LEGISLATIVE REPORT TO THE GENERAL ASSEMBLY
Adverse Event Reporting

General Statutes of Connecticut
Section 19a-127l

QUALITY IN HEALTH CARE PROGRAM

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EXECUTIVE SUMMARY

Under the current event definitions, the most common adverse events among 1,488 reports are: (1) falls resulting in serious disability or death, (2) perforations during open, laparoscopic, and/or endoscopic procedures, (3) stage 3-4 pressure ulcers acquired after admission to a healthcare facility, and (4) retention of foreign objects in patients after surgery. In 2010, a new event category, "death or serious injury associated with surgery" became reportable. The adverse event program conducts validation through screening mortality data for unreported fatal events.

After examining an adverse event report, which includes a Corrective Action Plan, the Department of Public Health (DPH) determines whether to initiate an investigation. In addition to adverse event monitoring by DPH, Patient Safety Organizations disseminate information to improve patient care.

BACKGROUND

Connecticut General Statutes §19a-127l required the Department of Public Health (DPH) to establish a Quality in Health Care program for health care facilities. An Advisory Committee, chaired by the DPH Commissioner or designee, advises the program. Mandatory adverse event[1] reporting began October 1, 2002. After evaluating the program for more than a year, the Advisory Committee recommended adoption of the National Quality Forum (NQF) list of Serious Reportable Events, plus five or six Connecticut-specific events.

Adverse events are reported to DPH by telephone and fax machine. Reporting forms and definitions are located at the DPH website under "Forms."[2] After the department has decided whether to launch in investigation, paper-based data are entered into an electronic database.

The Adverse Event reporting requirements were amended when CGS 19a-127n became effective July 1, 2004. The statute replaced the previous adverse event classification system with a list of reportable events identified by the NQF. Additionally, DPH added six Connecticut-specific adverse event definitions to supplement the NQF list, as allowed by the law. (The list appears in Appendix B). Items on the list are of concern to both the public and healthcare professionals, are clearly identifiable and measurable, and are often preventable. DPH completed development of the mandated regulations for reporting of adverse events, and these became effective November 1, 2007.

In May 2007, hospitals and ambulatory surgical centers were provided with the updated NQF List of Serious Reportable Events and the revised list compiled by the Commissioner of Public Health. A new category was included in the NQF list related to fertility clinics (4H).[3] The NQF

[1] As discussed in Connecticut's March 2004 Adverse Events report, adverse events are not the same as medical errors. While there is overlap between the categories, some adverse events do not result from medical errors, and some medical errors do not result in adverse events. Adverse Events Reports are available at www.ct.gov/dph under "Health Care Quality."

[2] http://www.ct.gov/dph/cwp/view.asp?a=3115&q=390100&dphNav_GID=1601

[3] Category 4H is "Artificial insemination with the wrong donor sperm or wrong egg."

category “patient death associated with a fall” (5D) was expanded to include “serious injury associated with a fall.” Reporting for this expanded category replaces the Connecticut-specific category (7B) that previously existed.

On January 1, 2010, an additional adverse event category (7G) entitled, “Patient death or serious disability associated with surgery” specific to Connecticut was added to the list of reportable adverse events. This category includes significant hemorrhage and/or unanticipated death in an American Society of Anesthesiologists (ASA) Class 2 patient.

Public Act 10-122, *An Act Concerning the Reporting of Adverse Events at Hospitals and Outpatient Surgical Facilities and Access to Information Related to Pending Complaints Filed with the Department of Public Health* was signed into law June 8, 2010. Passages relevant to the Quality in Health Care program are:

“For annual reports submitted on or after July 1, 2011, the commissioner shall include hospital and outpatient surgical facility adverse event information for each facility identified (1) by the National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the commissioner and adopted as regulations pursuant to subsection (c) of this section. Such reports shall be prepared in a format that uses relevant contextual information. For purposes of this subsection "contextual information" includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient surgical facility's total number of surgical encounters expressed as a fraction in which the numerator is the aggregate number of adverse events reported by each hospital or outpatient surgical facility by category as specified in this subsection and the denominator is the total of the hospital's patient days or the outpatient surgical facility's total number of surgical encounters, and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. In addition, a hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section. On and after July 1, 2011, any report submitted by the commissioner pursuant to this subsection shall include any informational comments received concerning an adverse event that is included in the report.”

