#	Measure	Numerator	Denominator	IOM Quality Domain	Donabedian Framework	Diagnosis Category	Measure Level*	Required Data Elements	Notes /Reference
* (A)Individual Clinician or Group of Clinicians (e.g. nurses, residents, attendings, fellows); (B) Facility (ED); (C) System-Wide Measure									
Quality and Safe Care for All Patients									
11.1	Hand-washing rates	Number of times hand washing is performed just prior to patient contact	Number of times a care provider enters a room to provide patient care	Safe	Process	General	A, B		-Data obtained from random periods of direct observation and includes all health care providers
11.2	Transfer Agreement for Pediatric Patients	Transfer agreement for pediatric patients in place (Y/N)	N/A	Effective, Safe	Structure	General	B		-Must include components from "Policy Statement—Guidelines for Care of Children in the Emergency Department"; Annals of Emergency Medicine and Pediatrics, October 2009 -Transfer agreements should include: • Defined process for initiation of transfer, including roles and responsibilities of referring and referral center • Transport plan for delivering children • Process for selecting appropriate care facility • Process for selecting appropriately staffed transport service • Process for patient transfer • Plan for transfer of patient information • Process for return transfer
11.3	Return Visits within 48 hours resulting in admission	Number of patients < 18 years of age returning within 48 hours of a prior visit whose return visit results in hospital admission	Total number of visits by patients < 18 years of age	Effective, Safe	Outcome	General	A, B	Unique visit identifier Patient arrival time Patient left ED time	
11.4	Medication error rates	Counts of each of the following types of errors • Medication given but not ordered • Medication ordered but not given • Wrong drug given from what was ordered • Wrong dosage • Wrong or inappropriate drug for • condition • Wrong administration technique • Wrong route • Wrong dosage form	Number of patients < 18 years of age with a medication ordered	Safe	Outcome	Cross-cutting (medications)	A, B		-Report rate of each type of error individually as well as total medication error rate Reference: Marcin JP et al. (2007). Medication errors among acutely ill and injured children treated in rural emergency departments. Ann Emerg Med. 50:361-7

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Quality and Safe Care for All Patients									
11.5	Follow up of abnormal tests	a. Number of times patient is contacted and corrective action is taken within 12 hours of notification of x-ray reread Number of times patient is contacted and appropriate treatment is taken within 12 hours of notification of positive culture Number of times patient is contacted and appropriate treatment is taken within 12 hours of notification of abnormal test	Number of times an x-ray (any diagnostic radiology study) reread is relayed to staff Number of times a positive culture is relayed to staff Number of times an abnormal laboratory test is relayed to staff	Effective, Safe	Process	Cross-cutting (diagnostic test)	A, B	Lab order Lab result available time Lab test type Imaging order time Imaging test result time Imaging test type Abnormal imaging test flag Abnormal lab test flag	Report each submeasure individually and report totals as well
11.6	Global sentinel never events	Number of global sentinel never events occurring in the ED in patients < 18 years of age within 1 year	Total number of ED visits by patients < 18 years of age within the same year	Safe	Outcome	General	A, B		See reference at Child Health Corporation of America (CHCA) website under Whole System Measures-Never Events. (Login required)