M I N U T E S

Quality of Care Advisory Committee

Location
Conference call

April 7, 2017

The semiannual meeting of the Quality of Care Advisory Committee was called to order by Yvonne Addo, Deputy Commissioner of the Department of Public Health, at 9:33 AM.

Members/Guests joining via conference call: Debra Abromaitis, Yvonne Addo, John Brady, Anne Elwell, Wendy Furniss, David Guttchen, Sue Newton & Jon Olson

Opening Remarks: Deputy Commissioner Yvonne Addo thanked everyone for joining the meeting via conference call.

Approval of Minutes: A motion was made by Wendy Furniss to approve the October 12, 2016 Advisory Committee Minutes. Debra Abromaitis seconded the motion. The Committee voted to approve the minutes with no one abstaining from voting.

Adverse Events Report: Jon Olson presented and summarized the Adverse Events Counts for 2012-2016. Overall in 2016 there has been a 5% decrease in reports from the previous year. Highlights discussed included:

- NQF 4F - Pressure Ulcers: A 20% reduction to the category of pressure ulcers was noted. This was attributed to more vigilance to patient movement by the nursing staff.
- NQF 5C – Burns: there were three reported burns in 2016. Of the three, only one occurred in a surgical suite. The others were related to food/beverage spills.
- NQF 7C – Sexual abuse/assault: Reports for this category increased in 2016. Many of the reports were allegations and not confirmed sexual assault. Clarifying guidance was introduced in 2017. The clarifying language should help to reduce the number of unsubstantiated reports going forward.

Sue Newton reported FLIS and IT are working on a web-based adverse events reporting system. They plan to shift to the new electronic system in the next couple months. This will allow for easier data mining as well as more timely data submission.

Other Business

- Having no other business, the meeting was adjourned at 9:56 AM

Next Meeting:
October 5, 2017 @ 9:30 AM - DPH Commissioner's Conference Room, 410 Capitol Avenue, Hartford, CT

Appendix B. Counts of Adverse Event Codes 2012-2016

Event Code	Description	Reports 2012	Reports 2013	Reports 2014	Reports 2015	Reports 2016
NQF 1A	Surgery performed on the wrong site	9	13	15	13	18
NQF 1B	Surgery performed on the wrong patient	0	1	0	1	1
NQF 1C	Wrong surgical procedure performed on a patient	2	1	4	1	6
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	12	25	24	19	20
NQF 1E	Intraoperative or immediate postoperative/ postprocedure death in an ASA class I patient	0	0	1	1	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	0	1
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	5	1
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	1	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	1	2
NQF 3B	Patient death or serious injury associated with patient elopement (disappearance)	0	1	0	0	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	3	6
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	7	7
NQF 4B	Patient death or serious injury associated with unsafe administration of blood products	0	0	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	1	3
NQF 4D	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	4	1	4	5	2
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	76	90	78	90	74
NQF 4F*	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	51	277	245	230	186
NQF 4G	Artificial insemination with the wrong donor sperm or wrong egg	0	0	0	0	0

Appendix B (cont.). Counts of Adverse Event Codes 2012-2016

Event Code	Description	Reports 2012	Reports 2013	Reports 2014	Reports 2015	Reports 2016
NQF 4H	Death or serious injury resulting from irretrievable loss of an irreplaceable biological specimen	NA	3	0	0	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	3	2
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	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	0	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	0	3
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	2	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	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	0	0
NQF 7B	Abduction of a patient/resident of any age	0	1	0	0	0
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	7	4	9	10	24
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	0	2
CT 1	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious injury.	55	79	71	49	58
CT 2	Patient death or serious injury as a result of surgery	14	13	12	14	14
	Total Reports	241	534	472	456	431

*Unstageable pressure ulcers became reportable in 2013.
NA is marked in cells where the event category did not exist prior to 2013.
There were zero NQF 7C reports among the 35 reports of all types in 2017, representing one month.