administrations had med error and/or adverse drug event (Nanji et al. 2015)

> 700,000 ED visits due to adverse drug event--120,000 need admitted (Budnitz et al. 2014)
• 12 Million patients experience diagnostic error (OP care), ½ which have potential to harm (Singh et al. 2014)
• 42.7 Million adverse events in 421 M hospitalizations/year/world (Jha et al. 2013)
<table>
<thead>
<tr>
<th>Patient Safety Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Culture</td>
</tr>
<tr>
<td>Systems Thinking</td>
</tr>
<tr>
<td>Swiss Cheese Model</td>
</tr>
<tr>
<td>Slips versus Mistakes</td>
</tr>
<tr>
<td>Blunt vs Sharp End</td>
</tr>
<tr>
<td>Complexity Theory</td>
</tr>
<tr>
<td>Complex Adaptive Systems</td>
</tr>
<tr>
<td>Transparency</td>
</tr>
<tr>
<td>Adverse Event Reporting</td>
</tr>
<tr>
<td>High Reliability</td>
</tr>
<tr>
<td>Nonpunitive Response to Mistakes vs Accountability</td>
</tr>
<tr>
<td>Psychological Safety</td>
</tr>
<tr>
<td>Human Factors Engineering</td>
</tr>
<tr>
<td>RCA² / FMEA</td>
</tr>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Teamwork</td>
</tr>
<tr>
<td>Transitions/Handoffs</td>
</tr>
<tr>
<td>Checklists</td>
</tr>
<tr>
<td>Forcing Functions</td>
</tr>
</tbody>
</table>
Survey on Patient Safety Culture

- Communication Openness
- Compliance With Procedures
- Feedback and Communication About Incidents
- Handoffs
- Management Support for Resident Safety
- Nonpunitive Response to Mistakes
- Organizational Learning
- Overall Perceptions of Patient Safety
- Staffing
- Supervisor Expectations and Actions Promoting Patient Safety
- Teamwork
- Training and Skills

Agency for Healthcare Research and Quality 2016 Hospital Survey on Patient Safety Culture
Survey Results

Agency for Healthcare Research and Quality 2016 Hospital Survey on Patient Safety Culture
March 1, 2017

The Joint Commission issued New Safety Event Alert on Establishing and Improving Safety Culture in Health Care

The essential role of leadership in developing a safety culture
Figure 1. The National Health Service’s Incident Decision Tree for responding to patient safety events

**INCIDENT DECISION TREE**
Work through the tree separately for each individual involved

1. **Start Here**
   - Deliberate Harm Test
     - Were the actions as intended?
       - NO
         - Incapacity Test
           - Does there appear to be evidence of ill health or substance abuse?
             - YES
               - Were adverse consequences intended?
                 - NO
                   - Consult NCAA or relevant regulatory body
                     - Advise individual to consult Trade Union Representative
                       - Consider: Suspension, Referral to police and disciplinary/regulatory body, Occupational Health referral
                 - YES
                   - Consult NCAA or relevant regulatory body
                     - Advise individual to consult Trade Union Representative
                       - Consider: Occupational Health referral, Reasonable adjustment to duties, Sick leave
   - YES
     - Foresight Test
       - Did the individual depart from agreed protocols or safe procedures?
         - YES
           - Were the protocols and safe procedures available, workable, intelligible, correct and in routine use?
             - NO
               - Is there evidence that the individual took an unacceptable risk?
                 - YES
                   - Consult NCAA or relevant regulatory body
                     - Advise individual to consult Trade Union Representative
                       - Consider: Corrective training, Improved supervision, Occupational Health referral, Reasonable adjustment to duties
                 - NO
                   - Were there any significant mitigating circumstances?
                     - YES
                       - Consult NCAA or relevant regulatory body
                         - Advise individual to consult Trade Union Representative
                           - Consider: Referral to disciplinary/regulatory body, Reasonable adjustment to duties, Occupational Health referral, Suspension
                       - NO
                         - Consult NCAA or relevant regulatory body
                           - Advise individual to consult Trade Union Representative
                             - Consider: Occupational Health referral, Suspension
       - NO
         - Were there any deficiencies in training, experience or supervision?
           - YES
             - Consult NCAA or relevant regulatory body
               - Advise individual to consult Trade Union Representative
                 - Consider: Referral to disciplinary/regulatory body, Reasonable adjustment to duties, Occupational Health referral, Suspension
           - NO
             - Consult NCAA or relevant regulatory body
               - Advise individual to consult Trade Union Representative
                 - Consider: Occupational Health referral, Suspension
   - NO
     - Substitution Test
       - Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?
         - NO
           - Consult NCAA or relevant regulatory body
             - Advise individual to consult Trade Union Representative
               - Consider: Referral to disciplinary/regulatory body, Reasonable adjustment to duties, Occupational Health referral, Suspension
         - YES
           - Consult NCAA or relevant regulatory body
             - Advise individual to consult Trade Union Representative
               - Consider: Referral to disciplinary/regulatory body, Reasonable adjustment to duties, Occupational Health referral, Suspension

