



LEGISLATIVE REPORT TO THE GENERAL ASSEMBLY
Adverse Event Reporting

General Statutes of Connecticut
Section 19a-127l-n

QUALITY IN HEALTH CARE PROGRAM

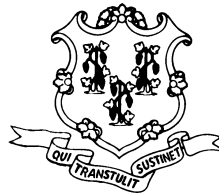
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Jewel Mullen, MD, MPH, MPA, Commissioner

Wendy H. Furniss, RNC, MS, Chief, Healthcare Safety & Quality Branch

Lloyd Mueller, PhD, Supervising Epidemiologist

Jon C. Olson, DPM, DrPH, Epidemiologist



State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, Connecticut 06134-0308

**State of Connecticut
Department of Public Health**

**Legislative Report to the General Assembly
Adverse Event Reporting**

Quality in Health Care Program

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EXECUTIVE SUMMARY

For 2014 the number of adverse events reports (n=471) was 12% lower than the preceding year (n=534). The most common adverse events among reports were: (1) stage 3-4 or unstageable pressure ulcers acquired after admission to a healthcare facility, (2) falls resulting in serious disability or death, (3) perforations during open, laparoscopic, and/or endoscopic procedures, and (4) retention of foreign objects in patients after surgery. These four categories accounted for 89% of events reported in 2014.

After examining an adverse event report, which includes a Corrective Action Plan, the Department of Public Health (DPH) determines whether to initiate an investigation. In addition to adverse event monitoring by DPH, Patient Safety Organizations disseminate information to improve patient care.

BACKGROUND

Connecticut General Statutes §19a-127l required the Department of Public Health (DPH) to establish a Quality in Health Care program for health care facilities. The program is operated through general DPH resources. An Advisory Committee, chaired by the DPH Commissioner or designee, advises the program. Mandatory adverse event¹ reporting began October 1, 2002. After evaluating the program for more than a year, the Advisory Committee recommended adoption of the National Quality Forum (NQF) list of Serious Reportable Events, plus five or six Connecticut-specific events.

Adverse events are reported to DPH by telephone and fax machine. Reporting forms and definitions are located at the DPH website under “Forms.”² After the department has decided whether to open an investigation, paper-based data are entered into an electronic database.

The Adverse Event reporting requirements were amended when CGS 19a-127n became effective July 1, 2004. The statute replaced the previous adverse event classification system with a list of reportable events identified by the NQF. Additionally, DPH added six Connecticut-specific adverse event definitions to supplement the NQF list. (The list appears in Appendix B.) Items on the list are of concern to both the public and healthcare professionals, are clearly identifiable and measurable, and are often preventable.³ DPH completed development of the mandated regulations for reporting of adverse events, and these became effective November 1, 2007.

In May 2007, hospitals and ambulatory surgical centers were provided with the updated NQF List of Serious Reportable Events and the revised list compiled by the Commissioner of Public

¹ As discussed in Connecticut’s March 2004 Adverse Events report, adverse events are not the same as medical errors. Some adverse events do not result from medical errors, and some medical errors do not result in adverse events. Annual Reports are at www.ct.gov/dph under Statistics & Research, then choose “Health Care Quality.”

² http://www.ct.gov/dph/cwp/view.asp?a=3115&q=390100&dphNav_GID=1601

³ More fully explained in Kenneth W. Kizer, “Clearing the Confusion about Connecticut’s New Adverse Event Reporting Law,” which appears as appendix B of Connecticut’s October 2004 Adverse Events report.

Health. A new category was included in the NQF list related to fertility clinics.⁴ The NQF category “patient death associated with a fall” was expanded to include “serious injury associated with a fall.” Reporting for this expanded category replaced the Connecticut-specific category that previously existed.

In January 2010, “Patient death or serious disability associated with surgery” was added to the list of reportable adverse events. This category includes significant hemorrhage and/or unanticipated death in a low risk (American Society of Anesthesiologists Class 2) patient.

Public Act 10-122 required that for all annual reports submitted after July 1, 2011:

the commissioner shall include hospital and outpatient surgical facility adverse event information for each facility identified (1) by the National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the commissioner and adopted as regulations pursuant to subsection (c) of this section. Such reports shall be prepared in a format that uses relevant contextual information. For purposes of this subsection "contextual information" includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient surgical facility's total number of surgical encounters expressed as a fraction in which the numerator is the aggregate number of adverse events reported by each hospital or outpatient surgical facility by category as specified in this subsection and the denominator is the total of the hospital's patient days or the outpatient surgical facility's total number of surgical encounters, and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. In addition, a hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section.

The NQF document *Serious Reportable Events in Healthcare-2011 Update*⁵ added four items, retired three items, and revised definitions, specifications, and numbering for the remaining items. The most substantial change in definition made unstageable pressure ulcers reportable in addition to stages three and four. The new items are: (1) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy; (2) patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen; (3) patient death or serious injury from failure to follow up or communicate laboratory, pathology, or radiology test results; (4) death or serious injury of a patient associated with the introduction of a metallic object into the MRI area. A summary of NQF changes appeared in Appendix J of the October 2012 DPH report, and the revised Connecticut adverse event list in Appendix K there. DPH promulgated guidance related to these changes during 2012 and implemented the revised list in January 2013.

CGS Section 19a-127o identifies the primary activity of a Patient Safety Organization (PSO), which is to improve patient safety and the quality of care delivered to patients through the

⁴ Prior to *Serious Reportable Events in Healthcare-2011 Update*, category 4H was “Artificial insemination with the wrong donor sperm or wrong egg.” In 2013 the Connecticut category label changed to NQF 4G.

⁵ http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

collection, aggregation, analysis, or processing of medical or health-related information submitted to the PSO by the health care provider. This “patient work product” may include reports, records, analyses, policies, procedures or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. PSOs disseminate appropriate information or recommendations on best clinical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Care Advisory Committee and the public. DPH has designated three PSOs: Qualidigm, the Connecticut Healthcare Research & Education Foundation (CHREF) and the Ambulatory Surgical Center Patient Safety Organization (ASC PSO) (see the DPH reports on Connecticut’s Quality of Care Program⁶).

Adverse event data were obtained from the electronic database at DPH. Inpatient days and primary payer information for acute care hospitals was obtained from hospital discharge data routinely gathered by the Office of Healthcare Access (OHCA) at DPH. Similar information for outpatient childbirth centers, hospice, chronic disease hospitals, and hospitals for the mentally ill, and outpatient surgical centers was obtained by DPH from those facilities.⁷

ADVERSE EVENT DATA

As of March 31, 2015, the DPH electronic database contained 471 reports of adverse events reported in 2014. Demographic information is shown in Appendix A. This reported information is influenced by several factors: varying rates of adverse events across facilities, patient case mix, quality of care, number of patients served, knowledge or interpretation of event definitions and reporting requirements, changes made to event definitions, additions to or deletions from the list of reportable events, willingness to report events, as well as the effectiveness of the institutional system to convey information from event participants to the designated reporter, and other factors.⁸ Consequently, clear conclusions about the causes of observed event fluctuations

⁶ Quality of Health Care reports are at www.ct.gov/dph under Statistics & Research, then choose “Health Care Quality.”

⁷ The Department thanks the Ambulatory Surgical Care Patient Safety Organization for assistance in gathering information from outpatient surgical centers.

⁸ Marieke Zegers et al, “Variation in the Rates of Adverse Events between Hospitals and Hospital Departments,” *International Journal for Quality in Health Care* 2011:1-8, identified during a study of Dutch hospitals and hospital departments that increased risk of suffering a preventable adverse event was associated with surgical admission, more co-morbidity, higher age, longer length of hospital stay, elective admission, and complication of a surgical or medical procedure. The clustering of preventable adverse events in hospital departments implied that “there is more room for improvement in patient safety at the hospital department level than at the hospital level.” Frank Attenello et al, “Incidence of ‘Never Events’ Among Weekend Admissions Versus Weekday Admissions to US Hospitals: National Analysis,” *BMJ* 2015;350:h1460 studied the CMS list of hospital acquired conditions (HACs) in the Nationwide Inpatient Sample from 2002-2010, involving 351 million patients. The most frequent conditions were falls (85%), pressure ulcers, and catheter-associated urinary tract infections. Independent predictors of experiencing an HAC were admission on a weekend, age >80, male sex, white race, private insurance or self pay, severity of APR-DRG group, teaching hospital, urgent, emergency or trauma admission, and hospital size > 200 beds. Curiously, number of co-morbidities decreased risk. Limitations of the study include dependence on ICD-9 coding.

and differences across facilities cannot be derived simply from the number of reports or fluctuations in the number of reports.⁹

Acute care or children's hospitals submitted 415 (88%) of the 471 adverse event reports; chronic disease hospitals, 42; hospitals for the mentally ill, 1; and outpatient surgical facilities (if not owned by a hospital), 13. Fifty-one percent of reported adverse events occurred in males and 49% in females. The majority of reports concerned patients over the age of 65 years. The most common location of occurrence was reported to be the adult medical ward (Appendix A).

Appendix B presents the number of adverse events reported by year for 2012-2014, according to the list of NQF events (1A-7D) and Connecticut-specific events (CT1 & CT2) that was adopted in 2013. Thus for example, the definition of falls was stable during the period shown but the category (4E) is that used in 2013-14 rather than the category (4F) used prior to 2013.

