Healthcare Safety Advisory Committee 2018 Annual Report

As Required by Texas Administrative Code, Title 25, Chapter 200.40

Healthcare Safety Advisory Committee

February 2019

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Executive Summary

Texas Health and Safety Code, Chapter 98 requires general hospitals and ambulatory surgical centers to report specific healthcare-associated infections (HAIs) and preventable adverse events (PAEs) occurring in their facilities to the Department of State Health Services (DSHS). Reporting is accomplished via the National Healthcare Safety Network and Texas Healthcare Safety Network. DSHS publishes facility-specific data biannually on its Healthcare Safety Data website to enable the public to make informed decisions about where they receive healthcare.

In the wake of Hurricane Harvey, Governor Greg Abbott suspended HAI and PAE reporting mandates from September 2017 through December 2018 in order to help healthcare facilities cope with disaster response. Therefore, facility-specific reports are unavailable for 2017 and 2018.

In 2016, DSHS adopted Texas Administrative Code, Chapter 200, Rule §200.40, establishing the Healthcare Safety Advisory Committee as a forum to obtain stakeholder input on program initiatives and proposals for consideration by the DSHS Emerging and Acute Infectious Disease Branch. The Committee consists of healthcare consumers, healthcare facilities staff (including physicians, infection preventionists, healthcare safety professionals, and a pharmacist), and a non-voting DSHS Licensing employee. The Committee must file an annual report with the Health and Human Services (HHSC) Executive Commissioner outlining Committee activities and actions taken during the previous calendar year and an annual report with the Texas Legislature regarding policy recommendations made to the HHSC Executive Commissioner.

The first meeting of the Healthcare Safety Advisory Committee took place in April 2018. Two subsequent meetings were held in July and October 2018. In this first year, the Committee elected a Chair and Vice-Chair and approved bylaws. Major actions taken included: developing a subcommittee to review reportable PAEs, approving the Centers for State and Territorial Epidemiologists' position statement regarding *Candida auris* becoming nationally notifiable, and recommending the resumption of HAI and PAE reporting following its suspension in the wake of Hurricane Harvey. The Committee made two policy recommendations to the HHSC Executive Commissioner: it affirmed its support to align Texas HAI reporting requirements with Centers for Medicare and Medicaid (CMS) reporting

requirements, but would like Texas to continue collecting HAI data on certain surgical site infections that CMS does not require to be reported, and recommended discontinuing HAI reporting from ambulatory surgical centers until statistical analyses can be produced.

In future meetings, the Committee would like to continue to discuss antimicrobial stewardship, extensively drug resistant organisms, multidrug-resistant organisms (including *Candida auris*), HAI data validation processes, and emerging healthcare safety-related issues.

1. Introduction

Texas Administrative Code, Chapter 200, Rule §200.40 requires the Healthcare Safety Advisory Committee to develop two annual reports, as follows:

- First, the Committee must file an annual written report with the Health and Human Services (HHSC) Executive Commissioner each February regarding activities and actions taken during the preceding calendar year. This report must include:

    1. Meeting dates;
    2. Member attendance records;
    3. Brief description of actions taken by the Committee;
    4. Committee accomplishments;
    5. Status of any Committee-recommended rules for consideration by the Department of State Health Services and HHSC;
    6. Anticipated Committee activities;
    7. Any amendments to this section requested by the Committee; and
    8. Costs related to the Committee, including the cost of agency staff time spent in support of the Committee's activities and the source of funds used to support the Committee's activities.

- Second, the Committee must file an annual written report with the Texas Legislature regarding any policy recommendations made to the HHSC Execute Commissioner.

The *Healthcare Safety Advisory Committee 2018 Annual Report* fulfills the requirements of both aforementioned reports.

2. Background

Each year, millions of patients experience adverse outcomes resulting from care received in healthcare settings, creating a tremendous burden on healthcare systems and public health. Since the early 2000s, national attention has been directed toward healthcare safety and infection prevention in healthcare settings. During this time, strides have been made to reduce medical harm, including healthcare-associated infections (HAIs) and preventable adverse events (PAEs) in healthcare facilities.

