NH Health Care

Quality and Patient Safety Commission

Annual Report of the New Hampshire Health Care Quality and Patient Safety Commission

June 1, 2026

RSA 151-G: 1 established the New Hampshire Health Care Quality and Patient Safety Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.*

Members of the New Hampshire Health Care Quality and Patient Safety Commission (NHHQPSC) include one representative from each hospital and free-standing ambulatory surgical center (ASC), a designee of the Commissioner of the Department of Health and Human Services (DHHS), and three 'at large' public members.

Members of the Executive Committee include:

Chair	**Hannah Sharp,** MS, RN, CNL, CPPS, CPHFH Patient Safety Officer Elliot Hospital, Manchester
Vice-Chair	**Mallory Hamilton,** MSN, RN, CPHQ, CPPS Senior Director of Quality & Patient Safety Exeter Hospital, Exeter
At Large	**Kelly Hussey** Director, Quality & Risk Management Cottage Hospital, Woodsville
	Sue Majewski, CASC Chief Operating Officer Bedford Ambulatory Surgery Center, Bedford
	Otelah Perry, MS, MT(ASCP), CPPS, CPHQ, CMQOE (ASQ), LSSBB Director of Quality Assurance and Safety Dartmouth Hitchcock Medical Center
	Helene Thibodeau, DNP, RN, CCRN, NEA-BC (vacated 3/2026) Chief Operating Officer/ Chief Clinical Officer Northeast Rehab Hospital Network, Salem
	Laura Hagley, DPT, FACHE, LSSBB, CPHQ Senior Director of Quality, Valley Regional Hospital
	Denise Lord, RN BSN, MS, CPHQ, LSSBB Vice President of Organizational Performance Monadnock Community Hospital

Executive Summary

The following principles were utilized as a guide by the Commission in its efforts to promote high quality and safe care to all patients seeking services in our organizations. Agenda planning incorporated these principles, including timely topics that support these principles.

Guiding Principles

Promote	**Promote High Reliability Organizations** •Improving systems and standardizing processes to yield best outcomes, and to detect and manage unexpected events before they escalate into situations resulting in harm to patients or employees.
Establish	**Establish 'Just Cultures' within Our Organizations** •Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process, and we clearly understand contributing factors that involve differentiating system and human failures from reckless behavior.
Adopt	**Adopt Evidence-Based Best Practices to Improve Outcomes** •Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.
Ensure	**Ensure Quality and Safe Care for All** •Incorporate the voice of the patient in adverse event investigation and root cause analysis, pro-active risk assessment and health care system design. Analyze data to identify variations in care.

Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329:29a.
Commission membership includes one representative from each of the 26 acute care hospitals and the 4 specialty hospitals; 15 of the 33 free standing ambulatory surgical centers (ASC) eligible to attend; a designee of the Commissioner of the Department of Health and Human Services, and three "at large" public members. The average number of attendees at Commission meetings is 30-35 members.

New members received an orientation and signed confidentiality agreements to allow for free exchange of sensitive information among members. All meetings were coordinated, and minutes recorded, by an administrative representative of the Foundation for Healthy Communities.

The Commission had 3 public members who provided the unique perspective of healthcare consumers in the realm of healthcare delivery and quality improvement. This year, public members offered feedback and observations about meeting topics and discussions, and they helped guide meeting agendas. They were integral to enhance the collaboration and sharing amongst members and they added to the richness and effectiveness of the conversations by ensuring the voice of the patient remained central to improvement efforts.

In its 21st year, the Commission met five times on the following dates:

August 8, 2025	January 9, 2026	May 8, 2026
October 10, 2025	March 13, 2026	

All meetings were in-person with a virtual Zoom option for extenuating circumstances. The Executive Committee met immediately after each meeting to debrief and to set agendas for future meetings with suggested topics that reflected current priorities focused on eliminating harm and improving quality.

Utilizing a combination of Ice Breaker, Round Robin, and Story Telling tactics to elicit feedback and sharing from all members, the following priority areas and topics were discussed:

- Restructuring falls prevention programs to maximize impact.
- Strategies to prevent delays in care related to radiology findings.
- Initiatives to engage organizations in *Patient Safety Awareness Week.*
- Best practices to prevent EMTALA violations.
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Prevention of Harm Topics the Commission Focused on this Year Included:

☑ Reducing Patient Falls and Falls with Injury

Data from NH Department of Health and Human Services' *State of New Hampshire Adverse Event Reporting 2024 Report* shows that adverse events related to patient death or serious injury associated with a fall while being cared for in a hospital or ambulatory surgery center is the second highest reportable adverse event in the state. Therefore, reducing patient falls and engaging patients and families in their care, and care planning, are a top priority for these health care organizations and was an area of focus for this commission.

Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Ambulatory Practices explained how they utilized data to benchmark their falls experience with like organizations and began identifying variations in practice. Using Plan-Do-Study-Act (PDSA) methodology, they implemented a *Falls Stand Down* process including staff and medical directors across disciplines, and shift- rounding on fall alarms and on patients refusing fall prevention interventions. A work group was formed to address 'refusal of care conversations' and to determine best practices for engaging patients and/ or their guardians or surrogate decision makers in fall prevention decisions. Technological advances and advanced reporting systems are being evaluated for potential adoption and electronic medical record optimization is underway to maximize fall risk assessments and alerts and to improve post-fall documentation.

Elliot hospital described the new Mobility Technician role they created to assist patients with their mobility needs and scheduled exercises that do not require licensed personnel. Mobility helps patients maintain function and strength to prevent falls related to deconditioning. Reporting to Rehabilitation Services, this non-clinical role supports clinicians and provides education to staff and patients.

The chairperson of the NH Fall Risk Reduction Task Force presented multiple resources for falls prevention for both clinicians and patients, and shared information on pertinent educational events, monthly meetings, and website offerings.

☑ Regulatory Considerations/ CMS & Accreditation Survey Lessons Learned

Hospitals and ASCs regularly undergo rigorous CMS (Centers for Medicare & Medicaid Services) or accrediting agency (e.g., Joint Commission (JC) or Det Norske Veritas (DNV)) surveys to ensure compliance with CMS Conditions of Participation and state licensing requirements, and to validate health care quality and enhance patient safety. Members discussed that all agencies are increasingly interviewing patients and staff separate from leadership during surveys, further emphasizing the need that these groups are educated on, and included, in quality improvement initiatives.

Areas of focus for surveyors included preventative maintenance of equipment and physical plant; high-level disinfection and infection control practices; patient rights and EMTALA compliance; restraint usage and documentation; quality validation for low-volume providers; pre-operative history and physical compliance; and medical record review. Members shared organizational policies and procedures in each of these areas and best practices were reviewed.

☑ Public Health Updates and Information Sharing

Collaboration between healthcare partners and public health is essential for the quality and safety of patient care in NH. For this reason, there is dedicated agenda time at each Commission meeting for the NH State Epidemiologist to provide updates on relevant topics and for members to ask questions and provide feedback. Topics included:

- Restructuring of Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) and how their immunization recommendations differ from those of various professional and expert medical organizations (i.e., American Academy of Pediatrics, American College of Obstetrics and Gynecology, etc.). NH Department of Health and Human Services (DHHS) continues to publish vaccine recommendations via Health Alert Network notifications.
- An overview of respiratory illness activity in NH compared to national, and associated emergency department visits and hospitalizations. High rates of influenza illness impacting hospital capacity and influenza vaccination as the best way to reduce flu severity.
- Resurgence of measles in the United States, with no identified cases in NH as of January, 2026. Importance for health care providers to be aware of measle 'hot spots' for transmission and to ask patients about potential exposures (contacts and travel) to these areas.

☑ Patient Safety Organizations

Under the authority of the Agency for Healthcare Research and Quality (AHRQ), Patient Safety Organizations (PSOs) serve as independent experts who conduct activities to assist providers in improving the quality and safety of patient care. Joining a PSO is voluntary for hospitals and ASCs and involves a substantial commitment for data collection and reporting, as well as annual membership dues. Recently, CMS has required PSO participation in its Patient Safety Structural Measure, which is applicable to NH hospitals participating in the CMS Hospital Inpatient Quality Reporting Program. Members shared information on PSOs they are working with as well as the benefits and limitations of participation.

☑ Just Culture for Quality Improvement

Monadnock Community Hospital shared their 'SPEAK UP' campaign which rewards staff and providers for reporting 'near miss' and actual patient safety events. Tracking data, and taking a systems approach to identify improvement opportunities builds trust and a just culture within the organization.

Members shared how they are utilizing Just Culture principles when investigating patient and staff safety events. Just Culture tools, algorithms, education, and training programs were shared.

☑ NH Bureau of Licensing & Certification, Health Facilities Administration, Updates

The State Agency Director and a compliance officer from DHHS Health Facilities Administration-Certification Unit provided essential updates to the Commission on key focus areas including patient complaint investigations; EMTALA considerations; patient rights (including chemical restraints and abuse); and adverse events trends and opportunities. Members had the opportunity to present scenarios and ask clarifying questions that benefited individual organizations while bolstering the knowledge base of the collective whole.

☑ Chemical Restraints: Definitions, Documentation & Best Practices

CMS Condition of Participation, §482.13, outlines the hospital standard for restraints and seclusion that may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. Utilized as a last resort when less restrictive measures have been determined to be ineffective, chemical restraints are highly regulated with strict criteria for usage, patient monitoring, and documentation. Members shared how they are proactively engaging patients in their care to avoid restraint usage; defining what constitutes a chemical restraint versus standard treatment; determining timelines for physiological monitoring for patients chemically restrained; documentation considerations; communicating among the care team to remove restraints as quickly as possible while maintaining safety; and tools and checklists to assist staff in identifying agitation early and deploying de-escalation strategies.