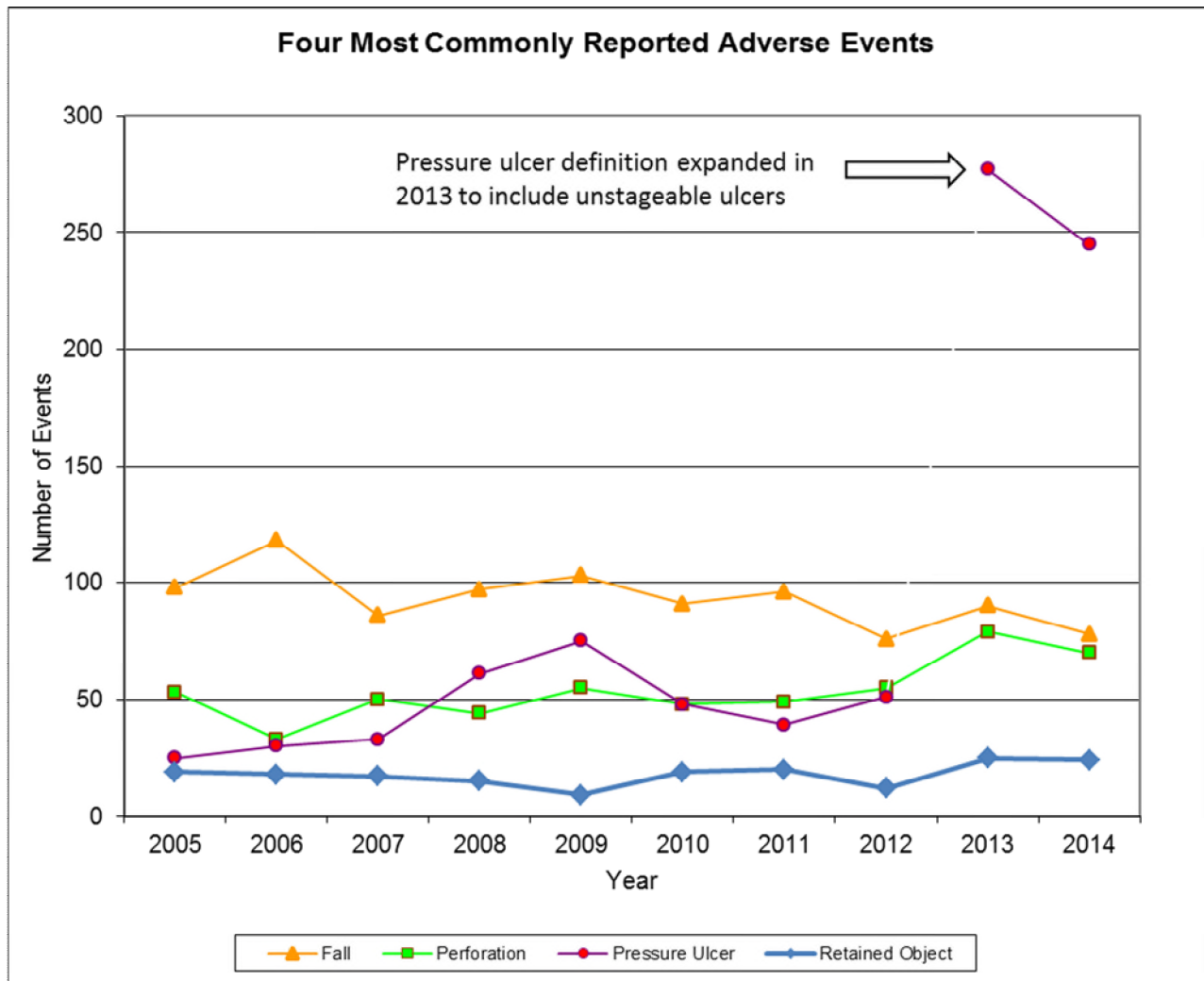
As shown in the chart below and Appendix C, the most commonly reported events in 2014 were pressure ulcers. Two hundred forty-five pressure ulcers comprised 52% of all 471 adverse events reported. The second most commonly reported events were falls resulting in death or serious injury, with 78 reports (17%). Perforations during open, laparoscopic, and/or endoscopic procedures, followed with 70 reports (15%).¹⁰ The next most commonly reported, 24 events, were retention of foreign objects in patients after surgery or other procedures (5%). The number of reports in each of these categories decreased between 2013 and 2014.

Between 2012 and 2013 the category of reportable pressure ulcers expanded to include unstageable ulcers in addition to stage 3 and 4, if acquired in the healthcare facility. As a result of this expansion, total counts in 2013 and 2014 should not be compared directly with counts in prior years. Of the 277 ulcers reported in 2013, 233 were unstageable, 5 deep tissue injury (DTI), 37 stage 3-4, and 2 unspecified. Of the 245 ulcers reported in 2014, 186 were unstageable, 6 DTI, 37 stage 3-4, and 16 unspecified. The patterns of stage reporting did not differ between acute care and chronic disease hospitals in either 2013 or 2014.

Pressure ulcer reports from acute care hospitals increased more rapidly (from 46 to 265 or 476%) than from chronic disease hospitals (from 5 to 12 or 140%) between 2012 and 2013, but reports from chronic disease hospitals increased among chronic disease hospitals (to 29) in 2014 while decreasing (to 216) among acute care hospitals. The relative two year pressure ulcer increases 2012-2014 among chronic disease hospitals (480%) were similar to the one year increases 2012-2013 among acute care (476%). See the October 2014 report for additional analysis of pressure ulcers.

⁹ For additional discussion of the limitations of passive incident reporting, see the Patient Safety section of the September 2011 issue of the Agency for Healthcare Research and Quality (AHRQ), Morbidity and Mortality Rounds at <http://webmm.ahrq.gov/>; Kaveh G. Shojania, "The Elephant of Patient Safety: What You See Depends Upon How You Look," *Joint Commission Journal on Quality and Patient Safety*, 36(9); September 2010, 399.

¹⁰ For more details about these adverse events, see the "Six Month Summary of Adverse Event Reports" (Appendix A of the June 30, 2005 DPH report on the Quality in Health Care Program).



The distributions and frequencies of perforations during surgery at various anatomic sites are logically related to the frequencies and difficulties of surgeries at those sites. However, DPH does not collect data about adverse event-free surgeries, so it is not possible to calculate event rates by surgeries performed. Among the 70 perforation reports in 2014, the sites or procedures mentioned were: colonoscopy (27), female reproductive system (10), other or unspecified colon procedure (6), endoscopy (4), endoscopic retrograde cholangio-pancreatography [ERCP] (4), hernia repair (4), urinary system (4), prostate (3) and eight procedures with one event each.

Twenty-four reports of retained objects after surgery from 2014 included sponge or towel (9), catheter fragment (5), guide wire piece (3), and seven other items. Sponge, catheter, and wire were also the leading types of objects, in the same order, in 2013.

Adverse event counts, patient days, and rate by facility and event type are shown in appendices D-G. These represent, respectively, acute care hospitals (D), chronic care hospitals and hospices (E), hospitals for the mentally ill (F), and ambulatory surgical centers, pain medicine centers, fertility centers, and outpatient childbirth centers (G). Not all adverse event categories are

relevant to all facilities. For example, events associated with birth are not applicable in a facility that does not handle deliveries. Also, patient populations differ considerably between types of facilities.

For acute care hospitals, the calculated rates are based on adverse events that occurred in the emergency department, inpatient, or an outpatient setting (in the numerator), but only inpatient days contribute to the denominator of the rate. There are several reasons for using this method. First, it defines Connecticut acute care hospital rates in the same way as some other states, making some state-to-state comparisons possible. Second, we found that outpatient days could not be reliably obtained from the database. Many of the choices for “Location of Event” (appendix A) could be either inpatient or outpatient. Fiscal Year 2014 (October 2013 to September 2014) data were used in the rate denominator and payer mix calculations because calendar year 2014 data were unavailable to DPH at the time this report was prepared.

Significant variation in facility reporting patterns are a common characteristic of passive surveillance systems (where the responsibility for reporting falls upon the health care provider) and this is not unique to Connecticut’s adverse events reporting system. A passive surveillance system “has the advantage of being simple and not burdensome” to administer, “it is limited by variability and incompleteness in reporting.”¹¹ Typically, data validation is a function of an active surveillance strategy that can be used to increase the completeness of reporting, as is being done in the separate Connecticut Healthcare Associated Infections program. However, data validation is often labor intensive and expensive, requiring dedicated resources. Nevertheless, without such validation we cannot determine how complete facility reporting is.

Based on these adverse event data alone we cannot derive certain conclusions. We cannot say whether a high reporting rate reflects highly complete reporting in a facility with good quality of care, or perhaps modestly complete reporting in a facility with poor care, or neither better nor worse quality care, as noted earlier.

Appendix H, based on billing data, shows the primary payer for patients seen at each facility. This contextual information is required by PA 10-122. Since Medicare pays for most care in patients 65 years and older, there is a positive correlation between the proportion of patients covered by Medicare and the average age of patients seen at a facility. Some studies have found an association between older age and greater risk of experiencing an adverse event, perhaps because multiple chronic conditions and frailty are more common among the elderly, and because the intensity of interventions is greater among the elderly or those with multiple co-morbidities.¹² We tested this hypothesis for Connecticut (see the 2011 report). Due to the poor single year correlation in 2010, no calculation was made for later years. No attempt was made here to risk adjust the rates based upon the average age of the population served or other contextual factors.