“The advisory committee shall establish methods for informing the public regarding access to the department's consumer and regulatory services.”

CGS Section 19a-127o identifies the primary activity of a Patient Safety Organization (PSO), which is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis, or processing of medical or health-related information submitted to the PSO by the health care provider. This “patient work product” may include reports, records, analyses, policies, procedures or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. PSOs disseminate appropriate information or recommendations on best clinical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Care Advisory Committee and the public. DPH has designated three PSOs, including Qualidigm, the Connecticut Healthcare Research & Education Foundation (CHREF) and the Ambulatory

Surgical Center Patient Safety Organization (ASC PSO) (see the June 30, 2010 DPH report on Connecticut's Quality of Care Program[4]).

ADVERSE EVENT DATA

As of September 2, 2010, the DPH electronic database contained 1,488 reports received using the reporting system that came into effect on July 1, 2004. Demographic information is shown in Appendix A. This information reflects reporting, which is influenced by the varying rates of adverse events in various settings, which depend on the patient case mix, the quality of care, and other factors, as well as the number of patients served, willingness to report events, and the institutional system in place to convey information to the designated reporter. Some external factors may lead us to expect a higher number of reported events, even in facilities providing excellent health care. Consequently, clear conclusions cannot be derived simply from number of reports or fluctuations in the number of reports.

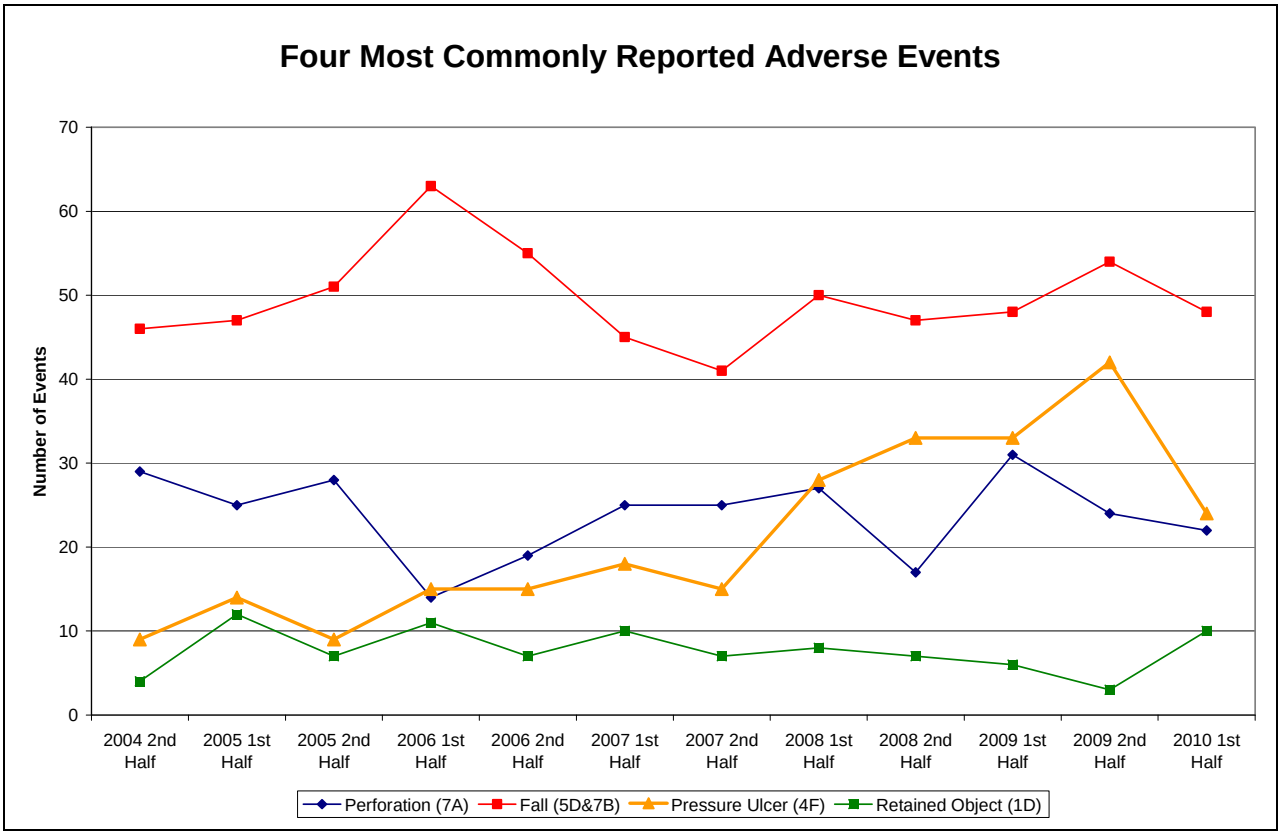
Acute care or children's hospitals submitted 1,301 (87%) of the 1,488 adverse event reports; chronic disease hospitals, 87; hospitals for the mentally ill, 54, and outpatient surgical facilities, 46. Forty-five percent of reported adverse events occurred in males and 55% in females. The majority of reports concerned patients over the age of 65 years. Reported events occurred at all hours of the day and night, though less so between 1 pm and midnight. The most common location of occurrence was reported to be the adult medical ward. One hundred forty-three deaths were reported in connection with an adverse event.