Increased public awareness and understanding about these types of events has prompted consumers and policy makers to take action. Healthcare safety reporting legislation that requires facilities to publicly disclose HAIs and PAEs encourages facilities to implement effective infection prevention and quality control measures to reduce the risk of adverse events. As patient demand for healthcare transparency increases, more states are publicly reporting healthcare quality information in consumer-directed reports.

Healthcare Safety Reporting

Texas began mandatory HAI reporting in 2007 with the passage of Senate Bill 288, 80th Legislature, Regular Session, 2007, which created Health and Safety Code, Chapter 98. In 2009, Senate Bill 203, 81st Legislature, Regular Session, 2009 expanded this reporting requirement to include PAEs. The Department of State Health Services (DSHS) is required to:

- Establish and implement the Texas HAI and PAE reporting system;
- Provide education and training to stakeholders;
- Verify the accuracy and completeness of reported data;
- Compile and make available to the public a data summary by healthcare facility, including risk-adjusted infection rates, at least annually;
- Allow healthcare facilities to submit concise written comments about their HAI reports that are available for public view; and
- Enforce reporting mandates.

HAI Reporting

DSHS uses the National Healthcare Safety Network (NHSN), maintained by the Centers for Disease Control and Prevention, to collect HAI data. NHSN is a secure, internet-based surveillance system that integrates patient safety and healthcare worker safety surveillance and has been utilized extensively by many states for HAI reporting. More information about NHSN can be found in Appendix A. Using the NHSN HAI surveillance definitions, licensed general hospitals (excluding comprehensive medical rehabilitation facilities), state-owned or operated hospitals, and ambulatory surgical centers report central line-associated primary bloodstream infections occurring in special care inpatient settings, along with surgical site infections associated with specific high-volume and high-risk surgical procedures. For a list of the specific HAIs that are mandated for public reporting, please refer to Appendix B. After data have been entered into NHSN, DSHS transfers the NHSN data to the Texas Healthcare Safety Network (TxHSN), which communicates with healthcare facilities and creates facility-specific healthcare safety reports. More info on TxHSN can be found in Appendix C.

PAE Reporting

Healthcare facilities report PAEs directly into TxHSN. Licensed general hospitals (excluding comprehensive medical rehabilitation facilities), state-owned or operated hospitals, and ambulatory surgical centers must report on 28 National Quality Forum Serious Reportable Events (listed in Appendix D) and on 14 Centers for Medicare and Medicaid Services Hospital-Acquired Conditions (listed in Appendix E). DSHS phased in PAE reporting over three years starting with Tier 1 in January 2015. Appendix B provides the complete list of reportable PAEs and Texas' PAE phase-in plan.

Facility-Specific Reports

In 2012, DSHS began publishing biannual facility-specific healthcare safety reports on the publicly accessible Healthcare Safety Data website. This website allows consumers to make informed choices about their own healthcare, and incentivizes facilities to reduce their infection rates and improve patient safety, thereby reducing healthcare costs. Notably, Governor Greg Abbott suspended the HAI and PAE reporting mandates from September 2017 through December 2018 to allow healthcare facilities to cope with Hurricane Harvey disaster response. Therefore, facility-specific data for 2017 and 2018 is unavailable. Before being posted, HAI and

PAE data undergo a thorough verification process where healthcare facilities have the opportunity to comment. The verification process is outlined in Table 1.

Table 1. Biannual HAI/PAE Reporting Schedule and Data Deadlines

Deadline	Jan. 1 – June 30	July 1 – Dec. 31
Facility data submission deadline	Per NHSN Guidelines	Per NHSN Guidelines
Departmental data reconciliation (Data from NHSN – emails facility contacts ~15th)	Sept. 1	Mar. 1
Facility data corrections due	Sept. 30	Mar. 31
DSHS data summary to facilities (DSHS sends email to contacts)	Oct. 15	April 15
Facility comment period (Facility enters comments into TxHSN)	Oct. 15	April 30
DSHS review of comments	Nov. 15	May 15
Public posting of summary (with approved comments)	Dec. 1	June 1

More information on TxHSN, the reporting schedule, and data deadlines can be found in Appendix C.