¹¹ Steven M. Teutsch, “Considerations in Planning a Surveillance System,” in Steven M. Teutsch and R. Elliott Churchill, eds., *Principles and Practice of Public Health Surveillance*, 2nd ed. (New York: Oxford University Press, 2000), 22.

¹² Aranz-Andres J, et al., “What makes hospitalized patients more vulnerable and increases their risk of experiencing an adverse event?” *International Journal for Quality in Health Care* 2011; Sept 6, 1-8 [Epub ahead of print]

Minimal correlation of age with total adverse events is partly due to adverse events being a heterogeneous category, with different causes and occurring in various locations.¹³ For example, perforations during surgery (CT1) are reported among surgical patients, while pressure ulcers (4F) are usually not.¹⁴ We combined 2013-2014 years of adverse event reports to DPH by category and divided by two years of inpatient days to create report rates for the most common events: pressure ulcers, falls, and perforations. Among acute care hospitals, the Pearson correlation between fall rates and ulcer rates was modestly positive (0.28), meaning that if a hospital reported more of one it tended to report more of the other. Conversely, the correlations were modestly negative between perforation rates and fall rates (-0.17) or ulcer rates (-0.19), meaning that hospitals that reported more of one tended to report less of the other, after accounting for hospital size. This is not entirely surprising, given that perforations and ulcers tend to occur in different types of patients who may be cared for by different doctors and nurses.

Appendix I contains facility comments about safety efforts, as allowed for by PA 10-122.

CURRENT ACTIVITIES AND FUTURE PLANS

DPH regularly screens death records for cause of death codes that might be related to an adverse event. (For a description of the system, see the 2011 Adverse Event report, appendix Q.) Selected records are reviewed further. The department gathers additional information to determine if reportable fatal adverse events occurred, and whether such events were reported to DPH.

Investigation of Adverse Events

The first responsibility for investigation of an adverse event lies with the facility in which the event occurred. Under Connecticut's Adverse Event reporting law, facilities are required to submit a Corrective Action Plan to DPH for each reported Adverse Event.

An external investigation at a healthcare facility due to an adverse event may begin in several ways: (1) as a result of a complaint to DPH made by any person; (2) following a sentinel event report by the facility to the Joint Commission, a complaint to the Joint Commission by any person (see www.jointcommission.org), or an unannounced, onsite visit to a facility by the Joint Commission during which an adverse event becomes known; or (3) as a consequence of an adverse event report sent by the healthcare facility to DPH. The last of these routes is discussed here.

¹³ Kaveh Shojania and Perla Marang-van de Mheen, "Temporal trends in patient safety in the Netherlands: reductions in preventable adverse events or the end of adverse events as a useful metric?" *BMJ Qual Saf* doi:10.1136/bmjqs-2015-004461 (Editorial). Excerpted in the *Selected Patient Safety Abstracts* section of this report.

¹⁴ Twenty-five of the 245 pressure ulcers reported in 2014 mentioned surgery in the "Facts and Status" field.

After examining an adverse event report, which includes a Corrective Action Plan, the DPH Healthcare Quality and Safety Branch determines whether to initiate an investigation. Screening to rule out medical error is based on clinical judgment and/or objective medical criteria. The screening team consists of healthcare clinicians at DPH.

DPH conducts investigations regarding adverse event reports that may indicate a systems issue or issues related to inadequate standards of care. These investigations determine regulatory compliance versus noncompliance and provide additional information that may allow one to distinguish between events that have been due to a medical error or system failure and those that have not. Investigations involving adverse events follow the same process as issues received through the public complaint process. Information is gathered through onsite inspection and observation, review of clinical records, interviews with institutional staff and vested parties as appropriate. The results of completed investigations are public, and may be obtained upon request, under the Freedom of Information (FOI) Act.

Patient Safety Organizations

Connecticut General Statutes section 19a-127o allowed DPH to designate “Patient Safety Organizations” (PSOs) and 19a-127p required hospitals to contract with a PSO. The primary activity of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care related information submitted to the PSO by the health care provider. This “patient safety work product” may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, and the Ambulatory Surgical Center Patient Safety Organization. PSO activities during the previous year appear in the annual June 30 report concerning the Quality in Health Care program, found on the DPH website.

Healthcare Associated Infections

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. Reports can be found on the DPH website (<http://www.ct.gov/dph/cwp/view.asp?a=3136&q=417318>).

Additional details about HAI prevention are in the June 30 report on the Quality in Health Care program at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388090&dphNav_GID=1601&dphPNavCtr=#Gen.

Hospital Acquired Conditions (including infections)

CMS Hospital Compare includes data about knee and hip replacement complications and healthcare associated infections: CLABSI, CAUTI, SSI, MRSA, and C Diff.¹⁵ Nursing Home Compare includes data about pressure ulcers, falls, UTI, and use of restraints.¹⁶

The CMS Partnership for Patients (<http://partnershipforpatients.cms.gov/>) set a goal of reducing preventable harm by 40% in US hospitals by the end of 2013. The Partnership targeted all forms of harm to patients but started by asking hospitals to focus on types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country. Unintended consequences were also of concern. For example, a Partnership goal was to prevent falls *and* immobility. Immobility is an unintended consequence of some efforts to prevent falls.

In February 2015 the Partnership for Patients announced a 17% decrease in hospital acquired conditions in 2013 compared with 2010 (<http://blog.cms.gov/2015/02/11/continuing-to-improve-patient-safety-in-hospitals/>). The Partnership was extended for one year.

Selected Patient Safety Abstracts¹⁷

Errors upstream and downstream to the Universal Protocol associated with wrong surgery events in the Veterans Health Administration.

Paull DE, Mazzia LM, Neily J, Mills PD, Turner JR, Gunnar W, Hemphill R. *Am J Surg.* 2015 Mar 21. pii: S0002-9610(15)00126-9. doi: 10.1016/j.amjsurg.2014.10.030. [Epub ahead of print]

Background: The Universal Protocol has been associated with the prevention of wrong surgery procedures; however, such events still occur. This article explores wrong surgery events, defined as those incorrect procedures (wrong site, wrong side, wrong procedure, wrong patient, wrong level, wrong implant) that would have occurred despite the Universal Protocol including the performance of a time-out by the surgical team. Understanding why some of these events are not caught by the steps of the Universal Protocol, culminating in the time-out, can help the field to add upstream and downstream safeguards to help prevent these never events.

Methods: The Veterans Health Administration database of root cause analyses was queried for all cases involving an incorrect surgical procedure between 2004 and 2013 to determine the relative frequency and characteristics of wrong surgery events because of errors upstream and downstream to the Universal Protocol. This subgroup of wrong surgery events was selected from among all the wrong surgery events by 2 clinicians with expertise in patient safety (Kappa = .91).

¹⁵ <https://www.medicare.gov/hospitalcompare/search.html>

¹⁶ <https://www.medicare.gov/nursinghomecompare/search.html>

¹⁷ Many are featured on the Agency for Healthcare Quality and Research's (AHRQ) Patient Safety Network, <http://psnet.ahrq.gov>. On 25 June, 2015 the House Appropriations Committee voted in favor of a bill to eliminate the AHRQ, but the Senate has not yet considered the matter.

Results: Forty-eight cases of wrong surgery events because of upstream/downstream errors were analyzed, representing 16% of the 308 root cause analyses for wrong surgery events reported during this period. Upstream errors included mislabeling of specimens, while downstream errors were associated with ineffective intraoperative process. Surgical procedures that were particularly vulnerable included wrong level spine operations, wrong patient prostatectomies, wrong implant cataract procedures, and wrong site skin lesion excisions.

Conclusions: Wrong surgery events can and do occur despite adherence to Universal Protocol including a time-out. The prevention of incorrect procedures requires complementary safety behaviors and technologies to address errors that occur upstream and downstream to the Universal Protocol and the time-out.

A patient-initiated voluntary online survey of adverse medical events: the perspective of 696 injured patients and families

Frederick S Southwick, Nicole M Cranley, Julia A Hallisy. *BMJ Qual Saf* doi:10.1136/bmjqs-2015-003980 Published Online 19 June 2015

Background: Preventable medical errors continue to be a major cause of death in the USA and throughout the world. Many patients have written about their experiences on websites and in published books.

Methods: As patients and family members who have experienced medical harm, we have created a nationwide voluntary survey in order to more broadly and systematically capture the perspective of patients and patient families experiencing adverse medical events and have used quantitative and qualitative analysis to summarise the responses of 696 patients and their families.

Results: Harm was most commonly associated with diagnostic and therapeutic errors, followed by surgical or procedural complications, hospital-associated infections and medication errors, and our quantitative results match those of previous provider-initiated patient surveys. Qualitative analysis of 450 narratives revealed a lack of perceived provider and system accountability, deficient and disrespectful communication and a failure of providers to listen as major themes. The consequences of adverse events included death, post-traumatic stress, financial hardship and permanent disability. These conditions and consequences led to a loss of patients' trust in both the health system and providers. Patients and family members offered suggestions for preventing future adverse events and emphasised the importance of shared decision-making.

Conclusions: This large voluntary survey of medical harm highlights the potential efficacy of patient-initiated surveys for providing meaningful feedback and for guiding improvements in patient care.