☑ Adverse Events Review

NH hospitals and ASCs licensed pursuant to Chapter 151 Residential Care and Health Facility Licensing, Section 151:38, are required to report Serious Reportable Events (SREs) per specifications of the National Quality Forum (NQF), as well as the exposure of a patient to a non-aerosolized bloodborne pathogen by a health care worker's intentional, unsafe act, to NH DHHS. Ongoing collaboration with the State of NH Licensing and Regulation Services staff includes quarterly adverse event reports which provides members an increased opportunity to validate data, ensure adherence to the adverse events reporting process, and plan for improvement to prevent future events.

In 2025, NQF updated its guidance for SRE reporting, including the addition of 5 new SREs which are highlighted in yellow below:

Procedural Events

SRE 1. Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong procedure, regardless of the type of procedure or the outcome

SRE 2. Unintended retention of a medical or surgical item in a patient after surgery or other invasive procedure, regardless of the type of procedure or the outcome

SRE 3. Patient harm associated with perioperative or periprocedural sedation of an ASA Class I or ASA Class II patient

SRE 4. Medically assisted reproduction with the wrong donor sperm or egg, regardless of the outcome

SRE 5. Introduction of an unapproved, unscreened, or inappropriately approved device, implant, or object into an MR Zone IV area, regardless of the outcome

SRE 6. Patient harm associated with an MRI–related thermal injury

SRE 7. Delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or greater than 25% above the planned radiotherapy dose, regardless of the outcome

Product or Device Events

SRE 8. Patient harm associated with the use of contaminated drugs, devices, or biologics

SRE 9. Patient harm associated with the use or function of a medical device in patient care, in which the device is used or functions other than as intended

SRE 10. Patient harm occurring when systems designated for oxygen or other gas to be delivered to a patient contain no gas, the wrong gas, or are contaminated by toxic substances

SRE 11. Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment

Patient Protection Events

SRE 12. Discharge or release of a patient who does not have decision-making capacity to other than an authorized person or entity, regardless of the outcome

SRE 13. Patient harm associated with the disappearance or unauthorized departure of a patient who does not have decision-making capacity

SRE 14. Patient suicide or suicide attempt that occurs after presentation for care or within seven days of discharge or release, regardless of the outcome

SRE 15. Patient harm associated with the use of chemical restraints, physical restraints, or seclusion

SRE 16. Sexual abuse or sexual assault within or on the grounds of a healthcare setting, regardless of the outcome

Care Provision Events

SRE 17. Patient harm associated with a fall

SRE 18. Patient harm associated with an unintended burn from any source

SRE 19. Patient harm associated with a medication error

SRE 20. Patient harm associated with unsafe processing or administration of blood products

SRE 21. Patient harm associated with a Stage 3 pressure injury, Stage 4 pressure injury, unstageable pressure injury, or deep tissue pressure injury acquired after admission

SRE 22. Patient harm associated with the irretrievable loss of a biological specimen that is irreplaceable or is only replaceable by an invasive procedure

SRE 23. Patient harm resulting from failure to act on clinically significant laboratory, pathology, or radiology test results

SRE 24. Patient harm associated with an intravascular air embolism

SRE 25. Maternal patient harm associated with labor or delivery in a low-risk pregnancy

SRE 26. Neonatal patient harm associated with labor or delivery in a low-risk pregnancy

SRE 27. Patient harm associated with the care of a neonate

SRE 28. Patient harm associated with unrecognized clinical deterioration

While many of the SRE categories remain the same, this update includes substantial changes in reporting criteria as well as in the technical guidance for reporting. Considering NQF definitions had not changed since 2011, the Commission recognized the importance of dedicating time for members to examine each SRE in detail to ensure understanding and to endeavor to achieve consistency in reporting.

Summary

In its 21st year, the Commission continued its mission to prevent medical harm. The confidential protections provided by law to this body remained essential in promoting learning, collaboration, and problem-solving among members. Commission topics continued to align with other efforts in the state including the work of many divisions within the Department of Health and Human Services, CMS Quality Improvement Organizations, and other professional organizations, to avoid redundancy and maximize efficient use of resources and to complement work.

Looking ahead to Year 22 (starting August 2026), the Commission remains committed to the goal of Zero Harm in healthcare. Promoting high reliability organizations, cultivating 'Just Cultures' in hospitals and ASCs, adopting evidence-based best practices and incorporating the voice of the patient and care giver will remain at the forefront as we also consider reducing variations in care for all. Public documents related to the Commission are available at www.healthynh.org.

For questions, please call: Hannah Sharp, Commission Chair: (603) 663-4171 or Kris Hering, Administrator: (603) 415-4271.

Respectfully submitted,

Kris Hering

Kris Hering,
Administrator, NH Health Care Quality and Patient Safety Commission

Foundation *for* Healthy Communities
Partnering to improve health for all.