Patient Safety Surveillance and Improvement

IONA THRAEN, ACSW PHD

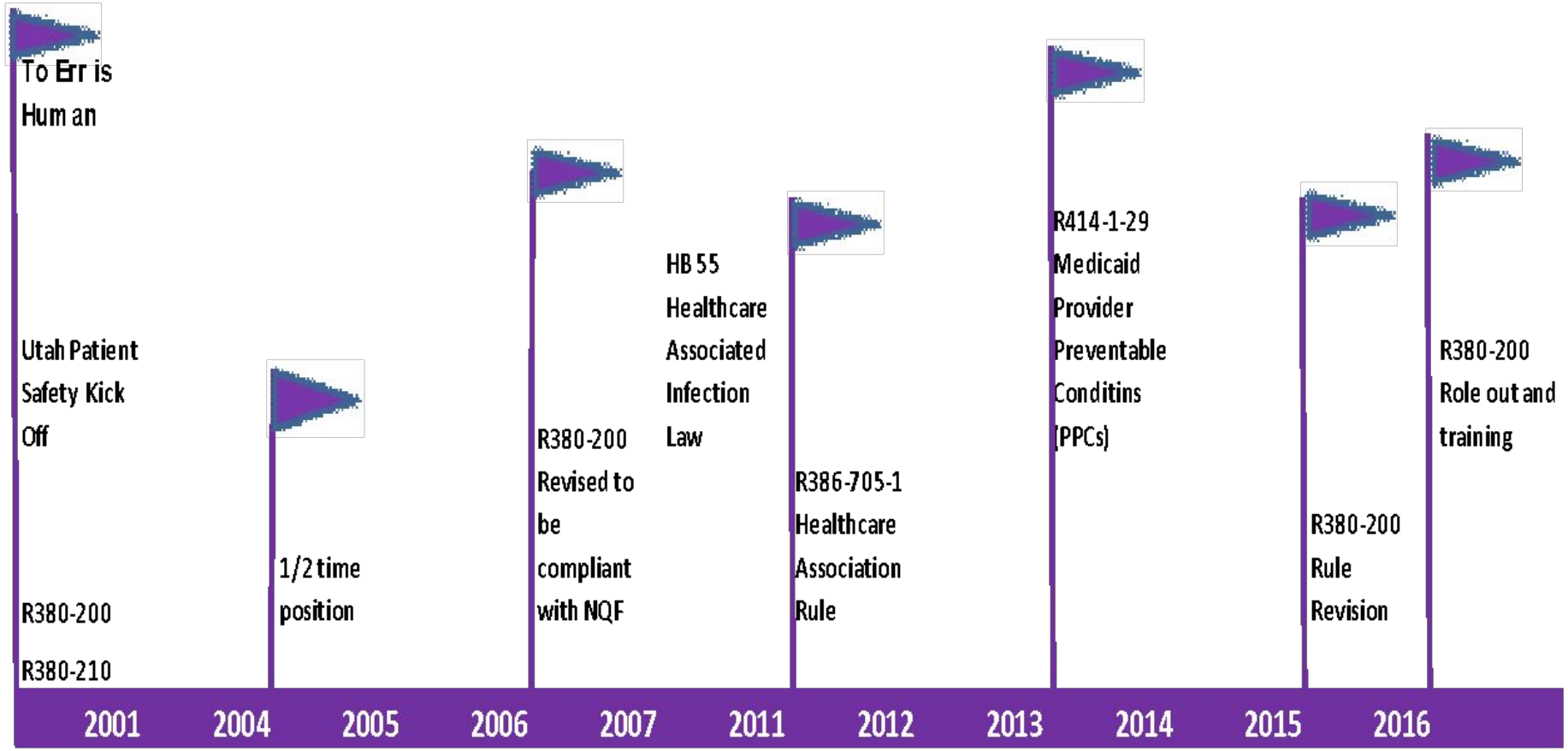
UDOH PATIENT SAFETY DIRECTOR

OCTOBER 2016

Patient Safety Surveillance Outline

1. History
2. Authority
3. Sentinel Event Data and reports
4. Rule change highlights

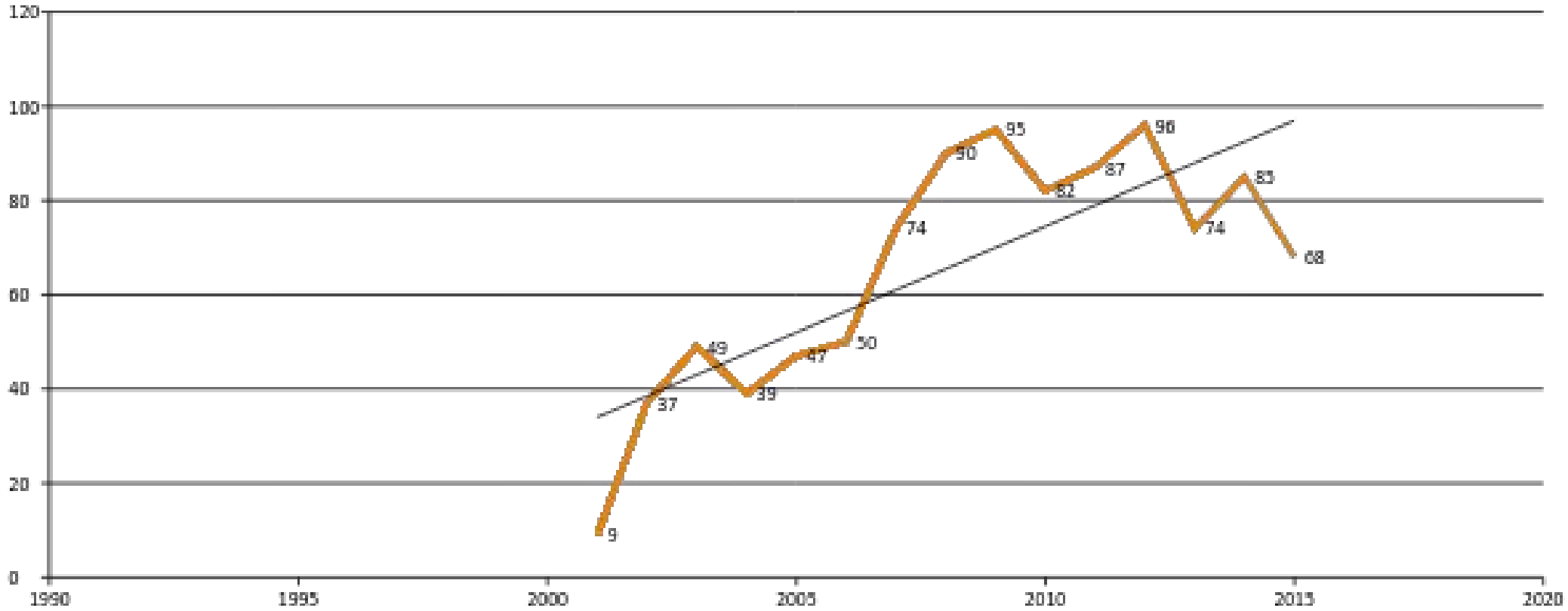
History


To Err is Human
Utah Patient Safety Kick Off
R380-200
R380-210
1/2 time position
R380-200 Revised to be compliant with NQF
HB 55 Healthcare Associated Infection Law
R386-705-1 Healthcare Association Rule
R414-1-29 Medicaid Provider Preventable Conditins (PPCs)
R380-200 Rule Revision
R380-200 Role out and training
2001
2004
2005
2006
2007
2011
2012
2013
2014
2015
2016

