Patient Safety Reporting Program

2012 Nursing Home Annual Summary & Guide to Reporting

Report. Learn. Improve Patient Safety.

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OREGON PATIENT SAFETY COMMISSION

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Table of Contents

Executive Summary

In 2012, Oregon nursing homes did not have a strong presence in the reporting program. Nursing homes continue to have opportunities for improvement in reporting and the Commission has been working closely with the nursing home community to engage and provide support.

This annual summary has two components:

1. **2012 Nursing Home Reporting** – provides an aggregate look at the adverse events reported by nursing homes in 2012. Based on an analysis of these reports, this summary provides information regarding the type and characteristics of adverse events reported. The Commission shares aggregate reports so that nursing homes can use the information as a tool, in conjunction with evidence-based best practices and quality improvement tools, to build and strengthen their organization's culture of patient safety.
2. **A Guide to Reporting Adverse Events in Nursing Homes** – designed to assist nursing homes in their reporting efforts by strengthening the quality of investigations to prevent recurrence of similar problems.

The voluntary, confidential nature of the Patient Safety Reporting Program (PSRP) is unique. Each year, the Commission strives to provide robust information on statewide trends and meaningful feedback to help nursing homes learn and improve. Adverse event reporting demonstrates a commitment to patient safety and helps to preserve the unique qualities of the program.

The Commission is dedicated to providing value to our reporting program participants. In addition to our work this year with the PSRP, the Commission offers many other programs specifically designed to support nursing homes with their patient safety efforts:

- Educational opportunities – obtain training about infection prevention and other key patient safety practices online or in person
- Monthly newsletters – access news, resources, and essential information for patient safety
- Action Alerts – get important information about potentially serious patient safety concerns
- Review, Findings, and Recommendations of the Resident Safety Review Council – review the comprehensive report by the Resident Safety Review Council that examines the relationship between adverse events and instances of alleged abuse, and provides recommendations for improving the current abuse investigation process and the definitions of abuse
- Root Cause Analysis Materials for LTC Facilities – A guide for long-term care facilities to conduct event investigations based on root cause analysis methods and current patient safety concepts
- Long-Term Care Falls Investigation Toolkit – A guide to investigate and reduce recurrence of falls (uses root cause analysis and incorporates other evidence-based quality improvement principles)

The Commission appreciates the continued support of our partners and the Patient Safety Reporting Program participants who are actively engaged in patient safety efforts. We are pleased to provide this *2012 Nursing Home Annual Summary* to inform efforts throughout Oregon to reduce the risk of serious adverse events and encourage a culture of patient safety.

Overview of Oregon's Nursing Home Patient Safety Reporting Program

Each year, nursing homes participating in Oregon's Patient Safety Reporting Program submit adverse event reports about the unintended harm (or potential harm) to patients that occur as a result of medical care. This annual summary provides a statewide, aggregate picture of the information reported by nursing homes in 2012. The reporting program focuses on learning from adverse events rather than simply measuring the number of events reported and aims to:

- Build a strong database for learning,
- Identify best-practices being used in Oregon to prevent adverse events, and
- Assist healthcare organizations with setting patient safety priorities and implementing improvement efforts.

In 2012, the Commission provided nursing homes with recognition targets designed to ensure that the goals of the program are achieved (including the optimization of shared learning at a statewide level) and to recognize healthcare organizations for their transparency efforts and commitment to patient safety. Patient safety evaluation systems (identification, investigation, and reporting of adverse events) are a necessary part of patient safety planning and culture development for all nursing homes.

Nursing homes participating in the reporting program are working to identify, investigate, and report adverse events. Through reporting, nursing homes demonstrate a commitment to building a culture of patient safety that can effectively reduce preventable injury and harm. To continue building a culture of safety, nursing homes must learn from, and capitalize on, opportunities to identify and correct the underlying system issues that lead to adverse events. Nursing homes can use this report, in conjunction with other services from the Oregon Patient Safety Commission, to support and improve their patient safety programs.

2012 Nursing Home Reporting

The following section provides an aggregate overview of adverse event reports submitted to the Oregon Patient Safety Commission by nursing homes in 2012, as well as selected comparisons with previous years.

Reporting History

The Commission has seen fluctuation in nursing home reporting from year to year since the reporting program began in late 2007. The first years of the program saw limited reporting as nursing homes were becoming familiar with the program. In 2009, the more established program saw gains in reporting; however, nursing home reporting has declined significantly from 2010 through 2012 with only 6% of participants submitting a report in 2012 (see Figure 1 and Figure 2).

Figure 1. Reports Submitted 2009-2012 by Quarter and Cumulatively

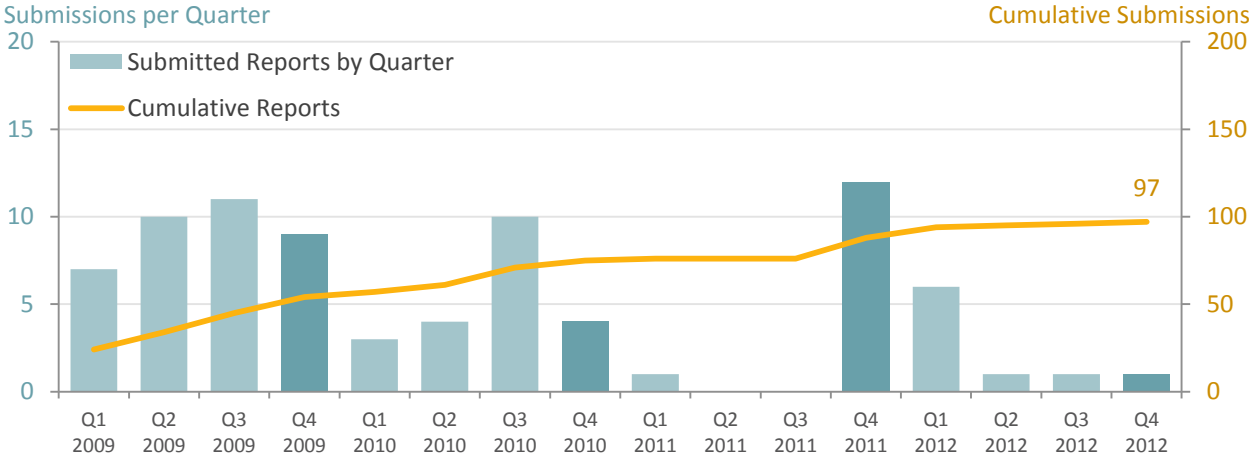
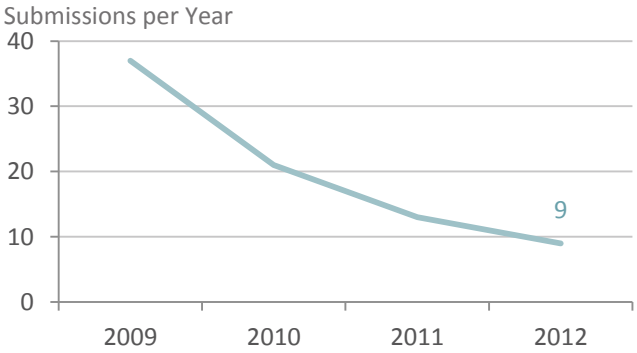


Figure 2. Reporting Frequency by year, 2009-2012*



**Annual submission totals are based on the report submission date, whereas in previous years, totals were based on the event date. Differences in previous years' reporting totals may be noted due to this change.*

The decline in reporting is interpreted not as a decrease in the number of reportable events occurring, but as a decrease in the reporting of events.

Since the release of the new online Patient Safety Reporting Program (PSRP) and increased outreach with the nursing home community at the end of 2012, the Commission has seen an encouraging uptick in reporting in early 2013. This increase in reports is not an indication that more adverse events are occurring, but rather, that nursing homes are improving their ability to identify adverse events.

