Serious Reportable Events*

- Surgery or other invasive procedure performed on the wrong body site
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Intraoperative or immediately post-operative or post-procedure death in an ASA Class 1 patient
- Patient death or serious injury related to contaminated drugs, devices, or biologics provided by the healthcare setting
- 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
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- Patient death or serious injury associated with patient elopement (unauthorized departure from a healthcare facility)
- Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
- Patient death or serious injury associated with unsafe administration of blood products
- Patient death or serious injury associated with a medication error (e.g. errors involving the wrong drug, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Maternal death or serious injury associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare setting
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Patient death or serious injury associated with a fall while being cared for in a healthcare facility
- Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- Artificial insemination with the wrong donor sperm or wrong egg
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
- Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare facility
- 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
- 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
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient/resident of any age
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- 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

Health Care Acquired Conditions (HCACs)*

- Air Embolism Events
- Blood incompatibility events
- Fractures, dislocations, intracranial injuries, crushing injuries, burns
- Foreign object retained after surgery
- Pressure ulcers, Stages 3 & 4
- Vascular catheter associated infections
- Catheter associated urinary tract infections
- Manifestations of poor glycemic control
- Surgical site infection, mediastinitis after CABG
- Surgical site infection following certain orthopedic procedures (spine, neck, shoulder, elbow)
- Surgical site infection following bariatric surgery for obesity
- Surgical site infection following Cardiac Implantable Electronic Device (CIED) procedure
- DVT or PE following orthopedic procedure (TKR and THR)
- Iatrogenic pneumothorax with venous catheterization

*Source: www.mass.gov

Tufts Health Plan®

Clinical Quality Improvement Department

Keeping Quality at the Forefront

WE need *YOU* to inform us of potential quality of care issues (e.g. SREs, Health Care Acquired Conditions, and Occurrences) that you encounter in your work every day!

You are our greatest source of information!

The Clinical Quality Improvement Department contacts:

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Clinical Quality Process

- The CQI Department is dedicated to investigating potential adverse events to ensure that our members are receiving quality care.
- Quality of care concerns tend to be related to in-patient events but include care across the healthcare provider spectrum, including skilled nursing facilities, rehabilitation hospitals, VNA, surgical day care centers, and mental health providers.
- Reporting of potential adverse events to the CQI Department comes from many sources--providers, claims data, Medical Director reviews, media, and our employees.
- When an adverse event is reported to the CQI Department, it is assigned to one of the Provider QI Specialists for investigation.
- Adverse events can be reviewed through the medical records and correspondence with our providers.
- Following completion of the investigation (e.g. review of medical records, outreach to the provider, review with one of the Medical Directors), the case is assigned a rating for severity of the issue (1-6) and a rating for preventability (0-2).
- The CQI Department maintains a confidential database that tracks and trends adverse events by provider.
- Closed cases are reported to the Quality of Care Committee (QOCC) at their monthly meeting.

CQI Department Occurrence Codes and Criteria

Code	Category
070	Readmission to Hospital
Within 48 hours of discharge from ED, within 10 days of discharge from inpatient stay, within 1 week of outpatient or same day surgery or procedure, or any other readmission that warrants review	

071	Inadequate Coordination of Care
Includes delay in diagnosis and/or treatment, inadequate discharge plan (e.g. discharge instructions with follow-up plan), inadequate COC with outpatient healthcare providers, inadequate COC with VNA/home health agencies/transportation services, inadequate communication between provider and out-patient providers (e.g. PCP, Behavioral Health providers)	

072	Complication from Surgery or Other Invasive Procedure
Invasive procedures include (but are not limited to): surgery, OB procedures, indwelling lines and catheters, all scopes, injections, and equipment failures. Complications include: infections requiring antibiotics, wound dehiscence, anesthesia complications, path report inconsistent with diagnosis, intra-operative complications, return to OR, cardiovascular events, neurological events, pulmonary events, bleeding problems, performance of inappropriate operation or procedure, foreign body left in patient, vascular catheter associated infections, surgical site infections, post-operative DVT/PE, accidental perforation/laceration	

073	Death
Excludes: anticipated deaths due to chronic diagnosis processes Includes: all unexpected deaths including intra-operative or post-operative, any self-inflicted while an inpatient, and all fetal demises greater than 20 weeks of gestation	

074	Harm to Self or Others
Harm to self, harm to others, harm from others requiring admission or transfer to a more acute medical or behavioral health facility. Includes harm to self, harm to others, harm from others during in-patient, ED, or any behavioral health setting	

076	Adverse Medical Outcome Secondary to Lack of Care
Medication errors, falls with and without injury, stage 2, 3, 4, unstageable pressure ulcer, deep tissue injury not present on admission, injury related to restraint or seclusion, catastrophic events with unexpected outcomes resulting in a life threatening situation, severe impairment, serious loss of functional levels (such as paralysis, hemodialysis, coma, loss of limb, or ventilator dependence), any infestations (lice, etc.), elopement, fire setting, sexual activity on inpatient unit, failure of staff to find potentially harmful objects on patient prior to admission, abuse of patient, air embolism, blood incompatibility, burns, manifestations of poor glycemic control (e.g. DKA or hypoglycemic coma not present on admission)	

Filing an Occurrence:

Please remember that members are not involved in the review, so please do not inform the member!

- ✓ Please note if the source of the quality event is a member or member representative, you should refer the member or member representative to Member Services as this is considered a grievance, and the processing of a grievance is time sensitive and starts when a member or member representative informs anyone at Tufts Health Plan of any dissatisfaction.
- ✓ Use Tufts Health Plan's QI Occurrence screens to identify potential quality of care concerns.

For Commercial and Medicare Preferred members:

- ✓ Create a quality event in CCMS
- ✓ Leave the event "Open" in CCMS (CQI downloads the information three times a week)
- ✓ If there are comments regarding the QI event, please document in the QA status text box or CCMS notes.

For SCO members:

- ✓ Create a quality event in CaseTrakker
- ✓ Report an adverse event in the Quality Assurance (QA) Event tab
- ✓ Remember to keep event status open and save to trigger CQI review

For Network Health members:

- ✓ Identify adverse event
- ✓ Complete "Quality Occurrence Report" form located in the W drive under Operations>.Public>Adverse Events
- ✓ Submit the form by email to: Adverse_Events_Submission@tufts-health.com

Please do not hesitate to contact any of the Provider QI Specialists with any questions or concerns.