CT DPH Note: This voluntary survey was posted on the Empowered Patient Coalition (EPC) website (see online supplementary file) and was administered from January 2010 to November

of 2013 using a password secure version of Survey Monkey that included both quantitative and open-ended qualitative question formats. EPC volunteers created the quantitative survey based on the categorisation of adverse medical errors by the Office of Inspector General (OIG) in their March 2010 report. Additional questions were added to assess the personal impact of adverse events on patients and their families. These questions were based on the EPC volunteers' personal experiences and those of fellow patients and families. The survey is available online <https://www.surveymonkey.com/r/?sm=p7JEPTM4TYa%2bxOAO1GILMQ%3d%3d>

Use of Temporary Names for Newborns and Associated Risks

Jason Adelman, Judy Aschner, Clyde Schechter, et al. *PEDIATRICS* Volume 136, number 2, August 2015

Background: Because there can be no delay in providing identification wristbands to newborns, some hospitals assign newborns temporary first names such as Babyboy or Babygirl. These nondistinct naming conventions result in a large number of patients with similar identifiers in NICUs. To determine the level of risk associated with nondistinct naming conventions, we performed an intervention study to evaluate if assigning distinct first names at birth would result in a reduction in wrong-patient errors.

Methods: We conducted a 2-year before/after implementation study to examine the effect of a distinct naming convention that incorporates the mother's first name into the newborn's first name (eg, Wendysgirl) on the incidence of wrong-patient errors. We used the Retract-and-Reorder (RAR) tool, an established, automated tool for detecting the outcome of wrong-patient electronic orders. The RAR tool identifies orders placed on a patient that are retracted within 10 minutes and then placed by the same clinician on a different patient within the next 10 minutes.

Results: The reduction in RAR events post- versus preintervention was 36.3%. After accounting for clusters of orders within order sessions, the odds ratio of an RAR event post- versus preintervention was 0.64 (95% confidence interval: 0.42–0.97).

Conclusions: The study results suggest that nondistinct naming conventions are associated with an increased risk of wrong-patient errors and that this risk can be mitigated by changing to a more distinct naming convention.

Temporal trends in patient safety in the Netherlands: reductions in preventable adverse events or the end of adverse events as a useful metric?

Kaveh G Shojania, Perla J Marang-van de Mheen. *BMJ Qual Saf* doi:10.1136/bmjqs-2015-004461 (Editorial)

It is also true, as Vincent and Amalberti write, (Vincent C, Amalberti R. *Safety in healthcare is a moving target. BMJ Qual Saf* 2015. *In press*) that AEs provide a very general sense of the 'burden of disease'—the degree to which safety problems cause measurable impacts on morbidity and mortality, and, as with any disease, one eventually wants more specific measures, especially when it comes to evaluating treatments. AE studies still make sense when a new clinical area is being investigated. For instance, most major AE studies have not included paediatrics. So, to characterise the approximate burden of the problem and the main categories of patient safety problems in paediatrics, it made sense to conduct a paediatric AE study. Similarly for home care, the overall burden of patient safety problems in this setting was not known, so it made sense to start with a broad measurement of AEs. However, to show progress in any of these settings once we have a general sense of the burden and types of patient safety problems, studies will need to capture specific AEs that measure the impact of implemented interventions, rather than continuing to rely on broad heterogeneous measures such as AEs, as they will dilute real effects that may have occurred. For instance, if hospitals have invested implemented safety strategies for frail elderly patients, measurement must comprehensively capture fall-related injuries, delirium that develops after admission, aspiration events, or whatever other outcomes the strategies targeted. We cannot expect to detect improvements by partially capturing all possible harms that elderly patients experience in hospital.

Fifteen years into the field of patient safety, we would of course like to say that we finally have a study showing substantial reductions in preventable AEs on a large national scale. Such a finding would indeed constitute a milestone for maturation of the field. For now, though, we may have to settle for the milestone consisting of moving on to better metrics of improvement than the broad measure of harm that established the field in the first place.

Patient safety reporting: a qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human'.

[Mitchell I](#), [Schuster A](#), [Smith K](#), [Pronovost P](#), [Wu A](#). *BMJ Qual Saf*. 2015 Jul 27. pii: bmjqs-2015-004405. doi: 10.1136/bmjqs-2015-004405. [Epub ahead of print]

One of the key recommendations of the Institute of Medicine's (IOM) report, *To Err is Human*, 15 years ago was for greater attention to incident reporting in healthcare, analogous to the role it has played in aviation and other high-risk industries. With the passage of time and maturation of the patient safety field, we conducted semistructured interviews with 11 international patient safety experts with knowledge of the US healthcare and meeting at least one of the following criteria: (1) involved in the development of the IOM's recommendations, (2) responsible for the design and/or implementation of national or regional incident reporting systems, (3) conducted research on patient safety/incident reporting at a national level. Five key challenges emerged to explain why incident reporting has not reached its potential: poor processing of incident reports (triaging, analysis, recommendations), inadequate engagement of doctors, insufficient subsequent visible action, inadequate funding and institutional support of incident reporting systems and inadequate usage of evolving health information technology. Leading patient safety experts acknowledge the current challenges of incident reports. The future of incident reporting lies in targeted incident reporting, effective triaging and robust analysis of the incident reports and meaningful engagement of doctors. Incident reporting must be coupled with visible,

sustainable action and linkage of incident reports to the electronic health record. If the healthcare industry wants to learn from its mistakes, miss or near miss events, it will need to take incident reporting as seriously as the health budget.

Color-coded prefilled medication syringes decrease time to delivery and dosing errors in simulated prehospital pediatric resuscitations: A randomized crossover trial.

[Stevens AD](#), [Hernandez C](#), [Jones S](#), [Moreira ME](#), [Blumen JR](#), [Hopkins E](#), [Sande M](#), [Bakes K](#), [Haukoos JS](#). [Resuscitation](#). 2015 Aug 3;96:85-91. doi: 10.1016/j.resuscitation.2015.07.035. [Epub ahead of print]

Background: Medication dosing errors remain commonplace and may result in potentially life-threatening outcomes, particularly for pediatric patients where dosing often requires weight-based calculations. Novel medication delivery systems that may reduce dosing errors resonate with national healthcare priorities. Our goal was to evaluate novel, prefilled medication syringes labeled with color-coded volumes corresponding to the weight-based dosing of the Broselow Tape, compared to conventional medication administration, in simulated prehospital pediatric resuscitation scenarios.

Methods: We performed a prospective, block-randomized, cross-over study, where 10 full-time paramedics each managed two simulated pediatric arrests in situ using either prefilled, color-coded syringes (intervention) or their own medication kits stocked with conventional ampoules (control). Each paramedic was paired with two emergency medical technicians to provide ventilations and compressions as directed. The ambulance patient compartment and the intravenous medication port were video recorded. Data were extracted from video review by blinded, independent reviewers.

Results: Median time to delivery of all doses for the intervention and control groups was 34 (95% CI: 28-39) seconds and 42 (95% CI: 36-51) seconds, respectively (difference=9 [95% CI: 4-14] seconds). Using the conventional method, 62 doses were administered with 24 (39%) critical dosing errors; using the prefilled, color-coded syringe method, 59 doses were administered with 0 (0%) critical dosing errors (difference=39%, 95% CI: 13-61%).

Conclusions: A novel color-coded, prefilled syringe decreased time to medication administration and significantly reduced critical dosing errors by paramedics during simulated prehospital pediatric resuscitations.

APPENDICES

Appendix A:
Demographic Data from Adverse Event Reports

Appendix B:
Counts and Crosswalk of Adverse Events Codes 2012-2014

Appendix C:
Adverse Event Reports by Frequency of Occurrence

Appendix D:
Acute Care Hospital
Adverse Event Reports and Rates by Facility and Event Type

Appendix E:
Chronic Disease Hospital and Hospice
Adverse Event Reports and Rates by Facility and Event Type

Appendix F:
Hospital for the Mentally Ill
Adverse Event Reports and Rates by Facility and Event Type

Appendix G:
Ambulatory Surgical Center, Pain Medicine Center,
Fertility Center, and Outpatient Childbirth Center
Adverse Event Reports and Rates by Facility and Event Type

Appendix H:
Primary Payer Source, by Facility

Appendix I:
Comments Submitted by Facilities

Appendix A.		
Demographic Data from Adverse Event Reports in the Electronic Database, Connecticut 2014		
Measure	Frequency	Percent
Facility Type (n=471)		
Acute Care or Children's Hospital	415	88.1%
Chronic Disease Hospital	42	8.9%
Hospital for Mentally Ill Persons	1	0.2%
Outpatient Surgical Facility	13	2.8%
Patient Gender (n=470)		
Male	241	51.3%
Female	229	48.7%
Patient Age (n=471)		
0-14	12	2.5%
15-44	61	13.0%
45-64	127	27.0%
65 and older	271	57.5%
Location of Event (n=470)		
Adult Medical	108	23.0%
Adult Surgical	48	10.2%
Ambulatory Surgical	7	1.5%
Cardiac Care	20	4.3%
Cardiac Cath Lab	0	0.0%
Diagnostic Services	5	1.1%
Emergency Department	10	2.1%
Medical ICU	66	14.0%
Neonatal ICU	2	0.4%
Obstetrical/Gynecological	9	1.9%
Operating Room	61	13.0%
Other	43	9.1%
Outpatient Services	22	4.7%
Pediatrics	5	1.1%
Psychiatric	22	4.7%
Rehabilitative Services	7	1.5%
Surgical ICU	35	7.4%