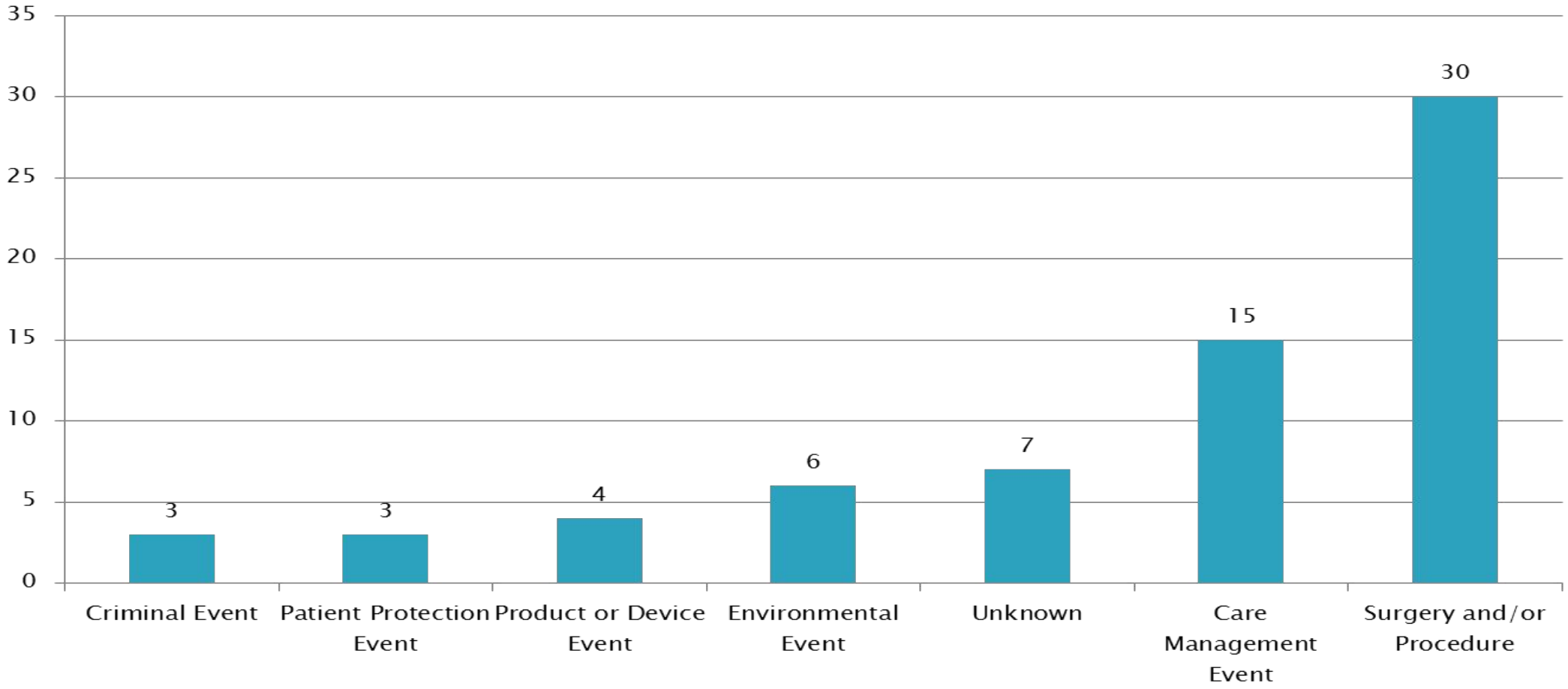
Authority

- Law: Title 26-1-30(2)(a); 26-1-30(2)(b); 26-1-30(2)(d); 26-1-30(2)(e); 26-1-30(2)(g); 26-3-8
- Rules
  - R380-200 (Sentinel Event Rule) Revised December 2015
  - R380-210 (Office of Health Data and Statistics – Hospital Discharge Data)
  - R414-1-29 (Medicaid - Preventable Provider Conditions)
  - R386-705 (Division of Epidemiology – Healthcare Associated Infections)
  - R313-20-5 (Department of Environmental Protection – Radiology events)

