

Department of Health

Patient Safety-Adverse Event Reporting: An Update

PS-AE Program: Update

- Since Sept 2005 half of states (25) passed legislation about hospital reporting of adverse events
- Adverse Event and Incident Reporting became WA law in 2006

PS-AE Program: Update

- Patient Safety Adverse Event (PSAE) Program began with a hotline and a Patient Safety-Adverse Event Quality Specialist
- Established a PS-AE List Serve and sent two communication packets—March & June

PS-AE Program: Update (cont'd)

- Established a PS-AE Advisory Committee. First Meeting scheduled for August, 2007
- Training plans
- Internet Based Adverse Health Event and Incident Reporting System begun. We are negotiating with the successful contract bidder.

PS-AE Program: Reporting Process for Adverse Events

- Hospitals, Psychiatric Hospitals, Child Birth Centers & Department of Corrections Medical Facilities are required to report. Ambulatory Surgery Centers begin in 2008
- June, 2006-July 2007 DOH received 180 reports from 45 of 98 hospitals, 7 were Critical Access Hospitals See Summary Report

PS-AE Program: Conducting Root Cause Analysis

- Facilities are required to conduct a Root Cause Analysis (RCA) within 45 days of event discovery/confirmation
- Received 30+ RCA's so far

PS-AE Program: Conducting Root Cause Analysis

- May utilize RCA methodology from the Joint Commission for Sentinel Event Reviews, from the Department of Veterans Affairs Center for Patient Safety or another published RCA process with prior permission from DOH
- Two documents available to assist—
“Conducting a Root Cause Analysis” and
“Root Cause Analysis Evaluation”

PS-AE Program: Conducting Root Cause Analysis

- RCA's will be returned to facilities following DOH consultation. The adverse event notification and the Root Cause Analysis Evaluation will be retained by DOH.

PS-AE Program

- Help Available

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