Appendix B. Counts of Adverse Event Codes 2012-2014

Event Code	Description	Reports 2012	Reports 2013	Reports 2014
NQF 1A	Surgery performed on the wrong site	9	13	15
NQF 1B	Surgery performed on the wrong patient	0	1	0
NQF 1C	Wrong surgical procedure performed on a patient	2	1	4
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	12	25	24
NQF 1E	Intraoperative or immediate postoperative/postprocedure death in an ASA class I patient	0	0	1
NQF 2A	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	0	0	3
NQF 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	2	3	2
NQF 2C	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	1	0	0
NQF 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	0
NQF 3B	Patient death or serious injury associated with patient elopement (disappearance)	0	1	0
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	1	5	0
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	3	6	1
NQF 4B	Patient death or serious injury associated with unsafe administration of blood products	0	0	0
NQF 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	2	0
NQF 4D	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	4	1	4
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	76	90	78
NQF 4F*	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	51	277	245
NQF 4G	Artificial insemination with the wrong donor sperm or wrong egg	0	0	0

Appendix B (cont.). Counts of Adverse Event Codes 2012-2014

Event Code	Description	Reports 2012	Reports 2013	Reports 2014
NQF 4H	Death or serious injury resulting from irretrievable loss of an irreplaceable biological specimen	NA	3	0
NQF 4I	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	0	2	0
NQF 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	0
NQF 5B	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	0	1	0
NQF 5C	Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	1	0	1
NQF 5D	Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting	1	1	0
NQF 6A	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.	NA	0	0
NQF 7A	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	2	1
NQF 7B	Abduction of a patient/resident of any age	0	1	0
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	7	4	9
NQF 7D	Death or serious injury of a patient or staff member resulting from a physical assault (i.e.battery) that occurs within or on the grounds of a healthcare setting	2	3	1
CT 1	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious injury.	55	79	70
CT 2	Patient death or serious injury as a result of surgery	14	13	12
Total Reports		241	534	471

Appendix C. Connecticut Adverse Events in 2014			
Most Frequently Reported Events			
NQF List (1A-7D) and Connecticut-Specific List (CT1 & CT2)			
Event	Description	Frequency	Percent of All Events
4F	Unstageable, stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	245	52.0%
4E	Patient death or serious injury associated with a fall while being cared for in a healthcare facility	78	16.6%
CT1	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	70	14.9%
1D	Retention of a foreign object in a patient after surgery or other procedure	24	5.1%
1A	Surgery performed on the wrong body part	15	3.2%
CT2	Death or serious injury associated with surgery	12	2.5%
All other reported adverse events		28	5.9%
Total		471	100.0%

**Appendix D. Adverse Event Reports by Event Type
Acute Care Hospitals. Connecticut, 2014.**

Hospital	Adverse Event Reports by Event Type																																		
	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	CT1	CT2				
Backus																2	2																		
Bridgeport	1			2												3	9												1	1					
Bristol				3													1													6	2				
CCMC				1												1	2													1	1				
Danbury																6	30						1										1		
Day Kimball																																			
Dempsey																4	4																		
Greenwich							1									2	1																		
Griffin			1			1																								4	1				
Hartford	2			2												1	31																		
Hungerford	1																																		
HOCC	1															3	9												1	8					
Johnson																1	2																		
L & M				2												1	2													5	1				
Manchester				3												1	1	8													3				
Middlesex				1												8	2															3			
Milford	1																																		
MidState																1	1														1	1			
New Milford																1	1																		
Norwalk	1															2	2												1	3					
Rockville																1	1																		
St Francis	3			1								1				7	32												1	7					
St Mary's	1			1												1											1			4					
St Vincent's				1			1									5	16												2	6	1				
Sharon																2																1			
Stamford				1												2	10															2			
Waterbury																1																	1		
Windham																1	1																		
Yale-NH	3		2	6		2										1	10	47													2	3		4	
All Acute Care	14	0	3	24	0	3	2	0	0	0	0	1	0	0	4	66	216	0	0	0	0	0	1	0	0	0	1	0	7	1	60		12		

Notes: Event categories changed between 2012 and 2013, e.g old 5D is new 4E (falls); old 7A is new CT1 (perforations during surgery).

Appendix D (continued).

Adverse Event Reports and Rates

Acute Care Hospitals. Connecticut, 2014.

Hospital	Reports Total	Patient Days* FY 2014	Rate per 100,000 Pt Days*
William W. Backus Hospital	4	48413	8.3
Bridgeport Hospital	17	99390	17.1
Bristol Hospital	12	28224	42.5
Connecticut Children's Medical Center	6	45168	13.3
Danbury Hospital	38	91993	41.3
Day Kimball Healthcare	0	17035	0.0
John Dempsey Hospital	8	38687	20.7
Greenwich Hospital	4	53268	7.5
Griffin Hospital	10	30301	33.0
Hartford Hospital	36	233563	15.4
Charlotte Hungerford Hospital	1	25785	3.9
Hospital of Central Connecticut	22	69103	31.8
Johnson Memorial Hospital	3	16245	18.5
Lawrence and Memorial Hospital	11	66368	16.6
Manchester Memorial Hospital	16	43997	36.4
Middlesex Hospital	14	56946	24.6
Milford Hospital	1	12724	7.9
MidState Medical Center	4	39490	10.1
New Milford Hospital	2	6769	29.5
Norwalk Hospital	9	59215	15.2
Rockville General Hospital	3	11215	26.7
Saint Francis Hospital	52	150782	34.5
Saint Mary's Hospital	8	51027	15.7
Saint Vincent's Medical Center	32	113122	28.3
Sharon Hospital	3	11690	25.7
Stamford Hospital	15	71354	21.0
Waterbury Hospital	2	58019	3.4
Windham Community Memorial Hospital	2	13266	15.1
Yale-New Haven Hospital	80	409544	19.5
All Acute Care Hospitals	415	1,972,703	21.0
* Inpatient patient days are used as rate denominators			

**Appendix E. Adverse Event Reports by Event Type and Rates per 100,000 Inpatient Days,
Chronic Disease Hospitals and Hospice. Connecticut, 2014.**

Facility	Adverse Event Reports by Event Type																															
	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	CT1	CT2	
Ct Hospice																																
Gaylord																1	9															
Hsp Special Care																	16												1			
Masonicare																	6															
Mount Sinai																																
Veterans																2	2															
Hebrew Home																3	1															
Chronic Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	29	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0

Note: Event definitions and categories changed between 2012 and 2013; old 5D is new 4E (falls); old 7A is new CT1 (perforations during surgery).

Facility	Reports	Patient	Rate per
	Total	Days	100,000
The Connecticut Hospice	0	12,309	0.0
Gaylord Hospital	10	120,960	8.3
The Hospital for Special Care	17	71,769	23.7
Masonicare Health Center	6	4,276	140.3
Mount Sinai Rehabilitation Hospital*	1	8,542	11.7
Levitow Veterans Health Center	4	41,860	9.6
Hebrew Home and Hospital	4	8,736	45.8
All Chronic Disease Hospitals	42	268,452	15.6
*denominator data are FY 2013			

**Appendix F. Adverse Event Reports by Event Type and Rates per 100,000 Inpatient Days
Hospitals for Mentally Ill Persons. Connecticut, 2014.**

Facility	Adverse Event Reports by Event Type																															
	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	CT1	CT2	
Natchaug																																
Silver Hill																													1			
Masonicare																																
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0

Note: Event definitions and categories changed between 2012 and 2013; old 5D is new 4E (falls); old 7A is new CT1 (perforations during surgery).

Facility	Reports Total	Patient	Rate per
		Days 2014	100,000 Pt Days
Natchaug Hospital*	0	19,148	0.0
Silver Hill Hospital**	1	12,841	7.8
Masonicare Behavioral Health	0	10,200	0.0
All Hospitals for Mentally Ill Persons	1	42,189	2.4
*denominator data are FY 2013			
** FY is March 2014-February 2015			

Appendix G. Adverse Event Reports by Event Type for Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Childbirth Centers. Connecticut, 2014.

Facility	Adverse Event Reports by Event Type																														
	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	CT1	CT2
Ct Childbirth & Women																															
Aesthetic Surg Center																															
Center for Adv Reprod																															
Central Ct Endoscopy																															
Coastal Digestive Care					1																										
Conn Center Plast Surg																															
Conn Eye, South																															
Connecticut Fertility																															
Connecticut Foot																															
Conn GI Endoscopy																															2
Conn Orthopaedic																															
Conn Surgery																															
Conn Surgical Arts																															
Constitution Surg, East																															
Danbury Surgical																															
Diagnostic Endoscopy																															1
Digestive Dis Endosc																															
Dr. Felice Youth Images																															
Eastern Ct Endoscopy																															2
Endoscopy Center of Ct																															1
Endoscopy, Fairfield																															
Endoscopy, Northwest																															1
Evergreen Endoscopy																															
Eye Surgery Center																															
Fairfield Endoscopy																															
Fairfield Surgery				1																											
Gary J. Price, M.D.																															3
Glastonbury Endoscopy																															
Glastonbury Surgery																															
Gregory Brucato, M.D.																															
Hartford Surgical																															
John J. Borkowski, M.D.																															
Laser and Vision Surg																															
Leif O. Nordberg, M.D. ¹																															
Litchfield Hills Surgery																															
Middlesex Endoscopy																															
Middlesex Orthopaedic	1																														
Naugatuck Endoscopy																															
New England Fertility																															
New Vision Cataract																															
North Haven Surgery																															
Norwalk Surgery																															
Orchard Medical Center																															
Orthopaedic Neurosurg																															
Orthopedic Associates																															
Plast Surg of South Ct																															
Reproductive Medicine																															
Robbins Eye																															
St Francis GI Endosc																															
Shoreline Colonoscopy																															
Southington Surgery																															
Shoreline Surgery																															
Split Rock Surgical																															
SSC II																															
Summer St Ambulatory Surg Center Fairfield																															
Surg Center-Ct Hand																															
Waterbury Outpatient																															
Western CT Ortho Surg ²																															
Wilton Surgery																															
Yale Health Services																															
All Ambulatory Facilities	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0

Notes: Event definitions and categories changed between 2012 and 2013, e.g old 5D is new 4E (falls); old 7A is new CT 1 (perforations during surgery).