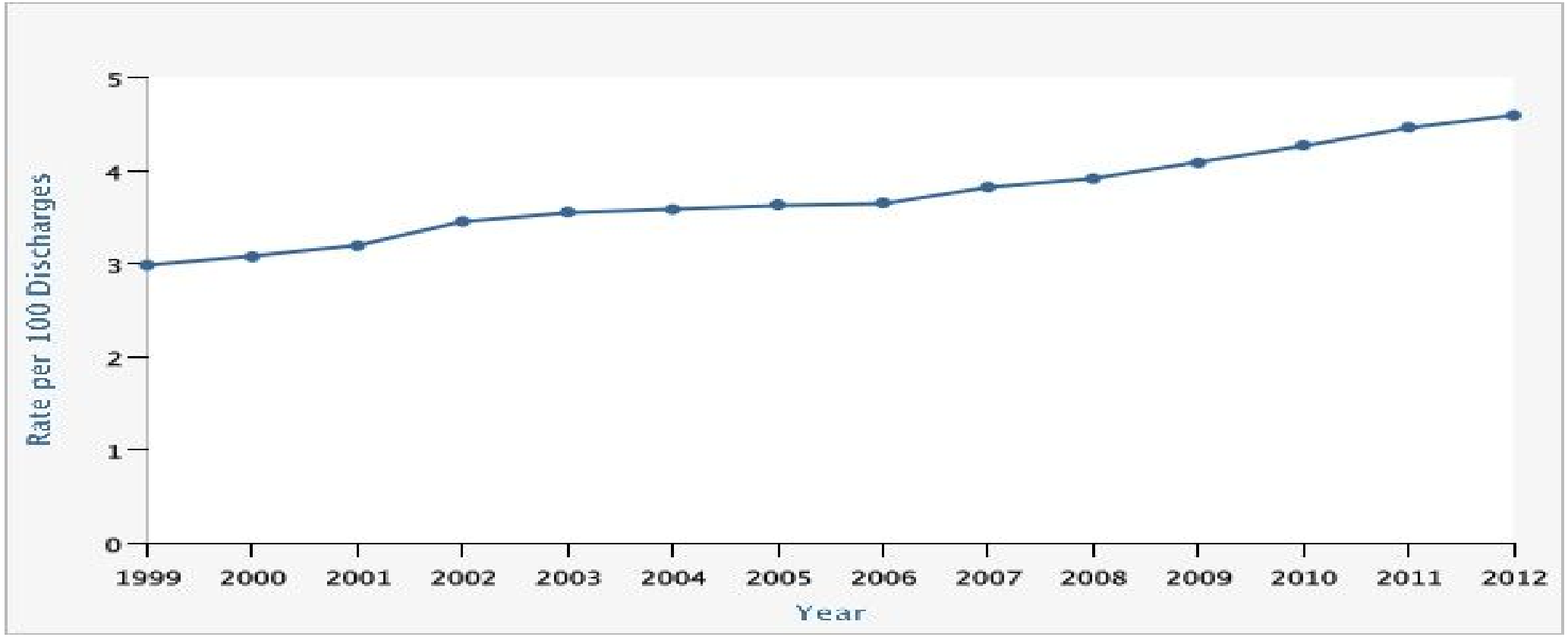
Sentinel Events



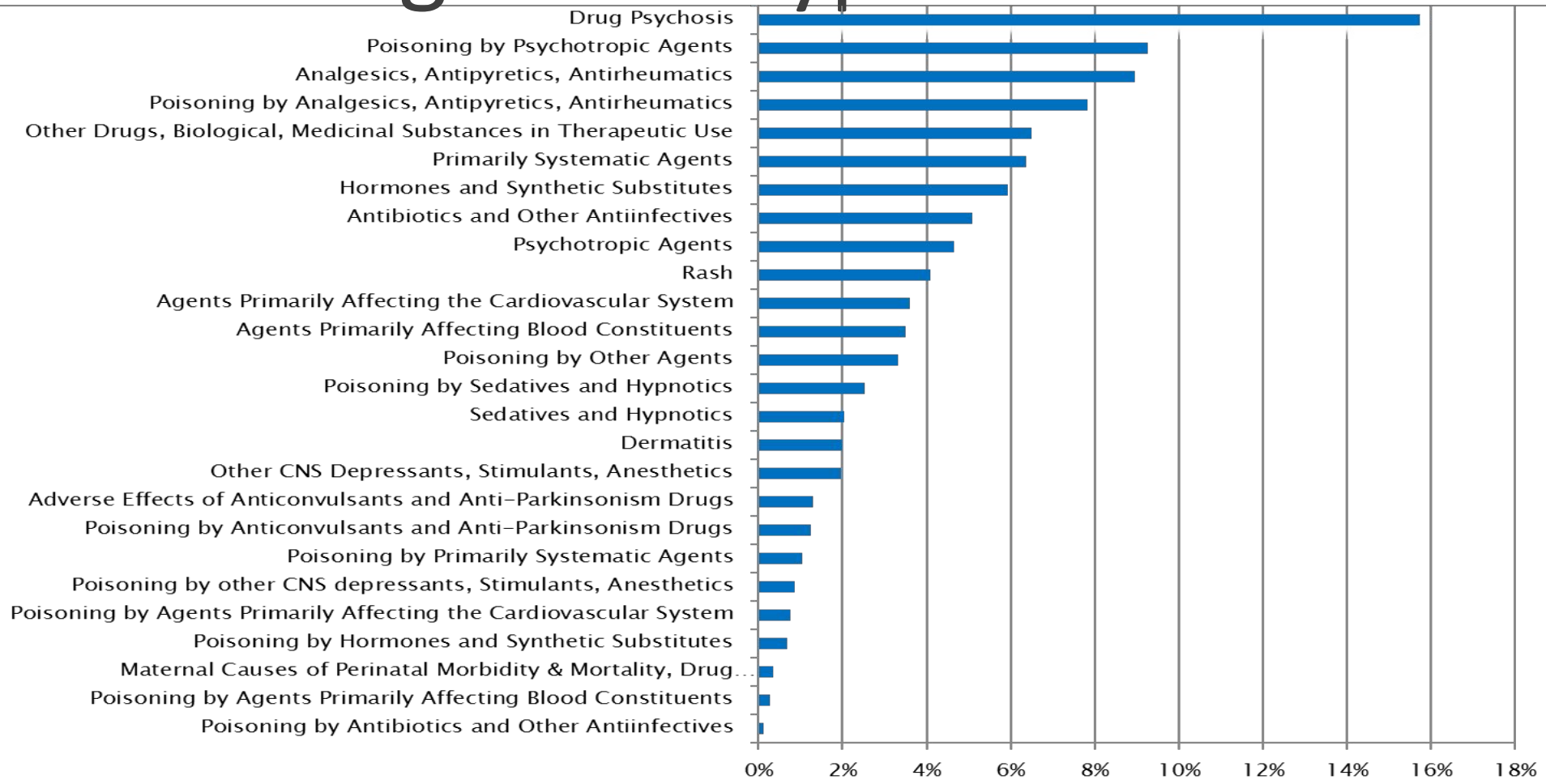
