NATIONAL QUALITY FORUM

CONFERENCE CALL FOR COMMON FORMATS EXPERT PANEL GROUP A

July 21, 2011

Group A Members Present: Nancy Ridley, MS (group lead); Helen Lau, RN, MHROD, BSN; Heather Sherman, PhD; William Munier, MD, MBA (liaison member)

Other Panel Members Present: Debra Bakerjian, PhD, RN, FNP; Peter Elkin, MD, MACP, FACMI

NQF Staff Present: Melinda Murphy, RN, MS; Jessica Weber, MPH

Others Present: Amy Helwig; Diane Cousins; Peter Goldschmidt; John Moquin; Deborah Perfetto; Sue Terrillion; Ira Yanowitz

PURPOSE

The purpose of this meeting was for the group to consider and make recommendations on comments received about Common Formats reporting forms for the Skilled Nursing Facility (SNF) Beta and Hospital Version 1.1:

- Healthcare Event Reporting Form (HERF),
- Patient Information Form (PIF),
- Summary of Initial Report (SIR).

Comments to be considered were those received through the National Quality Forum (NQF) Common Formats commenting tool as of July 12, 2011, which included 42 comments on the SNF Beta forms and 1 on the Hospital Versions 1.1 forms.

WELCOME AND INTRODUCTIONS

Ms. Ridley welcomed the Group A members and thanked them for their participation on the call. She noted that while Dr. Phillips was not able to be present the group would consider her written input in their deliberations. Ms. Murphy oriented the group to the documents provided for their review, noting that each comment is from a single individual representing a specified organization. She then oriented the group to the agenda and logistics for the Expert Panel meeting on August 1-2, 2011. Ms. Murphy noted that the breakout sessions at the August meeting have been arranged so that AHRQ members can be available as consultants to each of the work groups

Ms. Ridley stated that the biggest challenge in reviewing the comments was reconciling any suggested changes between the Hospital and the SNF forms. She encouraged the group to only make changes when they were convinced that an item needed to be addressed at this time rather than after a period of use. She noted that about half of the comments would involve making a change to only the SNF forms.

Ms. Ridley noted that comments had previously been reviewed based on a set of three objectives and five criteria, which have been revisited and reaffirmed by the Expert Panel over time. The objectives are:

- to review comments for any that should go directly to AHRQ;
- establish recommendations for any of the remaining comments that can be submitted to the Expert Panel at the next meeting; and,
- finalize the comments that the group would address at the next meeting.

Ms. Ridley also reviewed the five criteria for prioritizing consideration of the comments, which are:

- high volume;

- important;
- improve usability;
- improve acceptance; and,
- improve user implementation and maintenance.

Ms. Murphy noted that in the past the group has addressed all comments thus has not needed to prioritize them. These objectives and criteria will be reviewed in the future and Ms. Ridley suggested that they may need to be slightly altered based on experiences Panel members have had in using them. It was noted that the nursing home nomenclature and culture may warrant some adjustments to the SNF Common Formats language, which in most cases can be addressed with the use of examples.

Responding to a question about future versions of the Common Formats, Dr. Helwig clarified that there are currently two published sets, the SNF Beta and Hospital Version 1.1. However, the Agency for Healthcare Research and Quality (AHRQ) is in the process of drafting the next version of the Hospital set, which will be released as either Version 1.2 or Version 2.0. Changes have been made based on recommendations from the Common Formats Expert Panel. While some changes are distinct to the Hospital Version 1.1 , other changes will have to be reconciled between the future Hospital and SNF sets.

Following the August 1-2, 2011 meeting, AHRQ will incorporate the feedback and intends to release SNF Version 1.0 and the Hospital Version 1.2 or 2.0 simultaneously, including technical specifications, for both settings in mid-2012. AHRQ noted that slight discrepancies exist between the Hospital and SNF sets, since they were not published at the same time.

DISCUSSION AND RECOMMENDATIONS
Ms. Ridley introduced the topic areas to be discussed. Comments and recommendations related to all individual items discussed are included on the attached spreadsheet.

NQF MEMBER COMMENT
No comments were offered.