¹ Now CVW Body Design ² Formerly Hand Center

Appendix G (continued). Adverse Event Reports and Rates, Outpatient Visits for Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Childbirth Centers, Connecticut, 2014.

Facility	Location	Reports Total	per 100,000	
			Patient Visits 2014	Pt visits Rate 2014
Connecticut Childbirth & Women's Center ¹	Danbury	0		
Aesthetic Surgery Center	New Haven	0	327	0.0
Center for Advanced Reproductive Services	Farmington	0	19068	0.0
Central Connecticut Endoscopy Center	Plainville	0	6889	0.0
Coastal Digestive Care Center	New London	1	6740	14.8
Connecticut Center for Plastic Surgery ¹	Guilford	0		
Connecticut Eye Surgery Center South	Milford	0	6976	0.0
Connecticut Fertility	Bridgeport	0	218	0.0
Connecticut Foot Surgery Center ¹	Milford	0		
Connecticut GI Endoscopy	Bloomfield	2	5344	37.4
Connecticut Orthopaedic	Hamden	0	3741	0.0
Connecticut Surgery	Hartford	0	4013	0.0
Connecticut Surgical Arts/River Valley	Norwich	0	1868	0.0
Constitution Eye Surgery Center East	Waterford	0	5665	0.0
Danbury Surgical Center	Danbury	0	8618	0.0
Diagnostic Endoscopy	Stamford	1	6198	16.1
Digestive Disease Associates Endoscopy Suite	Branford	0	2100	0.0
Dr. Felice's Youthful Images	Bloomfield	0	113	0.0
Eastern Connecticut Endoscopy Center	Norwich	2	7661	26.1
Endoscopy Center of Connecticut	Guilford/Hamden	1	8223	12.2
Endoscopy Center of Fairfield, The	Fairfield	0	8612	0.0
Endoscopy Center of Northwest Connecticut	Torrington	1	3421	29.2
Evergreen Endoscopy Center	South Windsor	0	6331	0.0
Eye Surgery Center, The	Bloomfield	0	1733	0.0
Fairfield County Endoscopy Center	Trumbull	0	6004	0.0
Fairfield Surgery Center ¹	Fairfield	1		
Gary J. Price, M.D., Center for Aesthetic Surgery	Guilford	0	181	0.0
Glastonbury Endoscopy Center, LLC	Glastonbury	3	5303	56.6
Glastonbury Surgery Center	Glastonbury	0	4352	0.0
Gregory Brucato, M.D./Brucato Plastic Surgery	Ridgefield	0	49	0.0
Hartford Surgical Center	Hartford	0	1248	0.0
John J. Borkowski, M.D.	Middletown	0	41	0.0
Laser and Vision Surgery Center	Manchester	0	2557	0.0
Leif O. Nordberg, M.D. Now CVW Body Design	Stamford	0	0	0.0
Litchfield Hills Surgery Center	Torrington	0	1696	0.0
Middlesex Center for Advanced Orthopedic Surgery	Middletown	0	3719	0.0
Middlesex Endoscopy Center	Middletown	1	6548	15.3
Naugatuck Valley Endoscopy Center	Waterbury	0	4825	0.0
New England Fertility Institute	Stamford	0	250	0.0
New Vision Cataract Center	Norwalk	0	1720	0.0
North Haven Surgery/Pain Medicine Center	North Haven	0	3231	0.0
Norwalk Surgery Center	Norwalk	0	2885	0.0
Orchard Medical Center	New Haven	0	57	0.0
Orthopaedic & Neurosurgery Center of Greenwich	Greenwich	0	1491	0.0
Orthopedic Associates Surgery Center	Rocky Hill	0	7575	0.0
Plastic Surgery of Southern Connecticut	Westport	0	28	0.0
Reproductive Medicine Associates of Connecticut	Norwalk	0	917	0.0
Robbins Eye Center ¹	Bridgeport	0		
Saint Francis GI Endoscopy	Windsor	0	5507	0.0
Shoreline Colonoscopy Suites	Old Saybrook	0	521	0.0
Shoreline Surgery Center	Guilford	0	6095	0.0
Southington Surgery Center	Southington	0	402	0.0
Split Rock Surgical Associates	Wilton	0	165	0.0
SSC II	Guilford	0	3153	0.0
Summer Street Ambulatory Surgery Center	Stamford	0	23	0.0
Surgery Center of Fairfield County	Bridgeport	0	5384	0.0
Surgical Center of CT-CT Hand	Bridgeport	0	1465	0.0
Waterbury Outpatient Surgical Center	Waterbury	0	3551	0.0
Western CT Ortho Surgical Ctr (formerly Hand Ctr)	Danbury	0	984	0.0
Wilton Surgery Center	Wilton	0	7123	0.0
Yale University Health Services ASC	New Haven	0	1123	0.0
All Facilities		13		

¹ No data for patient visits during 2014 had been received at the time this report was prepared.

Appendix H.					
Primary Payer (%) of Inpatient Hospital Bills					
Acute Care Hospitals. Connecticut, FY 2014.					
				Blue Cross and	
Hospital	Self Pay	Medicare	Medicaid	Commercial	Other
William W. Backus Hospital	1.7	46.0	20.9	16.0	15.4
Bridgeport Hospital	1.2	38.1	33.3	17.7	9.8
Bristol Hospital	2.5	46.5	23.1	19.0	9.0
Connecticut Children's Medical Center	0.6	0.2	54.0	18.3	26.9
Danbury Hospital	0.8	41.0	18.3	37.3	2.7
Day Kimball Healthcare	1.2	43.9	26.6	15.5	12.9
John Dempsey Hospital	1.1	44.5	25.6	14.4	14.5
Greenwich Hospital	1.4	36.1	6.3	31.6	24.5
Griffin Hospital	1.9	48.1	20.8	15.1	14.2
Hartford Hospital	2.3	40.9	22.0	12.3	22.5
Charlotte Hungerford Hospital	2.2	54.0	19.4	14.4	10.0
Hospital of Central Connecticut	2.2	44.9	25.8	10.9	16.2
Johnson Memorial Hospital	1.7	49.1	21.2	16.2	11.9
Lawrence and Memorial Hospital	0.8	44.8	22.0	24.1	8.3
Manchester Memorial Hospital	1.9	41.0	23.1	7.9	26.2
Middlesex Hospital	0.2	50.8	17.0	18.2	13.8
Milford Hospital	2.1	60.5	10.6	12.5	14.3
MidState Medical Center	1.9	48.3	22.7	9.8	17.3
New Milford Hospital	2.3	64.0	7.8	10.2	15.8
Norwalk Hospital	3.5	42.7	18.8	24.7	10.4
Rockville General Hospital	1.7	65.1	13.0	5.2	15.0
Saint Francis Hospital	1.3	43.8	24.3	8.4	22.3
Saint Mary's Hospital	2.6	43.8	29.2	15.0	9.5
Saint Vincent's Medical Center	4.5	44.6	22.8	14.0	14.1
Sharon Hospital	2.9	55.7	15.9	9.4	16.0
Stamford Hospital	1.7	36.2	23.6	19.6	18.9
Waterbury Hospital	1.9	46.0	27.2	11.8	13.2
Windham Community Memorial Hospital	2.2	48.7	22.7	19.6	6.8
Yale-New Haven Hospital	0.9	35.6	28.2	22.5	12.9
Total	1.7%	41.6%	23.9%	17.7%	15.1%
Data Source: DPH Office of Health Care Access.					

Appendix H (continued).					
Primary Payer (%) of Bills,					
Hospices, Chronic Disease Hospitals, and Hospitals for Mentally Ill Persons.					
Connecticut, 2014.					
Facility	Self Pay	Medicare	Medicaid	Blue Cross and Commercial	Other
The Connecticut Hospice		100.0			
Gaylord Hospital		34.4	23.3	38.3	3.9
The Hospital for Special Care	0.5	11.1	75.7		12.7
Masonicare Health Center, Chronic Disease Hospital		90.0		10.0	
Mount Sinai Rehabilitation Hospital		57.0	17.3		25.7
Levitow Veterans Health Center		15.7	66.1		18.2
Hebrew Home and Hospital		84.5	6.7		8.8
Natchaug Hospital*	0.5	14.5	36.6	39.4	9.0
Silver Hill Hospital	3.0	10.0		87.0	
Masonicare Behavioral Health		91.0		9.0	
VA Medicaid includes with 59.1% Medicare and Medicaid, 7.0% Medicaid only, 18.2% service connected					
* FY 2013					

**Appendix H (continued). Case Mix or Primary Payer (%) of Bills
Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Outpatient Childbirth Centers.
Connecticut, 2014.**

