Hospital Surveillance Version 0.2 Beta

Blood

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.1.2	Administration of incompatible ABO type whole blood or red cells	There is no good reason for deleting Rh incompatibility from this data element. (It used to be ABO/Rh type.) Rh incompatibility should be restored as an event.		**Discussion:** CFEP members noted that Rh incompatible administration is not uncommon, and is clinically meaningless in most cases, suggesting it should not be considered a sentinel/reportable event. **Recommendation:** Do not restore Rh incompatibility to event description.	**Followed Recommendation:** Did not restore.
1.1.3.2.1	Administration of epinephrine and/or corticosteroids (e.g., budesonide, cortisone acetate, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisone)	Suggest to add the following exclusions: 1.3.2.1.1 Ordered for another condition 1.3.2.1.2 It is a pre-existing order		**Discussion:** AHRQ was getting a lot of false positives related to this event description; frequently, administration of epinephrine or steroids is not related to a transfusion event. CFEP members noted again that such conditions could be added for a lot of the event descriptions, and that there is a need to be careful not to obligate AHRQ to add exhaustive lists of exclusions for every event. However, this was identified as a particular problem, so CFEP members considered the additional exclusions justified. **Recommendation:** Add these exclusions.	**Followed Recommendation:** We are changing the definition to require the epinephrine or steroid administration to be followed by notation in the patient record that a transfusion reaction occurred. (This meets the goal of the recommendation, without adding exclusions, and is more specific.)

Device

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.0	Definition of Event	Recommend separating out HIT from other medical devices or equipment that are used in patient procedures. These have very different failure modes and very unique impacts on patients.		**Discussion:** It was noted that in initial runs of data extraction, there have been either zero or close to zero HIT events reported; there may not be enough such events to warrant a separate module. CFEP members also observed that many HIT events are system events, and are not commonly documented in charts. **Recommendation:** Do not separate out at this time.	**Followed Recommendation:** HIT has not been separated from the “Device” module.

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Generic

1.0 Patient Information

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.0	What, if any, patient safety events should be added? Please include rationale for suggestions.	I find the title Generic unhelpful, if not misleading. I would rename this document Patient, Hospitalization and Harm Information and would delete 3.0 and move 1.2 and 1.3 to replace it, with the heading Harm Information.		**Discussion:** CFEP members agreed that this module is intended largely to collect information on patient demographics; outcomes are reported through different event descriptions. **Recommendation:** Change to "patient and hospitalization information."	**Recommendation not Followed:** Did not address at this time, since it would require AHRQ to change "Generic" module and rename all CFs as "patient and hospitalization information." Intend to address in the future versions.
1.2.3	No harm: Event reached patient, but no harm was documented	Suggest providing for multiple no harm events for a stay: "One or more events reached patient, but ...". This presumes 1.2.1, 1.2.2, and 1.2.3 are mutually exclusive for a stay.		**Recommendation:** No change	**Followed Recommendation:** No changes made. Harm scale differs within Surveillance from Event Reporting, where harm is reported by someone with direct knowledge of the incident and is separated into severe, moderate, and mild. May be something to consider for next version, since a patient with more than one incident may experience harm or no harm. No change.
1.3	Notification of patient, patient's family, or guardian	Presumably this refers to notification about the occurrence of events. For uniformity of reporting, it should be specified whether this applies to "no harm" events.		**Discussion:** The CFEP discussed whether there were reasons to notify patients and/or families about events where there was no harm to the patient. Panel members noted that there may be instances where there is no immediate harm but there is potential for subsequent effects—e.g., a patient was sensitized to something—and that notification should occur in these cases. Panel members also agreed that the question about notification is independent of the question about harm, meaning there is no need to modify the event description in response to this comment. **Recommendation:** No change	**Followed Recommendation:** Did not make any changes. Question regarding notification remains included for all adverse events; for example, falls with no harm or with harm.

3.0 Outcomes of Interest

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
3.0	Outcomes of Interest	This section confuses a report specification with an event description. Everything in this section 3.0 has been specified elsewhere: 3.1 through 3.10 in the event descriptions for the individual modules; 3.11 from the UB-04 Discharge Status (see 2.5 above); and 3.11.1 and 3.11.2 from the entry questions for the Surgery/Anesthesia module. They are not needed in this document. They can be included in any report or dashboard that AHRQ desires.		**Discussion:** Panel members agreed that this comment had been handled implicitly while reviewing previous comments, particularly with respect to changing the title of the 'Generic' module. **Recommendation:** No change	**Followed Recommendation:** No change at this time. Discussions ongoing to update this module and perhaps for the next version.

