

NATIONAL QUALITY FORUM

CONFERENCE CALL OF THE SERIOUS REPORTABLE EVENTS IN HEALTHCARE STEERING COMMITTEE

October 20, 2010

Steering Committee Members Present: Gregg Meyer, MD, MSc (Co-Chair); Sally Tyler, MPA (Co-Chair); Tejal Gandhi, MD, MPH; Cynthia Hoen, Esq., MPH, FACHE; Helen Lau, RN, MHRD, BSN, BMus; John Morley, MD, FACP; Stancel Riley, Jr., MD, MPA, MPH; Diane Rydrych, MA; Doron Schneider, MD, FACP; Philip Schneider, FASHP, MS; Michael Victoroff, MD

Steering Committee Members Absent: Leah Binder; Patrick Brennan, MD; Christine Goeschel, RN, MPA; Kathryn McDonagh, PhD; Deborah Nadzam, PhD, RN, FAAN; Martha Radford, MD, FACC, FAHA; Eric Tangalos, MD, FACP, AGSF, CMD

NQF Staff: Helen Burstin, MD, MPH; Peter Angood, MD, FACS, FCCM; Melinda Murphy, RN, MS; Lindsey Tighe, MS

Others present: Angela Franklin, Esq.

WELCOME AND INTRODUCTIONS

Dr. Angood welcomed the Committee and thanked them for their participation on the call. Dr. Meyer and Ms. Tyler informed the Committee members that the purpose of this call would be to review the glossary definitions and reaffirm the event listings for the Serious Reportable Events (SREs) in the prioritized healthcare environments for expansion of the SREs. Those environments are Skilled Nursing Facilities (SNFs), Ambulatory Outpatient Practices, and Ambulatory and Office-based Surgery Centers.

GLOSSARY REVIEW

The Steering Committee reviewed terms contained within the glossary by exception, making comments as captured in the following table.

Term	Definition in Glossary	Steering Committee Comments
Adverse	“describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable”	<ul style="list-style-type: none">• The Committee has concern that the current definition requires the event reporter to make an assertion of whether the event was or was not preventable.• Suggestions to modify definition to “describes a consequence of care that results in an undesired outcome. It does not address preventability.”
Associated With	“means that it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship”	<ul style="list-style-type: none">• The Committee has concern that the current definition requires the event report to make an assertion of causation of the event.• Steering Committee members stated that the current definition allows for reporting of the event when it happens; however, if there is not a causal relationship between the event and the course of care of the patient, the event can be withdrawn from

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		reporting. The Steering Committee recommended no change to the definition.
Authorized	“means having official permission”	<ul style="list-style-type: none"> • The Committee has concern that the definition is not legally actionable. • It was suggested to modify to “The guardian or other individual(s) having the ability to consent on behalf of the minor or incapacitated individual (‘surrogate’), or person designated by the surrogate to release the patient to”
High Alert Medications	“are those medications that have a high risk of causing serious injury or death to a patient if they are misused. Examples of high-alert medications include warfarin and IV antithrombotics, insulin, cytotoxic chemotherapy, concentrated electrolytes, IV digoxin, opiate narcotics, neuromuscular blocking agents, and adrenergic agonists”	<ul style="list-style-type: none"> • It was suggested to include anticoagulants as an example. • The Committee suggested to provide a link to Institute for Safe Medications Practice’s (ISMP) listing of high alert medications (http://www.ismp.org/Tools/highalertmedications.pdf).
Healthcare Setting	means any licensed facility, including discrete unit of care within such facility that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence, or other care of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare settings include, but are not limited to hospitals, nursing homes, rehabilitation centers, medical centers or offices, outpatient dialysis centers, reproductive health centers, independent clinical laboratories, hospices, and ambulatory surgical centers. The boundary of a healthcare setting (the “grounds”) is the physical area immediately adjacent to the setting’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings. It does not include non medical businesses such as shops and restaurants located close to the setting.	<ul style="list-style-type: none"> • It was suggested to specifically include physician office settings and pharmacies in the definition. • It was suggested to remove the term “licensed” from the definition. Removing this term will be more encompassing of the expanded environments of care, as various facilities are licensed differently.

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ADDITIONAL SUGGESTIONS

The Steering Committee recommended that the term “under care” be added to the glossary. Discussion centered on the difficulty of defining when a patient is considered under the care of the provider; as such, the Steering Committee recommended that this term be defined by examples of when a patient is under care for each environment of healthcare.

The Steering Committee also recommended that the term “patient” be listed in the glossary and defined. NQF staff will draft a definition for Steering Committee review.

The Steering Committee members will e-mail NQF staff with any other suggested modifications to definitions in the glossary.

REVIEW OF CLABSI EVENT

The Steering Committee reviewed inclusion of an event capturing Development of Central Line Associated Blood Stream Infection (CLABSI) within 48 hours of insertion of a central line. The Steering Committee acknowledged that there likely will be difficulties in attributing causality of the event, as patients with central lines can be seen in many different departments of a healthcare setting. The Steering Committee also stated concerns that occurrence of this event has not been measured and publically reported yet. The Steering Committee would like to make recommendations in the report for the development of measurement of CLABSI incidence as well as standards and guidelines as relates to CLABSI prevention. The Steering Committee stated that this event should not be included in the serious reportable event listing at this time.

PUBLIC COMMENT

There were no public comments.

NEXT STEPS

A summary of this call will be e-mailed to Steering Committee members within the next few weeks.

The Steering Committee will be e-mailed a survey to complete the remaining loose ends of the work for the Serious Reportable Events in Healthcare project.