Healthcare Safety Advisory Committee

In an effort to increase healthcare transparency and accountability in Texas, the Texas Legislature established the Advisory Panel on Healthcare-Associated Infections and Preventable Adverse Events under Texas Health and Safety Code, Chapter 98, Subchapter B in 2007. The Advisory Panel was comprised of healthcare consumer advocates, infection preventionists, quality assessment and performance improvement professionals, healthcare facility leaders, physicians, and DSHS representatives. In 2015, the Advisory Panel was disbanded as a result of Senate Bill 200 and Senate Bill 277, 84th Legislature, Regular Session, 2015.

In 2016, DSHS established the Healthcare Safety Advisory Committee in rule under Texas Administrative Code Chapter 200, Rule §200.40. The Healthcare Safety

Advisory Committee serves as a forum to obtain stakeholder input on program initiatives and proposals for consideration by DSHS' Emerging and Acute Infectious Disease Branch. The Committee consists of healthcare consumers, staff from healthcare facilities (including physicians, a pharmacist, infection preventionists, healthcare safety professionals, and healthcare facility administrators), and a non-voting DSHS Licensing employee. These members provide input on healthcare safety issues and may produce formal recommendations to DSHS, the HHSC Executive Commissioner, and the Texas Legislature. Meetings of the new Advisory Committee began in 2018.

3. 2018 Healthcare Safety Advisory Committee Summary

1. Meeting Dates

- April 5, 2018
- July 19, 2018
- October 18, 2018

2. Member Attendance Records

Table 2. Member Attendance Records. √ = Present; √ - T = Present, Attending via Telephone; A = Absent

Member Name	Position	April 5	July 19	Oct. 18
Kelley Boston	Infection Preventionist	√	A	√
Joleen Chambers	Consumer	√	√ - T	√
Dr. Lawrence Donovan	Physician	√	√	√
Griselda Flores	Facility Administrator	√	A	√
Roy John	Consumer	√	√	√ - T
Dr. Charles Lerner	Physician	√	√ - T	√ - T
Susan Mellott	Quality Professional	A	√	A
Dr. William Musick	Pharmacist	√	√	√

Member Name	Position	April 5	July 19	Oct. 18
Victoria Pham	Facility Administrator	√	√	√ - T
Linda Scribner	Quality Professional	√	√	√
Dr. Ed Septimus	Physician	√	√	√
Patrick Waldron[1]	Non-Voting Member	A	A	A
Lynda Watkins	Infection Preventionist	√	√	√

3. Actions Taken

April 5, 2018

- Elected Dr. Ed Septimus as Committee Chair and Ms. Kelley Boston as Committee Vice-Chair
- Agreed to vote on bylaws at the July 2018 meeting
- Voted unanimously to develop a preventable adverse events (PAE) subcommittee to review reportable PAEs and consider aligning with National Quality Forum and adding long-term acute care settings
- Agreed to seek legislation to create an extensively drug resistant organism (XDRO) registry and send isolates for genomic testing

July 19, 2018

- Voted unanimously to approve the Healthcare Safety Advisory Committee bylaws

[1] Patrick Waldron resigned from the Committee on September 30, 2018.

- Voted unanimously to recommend the resumption of healthcare-associated infection (HAI) and PAE reporting (Mandatory reporting was suspended in September 2017 to alleviate the undue burden on healthcare facilities in the aftermath of Hurricane Harvey.)

- Approved the Centers for State and Territorial Epidemiologists position statement regarding *Candida auris* becoming nationally notifiable (Resistant *Candida auris* is an emerging pathogen of significant public health importance. It has caused several outbreaks around the country. Because it is particularly hard to eliminate, it is important to track it for prevention and control purposes.)