Appendix A also lists the leading adverse event in the following categories: facility type, patient age, and location of event in the facility. The short adverse event identifiers in the right-most column of Appendix A correspond to the longer adverse event descriptions in Appendices B and C.

Appendix B presents the number of adverse events reported by half year, according to the list of NQF events (1A-6D) and Connecticut-specific events (7A-G). For some types of events, none have been reported. As shown in Appendix C, the most commonly reported events were falls that resulted in serious disability or death (5D & 7B). Based on Connecticut's experience, the NQF expanded the fall definition for category 5D so that events formerly reportable under the Connecticut specific category 7B became reportable as category 5D in May 2007. The few reports in the second half of 2007 and later of type 7B therefore should have been reported as 5D. Six hundred seven falls comprised 41% of all 1,488 adverse events reported. The second most commonly reported events were perforations during open, laparoscopic, and/or endoscopic procedures, with 293 reports (20%).[5] The third and fourth most commonly reported events overall in Connecticut were Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, and retention of foreign objects in patients after surgery or other procedures. These four categories constitute 84.5% of reports overall. The number of reports in these four types and the

[4] Quality of Health Care Reports are available at www.ct.gov/dph under "Health Care Quality".
[5] For more details about these adverse events, see the "Six Month Summary of Adverse Event Reports" (Appendix A of the June 30, 2005 DPH report on the Quality in Health Care Program).

proportion of all adverse events that they comprise have been fairly stable throughout six years of reporting.



The number of pressure ulcer reports increased starting in 2008. However, reporting of in-hospital falls, perforations, or objects left in patients after surgery did not change.
See the 2009 adverse event annual report for further details. It has been said with regard to adverse event reporting in general, "The frequency of data generated cannot track changes in safety over time because variations more likely reflect changes in reporting patterns than alterations in underlying hazards."[6] These words provide a valuable note of caution which reminds us that these counts are not easily interpreted. Significant variations in facility reporting patterns are 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, "it is limited by variability and incompleteness in reporting."[7] Data validation is an active surveillance strategy that can be used to increase the completeness of

[6] 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.
[7] 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.

reporting, as is being done in the separate Connecticut Healthcare Associated Infections program. However, data validation is often labor intensive and requires dedicated resources.