NEXT STEPS
Ms. Ridley suggested it may be beneficial in the future for the group to input their review of the comments into the same document. They agreed that the remaining comments would be reviewed and notations added.

The Common Formats Expert Panel will meet for an in-person meeting on August 1-2, 2011 in Washington, DC. This meeting will include sessions on cross cutting considerations for skilled nursing facilities, breakout sessions to review comments received, parking lot issues, presentations of recommendations and a discussion with AHRQ regarding future work for Common Formats.

Common Formats Expert Panel
Action Taken on Comments Triaged to Panel
HERF/PIF/SIR
Skilled Nursing Facilities (SNF) and Hospitals, v.1.1

			Action			
Common Formats ED & (form) #	Device Event Description Item Title	NQF Member or Public Comment	To AHRQ	Group A Action Date	Expert Panel Action Date	Discussion & Recommendations
		SNF				
1.0 (HERF Q.6.c. includes HIT)	Type of Event	Compared to the hospital form, there are no questions for (1) whether HIT was implicated in the event and (2) whether it was an NQF SRE. This information is still important to have about the event. In particular, several of the serious reportable events clearly apply to NH residents.		7/21		Discussion: AHRQ plans to add NQF SREs to SIR after appeals are addressed. Questions related to HIT will be added to the hospital HERF form. The fact they are not included now is a function of timing of the development and testing of the HIT component. Recommendation: No change needed.
1.1.3 (HERF Q.1)	Unsafe Condition	May be the same as a near miss - could either double report or under report		7/21		Discussion: SNF staff will not have same skill/knowledge as hospitals' staff. "Incident" will resonate in terms of incident reports; near miss and unsafe condition will not be recognized. Recommendation: Add a few classic examples to the 1.b and 1.c. response options and/or include links to Users' and Quick Guide to educate SNF staff.
1.2 (HERF Q.6)	A patient safety concern is identified as one or more of the following categories	This question is overly complicated. The asterisks (*) and plus (+) symbol descriptions are lost in the question instructions. Recommend placing those items beneath question text.				Discussion: The mix of regular and bold face type, symbols, and alpha ordering makes the response options a bit confusing. While it is understood that the electronic form will overcome these concerns, the paper forms would benefit from additional clarification in the instructions. Recommendation: AHRQ should consider reordering the response options, grouping either in columns by relevance to

						event type or some other schema to make paper forms more clear. Also, in combination, rethink the instruction following the question to improve clarity.
1.2.1 (HERF Q.6.a.)	Abuse or neglect	not all concerns related to possible neglect are filed on incident reports. May not capture true volume.				Discussion: Response option 6.a. was included in the SNF beta version with the expectation that abuse or neglect might be more relevant in facilities with long stays. AHRQ staff appreciates the comment and would like a specific recommendation on this. The group noted that abuse or neglect will most often be addressed through personnel action rather than event reporting. Recommendation: Remove the response option.
1.2.3 (HERF Q.6.c.)	Device or Supply, including HIT	Need to define HIT as an incident				Discussion: HIT will not be recognized as an event in nursing homes and will require education on this point. Group A would like Group B to address this issue as it considers HIT during the discussion of the Device/HIT form. Is the definition on the specific Device/HIT form sufficiently clear to allow SNF personnel to identify an HIT related incident.
1.2.4 (HERF Q.6.d.)	Elopement	Unsafe wandering should be considered a safety concern				Discussion: Unsafe wandering can be viewed as wandering in unsafe areas (e.g., stairwells) and moving about without appropriate assistive devices. The group agrees that it is important to capture, that it can be captured in the "Other" response category as well as in Q.4 & Q.5 narratives as well as SIR. Recommendation: Add example(s) to response option 6.i. "Other" to suggest types of wandering that might be included. This might be done using a link to the