- Agreed that Texas should start with two organisms in the XDRO registry and legislation should include funding for this

October 18, 2018

- Voted unanimously to draft a letter to the Department of State Health Services (DSHS) Commissioner to recommend the resumption of HAI and PAE reporting in Texas (Mandatory reporting was suspended in September 2017 to alleviate the undue burden on healthcare facilities in the aftermath of Hurricane Harvey)

- Approved the continued use of the Institute for Clinical Systems Improvement's "List of Invasive, High-Risk, or Non-Surgical Procedures" for PAE determination

- Requested guidance from the DSHS Office of General Council regarding which healthcare safety data are discoverable and subject to Open Records Requests and the Freedom of Information Act

- Requested a presentation from the HAI Surveillance and Validation subcommittee to the Healthcare Safety Advisory Committee on common HAI reporting problems/errors at the January 15, 2019 Committee meeting

- Agreed to allow Committee Chair Dr. Ed Septimus to give final approval of the *Healthcare Safety Advisory Committee 2018 Annual Report* after Committee members have reviewed the document

4. Committee Accomplishments

- Committee Chair Dr. Ed Septimus sent a letter to the DSHS Commissioner to request that HAI and PAE reporting recommence. Governor Greg Abbott lifted the suspension on December 17, 2018.
- The Committee re-evaluated the healthcare safety data that are required for reporting and determined that the list of procedures for which surgical site infections are reported can be streamlined due to insufficient data.

5. Status of Recommended Rules for Consideration by DSHS and HHSC

- There are no Committee-recommended rules for consideration.

6. Anticipated Committee Activities

- Continue to make antimicrobial stewardship a high priority, especially for long-term care facilities, and continue education and awareness efforts
- Further discussion to address the possible use of an extensively drug resistant organism registry or similar system to track hospital admission of patients with a known history of multidrug-resistant organism infection in an effort to reduce transmission in healthcare facilities
- Further discussion regarding an emerging multidrug-resistant *Candida auris* public health threat due to the potential of it becoming nationally notifiable
- Further discussion regarding HAI data validation processes in order to reduce possible under-reporting of HAIs occurring in healthcare facilities
- Continued evaluation and discussion regarding current and emerging healthcare safety-related issues in order to guide DSHS' response and policies
- Implement the XDRO registry in Texas, if legislation passes in the 86th Legislative Session, 2019

7. Requested Texas Administrative Code Rule §200.40 Amendments

Texas Administrative Code, Rule §200.40 (h) states that Healthcare Safety Advisory Committee members serve two-year terms and are "appointed so that their terms expire on December 31st of each even-numbered year." However, since members were not appointed until October 31, 2017, and their first order of business did not occur until April 5, 2018 at the first Committee meeting, DSHS will allow members to serve until the Committee's abolition date of September 1, 2020, which is codified in Texas Administrative Code, Rule §200.40 (f).

8. Estimated Committee Costs

- **Number of Meetings held in 2018:** 3
- **Estimated Travel Expenses for Committee Members:** $3,000
- **DSHS Staff Support Expenses to Perform Committee Activities**
    - Estimated Personnel Salary & Wages: $12,500
    - Estimated Travel for DSHS Staff: $4,200
    - Other Estimated Operating Costs: $100
    - Method of Finance: General Revenue
- **Total Estimated Costs:** $19,800

4. Policy Recommendations for the HHSC Executive Commissioner

The Committee supports efforts to align Texas' healthcare-associated infection (HAI) reporting requirements with federal HAI reporting requirements as stipulated by the Centers for Medicare and Medicaid Services. However, the Committee recommends that reporting of surgical site infections following colon, hysterectomy, hip arthroplasties, knee arthroplasties, coronary artery bypass grafts, fusions, and refusions continue to be reported along with central line-associated bloodstream infections and catheter-associated urinary tract infections.