CURRENT ACTIVITIES AND FUTURE PLANS

DPH regularly screens mortality data for cause of death codes that might be related to an adverse event. Selected records are reviewed further. The department gathers additional information to determine if reportable fatal adverse events occurred, and whether such events were reported to DPH.

The Department has begun to consider how to present "contextual information" about adverse events, as defined in P.A. 10-122 (see above). The Department will be in close communication with the advisory committee regarding public access to consumer and regulatory services.

Investigation of Adverse Events

The first responsibility for investigation of an adverse event lies with the facility in which the event occurred. Under Connecticut's Adverse Event reporting law, facilities are required to submit a Corrective Action Plan to DPH for each reported Adverse Event.

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; (2) following a sentinel event report by the facility to the Joint Commission, a complaint to the Joint Commission by any person (see www.jointcommission.org), or an unannounced, onsite visit to a facility by the Joint Commission during which an adverse event comes to attention; 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.

After examining an adverse event report, which includes a Corrective Action Plan, the DPH Health Care Systems Branch determines whether to initiate an investigation. Screening to rule out medical error is based on clinical judgment and/or objective medical criteria. The screening team consists of a physician and nurse at DPH.

DPH conducts investigations regarding adverse event reports that may indicate a systems issue or issues 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. Investigations involving adverse events follow the same process as issues received through the public complaint process. Information is gathered through onsite inspection, review of clinical records, interviews with institutional staff and vested parties as appropriate. Beginning in the summer of 2004, resources for part-time DPH physician consultants have been allocated for the specialties of medicine, surgery, pediatrics, anesthesia, obstetrics, gynecology, psychiatry, and orthopedics. The results of completed investigations are public, and may be obtained upon request, under the Freedom of Information (FOI) Act.

Sharing of Lessons

Results from the adverse events program are shared with the Quality in Health Care Advisory Committee.

Connecticut General Statutes and national legislation encourage sharing of patient safety information between healthcare facilities and Patient Safety Organizations,[8] which are completely separate from regulatory entities. Through the Quality in Health Care Advisory Committee, DPH cooperates with PSOs to promote the adoption and development of best practices. The independence of the PSOs, and the confidentiality of their data, are ensured under the law.

Healthcare Associated Infections

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. The 2009 HAI Initiative annual report, available at http://www.ct.gov/dph/lib/dph/hai/pdf/annual_hai_report_2009.pdf, presents Central-Line Associated Blood Stream Infection (CLABSI) rates according to hospital size. The 2010 HAI Initiative annual report will be available in October. The HAI committee plans to develop facility-specific reporting and to post data for the period October 2009 through September 2010 on the DPH HAI website in or around January 2011.

On May 27, 2010, the Centers for Disease Control and Prevention released the first state-specific Healthcare Associated Infections summary data report, comparing CLABSI infection rates during 2009 with rates during 2006-2008 among hospitals that follow the National Healthcare Safety Network (NHSN) protocols. Connecticut data are included.
http://www.cdc.gov/hai/pdfs/stateplans/SIR_05_25_2010.pdf

[8] Other information about PSOs can be found in the June 30, 2009 Quality in Health Care Reports to the General Assembly.

APPENDICES

Appendix A:

Demographic Data from 1,488 Adverse Event Reports

Appendix B:

Adverse Events Reports by Event Type and Half Year of Occurrence

Appendix C:

Adverse Event Reports by Frequency of Occurrence

Appendix A. Demographic Data from 1,488 Adverse Event Reports in the Electronic Database, July 1, 2004-September 2, 2010