Reported Adverse Events

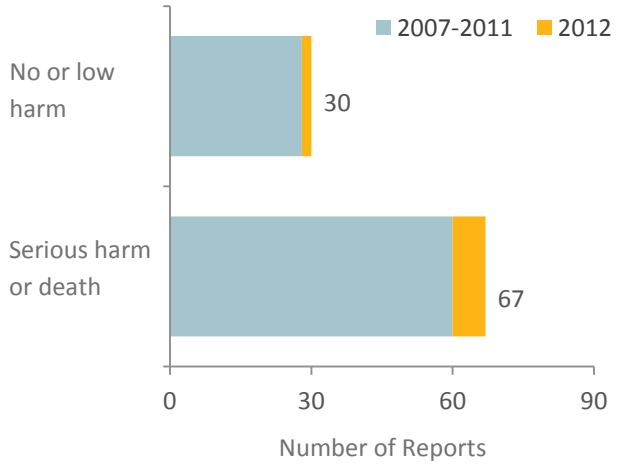
Figure 3. Most Frequently Reported Events, 2007-2012

Note: 2007-2010 data includes four reports that each represent two events.

When reporting adverse events, nursing homes categorize events by type of event that occurred from a list of 21 event types, including an *Other* category (see page 6 for a complete list of event types). In 2012, the Commission received nine adverse event reports from nursing homes, all of which were *Falls* (see Figure 3). Although nursing homes submitted only *Falls* in 2012, evidence strongly supports that other types of adverse events are occurring in nursing homes. For example, costs related to adverse medication events in nursing homes are reported at $7.6 billion a year (Herndon and Niemi, 2007). Medication events and other unreported events offer opportunities for learning and improvement.

Harm in Adverse Events

Figure 4. Number of Reports by Harm Category, 2007-2012



For a description of each harm category, see Appendix I.

Nursing homes report any serious adverse events (harm categories F-I). Nursing homes are encouraged to report less serious harm events, no harm events, and near miss events; doing so provides important opportunities to improve patient safety and helps prevent the likelihood of future serious adverse events. The number of reports submitted in 2012 by harm category can be found in Figure 4.

In 2012, a majority of the events reported by nursing homes (78%) were adverse events with serious harm (harm categories F-I). Two reports were of less serious harm events (harm category E).

Reporting Near Miss Events

Organizations that report near misses (also known as close calls) play a critical role in improving patient safety by investigating events that, although ultimately deemed near misses, allowed for the identification of system-level issues that could lead to an adverse event in the future. Rather than simply asking, "Did this system contribute to this patient's outcome?" some facilities go a step further asking, "Could this system create or contribute to an adverse event for any patient?" Such willingness to look beyond the specific circumstances of an event to the broader context of patient care is commendable.

Contributing Factors

Table 1. Top Contributing Factor Categories, 2012

Category	Number	Percent
Patient/resident factors	6	67%
Organizational factors	3	33%
Device or supply factors	2	22%
Patient management factors	1	11%
Policy or procedure factors	1	11%
Communication factors	1	11%

Because adverse events may be precipitated by many different factors, understanding why an event occurred (beginning with identification of contributing factors) can facilitate identification of preventive strategies (i.e., action plans). Avoid focusing only on the most apparent factors, often the patient/resident-specific factors, and think more broadly about the system of care.

Reports identified a range of zero to eight contributing factors per report. Of the reports with at least one contributing factor, an average of two factors were identified across six categories. Two reports did not indicate any contributing factors.

Of the reports that identified at least one factor, the categories with the most frequently reported factors were *Patient/resident factors* (67%), *Organizational* (33%), and *Device or supply* (22%) (see Table 1). While *Patient/resident factors* has been the top contributing factor category reported year to year, surprisingly, the other top categories for 2012 are not consistent with 2010 and 2011 reports. In 2010 and 2011, *Patient management* and *Communication* were in the top three factors.

Table 2. *Patient/Resident Factors*, 2012

Category	Number	Percent (n=6)
Mental status	4	67%
Other patient/resident factor	3	50%
Behavioral status	2	33%
Sensory impairment	1	17%

Within the *Patient/resident factors* category, the most frequently selected individual contributing factor was *mental status*, which represents 67% of reports that marked *Patient/resident factors* and 44% of all submitted reports (see Table 2). Of the three *Other* factors, one indicated "impulsiveness and poor safety awareness," another indicated the presence of an unknown infection, and the third noted the resident's personal choice to maintain independence.

Falls and Mental Status

In Oregon, 63% of nursing home patient/residents are cognitively impaired, which may increase their risk for falls (Alzheimer's Association, 2012). In general, people who have Alzheimer's or dementia are more likely to fall and be injured in a fall than people who do not. Additionally, when individuals with cognitive impairments become agitated, they are more likely to fall (Taylor and Saliba, 2012). Thoroughly investigating to understand why falls are occurring in individuals with cognitive impairments is crucial for the success of safety efforts.

Resources

Falls Management

Long-Term Care Falls Investigation Toolkit, Oregon Patient Safety Commission

> The toolkit offers long-term care providers tools and resources to strengthen their falls investigation process through integrating evidence-based quality improvement principles into investigations.

Improving Patient Safety in Long-Term Care Facilities, Module 3: Falls Prevention and Management, Agency for Healthcare Research and Quality

> The training module is intended for use in long-term care facilities to improve patient safety as it relates to falls prevention and management.

The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, Agency for Healthcare Research and Quality

> The program is an interdisciplinary quality improvement initiative designed to assist nursing facilities in providing individualized, person-centered care, and improving their fall care processes and outcomes.

Medication Safety

A Systems Approach to Quality Improvement in Long-Term Care: Safe Medication Practices Workbook, Commonwealth of Massachusetts

> Essential tools for healthcare professionals working in the long-term care setting, which will lead to improved medication management systems and a reduction in the incidence of medication errors and resident harm.

Drug Safety Toolkit for Nursing Homes, Focus: Medication Reconciliation, Ohio KePRO

> This toolkit is designed to help nursing homes address factors that contribute to challenges with medication management (e.g., care transitions and unknown medication histories). Materials support improved medication reconciliation processes to prevent adverse events.

References

Herndon L, Niemi J. (2007). A Systems Approach to Quality Improvement in Long-Term Care: Safe Medication Practices Workbook. Commonwealth of Massachusetts. Retrieved from http://www.macoalition.org/Initiatives/docs/safe_medication_practices_wkbk-2008.pdf

Alzheimer's Association. (2012) Oregon Alzheimer's Statistics. Retrieved from http://www.alz.org/oregon/documents/oregon_facts_and_figures_2012.pdf

Taylor SL, Saliba D. (2012). Improving Patient Safety in Long-Term Care Facilities. Module 3: Falls Prevention and Management, Student Workbook. AHRQ Publication No. 12-0001-4. Retrieved from http://www.ahrq.gov/legacy/qual/ptsafetyltc/ltcmodule3.pdf

The Patient Safety Reporting Program

A Guide to Reporting Adverse Events in Nursing Homes

The Patient Safety Reporting Program (PSRP) is an external reporting system that collects reports of adverse events from healthcare organizations throughout Oregon. Although each adverse event is unique, reporting to PSRP allows for aggregate analysis, which can identify trends and patterns that may otherwise go unnoticed. The program provides expertise and shares lessons learned with the larger healthcare community to promote learning, improve safety, and prevent the recurrence of adverse events.

> An *adverse event* is an event resulting in unintended harm or creating the potential for harm that is related to any aspect of a patient's care (by an act of commission or omission) rather than to the underlying disease or condition of the patient; adverse events may or may not be preventable.

How healthcare organizations respond to adverse events is representative of their culture of safety. The cornerstone of a strong culture of safety is transparency about adverse events. By reporting adverse events, organizations are able to learn and improve their complex systems. A good facility-level reporting system can help identify potential risks, promote learning from experiences, and play a role in monitoring the progress of improvement efforts. However, sharing lessons among internal staff and teams is only the first step. Lessons learned can be shared externally through the PSRP so that other organizations can benefit as well.

What to Report

Nursing homes report any serious adverse events (harm categories F-I, see Appendix I). Nursing homes are encouraged to report less serious harm events, no harm events, and near miss events; doing so provides important opportunities to improve patient safety and helps prevent the likelihood of future serious adverse events. Nursing homes should submit reports about any of the event types listed in Table 3 (See Appendix II for event type descriptions).