Sentinel Events by frequency (2015)



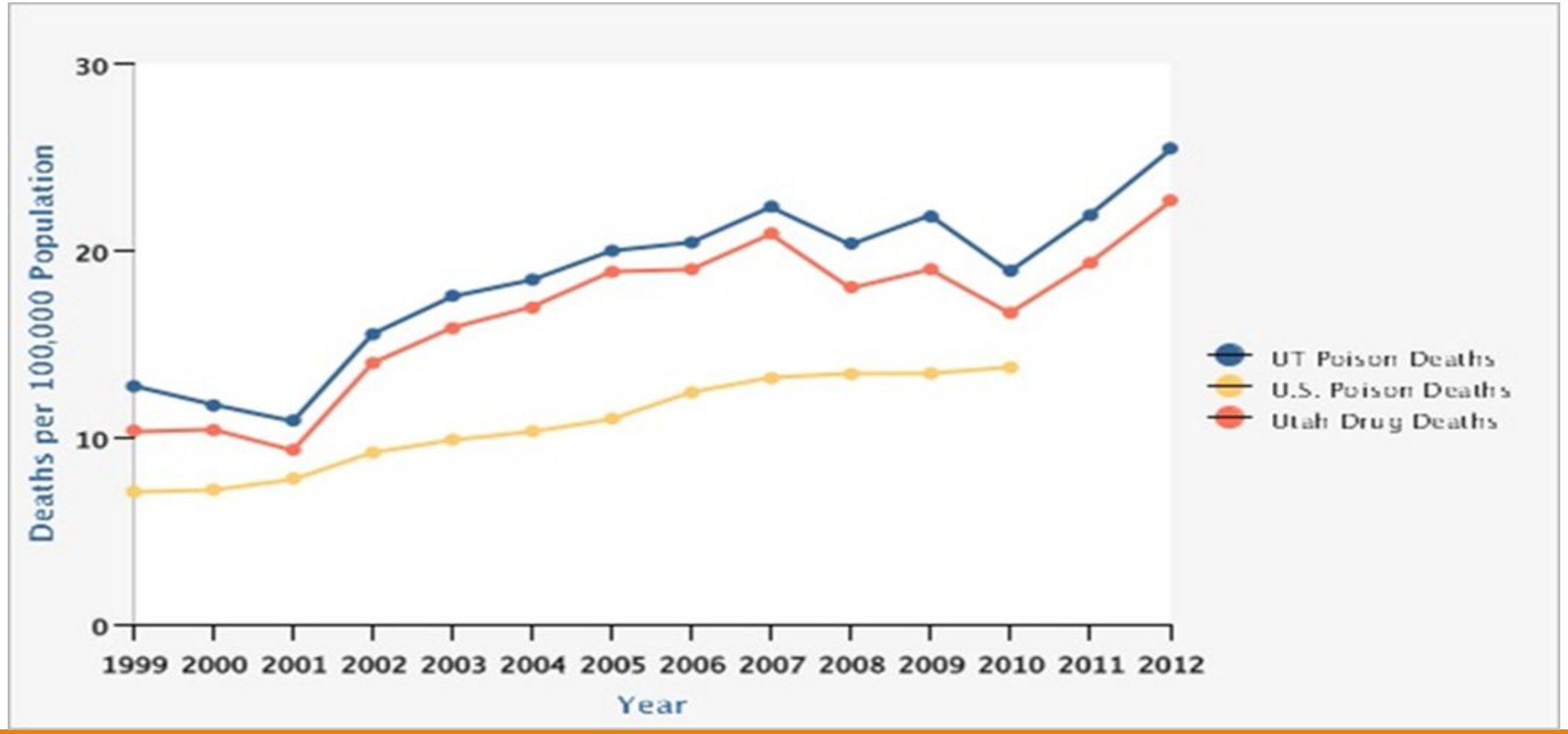
Adverse Drug Events Per 100 inpatient discharges