2. **System Failure**
   - Review system

*Based on James Reason’s Culpability Model*
2017 Top 10 Health Technology Hazards

- Infusion Errors
- Inadequate Cleaning of Complex Reusable Instruments
- Missed Ventilator Alarms
- Undetected Opioid-Induced Respiratory Depression
- Infection Risks with Heater-Cooler Devices
- Software Management Gaps
- Occupational Radiation Hazards in Hybrid ORs
- Automated Dispensing Cabinet Setup and Use Errors
- Surgical Stapler Misuse and Malfunctions
- Device Failures Caused by Cleaning Products and Practices

Adapted from: Health Devices 2016 November. ©2016 ECRI Institute www.ecri.org/2017hazards
**Top 10 Safety Concerns**

- Health IT configurations and organizational workflow that do not support each other
- Patient identification errors
- Inadequate management of behavioral health issues in non-behavioral-health settings
- Inadequate cleaning and disinfection of flexible endoscopes
- Inadequate test-result reporting and follow-up
- Inadequate monitoring for respiratory depression in patients prescribed opioids
- Medication errors related to pounds and kilograms
- Unintentionally retained objects despite correct count
- Inadequate antimicrobial stewardship
- Failure to embrace a culture of safety
Top Ten Checklist

2017 Adverse Drug Events

1. Standardize concentrations and minimize dosing options where feasible.
2. Set dosing limits for insulin and opioids.
3. Set target glucose levels at 140-180 mg/dL in the hospitalized patient.
4. Eliminate "sliding scale" insulin as the sole method of glycemic management. Manage all patients with basal+bolus+correction if eating, and basal+bolus if not.
5. Seek new insulin orders for any patient with a single episode of inpatient hypoglycemia (less than 70 mg/dL).
6. Coordinate meal and insulin times.
7. Implement pharmacist-driven warfarin management.
8. Use standard opioid equi-analgesic conversion tables.
9. Use standard order sets to avoid multiple concurrent prescriptions of opioids and sedatives.
10. Use effective tools to reduce over-sedation from opioids (e.g., risk assessment tools such as "STOP BANG" and sedation assessment tools such as the Richmond Agitation Sedation Scale or the Pasero Opioid-Induced Sedation Scale).

Joint Commission 2016
Types of Sentinel Events

- Voluntarily Reported N=824
- 14.6% Unintended Retention of a Foreign Body
- 12.6% Wrong patient, Site, Procedure
- 10.6% Suicide
- 11.2% Fall
- 8.5% Unassigned at time of report
- 6.5% Delay in Treatment
- 5.7% Other Unanticipated Event
- 5.5% Operative/Post-op Complications
- 4.0% Medication Error
- 3.9% Criminal Event
- 36.1% Other

Summary Data of Sentinel Events Reviewed by The Joint Commission
SE Statistics as of: 1/13/2017
Senate Bill 203 of the 81st Legislature (2009) amended the Health and Safety Code, Chapter 98.102.a.2,4,5, to require:

- Healthcare facilities to report certain preventable adverse events to the DSHS,
- DSHS to make this data available to the public by facility, by type, and by number.
How to Report

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

• PAE reporting deadlines, comment period and public posting of data follows the established HAI schedule.
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.
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.
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.
<table>
<thead>
<tr>
<th>SURGICAL OR INVASIVE PROCEDURE EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.</td>
</tr>
<tr>
<td>2. Foreign object retained after surgery.</td>
</tr>
<tr>
<td>3. Post-operative death of an ASA Class 1 Patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT PROTECTION EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.</td>
</tr>
<tr>
<td>ENVIRONMENTAL EVENTS</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>2. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
CARE MANAGEMENT EVENTS