Healthcare Associated Infection – Catheter Associated Tract Infection (CAUTI)

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.1.2.2	Asymptomatic CAUTI indicated by both of the following:	This should be called Asymptomatic bacteremic CAUTI a la CDC.		Discussion: Panel members discussed whether this event description should be modified to ensure alignment with National Healthcare Safety Network (NHSN) definitions of CAUTI. Some Panel members were confused by the event description, questioning whether asymptomatic CAUTI should be counted as patient safety event, and whether the event description requires both a positive urine culture *and* a positive blood culture or just one of the two. **Recommendation:** Revisit this event description to clarify the language (to ensure abstractors are not confused).	**Followed Recommendation:** The event description for Asymptomatic Bacteremic CAUTI is aligned with the CDC definition, requires both a positive urine culture and a matching blood culture, and is being retained. Asymptomatic Bacteremic UTI (ABUTI) that is not catheter associated will be added to the plain UTI event description, from which it had been omitted. [There had been no public comment regarding this omission.]

Healthcare Associated Infection - Pneumonia

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.1.1	Absence of pneumonia present on admission or occurring during the first 2 calendar days of hospitalization, indicated by the absence of a finding from a chest radiograph obtained during the first 2 calendar days of hospitalization that shows lung infiltrate, consolidation, or cavitation (or, in infants less than 1 year of age, a pneumatocele) and absence of any of the defining systemic or pulmonary findings listed in 1.3 or 1.4 during the same 2-day period.	Might you not want to extend the POA window backward, e.g., so that a positive chest radiograph taken one or two days prior to admission would make the pneumonia POA, even if the first radiograph after admission wasn't done until day 3? There would probably be systemic or pulmonary findings during the first two days of stay, but a positive chest radiograph might be easier to find and abstract, if available.		Discussion: Panel members noted that this item was meant to deal with false positives—i.e., pneumonia that was present on admission but not identified during the first two days of hospitalization. The Panel agreed that it would be desirable to have more specificity here, but that Ventilator-Associated Pneumonia is notoriously difficult to define, and that it may not be the CFEP's role to try solving this long-standing issue. **Recommendation:** AHRQ should work to refine this event description and see what happens at clinical test sites to gain insight into how the ED should be specified.	**Followed Recommendation:** No changes made to date. Inputs were sought from pilot test sites but no simplifying or other specific actionable recommendations were received. Perhaps needs to be addressed in the future version. Developments in the definition of Pneumonia, Ventilator Associated Events, and Ventilator Associated Pneumonia will be monitored, and CDC will be consulted regularly regarding potential changes.

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Medication

1.0 Definition of Adverse Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.1.2.1.1.1.1	PTT greater than 100 seconds	There are circumstances, e.g. ECMO, where the PTT can be elevated and the patient receives blood but no event should be created. This should be provided for.		**Discussion:** The Panel discussion whether the circumstances described by the commenter warrant a specific exclusion in the Common Formats. Panel members noted that there are a lot of potential exclusions to be added here, and that ECMO is probably the rarest of them. Panel members also suggested that if the criteria for an event include a bleed, there has been an event, and this should not be an exclusion. **Recommendation:** Do not exclude	**Followed Recommendation:** No changes made.
1.1.2.3.1.1	Administration of intravenous (IV) naloxone, unless:	What if there is more than one administration of naloxone and the first is excusable but the second is problematic? Does the abstractor need to check all administrations? Does he/she stop after the first problematic one? Will he/she even know if a problematic one is encountered?		**Discussion:** CFEP members noted that Naloxone could be administered for reasons other than opioid overdose (e.g., constipation or pruritis). These may be identifiable through dose level (i.e., 'excusable' administrations of Naloxone may be at much smaller doses). However, Panel members suggested there may be no way to specify this with any degree of reliability. **Recommendation:** Do not exclude/no change	**Followed Recommendation:** No change made. Throughout QSRS there are various types of adverse events that could happen more than once. In all cases such as for falls or hypoglycemic events, the abstractor is instructed to consider the information in the chart and see if any adverse events occurred, and if multiple potential events occurred, such as falls or naloxone uses occurred, then the abstractor is told to provide information on the instance that had the most severe outcome (as in a fall with injury) or qualified as an adverse event (such as one naloxone use for pruritis and one for an overdose during the same stay – in this case the information associated with the overdose should be entered)