Additionally, the Committee recommends discontinuing reporting of HAIs from ambulatory surgical centers (ASC) until the National Healthcare Safety Network provides statistical analyses for infections occurring in this type of healthcare setting. Currently, HAI data obtained from ASCs is limited and not statistically significant.

5. Conclusion

The Healthcare Safety Advisory Committee continues to guide healthcare-associated infection (HAI) and preventable adverse event (PAE) reporting efforts in Texas, and provides important information and feedback regarding new and emerging healthcare safety matters. Continued transparency in healthcare is necessary to drive competition amongst healthcare facilities, thus improving patient safety and reducing adverse health conditions. Because of this, the Healthcare Safety Advisory Committee recommended at its July 2018 meeting that mandatory reporting of HAIs and PAEs recommence, as there had been ample time for Hurricane Harvey-affected healthcare facilities to resume normal facility operations.

In 2019, the Committee will continue to guide the Department of State Health Services' efforts to improve patient safety in Texas. Antimicrobial stewardship will be a high priority, along with reducing transmission of multi-drug resistant organisms, including *Candida auris*. In addition, the Committee will continue discussions regarding HAI data validation processes in order to reduce possible under-reporting of HAIs occurring in healthcare facilities, and evaluate and discuss current and emerging healthcare safety-related issues in order to guide DSHS's response and policies.

6. List of Acronyms

Acronym	Full Name
ASC	Ambulatory Surgical Center
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
DSHS	Department of State Health Services
HAI	Healthcare-Associated Infection
HHSC	Health and Human Services Commission
MRI	Magnetic Resonance Imaging
NHSN	National Healthcare Safety Network
PAE	Preventable Adverse Event
TxHSN	Texas Healthcare Safety Network
XDRO	Extensively Drug Resistant Organism

Appendix A. National Healthcare Safety Network (NHSN)

As of December 15, 2016 a total of 20,290 healthcare facilities were enrolled in NHSN. These enrolled healthcare facilities include acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgical centers, and long-term care facilities.

NHSN is designed to accommodate the routine transfer of large amounts of healthcare data from the thousands of facilities reporting into the system. In order to assist in this process, many software vendors have developed compatible software systems for uploading the large facility data files into NHSN. This is especially helpful for large facilities that perform a high volume of surgeries on a regular basis.

Another important feature of the NHSN reporting system is that participating facilities are required to use standardized Centers for Disease Control and Prevention (CDC) definitions for identifying healthcare-associated infections (HAIs). Surveillance definitions have been in place since 2008 for central line-associated bloodstream infections and surgical site infections and continue to be revised as HAI understanding increases. These standardized definitions enable facilities' HAI experience to be comparable to healthcare facilities nationally. To aid in the use of these standardized definitions, CDC provides extensive online training and educational materials that facilities can use to educate themselves on the use of surveillance protocols and data entry.

In 2011, NHSN was designated as the web-based electronic reporting system for Texas HAI reporting. In addition to state reporting, the Centers for Medicare and Medicaid Services (CMS) also requires hospitals enrolled in the Hospital Inpatient Quality Reporting Program to report to NHSN all central line-associated bloodstream infections in adult, pediatric, and neonatal intensive care units and surgical site infections related to colon surgeries and abdominal hysterectomies in order to receive full reimbursement for services. These data are also posted for public reporting on the U.S. Department of Health and Human Services Hospital Compare website. However, it is important to note that the CMS NHSN data reports will differ from Texas NHSN data reports. This is due to differences in reporting requirements, data submission deadlines, and how the standardized infection ratio is calculated.