1. Patient death or severe harm associated with unsafe administration of blood or blood products.
2. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
3. Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
4. Perinatal death or severe harm (maternal or neonatal) associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.
5. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
2015 Texas Healthcare Facilities*

• 1033 CLABSI s
• 1027 CAUTIs
• 2913 SSIs (selected surgeries)
• 545 PAEs

* General Hospitals, State Owned/Operated Hospitals, ASCs
<table>
<thead>
<tr>
<th>PAEs associated with patient death</th>
<th>Number reported PAE</th>
<th>Number Deaths</th>
<th>Percent Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraoperative or immediately post-operative/post-procedure death in an ASA Class 1 patient</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in low-risk pregnancy</td>
<td>17</td>
<td>11</td>
<td>65%</td>
</tr>
<tr>
<td>Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology, or radiology test results</td>
<td>11</td>
<td>2</td>
<td>18%</td>
</tr>
<tr>
<td>Patient death or severe harm associated with a fall in a healthcare facility resulting in other injury</td>
<td>17</td>
<td>3</td>
<td>18%</td>
</tr>
<tr>
<td>Patient death or severe harm associated with a fall in a healthcare facility resulting in intracranial injury</td>
<td>43</td>
<td>5</td>
<td>12%</td>
</tr>
<tr>
<td>Foreign Object Retained After Surgery or Invasive Procedure</td>
<td>121</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Patient death or severe harm associated with a fall in a healthcare facility resulting in fracture</td>
<td>202</td>
<td>1</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
2015 Annual Healthcare Safety Report

http://txhhsn.dshs.texas.gov/HCSReports/AnnualReports.aspx
<table>
<thead>
<tr>
<th>SURGICAL OR INVASIVE PROCEDURE EVENTS</th>
<th>PATIENT PROTECTION EVENTS</th>
</tr>
</thead>
</table>
| 1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.  
2. Iatrogenic Pneumothorax with venous catheterization. | 1. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.  
2. Patient death or severe harm associated with patient elopement. |
ENVIROMENTAL EVENTS
1. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
2. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.

POTENTIAL CRIMINAL EVENTS
1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
<table>
<thead>
<tr>
<th>CARE MANAGEMENT EVENT</th>
<th>RADIOLOGICAL EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.</td>
<td>1. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.</td>
</tr>
<tr>
<td>Type of Event</td>
<td>2016</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Stage III, IV or Unstageable Pressure Ulcer Acquired after Admission</td>
<td>541</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in a Fracture</td>
<td>168</td>
</tr>
<tr>
<td>Foreign Object Retained After Surgery or Invasive Procedure</td>
<td>116</td>
</tr>
<tr>
<td>DVT/PE after Total Knee Replacement</td>
<td>79</td>
</tr>
<tr>
<td>Wrong Site Surgery or Invasive Procedure</td>
<td>67</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in an Intracranial Injury</td>
<td>47</td>
</tr>
<tr>
<td>Iatrogenic Pneumothorax with Venous Catheterization</td>
<td>43</td>
</tr>
<tr>
<td>DVT/PE after Hip Replacement</td>
<td>32</td>
</tr>
<tr>
<td>Wrong Surgery/Procedure</td>
<td>29</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in Other Injury</td>
<td>19</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results</td>
<td>13</td>
</tr>
<tr>
<td>Perinatal Death or Severe Harm (maternal or neonate) Associated with Labor or Delivery in a Low-Risk Pregnancy</td>
<td>13</td>
</tr>
<tr>
<td>Patient Suicide, Attempted Suicide, or Self-harm that Results in Severe Harm</td>
<td>10</td>
</tr>
<tr>
<td>Surgery or Invasive Procedure on Wrong Patient</td>
<td>8</td>
</tr>
<tr>
<td>Type of Event</td>
<td>2016</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Burn Incurred from Any Source</td>
<td>7</td>
</tr>
<tr>
<td>Any Incident in which Systems for O2 or Other Gas Contains No Gas, Wrong Gas, or are Contaminated by Toxic Substances</td>
<td>4</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with Patient Elopement</td>
<td>4</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Resulting from the Irretrievable Loss of an Irreplaceable Biological Specimen</td>
<td>3</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with Use of Physical Restraints or Bedrails</td>
<td>3</td>
</tr>
<tr>
<td>Sexual Abuse or Assault</td>
<td>3</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Resulting from a Physical Assault that Occurs within or on the Grounds of a Health Care Facility</td>
<td>2</td>
</tr>
<tr>
<td>Intra-operative or Immediately Post-operative Death of an ASA Class 1 Patient</td>
<td>2</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with a Fall Resulting in a Dislocation</td>
<td>2</td>
</tr>
<tr>
<td>Any Instance of Care Ordered or Provided by Someone Impersonating a Physician, Nurse, Pharmacist, or Other Licensed Health Care Provider</td>
<td>1</td>
</tr>
<tr>
<td>Discharge/Release of Patient of Any Age Who is Unable to Make Decisions, to Someone Other than an Authorized Person</td>
<td>1</td>
</tr>
<tr>
<td>Patient Death or Severe Harm Associated with Unsafe Administration of Blood or Blood Products</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1217</td>
</tr>
</tbody>
</table>
1. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.

1. 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.
Third Tier PAE Reporting
January 1, 2017

CARE MANAGEMENT EVENT

1. Artificial insemination with the wrong donor sperm or wrong egg.
2. Patient death or severe harm associated with a medication error.

CARE MANAGEMENT EVENT

Poor glycemic control:
1. hypoglycemic coma
2. diabetic ketoacidosis
3. nonketotic hyperosmolar coma
4. secondary diabetes with ketoacidosis
5. secondary diabetes with hyperosmolarity.
1. Surgical site infections following spinal, shoulder, elbow procedure; laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.

1. Patient death or severe harm associated with an intravascular air embolism that occurs while being cared for in a health care facility.
Facilities shall report:
An event included in the list of adverse events identified by the National Quality Forum (SREs) and
A health care-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 (HACs).
PAEs Reportable in Texas--SREs

- Serious Reportable Event (SRE) “Never Event”
  - List of 29 events developed by the National Quality Forum (2002)
  - https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx
- 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 (HAC)
  - List of 14 Events/Event categories for which Medicare will not provide additional payment to the facility (2006)
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond.icd10_hacs.html

- 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.
Pressure Ulcers—SRE and HAC

- HAC codes—include Stage III and IV
- SRE—includes Unstageable
- There are no ICD-10 codes for Unstageable (considered Stage III or IV)
- Unstageable Ulcers are to be reported as a PAE—
  - “Stage III or Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.
## Pressure Ulcers Reporting Guidance

<table>
<thead>
<tr>
<th>On Admission and Documented</th>
<th>Progresses to</th>
<th>Reportable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin intact</td>
<td>Stage 3, 4 or Unstageable</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 3</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 4</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Unstageable</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Stage 3</td>
<td>No</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Unstageable</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Stage 4</td>
<td>Yes</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Stage 4</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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 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 2017

- 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
# ICD-10 Codes for Surgical Orthopedic HACs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0RQJXZZ</td>
<td>Repair Right Shoulder Joint, External Approach</td>
</tr>
<tr>
<td>0RQK0ZZ</td>
<td>Repair Left Shoulder Joint, Open Approach</td>
</tr>
<tr>
<td>0RGJ04Z</td>
<td>Fusion of Right Shoulder Joint with Int Fix, Open Approach</td>
</tr>
<tr>
<td>0RGJ07Z</td>
<td>Fusion of Right Shoulder Joint with Autol Sub, Open Approach</td>
</tr>
<tr>
<td>0RGJ0JZ</td>
<td>Fusion of Right Shoulder Joint with Synth Sub, Open Approach</td>
</tr>
<tr>
<td>0RGJ0KZ</td>
<td>Fusion of R Shoulder Jt with Nonaut Sub, Open Approach</td>
</tr>
<tr>
<td>0RGJ0ZZ</td>
<td>Fusion of Right Shoulder Joint, Open Approach</td>
</tr>
<tr>
<td>0RGJ34Z</td>
<td>Fusion of Right Shoulder Joint with Int Fix, Perc Approach</td>
</tr>
<tr>
<td>0RGJ37Z</td>
<td>Fusion of Right Shoulder Joint with Autol Sub, Perc Approach</td>
</tr>
</tbody>
</table>

**AND**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K6811</td>
<td>Postprocedural retroperitoneal abscess</td>
</tr>
<tr>
<td>T814XXA</td>
<td>Infection following a procedure, initial encounter</td>
</tr>
<tr>
<td>T8460XA</td>
<td>Infect/inflm reaction due to int fix of unsp site, init</td>
</tr>
<tr>
<td>T84610A</td>
<td>Infect/inflm reaction due to int fix of right humerus, init</td>
</tr>
<tr>
<td>T84611A</td>
<td>Infect/inflm reaction due to int fix of left humerus, init</td>
</tr>
</tbody>
</table>
Intravascular Air Embolism
(Death or Severe Harm)

• Excludes death or severe harm associated with certain high risk neurosurgical procedures (head heart)

• Includes but not limited to:
  • Head and neck procedures
  • Vaginal and C-section deliveries
  • Spinal instrumentation procedures
  • Liver transplants
  • Low risk procedures e.g. line placement or IVs
Use or Function of Device
(Death or Severe Harm)

• Report defects, failures, incorrect use
• Report irregardless if the use is intended or described by the manufacturer.
• Includes implant, medical equipment, medical/surgical supply, HIT device
Use or Function of Device
(Death or Severe Harm)

• Includes, but not limited to, catheters, drains, and other specialized tubes, infusion pumps, ventilators, and procedural and monitoring equipment.
Use or Function of Device
(Death or Severe Harm)

• Excludes death or severe harm associated with certain high risk neurosurgical procedures (head above heart)

• Includes but not limited to:
  • Head and neck procedures
  • Vaginal and C-section deliveries
  • Spinal instrumentation procedures
  • Liver transplants
  • Low risk procedures e.g. line placement or IVs
Contaminated drugs/devices or biologics (Death or Severe Harm)

- Report irregardless of the source of contamination or product
- Contaminants – physical, chemical, biological
- Report events involving medications, biological products, vaccines, nutritional products, expressed human breast milk, medical gases or contrast media.
Contaminated drugs/devices or biologics (Death or Severe Harm)

- Includes:
  - threat of disease that changes patient’s risk status for life
  - contaminations both seen and unseen
  - serious infection from contaminated drug/device
  - occurrences r/t improperly cleaned / maintained device.
Artificial Insemination Errors

Artificial insemination with the wrong donor sperm or wrong egg.

- Must report the event when you are made aware of it.
Medication Errors
(Death or Severe Harm)

• Includes but is not limited to:
  • Over or under dosing
  • Administration of med if known allergy or contraindication
  • Drug-drug interaction if known potential for death or severe harm
  • Failure to administer prescribed drugs
  • Improper use of single or multi-dose vials if leads to dose adjustment problem
  • Wrong administration technic
Excludes:

– reasonable difference in clinical judgment on drug selection/dose
– events associated with allergies that could not have been known or discerned in advance.
Poor Glycemic Control

See ICD-10 codes for these:

- Hypoglycemic coma
- Diabetic ketoacidosis
- Nonketonic hyperosmolar coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity
<table>
<thead>
<tr>
<th>Code</th>
<th>Long Description</th>
<th>TxHSN PAE POOR GLYCEMIC CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0800</td>
<td>Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)</td>
<td>Poor Glycemic Control – Secondary diabetes with hyperosmolarity</td>
</tr>
<tr>
<td>E0801*</td>
<td>Diabetes mellitus due to underlying condition with hyperosmolarity with coma</td>
<td>Poor Glycemic Control – Nonketotic Hyperosmolar coma</td>
</tr>
<tr>
<td>E0810</td>
<td>Diabetes mellitus due to underlying condition with ketoacidosis without coma</td>
<td>Poor Glycemic Control – Secondary diabetes with ketoacidosis</td>
</tr>
<tr>
<td>E0900</td>
<td>Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)</td>
<td>Poor Glycemic Control – Secondary diabetes with hyperosmolarity</td>
</tr>
<tr>
<td>E0901*</td>
<td>Drug or chemical induced diabetes mellitus with hyperosmolarity with coma</td>
<td>Poor Glycemic Control – Nonketotic Hyperosmolar coma</td>
</tr>
<tr>
<td>E0910</td>
<td>Drug or chemical induced diabetes mellitus with ketoacidosis without coma</td>
<td>Poor Glycemic Control – Secondary diabetes with ketoacidosis</td>
</tr>
<tr>
<td>E1010</td>
<td>Type 1 diabetes mellitus with ketoacidosis without coma</td>
<td>Poor Glycemic Control – Diabetic ketoacidosis</td>
</tr>
<tr>
<td>E1100</td>
<td>Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)</td>
<td>Poor Glycemic Control - Diabetic Ketoacidosis</td>
</tr>
<tr>
<td>E1101</td>
<td>Type 2 diabetes mellitus with hyperosmolarity with coma</td>
<td>Poor Glycemic Control – Nonketotic Hyperosmolar coma</td>
</tr>
<tr>
<td>E1300</td>
<td>Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)</td>
<td>Poor Glycemic Control – Secondary diabetes with hyperosmolarity</td>
</tr>
<tr>
<td>E1301*</td>
<td>Other specified diabetes mellitus with hyperosmolarity with coma</td>
<td>Poor Glycemic Control – Nonketotic Hyperosmolar coma</td>
</tr>
<tr>
<td>E1310</td>
<td>Other specified diabetes mellitus with ketoacidosis without coma</td>
<td>Poor Glycemic Control – Secondary diabetes with ketoacidosis</td>
</tr>
</tbody>
</table>
AHRQ HAC improvements

• 21% decline in HACS since 2010
• 3 M fewer adverse events
• 125,000 lives saved
• $28 Billion in savings

AHRQ National Scorecard on Rates of Hospital-Acquired Conditions, 2010 to 2015
Texas ranks 17th with 78 of 212 (36.9%) scoring “A”. 

Fall 2016 Leapfrog Hospital Safety Scores

States that are shown in a darker green have a higher percentage of "A" hospitals.

http://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings
Health Care Safety Website

Health Care Safety

http://www.dshs.state.tx.us/idcu/health/Health-Care-Safety/

Health Care-associated Infections (HAI)

Preventable Adverse Events (PAE)

Antibiotic Resistance/MDROs
Preventable Adverse Events, also known as PAEs, can happen in health care. They are not supposed to happen. An example would be surgery on the wrong body part, or a bad injury from a fall. Health care workers try hard to make sure PAEs don’t happen.

The State of Texas decided that most hospitals and surgery centers must report PAEs. As of January 1, 2015, PAEs that happen are reported to the State Department of Health.
Data Website

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

Texas Health Care-Associated Infections (HAI) Reports by Healthcare Facility

People can get infections from hospitals, surgery centers or other places that offer health care. This is a big public health problem. A recent survey showed that 722,000 infections (HAIs) occurred in 2011 in the United States. This means that about 4% of hospital patients ended up with at least one infection. All hospitals, clinics and other health care facilities know that these infections are a big public health problem. They also know that they can prevent loss of life and high medical costs. So, they want to find ways to help manage and prevent these infections. And, they are required to report the following.

Search for Facility Report

Facility Type

- Hospital
- Ambulatory Surgical Center
- Both

Facility Name

Help... Facility Name

Name contains this text
Name begins with this text

City Name

Help... City Name

City contains this text
City begins with this text

County

Help... County Name

County contains this text
County begins with this text

Help... Multiple Criteria: Facility, City, County or Combination

Search

Search by Map
What is Posted for the Public?

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

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death or severe harm associated with unsafe administration of blood or blood products</td>
<td>1</td>
</tr>
<tr>
<td>Surgical site infection following a spinal procedure</td>
<td>1</td>
</tr>
</tbody>
</table>
Contact Information

*Help Desk Email*

HAITexas@dshs.state.tx.us
PAETexas@dshs.state.tx.us

512-776-7676
Fax 512-776-7616

Emily Engelhardt, TxHSN Administrator
Nesreen Gusbi, TxHSN Administrator
Vickie Gillespie, PAE Clinical Specialist
### TxHSN Reporting Schedule

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

HAI@dhhs.state.tx.us

PAE@dhhs.state.tx.us

512-776-7676

Fax 512-776-7616

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Contact Information
Questions?

Thank you!