2.0 Risk Assessments and Preventive Actions

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
2.0	Risk Assessments and Preventive Actions	The earlier version mentioned a history of allergies and sensitivities. That should not have been deleted and should be restored.		**Recommendation:** Restore this element as suggested by the commenter.	**Followed Recommendation:** Question regarding documentation of allergy status was restored. A future version may limit this to question to patients who experienced an adverse drug reaction or anaphylaxis. Medication administration practices now proscribe the providing medications to patients without a documented medication allergy status.
2.1	For patients receiving opioids during the stay	This inquiry might as well be done for all patients. Who knows what will be learned. Do users have a higher incidence of opioid events than non-users? Also, why not also track opioids prescribed at discharge for all patients discharged alive? How much was prescribed?		**Discussion:** Panel members discussed what the intent of this item is—e.g., is this intended to identify patients who are opioid-naïve? Meant to gather info about prescribing habits in general? The Panel agreed that the focus of the Common Formats for Hospital Surveillance should be on identifying and collecting information on adverse events, and that adopting the commenter's suggestion would be outside the scope of this intent. **Recommendation:** No change.	**Recommendation Not Followed:** AHRQ decided that collecting information on discharge information on Opioid prescriptions provided at hospital discharge may help address the national opioid crisis by providing presently unknown information on this aspect of prescribing practices. This change was reviewed with Federal partners including the VA and DoD, and was originally recommended by a Federal interagency opioid expert group. For all patients it will be determined if opioids were prescribed at discharge, and if so what drug was prescribed and at what dose. Whether refills were also allowed will also be captured.

Surgery or Anesthesia

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.2.1.9	Unplanned removal of organ	This should be limited at least to normal organs. There are legitimate reasons for the unplanned removal of an abnormal organ that was not diagnosed pre-op.		**Discussion:** The Panel discussed circumstances under which removal of an organ may not be a reportable event (e.g., during an unrelated operation, an organ needing removal was discovered). Panel members suggested these would be very rare events, and that an exclusion was not warranted. **Recommendation:** No change.	**Recommendation Not Followed**: in response to the original request and the review of preliminary data from QSRS, the text associated with this question was updated to "Unplanned removal of normal organ" to prevent counting of cases where an abnormal or seriously diseased organ was removed despite no specific pre-operative plan to remove the organ. This is consistent with typical informed consent processes for major surgery. (Early data from QSRS based on the previous text was producing data on appropriate organ removals rather than inappropriate organ removals.)

2.0 Risk Assessments and Preventive Actions

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
2.1	Patient's ASA physical status classification prior to operative procedure and/or administration of anesthesia: Class 1 - normal, healthy patient	If these classes are to be assigned only by an anesthesia professional, should there not be an indication when there is no assignment in the chart that this was because there was no professional anesthesia provider involved to make the assignment, if that is the case, rather than provider oversight.		**Discussion:** The Panel discussed whether there was a need for data to support this kind of a change. **Recommendation:** Collect more information on this issue from test sites and bring the question back to the CFEP when more data have been gathered.	**Followed Recommendation:** This data is only collected based on the specific presence of an ASA number in the patient's record. The abstractor will not use their own judgement to assign an ASA number if no number is present in the record. If no information on the ASA number is present in the chart, the abstractor is instructed to enter "Can't Tell" with respect to the ASA number.

3.0 Circumstances of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
3.1.2.4	Sedation only	What is meant by "sedation?" I assume here it refers to sedation in aid of a procedure, rather than just a sleeping med or for anxiety on the floor. How best to get this distinction across to a chart abstractor. Would it make sense to except minimal sedation? Would "procedural sedation" be abstractable? How best to get the point across when one doesn't control the documentation.		**Discussion:** AHRQ representatives clarified that the intent of this comment was to be more definitive for the benefit of chart abstractors. Should instructions be added for this question? Should mild sedation or sedation not in aid of a procedure be excluded? What are the right categories to use with regard to levels of sedation? The Expert Panel's specialist in anesthesia, Dr. Richard Dutton, suggested that events related to sedation in aid of a procedure are what should be of interest here, and recommended the term "procedural sedation" to provide greater clarity for chart abstractors. Dr. Dutton also suggested that requiring information about the level of sedation (e.g., mild moderate, deep) may not be useful, and recommended that the language be left simply as "procedural sedation." In response to an inquiry from AHRQ, Dr. Dutton clarified that any member of the care team can assign an ASA risk status to a patient. **Recommendation:** Use the term "procedural sedation," and do not specify levels of sedation.	**Followed Recommendation:** Text has been updated to "procedural sedation."

Venous Thromboembolism (VTE)