Measure	Frequency	Percent	Most Common Event
Facility Type (n=1488)			*Facility's Leading Event (n)*
Acute Care or Children's Hospital	1301	87.4	Fall (513)
Chronic Disease Hospital	87	5.9	Fall (63)
Hospital for Mentally Ill Persons	54	3.6	Fall (30)
Outpatient Surgical Facility	46	3.1	Perforation (34)
Patient Gender (n=1467)			
Male	654	44.6	
Female	813	55.4	
Patient Age (n=1488)			*Age Group's Leading Event*
0-14	59	4.0	Retained Object (11)
15-44	214	14.4	Perforation (41)
45-64	334	22.5	Fall (88)
65 and older	881	59.2	Fall (489)
Event Hour (n=1453)			
Midnight-3:59 am	440	30.3	
4 am-7:59 am	253	17.4	
8 am-11:59 am	397	27.3	
12 noon-3:59 pm	201	13.8	
4 pm-7:59 pm	107	7.4	
8 pm-11:59 pm	55	3.8	
Location of Event (n=1467)			*Location's Leading Event*
Adult Medical	410	28.0	Fall (294)
Adult Surgical	108	7.4	Fall (58)
Ambulatory Surgical	31	2.1	Perforation (17)
Cardiac Care	55	3.8	Fall (35)
Cardiac Cath Lab	10	0.7	Retained Object (4)
Diagnostic Services	48	3.3	Perforation (30)
Dialysis	2	0.1	--
Emergency Department	55	3.8	Fall (32)
Medical ICU	90	6.1	Stage 3-4 Ulcer (60)
Neonatal ICU	2	0.1	--
Obstetrical/Gynecological	47	3.2	Obstetric Event (22)
Operating Room	147	10.0	Perforation (75)
Other	170	11.6	Perforation (72)
Outpatient Services	71	4.8	Perforation (52)
Pediatrics	5	0.3	--
Psychiatric	133	9.1	Fall (96)
Rehabilitative Services	25	1.7	Fall (15)
Surgical ICU	58	4.0	Stage 3-4 Ulcer (42)
Patient Expired (n=1360)	143	10.5	

Appendix B. Connecticut Adverse Events Reports in Electronic Database
September 2, 2010, by Event Code and Half Year of Occurrence
NQF List (1A-6D) and Connecticut-Specific List (7A-7G)

Event Code	Description	Time - Period												Total
		2004	2005		2006		2007		2008		2009		2010	
		2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	
1A	Surgery performed on the wrong body part	1	2	2	0	3	1	2	1	4	1	1	2	20
1B	Surgery performed on the wrong patient	0	0	0	0	1	2	0	0	0	0	0	0	3
1C	Wrong surgical procedure performed on a patient	0	1	1	0	0	2	2	1	0	0	0	1	8
1D	Retention of a foreign object in a patient after surgery or other procedure	4	12	7	11	7	10	7	8	7	6	3	10	92
1E	Intraoperative or immediate post-operative death in an ASA class I patient	0	0	0	0	0	0	1	0	0	0	0	0	1
2A	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	0	1	0	0	0	0	0	1	0	0	1	0	3
2B	Patient death or serious disability 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	4	3	3	1	2	0	1	1	0	2	0	19
2C	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	0	2	1	0	0	0	0	1	0	2	1	0	7
3A	Infant discharged to the wrong person	0	0	0	0	0	0	0	0	0	0	0	0	0
3B	Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	0	0	0	0	0	0	0	0	0	0	0	0	0
3C	Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	0	2	1	1	2	2	2	1	3	0	0	0	14
4A	Patient death or serious disability 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)	4	2	2	5	0	0	1	2	1	0	2	0	19

Event Code	Description	Time - Period												Total
		2004	2005		2006		2007		2008		2009		2010	
		2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	
4B	Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	0	0	0	0	0	0	0	0	1	0	0	0	1
4C	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	1	0	2	1	0	0	0	0	2	0	0	1	7
4D	Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	0	1	0	0	1	2	0	0	0	0	0	0	4
4E	Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	0	0	0	0	0	0	0	0	0	0	0	0	0
4F	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	9	14	9	15	15	18	15	28	33	33	42	24	255
4G	Patient death or serious disability due to spinal manipulative therapy	0	1	0	0	0	0	0	0	0	0	0	0	1
4H	Artificial insemination with the wrong donor sperm or wrong egg							0	0	0	1	0	0	1
5A	Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	0	0	0	0	0	0	0	0	0	0	0	0	0
5B	Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	0	0	0	0	0	1	0	0	0	0	0	0	1
5C	Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	0	0	0	1	2	1	0	0	0	1	0	0	5
5D & 7B	Patient death or serious injury associated with a fall while being cared for in a healthcare facility	46	47	51	63	55	45	41	50	47	48	54	48	595