Facility	Case Mix	Self Pay	Medicare	Medicaid	Blue Cross and Commercial	Other
Connecticut Childbirth & Women's Center ¹						
Aesthetic Surgery Center		52.0			48.0	
Center for Advanced Reproductive Services		25.0			70.0	5.0
Central Connecticut Endoscopy Center						
Coastal Digestive Care Center		1.0	27.0	13.0	57.0	2.0
Connecticut Center for Plastic Surgery ¹						
Connecticut Eye Surgery Center South		1.0	64.0	3.0		32.0
Connecticut Fertility		73.0			27.0	
Connecticut Foot ¹						
Connecticut GI Endoscopy		1.0	22.0		77.0	0.3
Connecticut Orthopaedic		0.1	20.0	0.1	0.2	76.0
Connecticut Surgery			16.8	6.0	62.5	14.6
Connecticut Surgical Arts/River Valley		1.0	27.0	1.0	66.0	5.0
Constitution Surg, East		0.2	52.0	3.9	34.3	9.6
Danbury Surgical	45% GI, 29% Ortho, 23% Oph, 3% Pain					
Diagnostic Endoscopy	5228 colon/2384 egd/60 sig					
Digestive Dis Endosc	1809 colon/556 egd/15 flex sig					
Dr. Felice Youth Images		100.0				
Eastern Connecticut Endoscopy Center ¹		0.1	37.0	1.0	54.0	
Endoscopy Center of Ct		5.0	30.0	10.0	55.0	
Endoscopy, Fairfield		0.1	19.0		73.0	0.1
Endoscopy, Northwest	100% Gastroenterology					
Evergreen Endoscopy			21.0	9.0	70.0	
Eye Surgery Center	1115 Cataract/282 ophth/2 general/190 Yag/non standard cat					
Fairfield Endoscopy ¹						
Fairfield Surgery ¹						
Gary J. Price, M.D.		100.0				
Glastonbury Endoscopy			17.0	2.8	80.1	0.0
Glastonbury Surgery ^{3 5}		1.0	18.0	6.0	75.0	
Gregory Brucato, M.D./Brucato Plastic Surgery		100.0				
Hartford Surgical		1.0	5.5	5.5	88.0	
John J. Borkowski, M.D.		100.0				
Laser and Vision Surg		1.0	49.0	1.0	49.0	
Leif O. Nordberg, M.D. Now CVW Body Design ¹						
Litchfield Hills Surgery		1.0	25.5		24.3	49.9
Middlesex Orthopedic		1.0	23.6	6.7	42.6	26.1
Middlesex Endoscopy		0.1	26.9	8.2	65.4	
Naugatuck Valley Endoscopy Center	100% Gastro					
New England Fertility Institute		80.0			20.0	
New Vision Cataract ⁴						
North Haven Surgery		1.0	22.0	24.0	2.0	49.0
Norwalk Surgery		1.0	28.0	1.0	65.0	1.0
Orchard Medical Center		10.0			84.0	6.0
Orthopaedic Neurosurg		1.0	17.0		82.5	
Orthopedic Associates Surgery Center		1.0	20.0	2.0	77.0	
Plastic Surg of South Ct		89.0			10.0	
Reproductive Medicine		25.0			75.0	
Robbins Eye ¹						
Saint Francis GI Endosc		0.1	13.5	1.0	85.3	
Shoreline Colonoscopy			11.0	17.0	87.0	
Shoreline Surgery			18.4	2.8	78.8	
Southington Surgery Center			1.0		82.0	17.0
Split Rock Surgical		100.0				
SSC II		4.5	28.8	1.3	52.6	18.8
Summer St Ambulatory		100.0				
Surgical Center Fairfield		1.0	15.0	3.0	80.0	1.0
Surgical Center of CT-CT Hand		3.0	24.0	5.0	58.0	10.0
Waterbury Outpatient		1.0	53.0	11.0	26.0	1.0
Western CT Ortho Surgical Ctr (was Hand Center) ⁴	954 Ortho/30 Pain Mgmt					
Wilton Surgery ²			45.0		51.0	4.0
Yale Health Services					100% Yale HMO	

¹ No data for 2014 had been received when this report was prepared. ² Other payer includes self pay and Medicaid

Appendix I: Comments Submitted by Facilities

In accordance with legislation, facilities that are required to report adverse events to the Connecticut DPH may submit comments to DPH for inclusion in the annual report to the legislature. Submitting comments is OPTIONAL, not required. DPH encourages comments describing how a facility used data to measure or track adverse events or quality of care and measurably improve care or decrease adverse events. Do not list awards.

Facilities providing comments:

Day Kimball Healthcare
Charlotte Hungerford Hospital
Middlesex Hospital
Danbury, New Milford, and Norwalk Hospitals
Griffin Hospital
Stamford Hospital
Saint Vincent's Health Services
Saint Francis Hospital and Medical Center
Eastern Connecticut Health Network

Comments Submitted by Facilities, continued

Day Kimball Healthcare

Day Kimball Healthcare is committed to patient safety and employs a multitude of processes to prevent adverse events. We are also steadfast and transparent in addressing events when they do occur. We take every event seriously and work to identify practices and protocols necessary to prevent similar issues in the future. Most importantly, we work diligently to provide the highest level of patient safety possible.

- Day Kimball employees regularly participate in numerous quality improvement/ patient safety committees and collaborate with external organizations to ensure best practices are instituted to prevent adverse events.
- Our quality department proactively educates our staff on patient safety topics, consistently performs reviews of operations and policies, and institutes case reviews as needed.
- Day Kimball Healthcare immediately addresses each adverse event, conducts root cause analysis and provide feedback to staff.
- Day Kimball is a Community of Care partner working on a safe and comprehensive transition of care in collaboration with Qualidigm, our skilled nursing facilities and homecare agencies.
- Day Kimball Hospital implemented the Modified Lacey Tool to assist in identification of patients who may be at high risk for readmissions.
- Some patient safety initiatives include medication safety with the use of barcoding, surgical safety, computerized physician order entry and electronic medical records.
- Day Kimball conducts a thorough review of each Sentinel Event Alert from The Joint Commission in order to identify additional strategies and other opportunities for quality improvement initiatives for injuries that seem to be trending across the country.
- Day Kimball participates in aspects of the Journey to High Reliability with Connecticut Hospital Association.
- In March 2014, Day Kimball Hospital achieved re-certification for our Hip and Knee Joint Replacement Program from The Joint Commission with no findings.
- In May 2014, Day Kimball Hospital had their Full Unannounced Survey by the Joint Commission with no major findings.

Day Kimball Healthcare continues to be proactive in integrating best practices learned through our own experiences and comprehensive analyses as well as through collaborations with Connecticut Hospital Association, VHA, The Joint Commission, and CMS Partnership for Patients. We take very seriously the trust our community places in us, and commit to continuously improving patient-centered quality and safety.

Charlotte Hungerford Hospital

Our organization would like to report that none of the adverse events reported in Calendar Year 2014 were associated with death or serious disability. At Charlotte Hungerford hospital, we continually strive to learn and improve upon our patient safety outcomes. We also take pride in our commitment to our community, and work hard each day to instill confidence in those we serve.

Comments Submitted by Facilities, continued

Middlesex Hospital

The employees, medical staff, and leadership of Middlesex Hospital work every day to provide the safest, highest-quality health care and the best possible experience to our community. It is our mission and the reason we exist as a health care institution.

It is no mistake that “safest” is the first of the three parts of our mission. We firmly believe that safety is the single most important part of everything we do. We always consider how our decisions and actions will impact safety, for patients, employees and visitors.

However, providing health care, especially in a hospital, is an extremely complex process, and it is well known that mistakes do happen in health care. Unfortunately, people are sometimes harmed as a result, in ways that possibly could have been avoided. That is why we embarked on our “High Reliability” initiative over two years ago. There are other industries that are also very complex, with a high risk of errors happening, and with possible severe consequences if mistakes do occur. Yet, some of these industries have figured out how to function with far less error and harm than might otherwise occur. They are referred to as “High Reliability” industries and organizations. We are learning to use the habits and tools they have developed and to apply them to health care with the goal of ultimately eliminating any preventable harm from occurring. We truly believe that the only acceptable goal, when it comes to having harm happen to someone in a way that could have been avoided, is zero.

We also recognize that this kind of change does not happen overnight, and thus we are committed for the long term to the goal of eliminating preventable harm. Since we began tracking what is referred to as “Serious Safety Events”, we have seen an approximately 50% decrease from our baseline. While working toward the goal of zero preventable harm, we take any event that does or could result in harm to a patient or staff member very seriously. We are always vigilant to be able to know when this has happened and investigate each one carefully to understand why it happened and what we can do to prevent it from happening again in the future.

As one example, we are working on multiple processes to decrease the risk of people falling and getting injured while a patient here at Middlesex. This includes strategies such as better identification of those at risk of falling, more frequent rounding on those at increased risk of falling, new integrated alarms to warn when someone who is a risk to fall might be trying to get up on their own, using a strong team approach to preventing falls, creating a safer environment so if someone does fall they are not injured, and working to make sure people who are patients are stronger in the first place so they are less of a risk to fall. As a result of these efforts, the number of people who have fallen and sustained a serious injury has decreased by almost 80% since the beginning of 2014.

Finally, to anyone who has been affected by an adverse event while a patient at Middlesex Hospital, to their family members and loved ones, we sincerely apologize for any impact of such an event, and assure you that we have learned as much as we can from any event so we can do our best to be sure it does not happen again.

Danbury, New Milford, and Norwalk Hospitals

Danbury Hospital, New Milford Hospital, and Norwalk Hospital, members of Western Connecticut Health Network (WCHN), have long been focused on providing high quality, safe care to the patients in our

Comments Submitted by Facilities, continued

communities. This is driven by a deep-seated culture of accountability, best practice adoption, internal event reporting, transparency, and accurate reporting to external agencies. Over the past year, we've adopted High Reliability Organization (HRO) practices, in pursuit of the elimination of all-cause preventable harm. Over 7,000 of our employees and members of our medical staffs participated in mandatory HRO training. Also within the past year, we implemented daily Safety Huddles, Leadership Rounding, and Safety Coach programs- all focused on reinforcement of our safety culture.