1.0 Definition of Event

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.3.1	Patient receiving palliative or comfort care	A pulmonary embolus is not necessarily a pleasant way to die. Prophylaxis (and event occurrence) should only be excused with informed consent.		**Discussion:** The Panel discussed whether palliative care was a justifiable reason to exclude VTE events (currently, there is an exclusion for palliative care). Panel members noted that the same question might be asked about many adverse events. Panel members suggested that, given the intent of the Common Formats for Hospital Surveillance—that is, to measure adverse event rates, and potentially to compare performance across providers—it may be best to exclude all patients receiving palliative, comfort, and hospice care. These are unique patient populations with unique considerations, and including them may inappropriately distort event rates. In particular, patient choice is an especially important factor in care decisions for these populations, and Panel members suggested that events occurring as a result of informed decisions by patients should not be counted as adverse events. However, the Panel recognized that this is a broader issue related to the Common Formats for Surveillance as a whole, and should be considered separate from the response to this particular comment. **Recommendation:** The Panel recommended no change in the exclusions for this item, but suggested that AHRQ should consider whether patients receiving palliative, comfort, or hospice care should be excluded from all Common Formats for Surveillance.	**Followed Recommendation:** No changes were made to VTE module based on this input. Other instances where certain patients may be excluded from an adverse events have been added; for example, some instances of unconsciousness associated with administration an opioid medication that would not be excluded for a patient with a more favorable prognosis.
1.3.2	Patient with prior or chronic VTE who has leg swelling on admission	If you are tracking PE after a new DVT—you provide tracking for both during a single stay—why not also track PE after a POA DVT? Or DVT in another limb? This exclusion needs to be reconsidered.		**Discussion:** The Panel discussed situations where a patient is admitted to the hospital with (or develops) a DVT, and then acquires a PE (or the other way around). Should these instances count as two adverse events? Panel members suggested that, looking at it from the patient's perspective, these should be counted as two separate events. **Recommendation:** Remove exclusion 1.3.2	**Recommendation Not Followed:** Text has been modified based on input but not followed completely. Patients with "prior" VTE will not be excluded. However, patients with a POA VTE or with a diagnosis of chronic VTEs will be excluded from consideration for hospital-acquired VTE adverse events. This decision was made because for many patients POA VTEs may progress independent of any and all appropriate clinical responses, and similarly for some patients with chronic illnesses or conditions associated with VTEs, including leg swelling on admission. In these patients new inpatient VTEs may not be generally preventable. Counting hospital-acquired VTEs in these patients would likely result in many cases of nonpreventable VTEs being counted as adverse events. These would be considered "false positives" by many clinicians, as well as by QI and PS specialists.

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General Comments

Common Formats ED & (form question #)	Surveillance Event Description Item Title	NQF Member or Public Comment	Expert Panel Action Date	Discussion & Recommendations	UPDATE for Review with NQF on Feb 6, 2019
1.0	What, if any, patient safety events should be added? Please include rationale for suggestions.	Recommend consideration of the addition of patient behavior/ workplace violence events. These are increasing across the US; The Joint Commission has released Sentinel Event Alerts around this. This is a growing problem related to patients and should be captured. We use Common Formats as a foundation, but have added other categories that are relevant to our hospital (Behavior, codes, employee events, HIPAA, etc.). Visitor events are just as important to capture as patient events. Finally, HIT needs to be de-coupled from equipment. The two do not belong together as they are different teams and have different impacts on patients.		**Discussion:** The Panel discussed whether workplace violence events were within the scope of the Common Formats for Hospital Surveillance. Panel members noted that this would likely be a significant expansion of scope, and that such events may not really meet the definition of patient safety events. In addition, such events are unlikely to be captured in charts. **Recommendation:** No change.	**Followed Recommendation:** No changes were made to date, but the CFs for surveillance have been reviewed and compared with the JC list of Sentinel Events (SEs) and the NQF list of Serious Reportable Events (SREs). It was noted that many of the SEs and SREs are already include the CFs for surveillance (such as wrong surgery or retained surgical items). Other SEs and SREs that were not in the CFS for Surveillance may be added at a later date; for example, cases of elopement among mentally ill patients, suicide attempts, injuries from restraint use, etc.
1.0	What, if any, patient safety events should be added? Please include rationale for suggestions.	I recommend developing common formats for ambulatory services, primary care, physician practices. However, if that cannot be accomplished in the very near future, these changes are of limited use outpatient organizations that are participating in PSO or Quality initiatives By making HAI so granular it eliminates reporting of other HAI that are hospital related such as dental infections, break in sterile process etc. I understand these are hospital common format however, they are somewhat useful in ambulatory settings. Perhaps a generic infection category would meet the needs while the outpatient common formats are developed. Care delivery is rapidly moving away from the hospital and there is a great need to be developing support systems for ambulatory services.		**Discussion:** Panel members noted that Common Formats for ambulatory care settings is something the Panel has discussed in the past, and that AHRQ has expressed an interest in creating such Formats in the future. Panel members suggested that many events from the Hospital formats should be transferrable to the ambulatory setting, so creating an ambulatory care-specific set of formats may not be a large amount of work. **Recommendation:** The Panel agreed that AHRQ should work toward creation of Common Formats for the ambulatory setting.	**Recommendation Pending:** AHRQ is considering developing CFs for other settings of care. It is exploring the possibility of converting Nursing Homes V 0.1 beta into NH V1.0 with updated approved CFs language from Common Formats- event reporting. Work by AHRQ and contractors has focused on improving the CFs for Surveillance for inpatient acute care hospital settings, and the associated QSRS software.