						Users' and Quick Guide to educate SNF staff. (Same as the suggestion for Unsafe condition above). Beyond that, evaluate frequency of occurrence once reports begin to be made and make any additional adjustments based on that data.
1.2.6 (HERF Q.6.f.)	Healthcare-associated infection	Need to define. Is any infection in a nursing home resident considered "healthcare associated". People get sick and that should not be construed as a negative incident.				Discussion: The group noted that HAI is defined on the HAI event description (ED) and form. Members also noted that some, but not all of the terms used on the forms, are included in the glossary and suggested a few options for improvement. These included, adding all defined terms to the glossary; this could be done by a) integrating into the current list or by development of "chapters", one for terms not used on the ED/forms and one for terms included on the ED/forms; b) including the term in the glossary and referring the user to the relevant ED/form for the definition. SNFS likely will not be familiar with all terms and would benefit from simple explanation with reference to full definition if definitions are not included in all relevant locations. Group A recognizes that first time users will have a learning curve vis a vis such things. Once in electronic form, links to such things as definitions will resolve this concern. Recommendation: With respect to definitions on paper documents generally, standardize the placement for consistency. Group A would like Group D to address the specific comment/Group A suggestions.
1.2.7 (HERF	Medication or Other	Medication incidents might be its own category. Medication				Discussion: Since there is a form and event description that captures the

Q.6.g.)	Substance	incidents can include wrong medication, administration, reconciliation.				information, the group believes it possible that the commenter had not reviewed those event-specific documents prior to commenting. Recommendation: No change.
1.2.8 (HERF Q.6.h.)	Pressure Ulcer	if tracking via incident reporting system - will not collect all data. will require our company to modify incident reporting system				Discussion: The concern is noted. Nursing homes track pressure ulcers (PU) through a QA program and assess PUs weekly. AHRQ staff noted that they have discussed with CMS and others the desirability of having a single system (Quality and Safety) to which reports could be made from which relevant information could be pulled or routed to other systems which require the information. A group member noted that the PU Common Formats and SRE should be reconciled. AHRQ staff advised this has been done. Recommendation: No change specific to the comment.
1.2.9 (HERF Q.6.i.)	Other	Resident Self Injurious Behavior should be considered for Inclusion. Resident to Resident Behavior should be considered for Inclusion. Significant Contracture should be considered for Inclusion (loss of previous range). Significant Unplanned Weight Loss should be considered for Inclusion.				Discussion: The group agrees that injury to self or others are safety events; however, while contracture and weight loss are important concerns they are quality issues rather than safety. Recommendation: Consider including injury to self or others as examples of 6.i. "Other". Beyond that, reevaluate need for further change once the form is in use and data to indicate prevalence is available.
1.3 (SIR pending)	An event meeting NQF definition of SRE	Relationship to federal regulatory required reporting of reportable event or stand-alone?				Discussion: The group requested additional detail. Request has gone to the commenter. If the Commenter's issue is whether reporting to this system (PSO) suffices for regulatory reporting

						requirements, it does not. This system is voluntary and confidential.
2.1.1(HERF Q.2.)	Date the event was discovered	It may be more helpful to move Q12 (report date) up next to this question (event discovery date), or reference the two together to help ensure that these dates do not get confused with each other.				Discussion: The group briefly discussed the comment. Also, see below. Recommendation: No change.
2.1.2 (HERF Q.3.)	Time the event was discovered	The "unknown" category creates a problem when doing an investigation. If the time of the actual event is unclear then the time the Staff/Charge Nurse was made aware of the event is the time that should be recorded.				Discussion: Event Discovery date/time is not necessarily the same as the Event Occurrence date/time. AHRQ staff noted that the guide for use has been improved and should be helpful. Recommendation: No change
2.2.2 (SIR 2.b.)	Toileting, bathing, showering, room	These are very different types of areas. Suggest separating into resident bathroom (including toilet, bath, or shower), common bath/shower area, common toilet area.				Discussion: While these are different areas, they have some important commonalities; i.e., water, position change with greater opportunity for slip / fall. In most nursing homes, residents share bathrooms (could be two to four sharing) and have common shower areas. Recommendation: Apart from considering including examples to clarify, no change.
2.2.3 (SIR 2.c.)	Indoor activity area (e.g., TV room, gym)	A SNF does not normally have a "gym". "Gym" would be confused with a PT treatment area. If you are trying to describe a "common" area where residents may socialize or meditate, perhaps state--Indoor activity area such as TV room, activity room, library, game room. Keep in mind that SNFs have "multi-purpose"				Discussion: The group agrees that SNFs do not usually have gyms but do have common activity rooms. Also, they do not typically have a pharmacy but do have medication rooms and their treatment/ procedure room uses are quite different from the physical therapy area. Recommendations: 1) SIR 2.c., remove “gym” and add “activity room” as an example; 2) SIR 2.e., replace “Pharmacy” with “Medication Room”; 3) SIR 2.g.,