Appendix B. Reportable Healthcare-Associated Infections (HAIs) and Preventable Adverse Events (PAEs) in Texas

Reportable HAIs:

- **General Hospitals** are required to report central line-associated bloodstream infections and catheter-associated urinary tract infections from applicable intensive care units.
- **Ambulatory surgical centers and adult general hospitals** are required to report surgical site infections associated with vaginal hysterectomies, abdominal hysterectomies, colon procedures, peripheral vascular bypass grafts, carotid endarterectomies, abdominal aortic aneurysm repair, knee prosthesis procedures, hip prosthesis procedures, and coronary artery bypass grafts.
- **Pediatric general hospitals** (i.e. children's hospitals) are required to report surgical site infections associated with ventricular shunt procedures, cardiac surgeries, heart transplants, spinal fusions, spinal refusions and laminectomies.

First-Tier PAE Reporting, Beginning January 1, 2015

- Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
- Foreign object retained after surgery.
- Intraoperative or immediately post-operative/post-procedure death of an American Society of Anesthesiologists Class 1 Patient.
- Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.
- Abduction of a patient of any age.
- Sexual abuse or assault of a patient within or on the grounds of a healthcare facility.
- Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

- Patient death or severe harm associated with a fall in a healthcare facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn, or other injury.
- Patient death or severe harm associated with unsafe administration of blood or blood products.
- Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
- Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
- Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a healthcare facility.
- Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility.

Second-Tier PAE Reporting, Beginning January 1, 2016

- Deep vein thrombosis or pulmonary embolism after total knee replacement or after hip replacement.
- Iatrogenic Pneumothorax with venous catheterization.
- Stage III, Stage IV, or Unstageable pressure ulcer acquired after admission/presentation to a healthcare facility.
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Patient suicide, attempted suicide, or self-harm that results in severe harm while being cared for in a healthcare facility.
- Patient death or severe harm associated with patient elopement.
- Patient death or severe harm associated with an electric shock while being cared for in a healthcare facility.
- Patient death or severe harm associated with a burn incurred from any source while being cared for in a healthcare facility.
- Patient death or severe harm associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area.

Third-Tier PAE Reporting, Beginning January 1, 2017

- Surgical site infections following a spinal procedure, shoulder procedure, elbow procedure, laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery, or cardiac implantable electronic device.
- Artificial insemination with the wrong donor sperm or wrong egg.
- Poor glycemic control: hypoglycemic coma.
- Poor glycemic control: diabetic ketoacidosis.
- Poor glycemic control: nonketotic hyperosmolar coma.
- Poor glycemic control: secondary diabetes with ketoacidosis.
- Poor glycemic control: secondary diabetes with hyperosmolarity.
- Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the healthcare facility.
- Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- Patient death or severe harm associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
- Patient death or severe harm associated with a medication error.

Appendix C. Healthcare-Associated Infection (HAI) and Preventable Adverse Event (PAE) Reporting Schedule and Data Deadlines

The National Healthcare Safety Network (NHSN) data downloads occur eight times per year - twice per quarter - and follow a strict timeline. The reporting timeline breaks down the calendar year into four reporting time periods: the first quarter of the year (January through March) or Q1, the first half of the year (January through June) or H1, the third quarter (July through September) or Q3, and the second half of the year (July through December) or H2.

In order to aid facilities in the reporting process, the Texas Healthcare Safety Network (TxHSN) was developed by the Department of State Health Services (DSHS) as a database for the data downloaded from NHSN. Through TxHSN, DSHS is able to communicate with healthcare facility contacts, create data quality reports for facilities to review in order to identify data entry errors, and create the facility-specific healthcare safety reports that are made public. TxHSN has an email notification system that enables DSHS staff to send and track emails to the facilities' designated contacts. This enables DSHS to send reporting deadline reminders to facility contacts throughout the year and helps synchronize the reporting schedule. For each of the reporting time periods, facility contacts are notified and given an opportunity to check and correct data. In accordance with NHSN Rules of Behavior, HAI users must enter their HAI data into NHSN within 30 days of the end of the reporting month. For example, facilities must enter all April data by the end of May. DSHS will download a preliminary set of NHSN data approximately 60 days after the end of the calendar quarter to perform data reconciliation. The dates for the first data download of the reporting time period are June 1, Sept 1, December 1, and March 1.