Our quality and safety goals are Board-driven and tied to performance targets that represent top national performance. We use these national data to judge our performance, identify opportunities for increased attention, and measure our improvement. For example, through participation in the Nursing Database of National Quality Indicators (NDNQI), we have been able to validate fall and pressure ulcer rates that compare favorably to national performance. We have robust internal systems that detect early stage pressure ulcers, link to hardwired consultation with our certified specialists in skin care, and support stronger patient treatment plans. Such a comprehensive program leads to heightened centralized knowledge and external reporting of all known events. We also have dedicated fall prevention specialists and teams, and have utilized simulation science scenarios to enhance our fall reduction programs. Through our National Surgical Quality Improvement Program (NSQIP) database, we have been able to use patient outcome data, compared to national performance, to target those areas where we are not achieving "exemplary" surgical ratings, and then use the same database to verify that changes in practice have moved us in the right direction. Within the past year, we have had successful external validation of the quality and safety of our specialty programs in areas including but not limited to Joint Replacement, Spine Surgery, Stroke, Palliative Care, Lung Cancer, Colon Cancer, Breast Cancer, Vascular Surgery, Chest Pain, and Trauma.

We highly encourage not only the reporting of patient harm events, but also precursor and near miss events, which allows us to make changes before something untoward occurs. As a growing health system, we have been able to leverage "lessons learned" across our Network, further supporting our culture of continuous learning and improvement. Thankfully, the vast majority of our events do not involve harm. With the recognition that healthcare has become increasingly complex, and our patients often have multiple medical conditions, we know that we must focus more than ever on system-level and patient-specific factors that contribute to the risk of undesired outcomes. We are continually using drills, risk assessments, and causal analyses to identify potential areas of risk to our patients, and taking action to mitigate those potential risks. We take very seriously the trust our communities place in us, and fully commit to partnering with our patients and families in support of patient-centered quality and safety excellence.

Griffin Hospital

Griffin Hospital is committed to providing safe, patient centered, high quality care to all of our patients. In the fall of 2013 Griffin Hospital began the process of expanding our culture of safety to include the implementation of the Connecticut Hospital Association's state wide initiative "Safety Starts with Me" program. This state wide initiative to becoming a High Reliability Organization (HRO) focuses on a series of error prevention tools related to five safety habits which include: Clear Communication, Effective Hand-Offs, Attention to Detail, Mentoring for 200% Accountability and Practicing and Accepting a Questioning Attitude. Hospital wide incorporation of the HRO "People Bundle" with support from all levels of the organization has proven to significantly reduce medical errors at Griffin Hospital.

Comments Submitted by Facilities, continued

Griffin Hospital has successfully trained all hospital employees, active medical staff and licensed independent practitioners on the “Safety Starts with Me” program. In addition to training, Griffin Hospital has put into effect a hospital wide patient-centered safety huddle as well as departmental safety huddles. Employees are encouraged to speak up regarding safety concerns and are included in the problem solving for these concerns. Our focus continues to be on identifying issues with the potential to cause harm as well as system based errors through the application of multiple tools. In addition to our on-line safety reporting system, clinical debriefs, system reviews, proactive risk assessments are completed to identify and correct process problems and reduce the likelihood of experiencing adverse events. Through the review and investigation of adverse events, opportunities for improvement in processes and protocols are identified. The lessons learned are shared with all staff and all findings and the corrective action plans are reviewed and approved by the executive staff.

Stamford Hospital

Stamford Hospital is committed to continuously enhancing the safest and highest level of patient care by integrating the latest evidence based practices across the institution.

Additionally, the Hospital participates in the National Database of Nursing Quality Indicators (NDNQI). This system provides a framework for evaluating, benchmarking and continuously improving key nursing practices. These areas include fall reduction, prevention of hospital acquired infection, restraint usage, and reduction of hospital acquired pressure ulcers, among others. This is important because the CT Department of Public Health Adverse Event uses very specific event definitions that have evolved over time. In the area of pressure ulcers, the report requires the reporting of a specific subset of pressure ulcer events.

As part of its ongoing participation in NDNQI, Stamford Hospital follows the occurrence of all significant pressure ulcers. Over the past two years, the organization's overall rate of these pressure ulcers remained in line with, or more favorable than, the national averages reported in the NDNQI database. Stamford Hospital maintains a comprehensive skin care program to minimize the incidence of pressure ulcers. In addition to ongoing and regular assessment of skin integrity by nursing staff, certified wound specialists work collaboratively with nursing leadership, clinical staff, and an interdisciplinary skin champion team to effectively monitor and manage potential skin breakdown.

Saint Vincent’s Health Services

St. Vincent’s pioneered bringing the processes of high reliability and culture of safety to Connecticut hospitals and continues the journey it began in 2010 with renewed efforts to measure and evaluate data that can help improve patient outcomes. We have implemented initiatives that demand analysis, review and transformation of clinical practices. We have maintained our commitment to mandating a “high reliability” safety training program for every employee regardless of position, and for morning safety huddles as a way to communicate and prevent possible harm.

As part of our culture of safety, we have empowered staff to “speak up for safety” if they see something that has the potential to be unsafe in any situation, and have encouraged a culture of “200% accountability,” in which they are not only responsible for their own behaviors, but also for validating that their colleagues are practicing safe behaviors. We believe this is necessary to remain at the forefront of patient safety and quality, and to allow us to focus on our mission of creating a safe, holistic and compassionate environment in which we can deliver person-centered care.

Comments Submitted by Facilities, continued

Last year, St. Vincent's transitioned to a comprehensive electronic health record (EHR), called OneChart. OneChart places many safety features at the fingertips of our providers and staff, including medication administration bar coding and fully integrated patient data. This further supports our integrated approach to patient care, along with our hospitalist service, and intensive care unit, which is fully staffed with critical care physicians.

Our successful "Care Partner" program encourages the patient to designate an individual who is included as a member of their care team. This enhances communication and patient and family well-being and produces better outcomes while contributing to lower readmission rates.

Patient safety improvements continue to focus on items identified nationally as well as locally. The risk for alarm fatigue has been addressed by conducting an organizational assessment, with modifications to our alert signals.

Attention to infection prevention continues as a priority, with specific focus on environmental cleanliness and hand hygiene practices. We have made significant reductions in catheter associated urinary tract infections through the adoption of best practices. This includes the reduction of overall catheter utilization and better management of patients with catheters, such as prompt catheter discontinuation.

Fall prevention remains a high priority. A fall prevention "tool kit" is available to assist our staff in implementing best practices for the avoidance of patient falls in the hospital. Real time identification of causations coupled with the implementation of assessment strategies is contributing to the prevention and reduction of falls and injuries.

We remain vigilant in reducing the incidence of pressure ulcers. A dedicated certified wound and ostomy nurse consults on our patients and educates our staff and patients on pressure ulcer prevention. St. Vincent's is a member of the Ascension Health Pressure Ulcer Initiative, sharing best practices for pressure ulcer prevention with other health systems. St. Vincent's Center for Wound Healing, which currently operates a state-of-the-art facility in Trumbull, is dedicated to healing chronic wounds.

As St. Vincent's Medical Center led an initiative to bring high reliability organization training to Connecticut hospitals, we will now begin implementation of an advanced phase of high reliability training, with further focus on communication and simulated scenarios to strengthen teamwork. We hope to share the process with other Connecticut hospitals in the future.

Saint Francis Hospital and Medical Center

Saint Francis Hospital and Medical Center is committed to delivering the highest quality of care for our patients and strives to empower all members of our organization to speak up for patient safety. As we continue on our high reliability journey, our goal is to eliminate all preventable harm. Each time an adverse event does occur we thoroughly investigate how and why it occurred in order to understand how to prevent any such similar event from happening again. In 2015, we have identified the reduction of pressure ulcers as a priority. Saint Francis continually looks for opportunities to improve the quality of care we provide to our patients. After learning of additional education and training regarding pressure ulcers through the Agency for Healthcare Research and Quality (AHRQ), we applied for and were chosen by AHRQ as one of ten hospitals nationwide to participate in a multi-level national study for improving the quality of care with respect to pressure ulcers. This

Comments Submitted by Facilities, continued

two year endeavor is indicative of our hospital's dedication and stewardship for promoting better outcomes for our patients.

Eastern Connecticut Health Network

Manchester Memorial and Rockville General Hospitals have been working diligently to create and maintain a culture of safety and excellence in quality of care throughout our hospitals. All staff including the medical staff has attended a rigorous Patient Safety Program with the expectation that Safety Behaviors learned are used consistently in their practice. We foster a Just Culture and a Culture of Accountability that encourages the reporting of concerns to proactively identify and resolve any unsafe or potentially unsafe process or circumstance that may lead to error. We have rigorous programs in place to prevent pressure ulcers, falls, and health care acquired infections. A Universal Protocol and Time Out procedure is strictly followed prior to any surgical or invasive procedure. We have instituted a Safety Absolute regarding Patient Identification. We monitor all of our safety practices on a daily basis through an organizational wide safety huddle as well as individual unit huddles.

Our Hospitals are committed to excellent in Quality and Safety and will continue to implement best practices for excellent outcomes.