Table 3. Nursing Home Adverse Event Types

Aspiration	Fall
Burn (unrelated to use or misuse of a device)	Fecal impaction
Care delay (including delay in treatment, diagnosis)	Healthcare-associated infection (HAI)
Choking	Intravascular embolisms related to IV therapy
Contractures	Medication or other substance
Dehydration	Pressure ulcer
Device or medical supply (including use error)	Resident transfer related
Diabetic coma	Restraint or bed rail related
Discharge or release of a patient/resident of any age, who is unable to make decisions, to an unauthorized person	Strangulation
Elopement	Suicide or attempted suicide
	Other adverse event

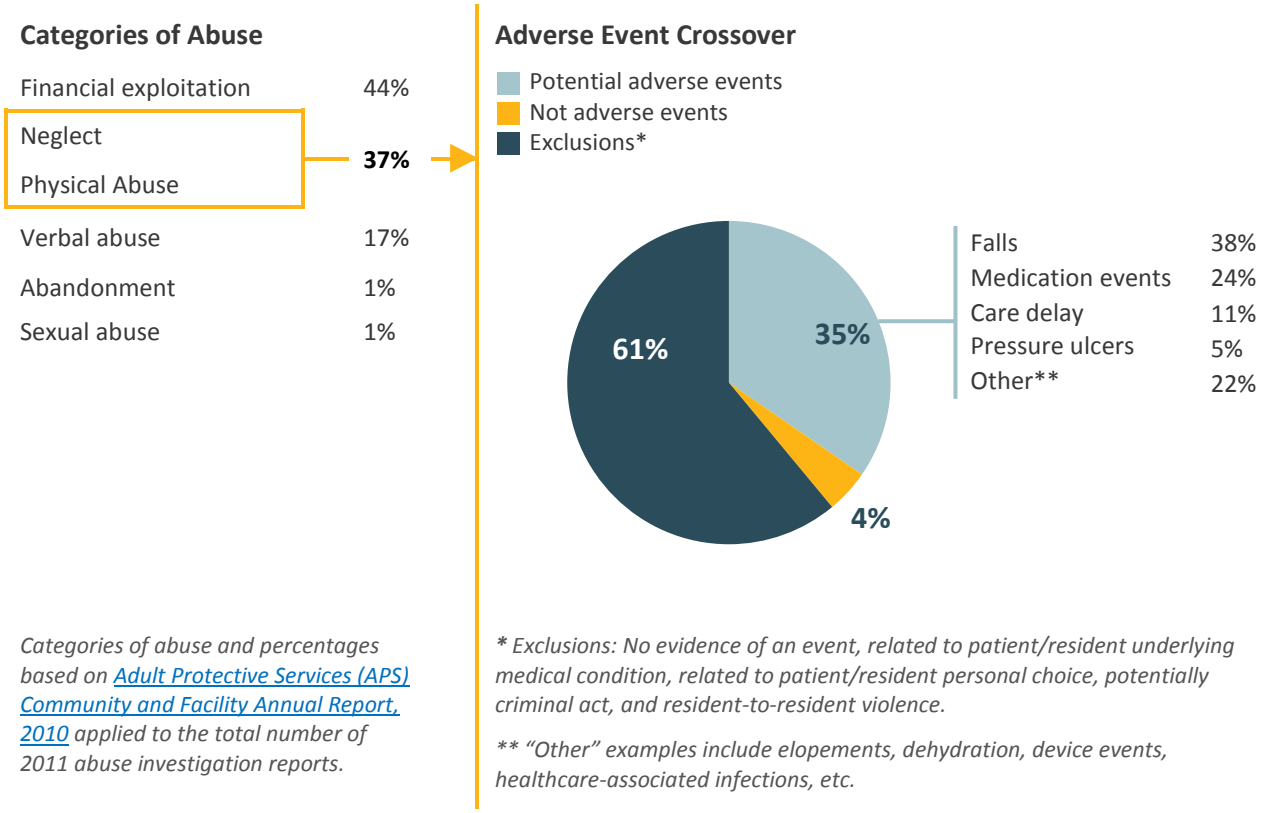
Any "Other" adverse event not included in the event type list that highlights a valuable patient safety lesson

Adverse Event and Abuse Crossover

Confusion is common when trying to decipher between adverse events and abuse in the long-term care environment. While some types of abuse are clearly not adverse events (e.g., financial exploitation or verbal abuse), in certain cases, distinguishing between the two is challenging. In fact, based on current abuse definitions in Oregon, two abuse categories have the potential to be adverse events: neglect and physical abuse (see Figure 5). For additional information about the connection between adverse events and abuse, read the Review, Findings, and Recommendations of the Resident Safety Review Council published by the Commission in 2013.

Figure 5. Adverse Event and Abuse Crossover, 2011 Long-Term Care Abuse Investigation Report Review

Figure 5 represents a case review of a 30% sample of abuse investigations from 2011 across all long-term care settings (i.e., nursing home, assisted living facility, residential care facility, and adult foster home) to determine if an investigated event had the potential to be an adverse event. The sample was drawn only from abuse type categories that had the potential to be adverse events (i.e., neglect and physical abuse).



Categories of abuse and percentages based on Adult Protective Services (APS) Community and Facility Annual Report, 2010 applied to the total number of 2011 abuse investigation reports.

** Exclusions: No evidence of an event, related to patient/resident underlying medical condition, related to patient/resident personal choice, potentially criminal act, and resident-to-resident violence.*

*** "Other" examples include elopements, dehydration, device events, healthcare-associated infections, etc.*

Adverse events offer the opportunity to understand what occurred and strengthen the system to prevent recurrence.

Conducting an Effective Investigation

A majority of the factors that lead to adverse events are systemic and are not the result of poorly performing individual nurses, caregivers, or other staff members. Adverse events are simply the symptoms or indicators that problems exist somewhere in the system. When an adverse event occurs, it offers organizations the opportunity to understand what occurred and why, which allows for system-level improvements to prevent recurrence. An adverse event serves as the starting point for a more in-depth investigation to identify the system-level contributing factors and root cause(s) and develop action plans to prevent recurrence of similar events.

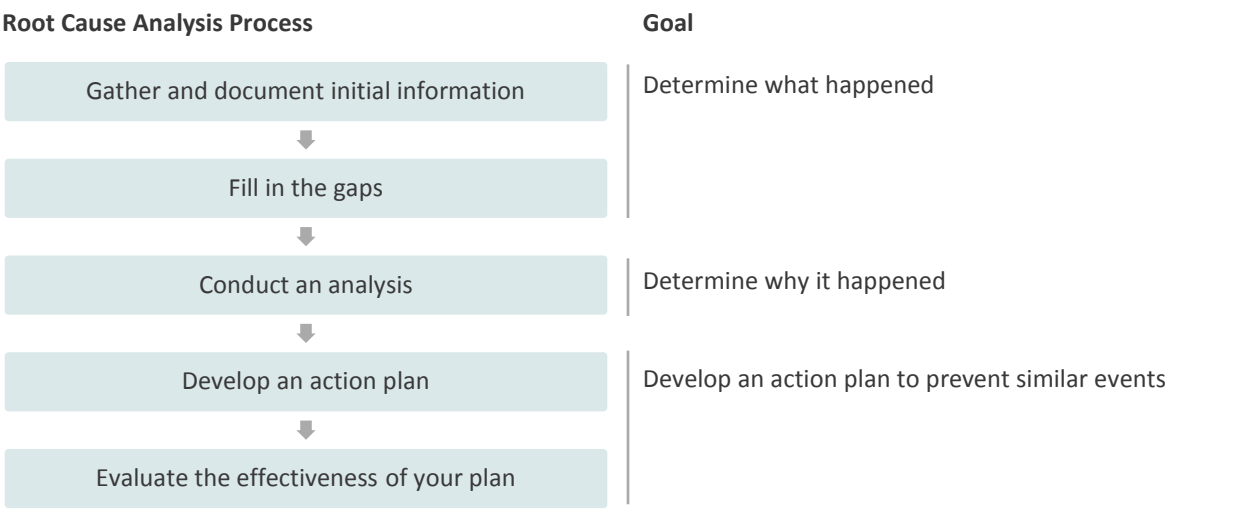
Root Cause Analysis

To better understand why adverse events occur, the Patient Safety Reporting Program is based on root cause analysis (RCA). RCA requires a systematic, in-depth review to learn the most basic reasons why an adverse event occurred. The goal is to understand the problem in sufficient depth to effectively eliminate the chance of future occurrence. The reporting program's adverse event reporting form is designed to walk adverse event investigators through the RCA process to determine what happened, why it happened, and develop an action plan to prevent similar events (see Figure 6).

Avoid Common RCA Pitfalls

1. Prematurely jumping to solutions
2. Spending too much time on what happened rather than why
3. Getting distracted by minor or moderate details of the event
4. Focusing on shortcomings of people rather than systems and processes

Figure 6. Root Cause Analysis Process and Goals



Root cause analysis guides the investigation process to help organizations learn from adverse events for improved patient safety.

Recognition Targets

The Commission established Patient Safety Reporting Program (PSRP) recognition targets to ensure that enough adverse event reports are received to build a strong database for learning, encourage effective investigations, and to recognize healthcare organizations for their transparency efforts and commitment to patient safety (see Table 4). Targets are designed to change each year as organizations build their reporting programs to meet the State of Oregon's reporting requirements (Oregon Revised Statute 442.820-442.835, Oregon Administrative Rules 325).

Each year, the Commission identifies leading PSRP participants and issues awards to the top performers based on established recognition targets. The Commission's website identifies all nursing homes that meet or exceed recognition targets. The recognition targets focus on the *quantity* of reports submitted as well as the *quality* and *timeliness* of those reports.

Table 4. 2012 Nursing Home Recognition Targets, Individual Nursing Homes

Quantity	1 report per quarter (4 annually)
	In 2011, the Commission established annual quantity targets for the first time. The Nursing Home Patient Safety Advisory Committee helped establish the quantity target of four reports annually per nursing home participant.[1] The target is designed to increase the number of reports submitted each year to ensure that the Commission has enough adverse event reports to build a strong database for learning. Nursing homes are encouraged to integrate reporting into their quarterly Quality Assessment and Performance Improvement (QAPI) program.
Quality	75% of reports meet acceptable quality criteria
	The quality of submitted adverse event reports are evaluated by the Commission using four Joint Commission criteria to determine if reports meet acceptable quality criteria: *complete*, *thorough*, *credible*, and having *effective action plan(s)* (See High-Quality Investigations on the next page). The Commission integrated a highly transparent quality scoring tool into the PSRP's online reporting tool. Participants are required to earn specific points in each of the four criteria. Participants can now view their overall scores, how the points were attributed, and, when relevant, receive suggestions from the Commission's patient safety consultant about how to improve.
Timeliness	50% submitted within 30 days
	After an adverse event, an immediate response is needed to collect full and reliable information on the circumstances surrounding the event. Timeliness is defined as the amount of time that passes between the date an event was discovered and the date a report is submitted to the Oregon Patient Safety Commission. The State of Oregon requires that nursing homes submit a completed adverse event report within 30 calendar days of discovery of a reportable serious adverse event (Oregon Administrative Rules, 325-020-0005(3) (2007)). This standard promotes timely responses to adverse events in an effort aid the development of preventative plans.

[1] The Nursing Home Patient Safety Advisory Committee is a group of nursing home professionals that work in partnership with the Oregon Patient Safety Commission to offer advice and insight into the ongoing development, implementation, and evaluation of the Commission's programs.

High-Quality Investigations

High-quality reports play a vital role in the success of the Patient Safety Reporting Program (PSRP) and have the greatest potential to contribute to shared learning across healthcare organizations. Program consultants evaluate reports submitted to the Commission for acceptable quality. The intent of evaluation is to support healthcare organizations in conducting in-depth investigations that focus on preventing future events. Acceptable quality is determined using four criteria (outlined in OAR 325-010-0035) (see Table 5.)

Table 5. PSRP Acceptable Quality Criteria

Complete	Report provides all information pertinent to understanding what happened
Thorough	Report represents an analysis that considered system-level contributing factors and identified root cause(s)
Credible	Report contains evidence that the investigation included leadership participation and was internally consistent
Effective action plan(s)	Report includes system-level plans that address identified causes and are likely to decrease the risk of future occurrences

The quality criteria serves as an indicator that organizations conduct effective investigations using root cause analysis to prevent similar adverse events and improve safety. The following sections provide guidance for completing an online PSRP reporting form that meets the quality criteria and supports the effective investigation and action plan development needed to prevent similar events.

Using the PSRP to Guide the QAPI Process

With an emphasis on learning, prevention, and continuous improvement, incorporating the PSRP and the use of root cause analysis into organizational culture is a natural fit for a nursing home's Quality Assessment and Performance Improvement Program (QAPI) and, more specifically, *Element 5: Systematic Analysis and Systemic Action*.[2] Nursing homes are encouraged to submit at least one adverse event report each quarter during the QAPI process.

> **Element 5: Systematic Analysis and Systemic Action**
> The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement (Centers for Medicare and Medicaid Services, Stratis Health, University of Minnesota, 2012).

[2] As a part of the 2010 Affordable Care Act, each nursing home will be required to have a Quality Assessment and Performance Improvement program. An implementation date has not yet been established by the Centers for Medicare and Medicaid Services.

Complete

Report provides all information pertinent to understanding what happened

Quality Measures	Characteristics of Complete Investigations
■ Sequence of actions and relevant surrounding circumstances/conditions	• Provides information pertinent to understanding what happened
□ Relevant clinical information	• Provides only clinical information that is relevant to understanding the event

Legend: ■ Measure required for acceptable quality score □ Measure not required for acceptable quality score

Sequence of Actions and Relevant Circumstances/Conditions

PSRP Report Form Location—Summary Tab: *Complete account*

Providing a clearly understandable description of the event ensures the information shared can be used for learning beyond the walls of the facility that submitted the report (see box). In the report's *Complete account*, summarize the sequence of activities and circumstances leading up to the event in a way that someone unfamiliar with the event could easily understand. Include details about identified contributing factors along with decisions and other rationale that influenced the occurrence of the event.

Strategies for
Submitting a Complete Report

- Start from the adverse event and work backwards to retrace the sequence of action leading up to the event
- Include those closest to the event on the review team
- Include information related to identified contributing factors and causes identified during the investigation process to help paint a clear picture about what happened

Two examples of *complete* reports are available in the section Examples of High-Quality Adverse Event Reports and can be used to inform a nursing home's reporting process.

Thorough

Report represents an analysis that considered system-level contributing factors and identified root cause(s)

Quality Measures	Characteristics of Thorough Investigations
■ System-level contributing factors directly associated with the event ■ At least one relevant root cause identified ☐ Presence of additional root or proximal causes	• Identifies the factors most directly associated with the event and the related process(es) and systems • Does not focus on individual performance • Identifies risks and their potential contributions to the event • Analyzes the underlying systems through a series of why questions to determine where changes might reduce risk

Legend: ■ Measure required for acceptable quality score ☐ Measure not required for acceptable quality score

System-Level Contributing Factors

PSRP Report Form Location—Contributing Factors Tab: *All questions,* Summary Tab: *Complete account* (may include information that supports or explains identified contributing factors)

Typically, multiple system-level contributing factors can be identified for a single adverse event if a thorough investigation is conducted. Contributing factors, as defined by the Agency for Healthcare Research and Quality, are circumstances that are retrospectively determined to have increased the likelihood of an adverse event. Contributing factors are generally external to the patient and frequently relate to the physical environment or to the care delivery system.

Root Cause(s)

PSRP Report Form Location—Summary Tab: *Causes*, *Is this a root cause?, Complete account* (may include information that supports or explains identified causes)

Adverse event reports should identify at least one relevant root cause—the most basic reason for why an adverse event occurred, which, if adequately addressed, will prevent or minimize recurrence of similar events. Root causes can be identified by examining specific contributing factors more thoroughly. Once contributing factors have been identified, an organization must continue the investigation until the root cause(s) have clearly been identified (see box). Ultimately, a successful investigative process can provide meaningful information about root causes that can be translated into ongoing system-level improvements.

Strategies for
Identifying System-Level Contributing Factors and Relevant Root Causes

- **Use the Five Whys** – To uncover the contributing factors and root causes of an event, continue to ask "why" until it is no longer reasonable.
- **Clearly show a cause and effect relationship** – Ask, if you eliminate this cause, will you minimize/prevent future events?
- **Identify the preceding causes, NOT the "human error" or potential policy/procedure violations** – Seek to understand why a "human error" or mistake was made or why a policy/procedure was not followed.

Credible

Report contains evidence that the investigation included leadership participation and was internally consistent

Quality Measures	Characteristics of Credible Investigations
■ Participation by senior management either through notification of individual/aggregate events, as a member of review team, or in a post-review briefing (only for serious harm events; i.e., F, G, H, and I)	• Includes participation by leadership and by the individuals most closely involved in the processes and systems • Is internally consistent; i.e., does not contradict itself or leave obvious questions unanswered
■ Less than four inconsistencies	

Legend: ■ Measure required for acceptable quality score ☐ Measure not required for acceptable quality score

Participation by Senior Management

PSRP Report Form Location—General Information Tab: *When was the DNS or administrator notified of the event?*, Review Tab: *Members of the review and analysis team*

One of the keys to conducting a credible investigation is engagement and support of nursing home senior management following an adverse event. Leadership can set the tone that patient safety is a priority by encouraging a culture of learning and improvement when adverse events occur. Participation by senior leadership is also essential to ensure appropriate resource allocation in addressing adverse events and in managing the response to adverse events in the larger organization context (see box).

Strategies for
Senior Management Participation Following Adverse Events

- Review, track, and trend adverse events on a continuous basis (this can be of aggregate information); leadership review of aggregate information satisfies the criteria for participation by senior management (e.g., review of aggregate quarterly event data or report)
- Promote open communication about safety concerns
- Empower staff to identify and address safety hazards and risks
- Allocate adequate safety resources
- Measure the effect of what has been done (e.g., data collection) to ensure patient safety efforts are having the intended impact

Effective Action Plan(s)

Report includes system-level plans that address identified causes and are likely to decrease the risk of future occurrences

Quality Measures	Characteristics of Effective Action Plans
■ A system-level action plan that decreases the likelihood of such events in the future*	• Includes participation by leadership and by the individuals most closely involved in the processes and systems
☐ Additional system-level action plans or action plans that fit the description of stronger actions*	• Is internally consistent; i.e., does not contradict itself or leave obvious questions unanswered
☐ Plans clearly link to the identified cause	

Legend: ■ Measure required for acceptable quality score ☐ Measure not required for acceptable quality score

*Based on the VA National Center for Patient Safety's root cause analysis tools, *Recommended Hierarchy of Actions*. The VA categorizes action plans into three categories based on their likelihood of reducing vulnerability: stronger, intermediate, and weaker. http://www.patientsafety.gov/CogAids/RCA/index.html#page-14

System-Level Action Plans

PSRP Report Form Location—Summary Tab: *Action plan(s)*, *Cause(s)* (the link between action plans and identified causes will be evaluated)

Action plans outline the steps an organization will take to prevent future adverse events and are a critical component of the root cause analysis. Many action plans do not effectively address the root cause(s) of an adverse event because they are focused on individual-level actions and not system-level actions. Strong, system-level action plans have a clear link to an event's root cause(s) and contributing factors, are easily understood, and are more likely to be successful in achieving system-level changes (see box).

Strategies for

Developing Effective Action Plans

- Address the identified root cause(s)/contributing factors
- Focus on systems, not on individuals
- Be specific and concrete
- Include stronger actions, which are more likely to eliminate or greatly reduce the likelihood of an event (see Table 6 on the following page)

Table 6. Stronger, Intermediate, and Weaker Action Plans

Stronger Action Plans	Actions that do not depend on staff to remember to do the right thing; the action may not totally eliminate the vulnerability but provides very strong controls (uses system fixes)	• Simplify the process and remove unnecessary steps • Standardize equipment or process • Tangible involvement and action by leadership in support of patient safety • Forcing functions* • New device with usability testing before purchasing • Architectural/physical plant changes	
Intermediate Action Plans	Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication	• Increase in staffing/decrease workload • Software enhancements/modifications • Eliminate/reduce distractions • Checklist/cognitive aid • Eliminate look-alikes and sound-alikes • Read back • Independent verification • Enhanced documentation/communication • Redundancy	
Weaker Action Plans	Actions depend on staff to remember their training or remember what is written in the policy	• Training/education • Additional study/analysis • New policy/memorandum • Double checks • Warnings and labels	*Weaker action plans alone DO NOT meet the acceptable quality criteria*

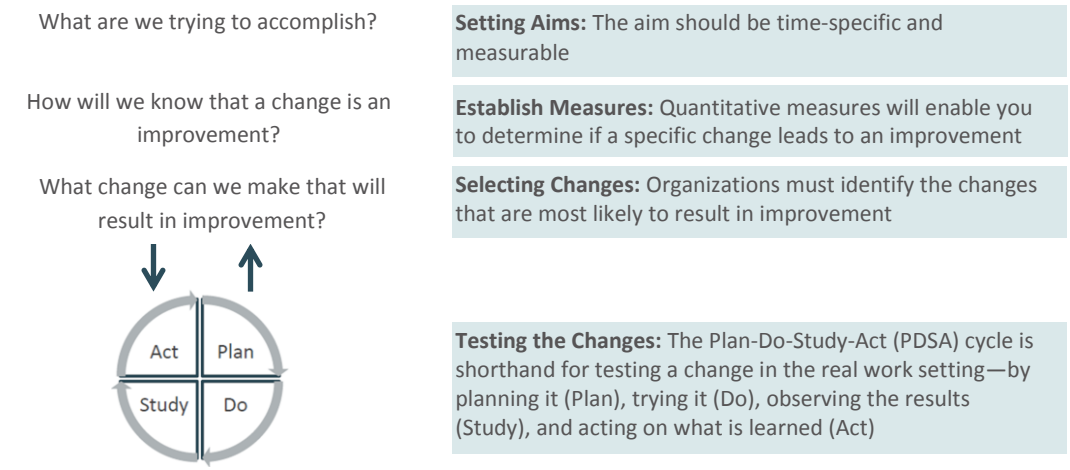
The VA National Center for Patient Safety's root cause analysis tools. Available at: http://www.patientsafety.gov/CogAids/RCA/index.html#page-14

*An aspect of a design that prevents an unintended or undesirable action from being performed or allows its performance only if another specific action is performed first (e.g., a single dose vial)

Testing an Action Plan

Once the decision has been made to implement an action plan, purposeful planning will help guide effective implementation. Organizations can use the Model for Improvement, a simple tool that serves as a roadmap for improvement, to structure this process. The Model for Improvement is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. Hundreds of healthcare organizations have used this model to improve many different healthcare processes and outcomes (Langley, Nolan, Nolan, Norman, and Provos, 2009). As shown in Figure 7, the Model for Improvement has two parts: 1) three fundamental questions and 2) the Plan-Do-Study-Act (PDSA) cycle to test and implement change.

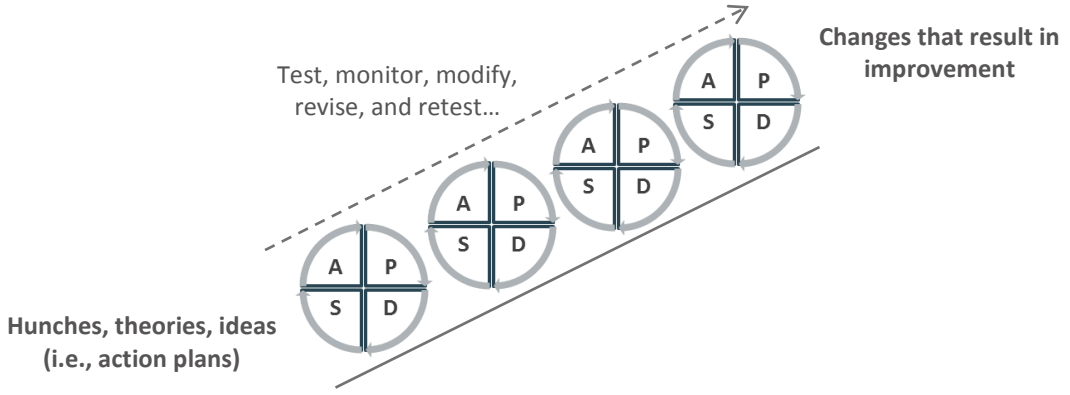
Figure 7. The Model for Improvement



(Langley et al., 2009)

When testing the change, the PDSA cycle helps guide the test to determine if the change is an improvement. The PDSA cycle is used to test change on a small scale (e.g., with one resident) multiple times in order to learn and make necessary modifications before implementing changes on a large scale (e.g., facility-wide) (see Figure 8).

Figure 8. The PDSA Cycle, Testing Action Plans Using Small Tests of Change



Examples of High-Quality Adverse Event Reports

The following examples provide guidance on completing a high-quality PSRP report. The examples include a majority of information the Commission uses to determine if reports meet the acceptable quality criteria: *complete*, *thorough*, *credible*, and having *effective action plan(s)*.

High-Quality Adverse Event Report Example – Medication Event

Contributing Factors:

Category	Contributing Factor
Human and environmental factors	*Interruptions/distractions*, *Stress*, *Other: similar looking medications stored together*
Organizational factors	*Assignment/work allocation*

✓Sequence of actions and relevant surrounding circumstances/conditions

Complete account: Per his morning routine, a 68 year old resident came to the nurses' station and waited to get his morning medications. The mediation aide was busy preparing medication for another resident. When the aide finished, she began preparing the waiting resident's medications. The aide was rushing because a new admit was expected in the next hour, she still had to finish the morning med pass, and several other residents had gathered to receive their medications on the way to breakfast. The aide grabbed the resident's insulin and prepared a syringe. After administering it, she realized that she had accidentally injected the rapid-acting insulin (which the resident received at a different time of day) instead of the ordered long-acting insulin. The resident became hypoglycemic and was transported to the hospital for observation.

✓ System-level contributing factors directly associated with the event

✓ Relevant clinical information

✓ At least one relevant root cause identified

Cause 1: The investigation revealed that all the insulin is kept in the same refrigerator and each resident has their own labeled bin.

Through this investigation, the facility was able to identify a system-level cause related to current process(es) and systems. This is critical for the development of strong action plans that are more likely to be effective in preventing the recurrence of similar events.

✓ System-level solutions that decrease the likelihood of such events in the future

Action Plan 1: Different insulin types will be stored in separate, clearly identified locations. We are working with our pharmacy to get prefilled syringes for once-daily doses of long-acting insulin, keeping short-acting insulin only in a vial.

✓ Plans clearly link to the identified cause

This strong action plan focused on process and system improvements that support safer medication management to decrease the likelihood of similar events in the future. While this action plan may not completely eliminate the vulnerability, it provides very strong controls (i.e., uses system fixes).

✓ Presence of additional root or proximal causes

Cause 2: The insulin names and packaging look very similar.

Appropriately identifies risk and its potential contributions to the event, and focuses on the sytem of care rather than on individual performace.

Action Plan 2: We are working to identify and differentiate all look-alike and sound-alike medications. If medication names or packaging are similar, tall man lettering will be used in the MAR and pharmacy labeling (e.g., NovoLOG, NovoLIN, HumaLOG, HumaLIN) to differentiate them.

✓ Additional system-level action plans or action plans that fit the description of strong actions

High-Quality Adverse Event Report Example – Fall Event

Contributing Factors:

Category	Contributing Factor
Communication–Healthcare team member factors	*Between supervisor and staff, Within units*
Device or supply factors	*Availability*
Organizational factors	*Assignment/work allocation, Systems to identify risks*
Policy/procedure factors	*Policy or procedure absent*

✓Sequence of actions and relevant surrounding circumstances/conditions

Complete account: A CNA was assisting an 82 year old, incontinent resident with peri-care while in bed. The resident was turned one her left side in bed while the CNA provided care and replaced the brief. The CNA let go of the resident to retrieve wipes that were not within reach. The resident started to roll to her left and rolled off the bed to the floor. Resident landed on the floor face down. Swelling of the forehead was noted immediately and the resident complained of pain in the right wrist. 911 was called and resident was transported to ER.

✓ System-level contributing factors directly associated with the event

During the investigation it was found that the CNA did not typically work on the unit she was assigned to at the time of the incident and was unfamiliar with the resident. Care staff who typically worked with the resident noted that there had been several close-calls recently with the resident nearly rolling out of bed during care. Those staff had started providing two-person care but no update had been made to reflect this in the care plan.

✓ Relevant clinical information

✓ At least one relevant root cause identified

Cause 1: The care plan had not been updated to reflect the resident's change of condition as there was no formal mechanism for staff to communicate changes in care needs. Although CNAs were documenting, there was not a way to ensure urgent needs were identified and addressed by care managers.

✓ System-level solutions that decrease the likelihood of such events in the future

Action Plan 1: The CNAs and nursing staff were pulled together to help design a more formalized communication system for resident needs with the ability to flag urgent/important changes or needs. Additionally, the quarterly care planning process will include a CNA who is familiar with the resident involved.

✓ Plans clearly link to the identified cause

This action plan appropriately identifies potential improvements in processes or systems rather than focusing on individual performance or one resident. Action plans that are directed toward individual-level changes have little chance of making lasting improvements or preventing similar events in the future.

Cause 2: Wipes were not located within easy reach while care was being provided.

✓ Presence of additional root or proximal causes

Action Plan 2: An item will be added to the shift-change checklist CNAs complete during walking-rounds to ensure all resident care supplies (e.g., briefs, wipes, and gloves) are available and within reach of care areas.

✓ Additional system-level action plans or action plans that fit the description of strong actions

By eliminating one opportunity for an adverse event by ensuring availability and placement of supplies, staff are able rely on easy access to supplies while providing care.

Getting the Most out of the Patient Safety Reporting Program

Nursing homes participating in the Patient Safety Reporting Program (PSRP) will identify users for their facility that will have access to the online reporting system. The number and position of designated reporting program users will vary by facility based on their needs. For security and confidentiality purposes, each user will be assigned their own individual login information by the Commission. PSRP users will log in to the main Patient Safety Reporting Program website where they will complete and submit reports as well as have access to all reports previously submitted by their facility.

PSRP website: http://oregonpatientsafety.org/psrp/

Available Resources

Information to help you effectively use PSRP is available on the Commission's main website and on the PSRP website. Resources include:

Quick Start Guide	Step-by-step instructions for how to log in to the adverse event reporting system, request a forgotten password, create a new report, save a report in progress, submit a report, print a submission receipt, and sort through previously submitted reports
What, When, and How to Report	Overview of what to report, when to report, and how to report
Data Dictionary	Technical specifications for each question in the adverse event reporting form
Frequently Asked Questions (FAQ)	Explanation of areas of common confusion in a question and answer format (updated frequently based on program participant feedback)
Add/Change/Remove User Form	Form to request an additional PSRP user, change a user's rights, or remove a user
Harm Categories and Algorithm	Definitions and a flowchart-style algorithm describing the enhanced harm category system adapted from material developed by the National Coordinating Council (NCC MERP) for Medication Error Reporting and Prevention and used in our adverse event reporting form

Using Your Patient Safety Consultant

The patient safety consultant, a resource available to all nursing home participants, and offers support and consultation for using PSRP, as well as conducting effective investigations (e.g., using root cause analysis). Nursing homes can contact their consultant at any point in the reporting process for assistance. The consultant also reviews and evaluates reports submitted to PSRP for acceptable quality with the intent of supporting nursing homes in conducting in-depth investigations that focus on prevention of future events. Nursing homes are encouraged to review consultant feedback of submitted reports for future learning.

Contact Your Patient Safety Consultant

Valerie Harmon
Email: val.harmon@oregonpatientsfety.org
Tel: 503.227.2632

The Value of Multiple PSRP Users

Each facility can have multiple reporting contacts and different levels of user rights can be assigned to each user. Three levels of user rights are available (see Table 7). For example, a nursing home corporation with multiple participating facilities may decide to have two users within the facility (the administrator and the director of nursing) with full submission rights (i.e., read, edit, submit) and several corporate-level users who use the information to track and trend information across the corporation who have read-only rights. A facility can determine what combination of users and user rights best meets their needs.

Table 7. PSRP User Rights

Read-only	User can view any submitted or in-progress report for the facility
Read and edit	User can view and edit any report in-progress or start a new report for the facility
Read, edit, submit	User can view, edit, and submit any report in-progress or start a new report for the facility

To request authorization for an additional user, change a current user's rights, or remove a current user's profile, please complete the Add/Change/Remove User Form and email the form to the Oregon Patient Safety Commission at info@oregonpatientsafety.org.

Technological Needs

If you are having trouble accessing the reporting program website, viewing the reporting form, or experiencing other technical issues, please work with your information technology department to implement the following troubleshooting strategies:

- **Internet Browser**: Ensure your internet browser is up to date
- **Java:** Ensure that Java and Active Scripting are enabled on your computer
- **Firewall:** Ensure that your organization's firewall is set to allow you access to the Commission's secure website

The Commission recommends accessing PSRP using one of the following internet browsers:


Internet Explorer 8 and 9


Mozilla Firefox


Google Chrome


Safari

PSRP may not function in older versions of Internet Explorer or in other browsers not listed here. If you are experiencing problems such as the program is slow to move from one field to the next, please check which browser you are using. If you are using Internet Explorer, determine which version you are using with the following steps:

1. Open Internet Explorer by clicking the Start button, and then clicking Internet Explorer
2. Press ALT+H and then click About Internet Explorer

If you cannot switch browsers, you may need to contact your Information Technology department for additional assistance. If you are still having trouble after checking your browser, Java, and firewall, please contact the Commission at 971.266.8079 or info@oregonpatientsafety.org.

Resources

Abuse and Adverse Event Crossover

Review, Findings, and Recommendations of the Resident Safety Review Council, Oregon Patient Safety Commission

Patient Safety Reporting Program

Patient Safety Reporting Program Recognition Targets, Oregon Patient Safety Commission

Add/Change/Remove User Form, Oregon Patient Safety Commission

Frequently Asked Questions (FAQ) , Oregon Patient Safety Commission

Harm Categories and Algorithm , Oregon Patient Safety Commission

Nursing Home Data Dictionary, Oregon Patient Safety Commission

Quick Start Guide, Oregon Patient Safety Commission

What, When, and How to Report, Oregon Patient Safety Commission

Quality Improvement

Long-Term Care Falls Investigation Toolkit, Oregon Patient Safety Commission

Model for Improvement, Institute for Healthcare Improvement

Oregon's Guide to Root Cause Analysis in Long-Term Care, Oregon Patient Safety Commission

QAPI Resources, Centers for Medicare and Medicaid Services

References

Centers for Medicare and Medicaid Services, Stratis Health, University of Minnesota. (2012). QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home. Retrieved from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf

Langley GL, Nolan KM, Nolan TW, Norman CL, Provos LP. (2009). The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers.

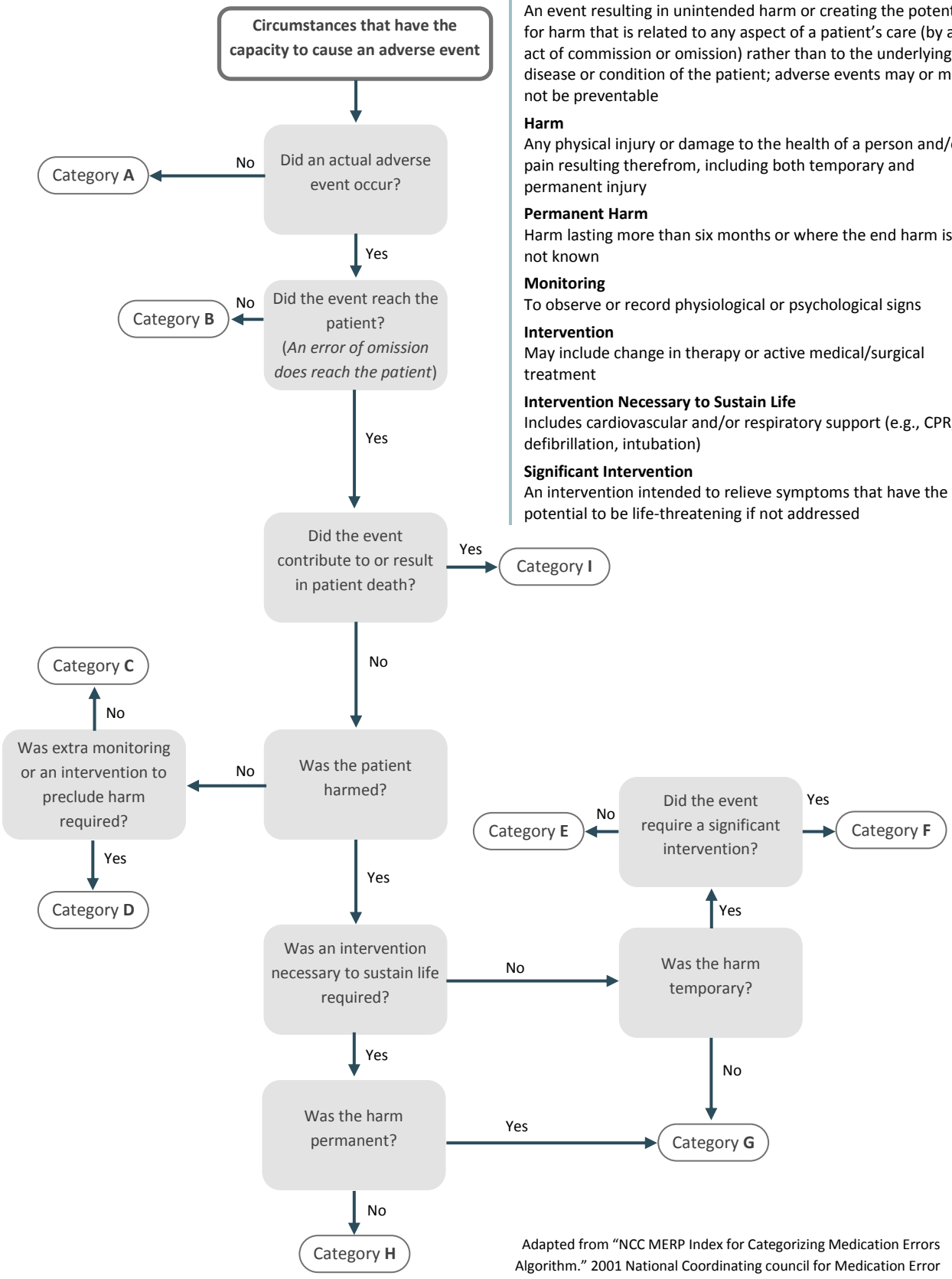
Appendix I: Harm Categories and Algorithm

When nursing homes report adverse events, they assess harm related to the event. In 2012, the Commission adopted formally validated national harm categories established by the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) (see Table 8). Adoption of the national NCC MERP harm categories improves the Commission's ability to interpret the impact of adverse events in a standardized way. With the enhancements implemented in 2012, reporters now follow an algorithm embedded in the adverse event report and answer a series of yes/no questions to assign an appropriate harm category (See Figure 9).

Table 8. NCC MERP Harm Categories

Category A	Circumstances that have the capacity to cause an adverse event	**No adverse event**
Category B	An event occurred that did not reach the patient (an "error of omission" does reach the patient)	**Adverse event, no harm**
Category C	An event occurred that reached the patient but did not cause patient harm *Harm is defined as "any physical injury or damage to the health of a person requiring additional medical care, including both temporary and permanent injury"*	
Category D	An event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm *Monitoring is defined as "to observe or record physiological or psychological signs"*	
Category E	An event occurred that may have contributed to or resulted in temporary harm to the patient but did not require a significant intervention *A significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed"*	**Adverse event, harm**
Category F	An event occurred that may have contributed to or resulted in temporary harm to the patient and required a significant intervention *A significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed"*	
Category G	An event occurred that may have contributed to or resulted in permanent patient harm *Permanent harm is defined as "harm lasting more than 6 months, or where end harm is not known ('watchful waiting')"*	
Category H	An event occurred that required intervention necessary to sustain life *An intervention necessary to sustain life is defined as including "cardiovascular and/or respiratory support (e.g., CPR, defibrillation, intubation)"*	
Category I	An event occurred that may have contributed to or resulted in patient's death	**Adverse event, death**

Figure 9. Harm Category Algorithm



Adverse Event
An event resulting in unintended harm or creating the potential for harm that is related to any aspect of a patient's care (by an act of commission or omission) rather than to the underlying disease or condition of the patient; adverse events may or may not be preventable

Harm
Any physical injury or damage to the health of a person and/or pain resulting therefrom, including both temporary and permanent injury

Permanent Harm
Harm lasting more than six months or where the end harm is not known

Monitoring
To observe or record physiological or psychological signs

Intervention
May include change in therapy or active medical/surgical treatment

Intervention Necessary to Sustain Life
Includes cardiovascular and/or respiratory support (e.g., CPR, defibrillation, intubation)

Significant Intervention
An intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed

Adapted from "NCC MERP Index for Categorizing Medication Errors Algorithm." 2001 National Coordinating council for Medication Error

Appendix II: Event Type Descriptions

A brief definition for each event type is provided below. If pertinent, common inclusions ("INCLUDES"), common exclusions ('EXCLUDES"), and a note about specific instances that should be submitted as two different event types ("NOTE") are also provided. The lists of inclusions and exclusions are not exhaustive; if you have additional questions, please contact your Patient safety Consultant.

Event type	Definition
Aspiration	Patient/resident death or serious injury associated with an aspiration. **INCLUDES**: aspiration pneumonia (submit as both *Aspiration* and *Healthcare-associated infection* events)
Burn (unrelated to the use or misuse of a device)	Patient/resident death or serious physical injury associated with a second or third degree burn incurred from any source other than the use or misuse of a device or medical supply while being cared for in a healthcare facility. **INCLUDES**: burn caused by something other than a piece of equipment or medical supply (e.g. hot water, sunburn, smoking in patient/resident care environment) **EXCLUDES**: burn caused by a piece of equipment or medical supply (submit as *Device or supply (including use error)*)
Care delay (including delay in treatment, diagnosis)	Patient/resident death or serious injury related to a delay in care, diagnosis, or treatment. **INCLUDES**: delay in treatment or intervention; delay in diagnosis; delay in recognizing changing condition; failure to rescue
Choking	Patient/resident death or serious injury associated with choking. **INCLUDES**: choking resulting from food not indicated for dietary needs (e.g., receiving a regular diet when assessed for a therapeutic diet) or medication in the incorrect form or route based on choking hazard/dietary needs; choking resulting from inappropriate eating assistance; choking resulting from patient/resident attempting to ingest an item not indicated for consumption. **EXCLUDES**: events associated with a patient/resident's personal choice to receive a diet not indicated for their dietary needs and when associated risks have been communicated and documented.
Contractures	Patient/resident death or serious injury associated with development of a contracture. **INCLUDES**: the patient/resident had clinical conditions that are the primary risk factors for a decreased range of motion (e.g., immobilization, deformities arising out of neurological deficits, and pain, spasms, and immobility associated with arthritis or late state Alzheimer's disease) but development was avoidable (i.e., facility did not provide adequate assessment, appropriate care planning, and preventive care) **EXCLUDES**: a contracture that is unavoidable due to limb or digit immobilization resulting from injury or surgical procedures (e.g., surgical adhesions); the patient/resident had clinical conditions that are the primary risk factors for a

Event type	Definition
	decreased range of motion (e.g., immobilization, deformities arising out of neurological deficits, and pain, spasms, and immobility associated with arthritis or late state Alzheimer's disease) but development was unavoidable (i.e., facility provided adequate assessment, appropriate care planning, and preventive care)
Dehydration	Patient/resident death or serious injury associated with not receiving sufficient fluid intake to maintain proper hydration and health. "Sufficient fluid" means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates (e.g., increase fluids if resident has fever or diarrhea).
Device or supply (including use error)	Patient/resident death or serious injury associated with the use or function of a device or supply, including disposable products, in patient/resident care, in which the device is used or functions other than as intended. **INCLUDES**: use error; non-functional/unavailable equipment; patient/resident misuse of equipment; latex gloves used for a procedure on a latex allergic patient/resident
Diabetic coma	Patient/resident death or serious injury associated with a diabetic coma. **INCLUDES**: diabetic coma related to hypoglycemia or hyperglycemia
Discharge or release of a patient/resident of any age, who is unable to make decisions, to an unauthorized person	Discharge or release of a patient/resident of any age, who is unable to make decisions, to an unauthorized person. **INCLUDES**: minors; adults with cognitive impairments (e.g., Alzheimer's and dementia) **EXCLUDES**: events involving competent adults with decision-making capacity who leave against medical advice
Elopement	Patient/resident death or serious injury associated with patient/resident elopement (disappearance). **INCLUDES**: events that occur after the individual presents him/herself for care in a healthcare setting **EXCLUDES**: events involving competent adults with decision-making capacity who leave against medical advice or voluntarily leave without being seen; death or serious injury that occurs (after the patient/resident is located) due to circumstances unrelated to the elopement
Fall	Patient/resident death or serious injury associated with a fall while being cared for in a healthcare setting. **INCLUDES**: falls resulting in fractures, head injuries, intracranial hemorrhage; newborn or infant drops; patient/resident falls or drops from equipment (e.g., bed, lift) **EXCLUDES**: falls associated with suicide or attempted suicide
Fecal impaction	Patient/resident death or serious injury associated with fecal impaction.
Healthcare-Associated Infection (HAI)	Patient/resident death or serious injury associated with an infection associated with being cared for in a healthcare setting. **INCLUDES**: infections associated with being cared for in a facility that result in increased length of stay or cause/contribute to patient/resident death, (e.g. eye, ear,

Event type	Definition
	nose, throat, and mouth infections; gastrointestinal system infections; lower respiratory tract infections (including pneumonia and ventilator-associated pneumonia (VAP)); skin or soft tissue infections; primary blood stream infections (including central line associated blood stream infections (CLABSI)); sepsis; urinary tract infection (UTI) (including catheter-associated urinary tract infection (CAUTI)) **EXCLUDES**: infections present or incubating on admission that are assessed and treated appropriately
Intravascular embolisms related to IV therapy	Patient/resident death or serious injury associated with intravascular air embolism that occurs as a result of being cared for with IV therapy in a healthcare facility. **INCLUDES**: IV lines inserted in another facility if the event occurred as a result of care at your facility; IV lines inserted and care for in your facility
Medication or other substance	Patient/resident death or serious injury associated with a medication or other substance. **INCLUDES**: hypoglycemia; incorrect medication or substance; incorrect dose; incorrect patient/resident; incorrect time; incorrect rate; incorrect preparation; incorrect route of administration, incorrect dosage form; incorrect strength; expired medication or substance; incorrect or incomplete labeling; contraindication; omission/discontinuation; adverse reaction, allergic reaction; drug interaction; anesthetic medication; contrast media or other diagnostic substances **EXCLUDES**: reasonable differences in clinical judgment on drug selection and dose
Pressure ulcer	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission, or that was present on admission and fails to show some evidence of progress toward stabilization or healing within 2-4 weeks. **INCLUDES**: Stage 3 or 4 pressure ulcers, or pressure ulcers present on admission that failed to show evidence of stabilization or healing within 2-4 weeks; suspected deep tissue injuries **EXCLUDES**: progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission; pressure ulcers that develop in areas where deep tissue injury is documented as present on admission/presentation; development of a pressure ulcer in a patient/resident who's clinical condition demonstrates that it was unavoidable; failure of a pressure ulcer that was present on admission to show evidence or progress towards stabilization or healing within 2-4 weeks when the complexity of the patients/resident's condition is such that it may limit responsiveness to treatment or tolerance for certain treatment modalities. "Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
Resident transfer related	Patient/resident death or serious injury associated with transferring from one surface (seated or laying down) to another (e.g., bed, chair, wheelchair, toilet).

Event type	Definition
	INCLUDES: assisted transfers; patient/resident self-transfers; transfers using a lift **EXCLUDES**: patient/resident transfers from one facility to another (e.g., from the nursing home to the hospital) (submit as *Other* event)
Restraint or bed rail related	Patient/resident death or serious injury associated with the use of restraints or bedrails while being cared for in a healthcare facility. **INCLUDES**: entrapment **EXCLUDES**: suicide (submit as *Suicide or attempted suicide*)
Strangulation	Patient/resident death or serious injury associated with unintentional strangulation. **INCLUDES**: unintentional strangulation associated with window blind cords or other object within a facility that are not restraints or bed rails **EXCLUDES**: strangulation associated with the use of a restraint or bed rail (submit as *Restraint or bed rail related*); suicide (submit as *Suicide or attempted suicide*)
Suicide or attempted suicide	Patient/resident suicide or attempted suicide resulting in serious physical injury, while being cared for in a healthcare facility. **INCLUDES**: events that result from patient/resident actions after admission to the facility **EXCLUDES**: deaths resulting from self-inflicted injuries that were the reason for admission to the facility
Other	Patient/resident death or serious injury related to an event not otherwise included in the above categories. **INCLUDES**: any unanticipated, usually preventable event that results in serious physical injury; events that are NOT related to the natural course of the patient/resident's illness or underlying condition; injuries not related to another event; thromboembolism; events related to poor discharge planning or inadequate patient/resident assessment; premature pronouncement of death; events related to the transfer or transport of a patient/resident from one facility to another **EXCLUDES**: events related to the natural course of the patient/resident's illness or underlying condition; injuries related to another event