Unlike HAI data, PAEs are reported directly into TxHSN by healthcare facility PAE users. These data can be edited throughout the reporting period. However, after the data corrections deadline, these data are locked and cannot be edited by PAE users. If a facility did not have any PAEs to report, they must report "No PAE Events" prior to the data correction deadline for the given time period.

Preliminary data are compiled in facility-specific reports called Internal Data Review Reports that include record counts for HAIs and PAEs. Facilities are notified by email that their Internal Data Review Report is ready to be reviewed in TxHSN and will have 15 days to correct any errors before the final data are compiled. The final

data compilation occurs at the beginning of July, October, January, and April. After this occurs, the data for the given time period cannot be changed. Twice a year - for each half year - DSHS creates facility-specific Healthcare Safety Reports that are published on the public Healthcare Safety data website. Prior to this, TxHSN facility users receive a second email to notify them that their Facility Healthcare Safety Reports are ready to preview in TxHSN.

After facility contacts review the reports in TxHSN, they may wish to further explain what their data mean and may do so by submitting a comment in TxHSN. Facilities may also wish to provide additional information to the public about current infection prevention or quality improvement efforts being taken at their facility. Once submitted, DSHS program staff must review and approve the submitted comment in order for it to appear on the final published reports. Approved comments are appended to the facility's HAI reports that are posted in December (for H1 data) and June (H2 data of the previous year). An outline of the reporting schedule and data deadlines can be found in Table 2.

Table 3. HAI/PAE Reporting Schedule and Data Deadlines

Deadline	Q1: Jan. 1 – March 31	H1: Jan. 1 – June 30	Q3: July 1 – Sept. 30	H2: July 1 – Dec. 31
Facility data submission deadline	Per NHSN Guidelines	Per NHSN Guidelines	Per NHSN Guidelines	Per NHSN Guidelines
Departmental data reconciliation (Data from NHSN – emails facility contacts ~15th)	June 1	Sept. 1	Dec. 1	Mar. 1
Facility data corrections due	June 30	Sept. 30	Dec. 31	Mar. 31
DSHS data summary to facilities (DSHS sends email to contacts)	NA	Oct. 15	NA	Apr. 15
Facility comment period (Facility enters comments into TxHSN)	NA	Oct. 30	NA	Apr. 30

Deadline	Q1: Jan. 1 – March 31	H1: Jan. 1 – June 30	Q3: July 1 – Sept. 30	H2: July 1 – Dec. 31
DSHS review of comments	NA	Nov. 15	NA	May 15
Public posting of summary (with approved comments)	NA	Dec. 1	NA	June 1

Appendix D. National Quality Forum Serious Reportable Events in Healthcare

1. Surgical or Invasive Procedure Events
    a. Surgery or other invasive procedure performed on the wrong site
    b. Surgery or other invasive procedure performed on the wrong patient
    c. Wrong surgical or other invasive procedure performed on a patient
    d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
    e. Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class 1 patient
2. Product or Device Events
    a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
    b. 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
    c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. Patient Protection Events
    a. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
    b. Patient death or serious injury associated with patient elopement (disappearance)
    c. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. Care Management Events
    a. 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)
    b. Patient death or serious injury associated with unsafe administration of blood products
    c. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
    d. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

    e. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
    f. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
    g. Artificial insemination with the wrong donor sperm or wrong egg
    h. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
    i. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
5. Environmental Events
    a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
    b. 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
    c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
    d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
6. Radiologic Events
    a. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area
7. Potential Criminal Events
    a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
    b. Abduction of a patient/resident of any age
    c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
    d. 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

Appendix E. Centers for Medicare and Medicaid Services Hospital-Acquired Conditions[2]

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow

[2] As of December 2018. The current list is available online at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

- Surgical Site Infection Following Cardiac Implantable Electronic Device
- Deep Vein Thrombosis/Pulmonary Embolism Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization