



Report to the General Assembly

Adverse Event Reporting

Section 19a-127l-n

Events Reported for Year 2024

Manisha Juthani, MD, Commissioner

Jennifer Olsen Armstrong, MS, RD, Section Chief,
Facilities Licensing and Investigations
Karyn Backus, MPH, Supervising Epidemiologist,
Surveillance Analysis and Reporting

August 2026



State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

State of Connecticut Department of Public Health Report to the Public Health Committee Adverse Event Reporting 2024

Table of Contents

Executive Summary	3
Adverse Event Data.....	4
Adverse Events Reported in 2024.....	5
Current Activities.....	6
Investigation of Adverse Events.....	6
Conclusion	6
Appendix A: Demographic Data from Adverse Event Reports	8
Appendix B: Counts of Adverse Event Codes 2014-2024.....	10
Appendix C: Connecticut Adverse Events in 2024	13
Appendix D: Adverse Event Reports by Event Type.....	14
Appendix E: Adverse Event Reports and Rates by Facility.....	15
Appendix F: Primary Payer (%) of Inpatient Hospital Bills	21
Appendix G: Comments Submitted by Facilities	26
Facilities providing comments:	26
CT Behavioral Health Hospital of Hebrew Senior Care	27
Day Kimball Healthcare.....	28
Griffin Hospital	29
Middlesex Hospital	30
Nuvance Health System	31
Stamford Health	33
UCONN Health John Dempsey Hospital.....	34

Executive Summary

Adverse event reporting by hospitals and ambulatory care facilities to the Department of Public Health is required under Connecticut General Statutes § 19a-127n. The purpose of this report is to inform the legislature of the trends in adverse events in healthcare facilities and to increase hospital transparency and accountability to healthcare quality and safety. The number of adverse events reports in 2024 were 461. These events were reported by Connecticut healthcare facilities that accounted for over 2 million inpatient days annually, in addition to outpatient visits.

The most common adverse event reported this year was stage 3-4 or unstageable pressure ulcers acquired after admission to a healthcare facility, with 52% of reports this year. Following this was falls resulting in serious disability or death, making up 18% of reports. Hospitals reported increased cases of retained foreign objects after surgery, making 5% of reports, while wrong or no gas delivered to a patient dropped to the fourth most common event, at 4% of this yearly report.

Following an adverse event, facilities must submit an adverse event report including a corrective action plan. From this report, the Department determines whether to initiate an investigation.

Adverse Event Data

An adverse event is defined as a set of patient safety events that are serious, largely preventable, and may indicate a problem with a healthcare facility's safety systems. Conn. Gen. Stat. § 19a-127l defines adverse events based on the National Quality Forum's List of Serious Reportable Events.

Demographic information based on reported adverse events is provided in Appendix A for 2024. Several factors may influence the report of an adverse event. These factors include varying rates of adverse events across facilities, patient case mix, quality of care, number of patients served, knowledge or interpretation of event definitions and reporting requirements, changes made to event definitions, additions to or deletions from the list of reportable events, willingness to report them, as well as the effectiveness of the institutional system to convey information from the event participants to the designated reporter, and other factors.¹ Consequently, clear conclusions about the causes of observed event fluctuations and differences across facilities cannot be derived simply from the number of reports or fluctuations in the number of reports.²

Appendix B presents the number of adverse events reported by year for 2014 through 2024, according to the lists of National Quality Forum events (1A-7D). As of 2017, there are no longer Connecticut-specific events.

Appendix C shows the leading reports by type for 2024. The most common adverse events reported this year were stage 3-4 or unstageable pressure ulcers, falls resulting in serious disability or death, and retained foreign objects after surgery.

Adverse event counts, patient days, and rate by facility and event type are shown in Appendices D through F. These represent, respectively, acute care hospitals (E), Chronic Disease Hospitals and Hospice and Hospital for Psychiatric Disabilities (E-part 2), fertility centers and Childbirth Centers (E-Part2), Ambulatory Surgical Centers and Pain Medicine Centers (E-Part 3). Not all adverse event categories are relevant to all facilities. For example, events associated with birth are not applicable in a facility that does not handle pregnancy, labor, and deliveries. Additionally, patient populations differ considerably between types of facilities, which impacts the event counts in each facility.

For acute care and chronic care hospitals, the calculated rates are based on adverse events that occurred in the emergency department, inpatient, or an outpatient setting (in the numerator), but only inpatient days are used for the denominator of the rate. Inpatient days are used because outpatient days cannot be reliably obtained from the acute care database. Many of the choices for "Location of Event" (Appendix A) could be either inpatient or outpatient.

¹ Zegers et al, "Variation in the Rates of Adverse Events between Hospitals and Hospital Departments," *International Journal for Quality in Health Care* 2011:1-8; Attenello et al, "Incidence of 'Never Events' Among Weekend Admissions Versus Weekday Admissions to US Hospitals: National Analysis," *BMJ* 2015;350:h1460.

² For additional discussion of the limitations of passive incident reporting, see the Patient Safety section of the September 2011 issue of the Agency for Healthcare Research and Quality (AHRQ), Morbidity and Mortality Rounds at <http://webmm.ahrq.gov/>; Kaveh G. Shojania, "The Elephant of Patient Safety: What You See Depends Upon How You Look," *Joint Commission Journal on Quality and Patient Safety*, 36(9); September 2010, 399.

Significant variation in facility reporting patterns is a common characteristic of passive surveillance systems (where the responsibility for reporting falls upon the health care provider) and this is not unique to Connecticut's adverse events reporting system. A passive surveillance system "has the advantage of being simple and not burdensome" to administer, however "it is limited by variability and incompleteness in reporting."³ Typically, data validation is a function of an active surveillance strategy that can be used to increase the completeness of reporting, as is being done in the separate Connecticut Healthcare Associated Infections program. However, data validation is often labor intensive and expensive, which requires dedicated resources. Without such validation, it cannot be determined how complete facility reporting is. High reporting rates to DPH in this report may reflect highly complete reporting in a facility with good quality of care, or perhaps modestly complete reporting in a facility with poor care, or neither better nor worse quality care, as noted earlier. In addition, retained objects are often discovered from prior surgeries at other facilities.

Adverse Events Reported in 2024

The number of adverse events reports (n=461) in 2024 was 2% higher than in 2023. These events were reported by Connecticut healthcare facilities that accounted for over 2 million inpatient days in 2024, in addition to outpatient visits.

Acute care hospitals including children's hospitals submitted 414 (90%) of the 461 adverse event reports in 2024; chronic disease hospitals, 14; hospitals for psychiatric disabilities, 25; and outpatient surgical facilities (if not owned by a hospital), 8. Fifty-five percent (55%) of reported adverse events occurred in males and 45% in females. The majority of reports concerned patients 60 years of age and older. The most common location of occurrence was reported to be the hospital adult medical ward (Appendix A).

A substantial portion of reports did not indicate race or ethnicity. Race was missing for 39% and ethnicity was missing for 38%. Of reports that recorded race, the most common were white (42%) and black (12%). Hispanic ethnicity was recorded in 7% of reports where ethnicity was stated.

As shown in Appendix C, the most reported events in 2024 were pressure ulcers. Two hundred thirty-nine (239) pressure ulcers comprised 52% of all 461 adverse events reported. The second most reported events were falls resulting in death or serious injury, with 84 reports (18%). Retention of a foreign object in a patient after surgery or other procedure followed with 24 reports (5%). Incidents which systems designated for oxygen or other gas to be delivered to a patient that contains no gas, the wrong gas, or are contaminated by toxic substances and sexual abuse/assault on patient or staff within or on grounds of healthcare setting were both reported 20 times (4%). The next most reported event, at 18 instances (3.8%), was patient death or serious injury associated with a medication error.

³ Steven M. Teutsch, "Considerations in Planning a Surveillance System," in Steven M. Teutsch and R. Elliott Churchill, eds., *Principles and Practice of Public Health Surveillance*, 2nd ed. (New York: Oxford University Press, 2000), 22.

Current Activities

During healthcare inspections, DPH activities include, but are not limited to, a review of medical records to ensure that care has been provided in accordance with applicable state and federal laws and regulations as well as standards of care. Not only are inpatient medical records reviewed but closed medical records are as well. Such review includes compliance with the requirements of adverse event reporting and compliance with applicable state and federal laws and regulations.

Investigation of Adverse Events

Adverse events need to be reported when they occur within a facility as well as provide the Department with a corrective action in accordance with the Connecticut adverse event reporting law (Conn. Gen. Stat. § 19a-127n).

An external investigation at a healthcare facility due to an adverse event may begin in several ways: (1) as a result of a complaint to DPH made by any person;⁴ (2) following a sentinel event report by the facility to the Joint Commission, a complaint to the Joint Commission by any person,⁵ or an unannounced, onsite visit to a facility by the Joint Commission during which an adverse event becomes known; or (3) as a consequence of an adverse event report sent by the healthcare facility to DPH. The last of these routes is discussed here.

The Department conducts investigations regarding adverse event reports that may indicate a systems issue, or problems related to inadequate standards of care. These investigations determine regulatory compliance versus noncompliance and provide additional information that may allow one to distinguish between events that have been due to a medical error or system failure and those that have not. All investigations follow the same inspection process regardless of the origin or type of complaint, adverse event or routine certification survey. Information is gathered through onsite inspection and observation, review of clinical records, review of the institution's policies and procedures, interviews with staff and vested parties as appropriate. The results of completed investigations are public and may be obtained through eLicensing or by request, under the Freedom of Information (FOI) Act.

Conclusion

Pursuant to Conn. Gen. Stat. § 19a-127n, DPH collects annual adverse event data from healthcare facilities. This report covers the data from January 1, 2024, through December 31, 2024. Adverse event reports enable the Department to ensure that Connecticut hospitals and other healthcare facilities remain committed to patient safety. This is evident in the comments submitted by facilities (Appendix G).

⁴ <https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/PLIS/Reporting-a-Complaint>

⁵ <https://www.jointcommission.org/en-us/knowledge-library/sentinel-events>

Following an adverse event, facilities must submit a report that includes a corrective action plan. Data sharing on adverse event trends enables the Department and legislature to identify areas of improvement in facilities across the state.

Appendix A: Demographic Data from Adverse Event Reports in the Electronic Database, Connecticut 2024

Measure	Frequency	Percent
Facility Type (n=461)		
Acute Care or Children's Hospital	414	89.8%
Chronic Disease Hospital	14	3.0%
Hospital for Psychiatric Disabilities	25	5.4%
Outpatient Surgical Facility and Other ¹	8	1.7%
Patient Gender (n=461)		
Male	254	55.1%
Female	207	44.9%
Patient Age (n=461)		
0-14	11	2.4%
15-29	31	6.7%
30-44	44	9.5%
45-59	64	13.9%
60-74	172	37.3%
75-89	120	26.0%
90-104	19	4.1%
Location of Event (n=461)		
Adult Medical	141	30.6%
Adult Surgical	25	5.4%
Ambulatory Surgical	3	0.7%
Cardiac Care	38	8.2%
Diagnostic Services	5	1.1%
Emergency Department	46	10.0%
Medical Intensive Care	50	10.8%
Neonatal Intensive Care	1	0.2%
Obstetrical/Gynecological	5	1.1%
Operating Room	20	4.3%
Other	39	8.5%
Outpatient Services	5	1.1%
Pediatrics	3	0.7%
Psychiatric	43	9.3%
Rehabilitative Services	3	0.7%
Surgical Intensive Care Unit	34	7.4%

¹ Includes ambulatory surgical centers not owned by a hospital, pain medicine, Fertility Clinics and Freestanding birthing center.

**Appendix A Continued. Demographic Data from Adverse Event Reports in the
Electronic Database, Connecticut 2024**

Measure	Frequency	Percent
Inpatient/Outpatient (n=461)		
Inpatient	413	89.6%
Outpatient	48	10.4%
Admission Type (n=461)		
Ambulatory Surgical Center	9	2.0%
Hospital Based	450	97.6%
Off Campus Satellite Site	2	0.4%
Patient Race (n=461)		
White	193	41.9%
Black or African American	57	12.4%
Other	25	5.4%
Asian	3	0.7%
Chinese	1	0.2%
Native Hawaiian or Pacific Highlander	1	0.2%
BLANK	181	46.0%
Patient Ethnicity (n=461)		
Not Hispanic or Latino	235	51.0%
Hispanic or Latino	33	7.2%
Other	18	3.9%
BLANK	175	38.0%
Spoken Language (n=461)		
English	259	56.2%
Spanish	10	2.2%
Other Language	6	1.3%
Chinese, Mandarin	2	0.4%
BLANK	184	39.9%
English Proficiency (n=461)		
Not at All	2	0.4%
Not Well	6	1.3%
Unknown	41	8.9%
Very Well	94	20.4%
Well	51	11.1%
BLANK	267	57.9
Interpreter Used? (n=461)		
No	454	98.5%
Yes	7	1.5%
Patient Expired (n=461)		
No	443	96.1%
Yes	18	3.9%

Frequency and percent reflect only the non-missing values.

Appendix B: Counts of Adverse Event Codes 2014-2024

Event Code	Description	Number of Reports										
		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NQF 1A	Surgery performed on the wrong site	15	13	18	10	11	17	14	17	10	12	11
NQF 1B	Surgery performed on the wrong patient	0	1	1	0	0	1	1	2	1	0	0
NQF 1C	Wrong surgical procedure performed on a patient	4	1	6	3	7	5	7	13	6	4	4
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	24	19	20	17	28	23	12	22	20	18	24
NQF 1E	Intraoperative or immediate postoperative/ postprocedure death in an ASA class I patient	1	1	1	1	0	0	0	0	0	0	1
NQF 2A	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	3	0	1	1	2	1	1	1	0	2	0
NQF 2B	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	2	5	1	1	0	2	1	2	1	2	0
NQF 2C	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	0	1	0	2	1	3	0	3	1	0	1
NQF 3A	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	0	1	2	0	1	3	3	9	6	4	6
NQF 3B	Patient death or serious injury associated with patient elopement (disappearance)	0	0	0	0	0	0	1	1	2	1	0
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	0	3	5	3	4	7	14	9	18	18	16

Appendix B Continued. Counts of Adverse Event Codes 2014-2024

Event Code	Description	Number of Reports										
		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	1	7	7	4	3	6	10	10	7	10	18
NQF 4B	Patient death or serious injury associated with unsafe administration of blood products	0	0	0	0	0	0	0	0	0	0	0
NQF 4C	Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	0	1	3	0	1	1	1	0	2	1	0
NQF 4D	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	4	5	2	1	0	2	1	5	3	2	2
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	78	90	74	84	106	101	84	102	106	101	84
NQF 4F	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	245	230	186	208	194	206	221	228	241	221	239
NQF 4G	Artificial insemination with the wrong donor sperm or wrong egg	0	0	0	0	0	0	1	0	0	0	0
NQF 4H	Death or serious injury resulting from irretrievable loss of an irreplaceable biological specimen	0	0	0	0	1	1	0	0	0	0	0
NQF 4I	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	0	3	2	0	4	2	2	2	2	3	2

Appendix B Continued. Counts of Adverse Event Codes 2014-2024

Event Code	Description	Number of Reports										
		2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NQF 5A	Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	0	0	0	0	0	0	0	0	0	0	0
NQF 5B	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	0	0	0	0	0	8	8	10	19	33	20
NQF 5C	Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	1	0	4	8	2	4	2	2	2	1	2
NQF 5D	Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting	0	2	0	1	1	2	1	0	2	2	2
NQF 6A	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.	0	0	0	0	0	0	0	0	0	0	0
NQF 7A	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	1	0	0	0	0	0	0	0	0	0	1
NQF 7B	Abduction of a patient/resident of any age	0	0	0	0	1	0	0	0	0	0	0
NQF 7C*	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	9	10	24	5	5	4	4	12	9	11	20
NQF 7D	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	1	0	2	2	4	5	7	5	7	8	8
Total Reports		389	393	359	351	376	404	396	455	465	454	461

*The definition of NQF 7C was clarified to include only substantiated allegations beginning January 2017.

Appendix C: Connecticut Adverse Events in 2024

Most Frequently Reported Events NQF List (1A-7D)

Event	Description	Frequency	Percent of All Events
NQF 4F	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	239	51.8%
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	84	18.2%
NQF 1D	Unintended retention of a foreign object in a patient after surgery or other procedure	24	5.2%
NQF 5B	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	20	4.3%
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	20	4.3%
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	18	3.9%
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	16	3.5%
NQF 1A	Surgery performed on the wrong site	11	2.4%
NQF 7D	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	8	1.7%
NQF 3A	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	6	1.3%
All other reported adverse events		15	3.3%
Total		461	100.0%

Appendix D: Adverse Event Reports by Event Type

By Facility Type Connecticut, 2024.

Facility Type	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	Total
Acute Care Hospitals	8		2	22				1	5		7	17			2	73	231			2		18	2	2		1		17	4	414
Chronic Disease Hospitals				1					1							4	4					2						2		14
Mental Health Hospitals											9	1				6	4											1	4	25
Fertility Childbirth Centers																														0
Ambulatory Surgery Centers	3		2	1	1											1														8
Totals	11	0	4	24	1	0	0	1	6	0	16	18	0	0	2	84	239	0	0	2	0	20	2	2	0	1	0	20	8	461

Appendix E: Adverse Event Reports and Rates by Facility

Acute Care Hospitals. Connecticut, 2024

Hospital	CY 2024 Reports Total	Patient Days* CY 2024	Rate per 100,000 Patient Days*
William W. Backus Hospital	15	41942	35.8
Bridgeport Hospital ¹	29	97327	29.8
Bristol Hospital	1	18344	5.5
Connecticut Children's Medical Center	3	38775	7.7
Danbury and New Milford Hospitals	12	68165	17.6
Day Kimball Healthcare	6	9499	63.2
John Dempsey Hospital	18	42264	42.6
Greenwich Hospital	9	34520	26.1
Griffin Hospital	6	22797	26.3
Hartford Hospital	33	206826	16.0
Charlotte Hungerford Hospital	7	20624	33.9
Hospital of Central Connecticut	20	57901	34.5
Johnson Memorial Hospital	4	6255	63.9
Lawrence and Memorial Hospital	16	49483	32.3
Manchester Memorial Hospital			
Middlesex Hospital	6	40116	15.0
MidState Medical Center	7	31132	22.5
Norwalk Hospital	7	32785	21.4
Rockville General Hospital			
Saint Francis Hospital	40	85440	46.8
Saint Mary's Hospital	8	25391	31.5
Saint Vincent's Medical Center	20	69144	28.9
Sharon Hospital	0	8402	0.0
Stamford Hospital	22	55939	39.3
Waterbury Hospital			
Windham Community Memorial Hospital	1	6023	16.6
Yale-New Haven Hospital	112	355844	31.5
<i>All Acute Care Hospitals</i>	402	1,424,938	28.2

*Inpatient patient days are used as rate denominators.

Appendix E Continued. Adverse Event Reports and Rates per 100,000 Inpatient Days
Chronic Disease Hospitals and Hospice. Connecticut, 2024.*

Facility	Reports Total	Patient* Days 2024	Rate per 100,000 Pt. Days
The Connecticut Hospice ¹	0	3656	0.0
Gaylord Hospital	4	41,809	9.6
The Hospital for Special Care	9	82,315	10.9
Mount Sinai Rehabilitation Hospital	1	10,254	9.8
<i>All Chronic Disease Hospitals</i>	14	138,034	10.1

*Inpatient days are used for rate calculation.

Hospitals for Psychiatric Disabilities. Connecticut, 2024.*

Facility	Reports Total	Patient* Days 2024	Rate per 100,000 Pt. Days
	3	10,581	18.9
Masonicare Behavioral Health	5	16,099	31.1
Natchaug Hospital	0	17,346	0.0
Silver Hill Hospital	1	16,850	5.9
Whiting Forensic Hospital	16	79,876	20.0
<i>All Hospitals for Psychiatric Disabilities</i>	25	140,752	17.8

*Inpatient days are used for rate calculation

**Appendix E Continued. Adverse Event Reports and Rates,
Fertility Centers and Childbirth Centers. Connecticut, 2024. ***

Facility	Location	Reports	Patient Visits	Per 100,000 Pt Visits Rate
FERTILITY				
Center for Advanced Reproductive Services	Farmington	0	1,300	0.0
New England Fertility Institute	Stamford	0	250	0.0
Reproductive Medicine Associates of Connecticut	Norwalk	0	2,040	0.0
<i>Fertility Totals</i>		0	3,590	0.0
CHILDBIRTH				
Connecticut Childbirth & Women's Center	Danbury	0	108	0.0
<i>Childbirth Totals</i>		1	108	0.0

**Appendix E Continued. Adverse Event Reports and Rate per 100,000 Visits
Ambulatory Surgical Centers and Pain Medicine Centers. Connecticut, 2024.**

Facility	Location	Reports	Patient Visits	Per 100,000 Rate
Aesthetic Surgery center LLC	Darien	0	368	0.0
Bloomfield ASC, LLC	Bloomfield	0	6,964	0.0
The Eye Surgery Center	Bloomfield	0	1,260	0.0
Central Connecticut Endoscopy Center, LLC	Plainville	0	8,949	0.0
Coastal Digestive Care Center, LLC	New London	0	7,052	0.0
Connecticut Eye Surgery Center South, LLC	Milford	1	7,754	12.9
Connecticut Orthopaedic Specialists Outpatient Surgical Center*	Branford			
CT Orthopaedic Surgery Center, LLC	Milford	0	4,157	0.0
Connecticut Surgery Center	Farmington	0	5,196	0.0
Constitution Surgery Center East, LLC	Waterford	0	8,471	0.0
Connecticut GI Endoscopy, LLC	Bloomfield	0	9,272	0.0
Surgical Center of Ridgefield	Ridgefield	1	10,455	9.6
Diagnostic Endoscopy Center	Stamford	0	9,500	0.0
Digestive Disease Associates Endoscopy Suite LLC	Branford	0	4,889	0.0
Eastern Connecticut Endoscopy Center, LLC	Norwich	0	6,286	0.0
Endoscopy Center of Connecticut, LLC	Guilford	1	8,433	11.9
Endoscopy Center of Connecticut, LLC *	Hamden			
Endoscopy Center of Northwest Connecticut, LLC	Torrington	0	4,386	0.0
Enfield Surgery Center - license granted 11.2024				
Evergreen Endoscopy Center, LLC	South Windsor	0	8,406	0.0
Fairfield Surgery Center	Fairfield	0	1,896	0.0
Endoscopy Center of Fairfield, The LLC	Fairfield	0	15,359	0.0
Glastonbury Endoscopy Center, LLC	Glastonbury	0	9,418	0.0
Glastonbury Surgery Center, LLC	Glastonbury	0	3,600	0.0
North East Alliance Surgery Center	Hamden	1	4,086	24.5
Guilford Surgery Center, LLC	Guilford	0	2,121	0.0

**Appendix E Continued. Adverse Event Reports and Rate per 100,000 Visits
Ambulatory Surgical Centers and Pain Medicine Centers. Connecticut, 2024.**

HHC Hartford Surgery Center *	Hartford	1	3,288	30.4
Cheshire Surgery Center	Cheshire	0	3,592	0.0
Laser and Vision Surgery Center, LLC *	Manchester			
Lighthouse Surgery Center	Hartford	0	5,680	0.0
Litchfield Hills Surgery Center	Torrington	0	1,707	0.0
Middlesex Center for Advanced Orthopedic Surgery, LLC	Middletown	0	3,503	0.0
Middlesex Endoscopy Center, LLC	Middletown	0	7,921	0.0
Waterbury Surgery Center	Waterbury	0	6,849	0.0
Split Rock Surgical Associates *	Wilton			
Fairfield County Endoscopy Center (NEMG)	Trumbull	0	7,315	0.0
New Vision Cataract Center	Norwalk	0	3,055	0.0
North Haven Surgery/Pain Medicine Center, LLC	North Haven	0	3,463	0.0
Norwalk Surgery Center, LLC	Norwalk	0	2,482	0.0
Orthopaedic & Specialty Surgery Center	Danbury	0	2,614	0.0
Orthopedic Associates Surgery Center	Rocky Hill	2	10,760	18.6
Refocus Eye Surgery Center-Waterbury	Waterbury	0	1,797	0.0
River Valley ASC, LLC	Norwich	0	4,073	0.0
Rocky Hill Surgery Center, LLC	Rocky Hill	0	6,332	0.0
Saint Francis GI Endoscopy, LLC	Windsor	0	7,223	0.0
Southwest Connecticut Surgery Center, LLC	Wilton	0	2,380	0.0
Shoreline Endoscopy Center, LLC *	Guilford			
Shoreline Colonoscopy Suites*	Old Saybrook			
Sasco Hill Surgery Center *	Southport			
Stamford ASC, LLC *	Stamford			
Specialty Surgery Center of Connecticut	Stamford	0	2,263	0.0
Surgery Center of Fairfield County, LLC	Trumbull	0	3,666	0.0
The Surgical Center of Connecticut, LLC	Bridgeport	1	1,531	65.3
Wallingford Endoscopy Center, LLC	Wallingford		9376	0.0
West River Surgery Center, LLC *	Guilford			
Western Connecticut Orthopedic Surgical Center, LLC	Danbury	0	4,090	0.0
Wilton Surgery Center, LLC	Wilton	0	6,102	0.0
Yale Health Center Outpatient Surgical Center	New Haven	0	1,431	0.0
All Facilities		8	260,771	3.1

* indicates facilities from which DPH did not receive 2024 data.

Appendix F: Primary Payer (%) of Inpatient Hospital Bills

Acute Care Hospitals. Connecticut, CY 2024

Hospital	Self Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
William W. Backus Hospital	1.23	61.54	19.48	16.2	1.55
Bridgeport Hospital	2.9	58	23.18	15.1	0.81
Bristol Hospital	1.57	60.76	21.95	14.08	1.64
Connecticut Children's Medical Center	0.42	0.38	58.68	39.82	0.71
Danbury and New Milford Hospitals	1.11	59.33	15.66	22.21	1.71
Day Kimball Healthcare	0.85	63.12	18.29	15.54	2.19
John Dempsey Hospital	0.31	47.44	19.18	30.28	2.79
Greenwich Hospital	1.76	55.5	8.78	33.28	0.68
Griffin Hospital	1.11	57.75	22.26	17.2	1.7
Hartford Hospital	1.65	53.21	24.16	20.16	0.83
Charlotte Hungerford Hospital	0.73	60.42	23.16	14.44	1.26
Hospital of Central Connecticut	1.72	56.26	23.51	16.49	2
Johnson Memorial Hospital	0.8	45.22	31.56	13.35	9.09
Lawrence and Memorial Hospital	1.46	61.71	17.56	15.74	3.53
Manchester Memorial Hospital*					
Middlesex Hospital	1.01	59.21	17.97	19.47	2.34
MidState Medical Center	1.12	65.36	15.37	17.33	0.81
Norwalk Hospital	1.17	58.36	20.36	19.03	1.08
Rockville General Hospital*					
Saint Francis Hospital	1.64	54.9	26.51	14.54	2.39
Saint Mary's Hospital	2.7	56.35	28.32	10.54	2.1
Saint Vincent's Medical Center	4.55	49.19	28.49	17.17	0.6
Sharon Hospital	1.43	56.45	8	34.01	0.12
Stamford Hospital	1.49	51.78	23.17	23.06	0.5
Waterbury Hospital*					
Windham Community Memorial Hospital	1.16	75.1	11.67	11.11	0.96
Yale-New Haven Hospital	1.98	48.58	27.2	20.38	1.85
Total	1.78	52.66	24.18	19.84	1.55

*Data from CY 2024 is not available for Manchester Memorial Hospital, Rockville General Hospital, and Waterbury Hospital. The Department received data from Waterbury Hospital but was unable to verify the accuracy as of the drafting of this report.

Appendix F Continued. Case Mix or Primary Payer (%) of Bills

Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Outpatient Childbirth Centers. Connecticut, CY 2024

Facility	Self Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Connecticut Childbirth & Women's Center*					
Aesthetic Surgery Center LLC	95.0	0.0	0.0	15.0	0.0
Bloomfield ASC LLC	0.3	58.0	5.8	29.6	0.0
Center for Advanced Reproductive Services*					
Central Connecticut Endoscopy Center	1.0	23.0	9.0	64.0	3.0
Cheshire Surgery Center					
Coastal Digestive Care Center	1.0	13.0	12.0	27.0	47.0
Connecticut Eye Surgery Center South	0.4	50.8	3.9	30.4	14.0
Conn GI Endoscopy	1.0	7.0	4.0	88.0	
Conn. Orthopaedic Specialists Outpatient Surgical Center					
Conn Orthopaedic Surgery center LLC		23.5	0.1	55.0	21.0
Conn SurgeryCenter	2.2	41.9	3.9	26.1	26.0
Constitution Surgery Center, East	0.2	20.7	3.0	34.2	41.9
Surgical Center of Ridgefield	1.0	39.2	5.6	19.5	29.7
Diagnostic Endoscopy Center	5.0	14.0	1.0	80.0	
Digestive Disease Assoc. Endoscopy Suite LLC (100% gastro)	0.3	37.6	3.1	59.0	
Eastern Conn. Endoscopy Center LLC	1.0	28.0	11.0	35.0	26.0
Endoscopy Center of Conn. LLC	0.1	18.9	11.8	65.8	3.5
Endoscopy Center of Fairfield LLC					
Endoscopy Center of Northwest Conn. LLC	1.0	12.0	8.7	25.0	53.3
Evergreen Endoscopy Center LLC	1.0	7.0	10.2	34.8	47.0
The Eye Surgery Center	1.0	47.0	3.0	45.0	4.0
Fairfield Surgery Center	1.0	23.0	1.0	63.0	12.0
Glastonbury Endoscopy Center LLC	1.0	8.0	6.0	85.0	
Glastonbury Surgery Center LLC	0.3	30.7	5.2		8.6
Guilford Surgery Center LLC	1.0	32.0	2.0	62.0	1.0
HHC Hartford Surgery Center	0.0	39.5	8.7	44.3	7.5
Laser and Vision Surgery Center					
Lighthouse Surgery Center	1.0	33.0	5.0	56.0	6.0
Litchfield Hills Surgery Center	0.4	31.6	0.4	54.9	12.4

*Blank cells indicate facilities from which the Department was unable to obtain data in CY 2024.

Appendix F Continued. Case Mix or Primary Payer (%) of Bills

Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Outpatient Childbirth Centers. Connecticut, CY 2024

Facility	Self Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Middlesex Endoscopy Center LLC	0.0	32.9	7.4	32.7	27.0
Middlesex Center for Advanced Orthopedic Surgery LLC	0.1	29.0	2.6	58.4	9.9
Fairfield County Endoscopy Center NEMG	0.2	33.8	6.5	31.2	
New Vision Cataract Center	5.0	80.0	10.0	5.0	
North East Alliance Surgery Center	7.9	36.4	8.7	41.0	3.0
North Haven Surgery /Pain Medicine Center LLC	0.1	14.5	20.1	63.3	1.2
Norwalk Surgery Center LLC	4.5	30.0	11.0	54.0	0.1
Stamford ASC, LLC	0.0	28.0		67.0	5.0
Orthopedic Associates Surgery Center	0.1	39.5	2.4	58.0	
Orthopaedic & Speciality Surgery Center	5.0	43.0	1.0	45.0	6.0
River Valley ASC LLC	2.0	30.0	9.0	58.0	1.0
Rocky Hill Surgery Center LLC	0.1	78.3	2.4	19.2	
Sasco Hill Surgery Center*					
St Francis GI Endosc LLC		22.0	2.0	76.0	
Shoreline Colonoscopy Suites*					
Shoreline Endoscopy Center LLC					
Southwest Conn. Surgery Center LLC	0.8	34.6	7.0	51.8	5.8
Specialty Surgery Ctr of Conn.	0.5	18.6	4.8	27.9	48.0
Split Rock Surgical*					
Surgery Center of Fairfield County LLC	9.9	35.0	4.6	19.5	31.0
The Surgical Center of Conn.	0.0	31.1	10.4	50.4	7.9
Wallingford Endoscopy Center	1.0	6.1	15.8	28.3	48.8
Refocus Eye Surgery Center- Waterbury	1.0	66.0	5.0	27.0	1.0
Waterbury Surgery Center	3.0	41.0	10.0	47.0	2.3
West River Surgery Center LLC					
Western Conn. Orthopedic Surgical Center LLC	0.4	15.0	0.2	80.8	3.0
Wilton Surgery Center LLC	0.5	49.0	4.1	44.4	2.0
Yale Health Center Outpatient Surgical Center					

*Blank cells indicate facilities from which the Department was unable to obtain data in CY 2024.

Appendix F Continued. Case Mix or Primary Payer (%) of Bills

Chronic Disease Hospitals and Hospice. Connecticut, CY 2024

Facility	Self-Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
The Connecticut Hospice	0	88.0	4.7	7.3	0
Gaylord Hospital	0.2	42.2	11.5	39.4	6.7
The Hospital for Special Care	0.01	6.6	83.5	9.8	0
Mount Sinai Rehabilitation Hospital	0	58.2	17.2	10.6	14.0

Hospitals for Psychiatric Disabilities. Connecticut, CY 2024

Facility	Self Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Connecticut Behavioral Health	0.8	64.7	7.5	26.2	0.8
Masonicare Behavioral Health	0.0	47.0	0.0	53.0	0
Natchaug Hospital	0.05	15.5	34.5	24.4	25.5
Silver Hill Hospital	9.10	5.7	0.0	85.2	0
Whiting Forensic Hospital	0.0	0.0	0.0	0.0	100*

*Whiting Forensic does not bill.

Appendix G: Comments Submitted by Facilities

In accordance with Conn. Gen. Stat. § 19a-127n(d), facilities that are required to report adverse events to DPH may submit comments to the Department for inclusion in the annual report to the legislature. Submitting comments is optional, not required. DPH encourages comments describing how a facility used data to measure or track adverse events or quality of care and measurably improve care or decrease adverse events.

Facilities providing comments:

- CT Behavioral Health Hospital of Hebrew Senior Care
- Day Kimball Healthcare
- Griffin Hospital
- Middlesex Health
- Nuvance Health System
- Stamford Hospital
- UCONN Health John Dempsey Hospital

CT Behavioral Health Hospital of Hebrew Senior Care

The CT Behavioral Health Hospital of Hebrew Senior Care takes great pride in our ongoing efforts to keep our patients safe and to reduce harm. Ensuring patient safety and dignity is embedded in all patient interventions. A comprehensive review of our “Restraint and Seclusion Policy” and of our “Fall Prevention Policy” was completed in 2024.

Interdisciplinary staff completed additional training to remain current regarding these policies that are a key component of our patient safety initiatives. Clinical staff participated in targeted de-escalation training that highlighted interventions that can be used to reduce the need for restraint and/or seclusion. In addition, clinical staff participated in a review of fall prevention strategies to reduce harm.

In 2024, the CT Behavioral Health Hospital of Hebrew Senior Care reported three adverse events related to two falls with injury and one pressure ulcer. Our adverse event rate per 100,000 patient days in calendar year 2024 is 28.4, an impressive 26.4% reduction from the 2023 rate. In addition, the CT Behavioral Health Hospital achieved an 18% reduction in fall rates from 2023 to 2024. Our hospital is proud of these achievements and remains dedicated to reducing patient harm.

Day Kimball Healthcare

Patient safety is a core philosophy at Day Kimball Health. We strive to deliver high quality safe care to all of our patients, their families and to everyone in the surrounding communities. As part of that commitment, we continue to identify improvement opportunities to prevent patient harm events. As a high reliability organization, we learn from adverse event occurrences and implement strategies to try to prevent similar events in the future.

Fall Prevention Initiative: Our Fall Prevention Committee re-established its focus and is multidisciplinary in nature. The committee members include all clinical unit nursing leadership, nursing educators, the Chief Nursing Officer, Quality Department leadership (e.g. Quality/Safety/Risk/Regulatory/Performance Improvement/Compliance), Pharmacy and Physical/Occupational Therapy representatives and Home Care staff. We have included Apparent Cause Analysis data into the regular discussion and review of all patients falls to determine if there are commonalities to help drive our prevention strategies. Education and assessments (both competency for staff and demonstrated knowledge by patients/families) are provided as indicated, especially with fall risk patients and infants.

HRO Forward Initiative: We continue to pursue improving and enhancing our continued dedication to High Reliability Principles and Patient Safety. We have added HRO training as a core requirement as part of our new employee orientation program. Key leadership in the organization participated in the statewide planning for “HRO 2.0 / HRO Forward” which focused on the Institute for Healthcare (IHI) National Action Plan for safety. This program was a year-long endeavor that was led by the Connecticut Hospital Association. We have also hardwired Executive Leader Rounding into our practice to ensure that the voice of employees and patients is heard directly as part of identifying areas of performance improvement and quality/safety elevation. Day Kimball remains committed to continue this meaningful work on advancing HRO principles in support of patient safety.

Day Kimball is a rural community hospital that is committed to serving patients, families and all people with empathetic care. We take that responsibility seriously and strive to learn from any adverse event that happens and are dedicated to continuous quality and performance improvement to prevent the potential of future occurrences.

Griffin Hospital

Griffin Health remains committed to advancing high reliability in healthcare delivery through its collaboration with the Connecticut Hospital Association (CHA) and participation in “HRO Forward,” a program focused on adopting High Reliability Organization (HRO) principles to minimize preventable harm and foster a culture of safety by implementing safety science into everyday operations. Griffin incorporates core HRO principles and actively promotes transparency, teamwork, and continuous learning to reduce medical errors and ensure a safe environment for both patients and staff.

In 2024, the patient fall reduction was a key initiative undertaken by Griffin Health. Griffin implemented an evidence-based fall assessment tool that has been shown to more reliably identify patients with an increased fall risk. Griffin caregivers deploy fall prevention strategies based on their assessment and tailored to each patient’s risk factors. The fall reduction initiative was co-designed with patients and families who provided valuable insights throughout the process. Griffin’s collective efforts have helped drive the hospital’s fall rate down significantly.

This is just one example of the quality improvement efforts undertaken to improve safety and patient outcomes. Griffin Health is committed to empowering patients to be active participants in their care and incorporating the voices of patients into its goal of eliminating patient harm.

Middlesex Hospital

The employees, physicians, and leaders of Middlesex Health are dedicated to providing the safest, highest - quality care and the best possible experience to the community we serve. It is our mission and the reason we exist as a health care system. There is no issue more important to us than the safety of our patients, visitors and staff. The science behind the concept of High Reliability is proven to decrease human and systems errors and eliminate preventable harm. To that end, Middlesex made the decision to become one of the first in a group of Connecticut Hospitals to collaborate through the Connecticut Hospital Association to learn and implement the tools and techniques of High Reliability.

Our work began in 2013 with the training of 100% of our employees and medical staff who, once trained, began to implement the mandatory use of a standardized set of tools in their daily work, patient care, and communication with each other. This was the beginning of a transformational change which is now constant and widely accepted as the way we do business: all of us, every day, in every situation, and with every patient. In this transformation to zero harm, we remain committed to decreasing the number of serious safety events and have decreased that number by over 90% with sustainment.

One specific example of the work we have done to improve and sustain outcomes is related to our targeted focus in reducing hospital readmissions. Since 2022, we have observed a 14.5% reduction in our overall hospital readmission rate. Focusing on the root causes of readmissions has assisted in the identification of targeted strategies to prevent future readmissions. This work is critical as it improves patient outcomes, patient satisfaction, lowers healthcare costs, and is a reflection of the excellent quality of care that we provide our patients. Our transformation to becoming harm-free is a long term and ongoing process. We continue to collaborate with other hospitals and organizations to learn and implement new ways of improving reliability, care, and outcomes. Again, it is our mission and, as such, will always be the top priority.

Finally, to anyone who has been affected by an adverse event while a patient at Middlesex Health, to their family members and loved ones, we sincerely apologize for any impact of such an event, and assure you that we strive to learn as much as we can from any event in order to do our best to prevent it from happening again.

Nuvance Health System

As part of Nuvance Health System, Danbury, New Milford, Norwalk and Sharon Hospitals strive to improve the health of every person served through the efficient delivery of excellent, innovative and compassionate care. While each hospital has local leadership to ensure a keen eye on local community needs, collaboration at all levels across the system occurs to ensure delivery of the highest quality of care.

All hospitals are engaged and committed to a robust Quality and Patient Safety Plan with an emphasis on diverse community needs, improvement, learning, transparency, honesty and ethical behavior. We better serve our patients by overcoming barriers, pivoting with efficiency and staying open-minded.

Nuvance Health hospitals are actively engaged in local and statewide initiatives to deliver safe care to our communities. Danbury, New Milford, Norwalk and Sharon Hospitals are members of the Connecticut Hospital Association's Patient Safety Organization and actively participate in the statewide high reliability collaborative to reduce patient harm across the state. We continue to recognize and review every adverse event for lessons learned to hardwire interventions to permanently reduce preventable harm to zero.

Some of the patient safety initiatives we have implemented to improve the quality and safety of our patients include the following:

Safety Event Review Team (SERT): Standardized approach to review and categorize safety events utilizing the HPI/Press Ganey safety event review process. This allows us to identify pre-cursor safety events and serious safety events in a timely and standardized manner. The process enables us to monitor for trends in event types, frequency, and severity of events as well as our individual entity and systemwide serious safety event rate (SSER).

Social Determinants of Health for Safety: All events that are reviewed during our SERT and RCA2 processes are also reviewed through the social determinants of health lens. An algorithm is utilized and if opportunities are identified related to social determinates of health, action plans are put in place to address.

CHAMP for SAFETY Safety Coaches: Unit based safety coaches are front line staff who are trained in the principles of high reliability and the safety habits and behaviors that should be utilized to keep our patients safe. They act as peer influencers in their departments and units to encourage safe behavior and as champions for our patient safety initiatives.

SBARs for System Wide Learning: SBARs are generated and disseminated across the system following events of harm or potentially catastrophic events where systemwide implications are identified. This heightens awareness, increases transparency and aids in immediate enterprise-wide safety plan for our patients.

Just Culture: All people managers are required to attend an interactive 4 hour Just Culture workshop where they are trained in the principles of Just Culture and application of the Just Culture algorithm utilizing real life scenarios. Additionally, all staff are required to view a 10-minute video during mandatory annual training related to Just Culture so there is a clear understanding of how they will be treated when errors occur.

BRAVO, Safety Stars: Great catch program where employees are recognized and celebrated for practicing high reliability safety behaviors in high-risk situations that allow us to make great catches and keep our patients safe.

PACT (Provider Associate Care Team): Peer to peer support program that supports our front line when they are impacted by trauma related to medical error, workplace violence, unanticipated outcomes, burnout, and moral distress.

Do Safety Differently – Safety II: We have begun our journey to shift the focus from solely reacting to adverse events to understanding and supporting everyday clinical work and learning from success. Safety is not just the absence of failure, but the presence of capacity – how people adapt, adjust and succeed in delivering care under varying conditions and explore how we can better support human performance. We are doing this work through the incorporation of Success Cause Analysis, Learning Teams and Success Debriefs in our patient safety portfolio.

We are proud of our efforts to outperform established national standards to meet the needs of our community. We believe in our community and take very seriously the trust it places in our healthcare system.

Stamford Health

Stamford Health is committed to patient safety and to providing the highest quality of patient care. Our patient safety programs include comprehensive programs in pressure injury and fall prevention, and in surgical and perioperative care.

Our pressure injury prevention program includes a specialized team of certified wound specialists, comprehensive nursing skin assessments, ongoing educational programs for clinical staff, and the deployment of specialized devices to support pressure injury prevention. Similarly, our fall prevention program includes an interdisciplinary fall prevention task force focused on evaluating our fall prevention interventions, risk assessment tools, and outcomes. We provide remote and in-person safety monitoring for at risk patients. We also have a comprehensive delirium management program in collaboration with gerontologists to keep our most vulnerable older adult population safe.

As an organization, we benchmark hospital acquired pressure injuries and patients falls through the National Database of Nursing Quality Indicators (NDNQI®). Stamford Hospital's outcomes for hospital acquired pressure injuries and falls with injury have been more favorable than other hospitals. According to NDNQI, 90% of our inpatient units exceed the national benchmark for hospital acquired pressure injuries. All of our inpatient units and ambulatory departments exceed the national benchmark for falls with injury over the past two years.

Our perioperative safety program includes dedicated policies, protocols, and checklists to promote safe surgical practice. Stamford Health participates and benchmarks favorably in national surgical databases focused on quality and safety, including the American College of Surgeons National Surgical Quality Improvement Program and Society of Thoracic Surgeons databases, among others. Stamford Health also reports surgical outcomes to the National Database of Nursing Quality Indicators (NDNQI®). All of our operative and procedural areas exceed the national benchmark for surgical errors and patient burns.

UConn Health John Dempsey Hospital

UConn Health is committed to providing the highest level of quality care to our patients, the citizens of the state of Connecticut, and the communities we serve. We take tremendous pride in focusing on the safety of patients, visitors and staff. When an Adverse Event occurs, we use the tools that the Connecticut Hospital Association recommended to thoroughly investigate the event, performing either a Root Cause Analysis or Apparent Cause Analysis with a multidisciplinary team within our organization. We work to determine any potential individual or system errors that may have contributed to an adverse event that we can mitigate to prevent the event from reoccurring in the future. In addition to the High Reliability tools and education that is provided to all of our staff, we have demonstrated our commitment to improve patient safety and quality at UConn Health in new and expanded ways:

- **Leapfrog Safety Grade Rating:** As of the Spring 2025 release of Hospital Safety Grades from The Leapfrog Group, UConn Health has earned its ninth straight “A” in patient safety.
- **Carechex Award by Quantros:** UConn Health has been recognized in the Medical Excellence Category as being in the top 10% of Hospitals in the nation for Overall Medical Care and the top 10% of Hospitals in the Northeast for Overall Hospital Care as well as being in the top 10% of Hospitals in the nation for Major Orthopedic Surgery in the Patient Safety Category.
- **Women’s Choice Award for Patient Safety:** UConn John Dempsey Hospital has been named one of America’s 2024 Best Hospitals for Patient Safety by the Women’s Choice Award. The award signifies that John Dempsey Hospital is in the top 5% of 4,728 U.S. hospitals for patient safety in safe surgery practices and lower rates for complications and infections.
- **Healthgrades 5-Star Rating:** UConn John Dempsey Hospital was rated for 2025 as five stars for procedures and conditions, including treatment of upper gastrointestinal surgeries, pulmonary embolism, pneumonia, and sepsis. The ratings are based on risk-adjusted mortality and complication rates at approximately 4,500 hospitals nationwide.

Falls Prevention Initiative: At UConn Health, we remain committed to reducing patient safety events associated with falls, and most especially falls with harm. We investigate every fall that occurs and identified that the fall tool we were using was not adequately identifying certain characteristics of our high fall risk patient population. Subsequently, we have transitioned our fall risk assessment tool to the John Hopkins Fall Risk Assessment

Tool (JHFRAT) which is demonstrating to be more easily understood by clinical staff and was more adaptable to allow for facility specific mitigation interventions.

In addition, we have a dedicated quality assurance nurse who works closely with our clinical staff to ensure that hourly rounds are completed, fall risk evaluation of patients is appropriate, and interventions to reduce falls are consistently in place. Our QA specialist is the key clinical expert related to falls and is available for staff whenever a question, concern, or innovative idea arises. We are committed to continuous quality improvement and anticipate these changes will trend in a positive direction.

HAPI: Our HAPI rate continues to be one of the best in CT. Our nurses have a sustained commitment to identifying and preventing these hospital-acquired pressure injuries.

UConn Health remains committed to patient safety and delivering quality care. Despite striving each day for zero patient harm, adverse events can still occur. At UConn Health, each of these events is scrutinized to understand what occurred, and how we can continue to better ourselves and our health care system to continually improve patient outcomes. At UConn Health we are dedicated to continuous quality improvement across all of our service areas in order to best serve the patients of the state of Connecticut.

We thank you for trusting us with your care.