		common areas that are used for dining as well as group events/meetings/entertainment.				remove “physical therapy” as an example and add it as a separate response option.
2.2.5 (SIR 2.e.)	Pharmacy	if meant to reflect a location, our facilities do not have internal pharmacies				See discussion at 2.2.3 comment above.
2.2.7 (SIR 2.g.)	Treatment or procedure room (e.g., physical therapy)	recommend therapy space be a dedicated location as events do specifically occur in this area and would want to track therapy versus nursing supervised space				See discussion at 2.2.3 comment above.
2.2.8 (SIR 2.h.)	Other area within the facility	Add hallway, stairs				The suggested additions are examples of 2.h. “Other area within the facility” that as well as in Q.5 narrative. Recommendation: Add example(s) to response option 2.h. to suggest these as areas that might be included. This might be done using a link to the Users’ and Quick Guide to educate SNF staff. Beyond that, evaluate frequency of occurrence once reports begin to be made and make any additional adjustments based on that data.
2.3 (SIR Q.9)	Factors contributing to the event known at the time of the initial report	The response category of "equipment/device" does not appear in the SNF beta version, but it does in hospital v1.1. I understand that this information is being captured in a different format in the new device (with HIT) form. Still, it is a concern that such an important response category is missing from the overall "contributing factors" question. Plus, it will be difficult to				Discussion: Form content in this regard will be reconciled in the next version of the hospital and SNF sets. The Device form, which includes HIT, collects greater detail and would be completed for an event that involved HIT. Recommendation: No change

		compare events across settings if these response category differences persist in the hospital (v2.0?) and SNF (v1.0?) versions available at the same time.				
2.3 (SIR Q.9)	Factors contributing to the event known at the time of the initial report	Vendor related Factors should be considered for Inclusion (many LTC Pharmacies, supplies, staff are provided through contracts to the facilities). Facility Systems status should be considered for Inclusion -some Facilities do not have capacity for their systems 24/7.				
2.3 (SIR Q.9)	Factors contributing to the event known at the time of the initial report	Why is equipment/ device not considered a contributing factor as in acute care?				Discussion: Questions related to HIT (1.0 and 2.3) will be added to the HERF and SIR forms. The fact they are not included now is a function of timing of the development and testing of the HIT component.
2.3.3 (HERF Q.17; SIR Q.3)	Staff qualifications, competence (e.g. qualifications, experience)	To answer this question would take an in-depth analysis of the situation. For example, for a fall in a patient room - there is no staff competence. from 2.3.3 through 2.3.6 need to be completed after an analysis of the event, not at the reporting stage.				
2.3.3 (HERF Q.17; SIR Q.3)	Staff qualifications, competence (e.g. qualifications,	Unless there are standardized competency criteria, this data collection point may not be valid				

	experience)					
2.3.8 (SIR Q.9.h.)	Policies and procedures, includes clinical protocols: Clarity of policies	The clarity of the policy would be established after the investigation of the event, not to report the event. The first part of this section is for event reporting. The 2.3 section is for analysis of the event. I think they should be reported separately				
2.3.13 (SIR Q.9.m.)	Communication: Among staff or team members	Will this include SBAR				
2.3.15 (SIR Q.9.o.)	Human factors: Fatigue	Inappropriate data collection item				
2.3.16 (SIR Q.9.p.)	Human factors: Stress	Inappropriate data collection item – how measured?				
2.3.17 (SIR Q.9.q.)	Human factors: Inattention	Inappropriate data collection item – how measured?				
2.5 (SIR Q.10)	Preventability of incident	Somewhat subjective. Some root cause analysis could get to real issue but many are not trained well enough in this area to get to that point				
3.0 (HERF Q.7 – 11)	Patient Information	Asks for Patient information, but Q7 asks for a specific name while Q11 asks about the number the incident reached. Which name do you pick? Should also mention/remind user to fill out PIF if they are filling in this section (one for each person represented in Q11?) Note: here it asks for gender, and DOB. The PIF form does not ask for both of those.				

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3.0 (HERF Q.7 – 11)	Patient Information	Noticed that "principal diagnosis" is not on this form (it is for hospital patients). Seems that this information could still be relevant to understanding the circumstances of a patient safety event.				
3.1(HERF Q.7 – 11)	Identifying information about patient(s)/ resident(s) affected	How will this and other PHI information be protected outside the facility?	??			
3.1.4 (HERF Q.7 – 10; PIF Q.1)	Age range	On the HERF Q7 asks for a name, gender, and DOB, but this form does not. Are these necessary on the HERF, or are they needed here? How are different patients affected by the same event kept separate or linked to appropriate patient information on HERF?				Discussion: AHRQ staff noted that this will be reconciled. This will become a non-issue once the forma are electronic.
3.1.4.4 (PIF Q.1.d.)	Adult (18-64 years)	Why is it adequate for this category to cover a nearly 50-year age span? There is huge variation in this group, based on age. Most other response categories represent 10 year age groups. Why not allow a more detailed age-related analysis of "adults"?				
3.2.1 (PIF Q.6.)	Degree of Harm – AHRQ Harm Scale	Occasionally difficult to determine until some time in future				
3.4 (PIF Q.8)	Notification of patient/resident, family or guardian	Notification to attending physician should also be considered				

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4.2 (HERF Q.12; SIR Q.1.)	Report date	the wording says "What is the date of this report". Is Q1 asking for today's date (our assumption) or the report date? The wording should match the HERF form if it is asking for the same information. If not, they should use different wording for "report."				
4.3 (HERF Q.13 – 17)	Reporter information	The common format should clearly show the individual reporting the episode that the event pertains to their practicing setting of care and their patient population.				
4.3.5	Are there elements missing from this event description? If so, please list the elements.	want to include as healthcare professional: direct care workers? administrator/manager? speech therapist/PT/OT? Dietary? housekeeping, maintenance?				
4.3.5	Are there elements missing from this event description? If so, please list the elements.	A Conclusion Statement should be considered as a separate Element as a review of all data and impressions must be conducted by the supervising person so a conclusion regarding the occurrence of Abuse, Neglect, Mistreatment or Misappropriation of Property can be determined and documented to meet regulatory compliance and Resident safety goals.				
	Comments on reporting form	I commend the authors of the form, it is well done.				

		Unfortunately I predict that mandatory use of this form will require so much time that the licensed staff will have significantly less time to care for residents and the overall effect will be negative. The form should initially be introduced as background/ teaching information only to allow familiarization. It should then be extensively piloted monitoring for the indirect displacement of other important tasks the overloaded staff must perform.				
	General comments on the event description	The purpose of the HERF, PIF, and SIR report is not clear as well as how it relates to the specific Common Formats for Pressure Ulcer, Fall, HAI, Medication and Other Substance, and Device, Supply and HIT. Is this report intended to be an aggregate report for reporting Serious Reportable Events? The HERF, PIF and SIR report includes categories associated with abuse and neglect. It is not clear how this will be defined and determined. States define abuse and neglect differently and we are not aware of any one definition that can be applied nationally				
		Hospitals v.1.1				
2.3.1 (SIR	Environment:	"Culture of safety" is a very				

Q.9.a)	culture of Safety, management	broad term and means somewhat different things to different people. It also overlaps significantly with other factors in this list. The strongest overlap is with 2.3.16-2.3.18. And "Management" is similarly problematic. How is that compared to 2.3.5 and 2.3.6? And wouldn't 2.3.7 and 2.3.8 be a measure of management?				