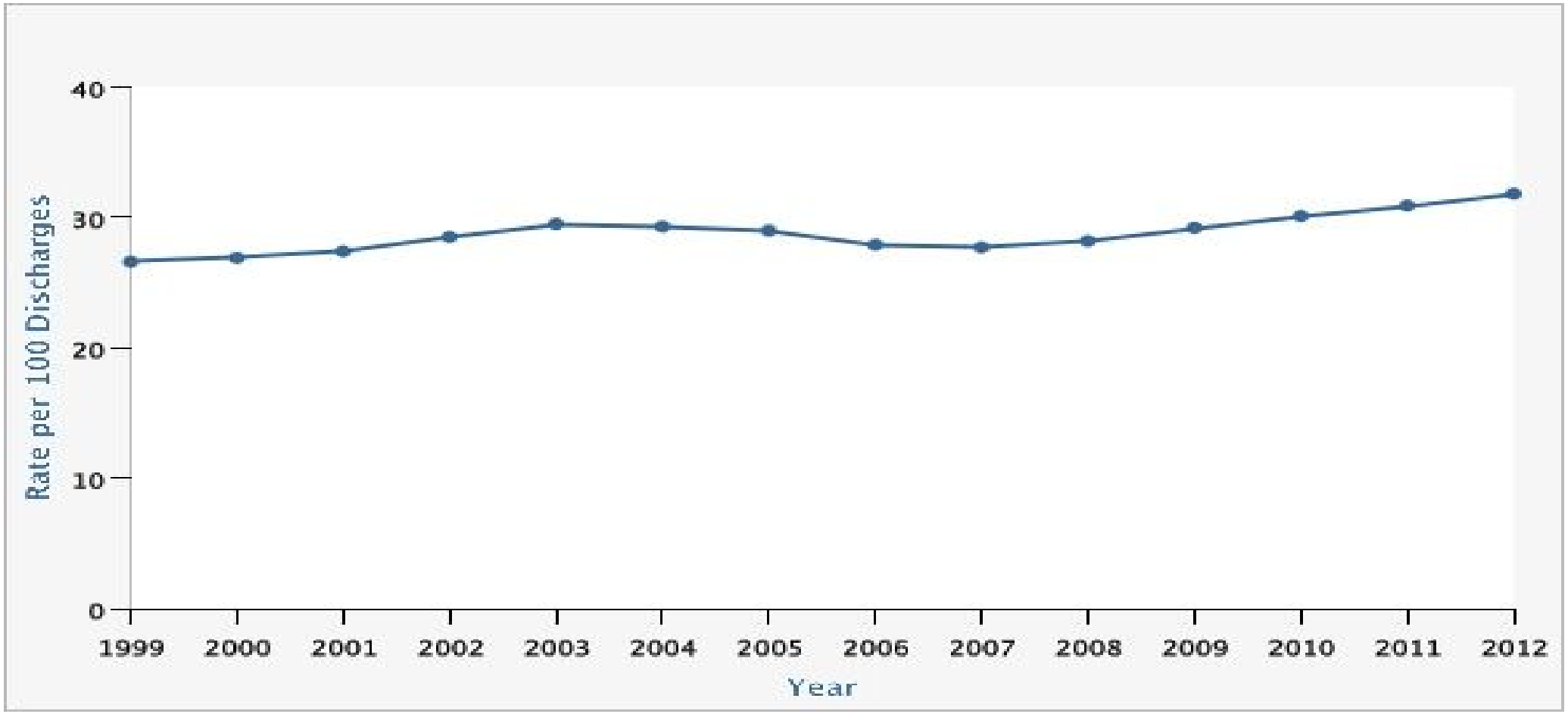
Adverse Drug Event Types



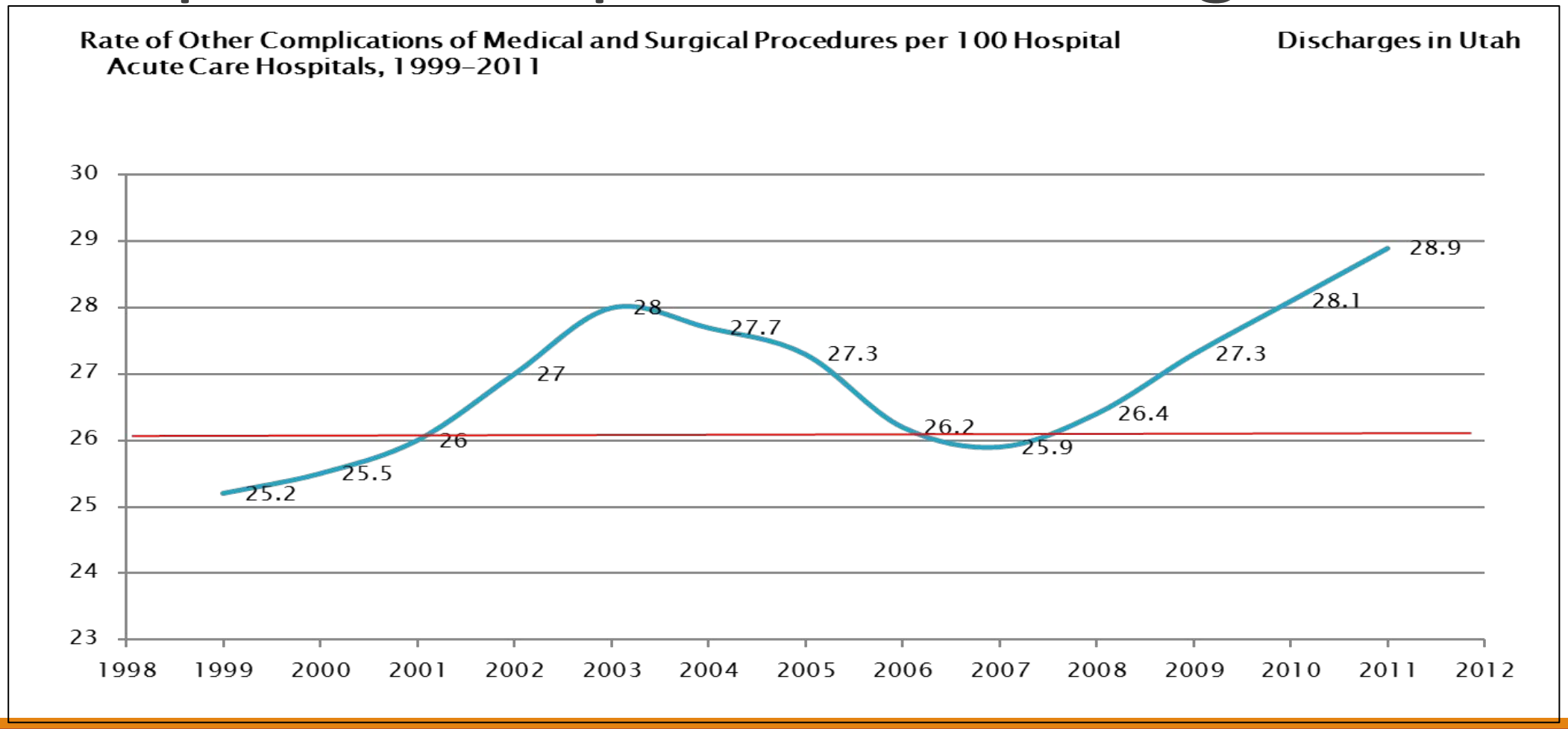
Prescription Deaths and Overdoses



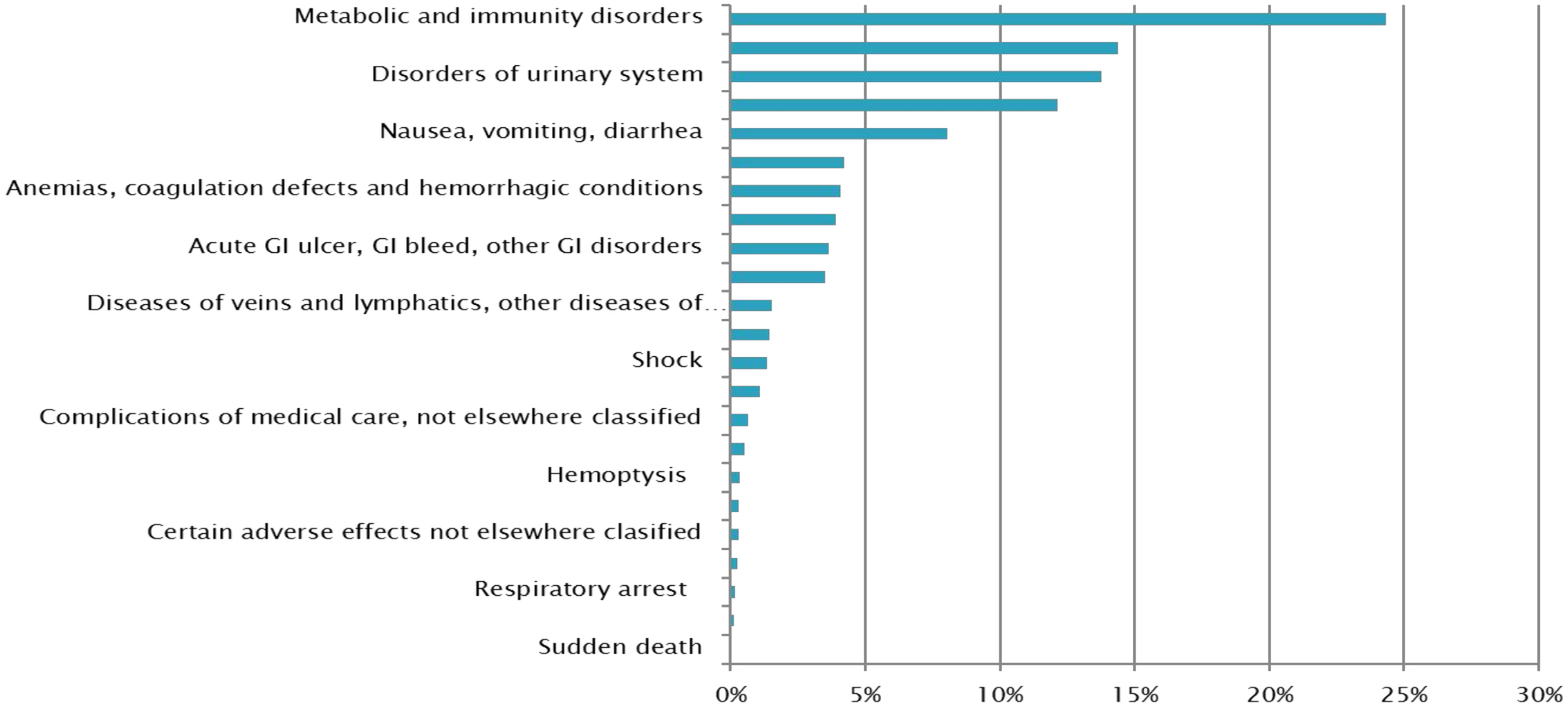
Adverse Events per 100 Discharges



Complications per 100 Discharges

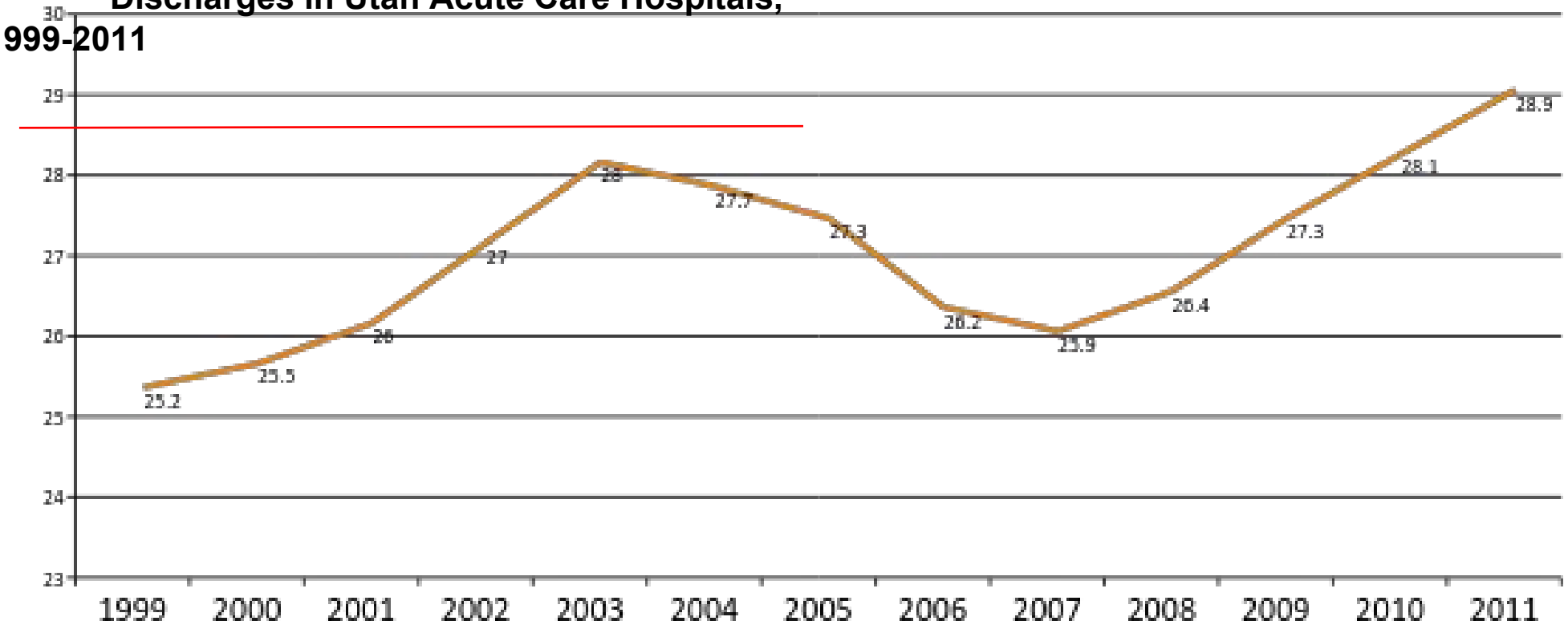


Complication Types (2011)

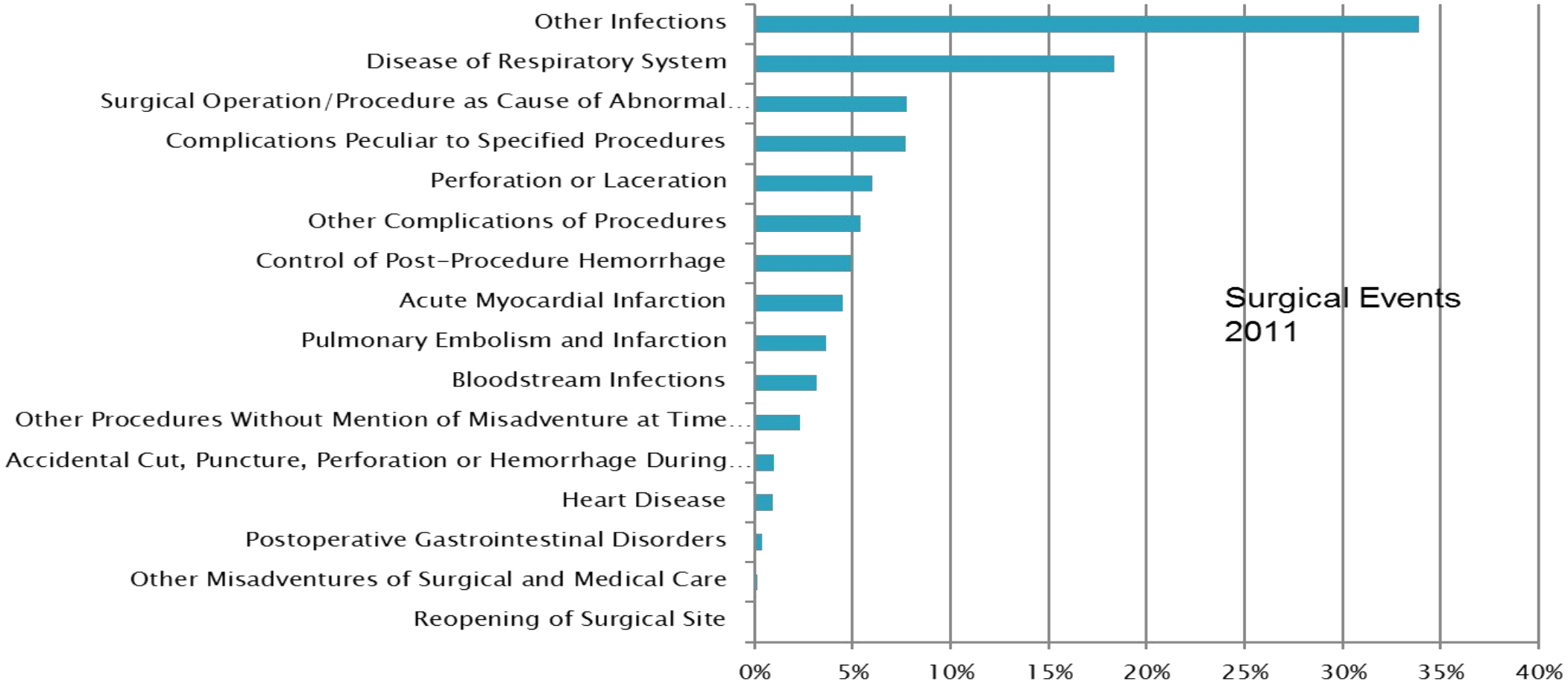


Medical and Surgical Procedures

Rate of Other Complications of Medical and Surgical Procedures per 100 Hospital Discharges in Utah Acute Care Hospitals, 1999-2011



Types of Surgical Complication Events



Rule Changes

- Sentinel Event Rule
  - Revised December 2015
  - Roll out October 2016
    - Database changes
    - Training
- Goal - **Improve patient safety surveillance for the state of Utah**
  - Improve reporting functions through a standard set of reports using state wide benchmarks
  - Improve automation of reporting between healthcare facilities and reporting system
  - Improve public transparency for annual standardized reporting
  - Improve development of state-wide interventions to decrease likelihood of patient safety events
  - Improve state-wide agency involvement through biannual trainings
  - Coordinate with existing patient safety organizations (NQF, UAHQ, Infection Control, etc.)
  - Align patient safety event reporting with national standards

Maternal Mortality changes – Elimination of Low Risk Pregnancy Language

Maternal death or major permanent loss of function in a low-risk pregnancy arising from labor or delivery while being cared for in a facility,

- except deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.

"Low Risk Pregnancy" refers to a woman aged **18-39,**

- with no previous diagnosis of essential hypertension,
- renal disease,
- collagen-vascular disease,
- liver disease,
- cardiovascular disease,
- **placenta previa,**
- **multiple gestation,**
- intrauterine growth retardation,
- **smoking,**
- pregnancy-induced hypertension,
- premature rupture of membranes,
- or other previously documented condition that poses a high risk of poor pregnancy outcome.

Additional Changes

- Minimize redundancies
- Create Interpretive guidelines
- Institutionalize annual report
- Bring into compliance with NQF Serious Reportable Events
- Explore Use of APCD
- Improved reporting functions
- Link to revised Sentinel Event Rule
  - http://www.rules.utah.gov/publicat/code/r380/r380-200.htm
- Contact Information – http://health.utah.gov/psi
  - Iona Thraen (801)-273-6643 (o) 435-640-2466 (c)
  - ithraen@utah.gov