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115TH CONGRESS
1ST SESSION

H. R. 3752

To direct the Secretary of Veterans Affairs to develop and implement plans to improve the safety of medical facilities of the Department of Veterans Affairs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 2017

Mr. NORCROSS (for himself and Mr. COSTELLO of Pennsylvania) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To direct the Secretary of Veterans Affairs to develop and implement plans to improve the safety of medical facilities of the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Policies to Address Tragic Injuries Enabled by Never events Thoroughly Act'' or the ''PATIENT Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Never events continue to occur in the health care system of the Department of Veterans Affairs and remain a growing source of patient morbidity.

(2) Despite their importance, never events seem to persist as an unsettled issue across the Nation.

(3) In 2016, a national survey announced that ''One in Five U.S. Hospitals Fail to Adopt Crucial Never Events Policies.''.

(4) The Department lacks a mandated reporting system for never events that would help quantify this problem.

(5) Never events, such as operating room fires, including those caused by unsafe laser fiber practices, pose serious risks, such as injuries or burns that can be severe and permanent, to both patients and health care professionals.

(6) The Department does not currently have a comprehensive operating room fire safety policy in place to improve operating room safety.

SEC. 3. IMPROVEMENT OF SAFETY AT MEDICAL FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) PLANS.—The Secretary of Veterans Affairs, acting through the Veterans Health Administration, the Na-

tional Surgery Office, and the National Center for Patient Safety, shall develop and implement the following:

(1) A comprehensive, system-wide plan to decrease never events that incorporates technological tools.

(2) A comprehensive operating room fire safety plan that requires—

(A) the reporting of operating room fires;

(B) the inclusion of the directives outlined in the 2011 fire safety alert of the Food and Drug Administration to mitigate risks relating to fires; and

(C) the carrying out of a pilot project that tests and validates new operating room fire safety technology at multiple medical facilities of the Veterans Health Administration.

(b) REPORT.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report containing the plans developed under subsection (a).

SEC. 4. NEVER EVENT DEFINED.

In this Act, the term ''never event'' means an event involving the delivery of (or failure to deliver) hospital care or medical services furnished at a medical facility of the Department of Veterans Affairs in which there is an error

in the care or services that is clearly identifiable, usually preventable, and serious in consequences to patients, and that indicates a deficiency in the safety and process controls of the care or services furnished with respect to the physician or medical facility involved. Such term includes operating room fires.

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