Appendix B continued

Event Code	Description	Time - Period												Total
		2004	2005		2006		2007		2008		2009		2010	
		2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	
5E	Patient death or serious disability associated with the use of restraints or bedrails while being	0	0	0	1	0	0	1	0	0	1	1	1	5
6A	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	0	0	0	0	1	0	0	0	0	0	0	0	1
6B	Abduction of a patient of any age	0	0	0	0	0	0	0	0	0	1	0	0	1
6C	Sexual assault on a patient within or on the grounds of a healthcare facility	2	3	2	7	5	5	2	5	0	1	1	1	34
6D	Death or significant 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 facility	2	1	1	0	0	1	0	2	0	0	1	1	9
7A	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	29	25	28	14	19	25	25	27	17	31	24	22	286
7B	See event code 5D & 7B*													
7C	Obstetrical events resulting in death or serious disability to the neonate	3	2	4	3	1	3	2	1	0	1	1	3	24
7D	Significant medication reactions resulting in death or serious disability	0	1	2	0	1	2	1	1	3	0	1	0	12
7E	Laboratory or radiologic test results not reported to the treating practitioner or reported incorrectly which result in death or serious disability due to incorrect or missed diagnosis in the emergency department	0	0	0	0	1	0	0	0	0	0	0	1	2
7F	Nosocomial infections resulting in death or serious injury	3	1	1	2	1	1	2	3	3	2	0	1	20
7G	Patient death or serious disability as a result of surgery											1	5	6
Total		**106**	**122**	**117**	**127**	**116**	**123**	**104**	**133**	**122**	**129**	**136**	**121**	**1456**

Adverse events reported using the older classification system, Oct 2002-June 2004 are not included.
Events reported using the NQF classification system but occurring prior to July 1, 2004 or after June 30, 2010 are not included.
Category 4H was added to the list of reportable adverse events in May 2007.
Category 7G was added to the list of reportable adverse events in January 2010.
*Prior to May 2007 category 5D included only death associated with a fall.
*Events formerly classified as 7B are reportable as 5D starting May 2007.

Appendix C. Connecticut Adverse Event Reports in Electronic Database September 2, 2010, by Frequency of Occurrence NQF List (1A-6D) and Connecticut-Specific List (7A-7G)

Event	Description	Frequency	Percent
5D & 7B*	Patient death or serious injury associated with a fall while being cared for in a healthcare facility	607	40.8%
7A	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	293	19.7%
4F	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	261	17.5%
1D	Retention of a foreign object in a patient after surgery or other procedure	96	6.5%
6C	Sexual assault on a patient within or on the grounds of a healthcare facility	34	2.3%
7C	Obstetrical events resulting in death or serious disability to the neonate	24	1.6%
1A	Surgery performed on the wrong body part	21	1.4%
7F	Nosocomial infections resulting in death or serious injury	20	1.3%
4A	Patient death or serious disability 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)	20	1.3%
2B	Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	19	1.3%
3C	Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	14	0.9%
7D	Significant medication reactions resulting in death or serious disability	12	0.8%
6D	Death or significant 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 facility	10	0.7%
1C	Wrong surgical procedure performed on a patient	8	0.5%
4C	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	7	0.5%
2C	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	7	0.5%
7G	Death or serious injury associated with surgery	6	0.4%
5C	Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	5	0.3%
5E	Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	5	0.3%

Appendix C continued

Event	Description	Frequency	Percent
4D	Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	4	0.3%
1B	Surgery performed on the wrong patient	3	0.2%
2A	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	3	0.2%
7E	Laboratory or radiologic test results not reported to the treating practitioner or reported incorrectly which result in death or serious disability due to incorrect or missed diagnosis in the emergency department	2	0.1%
4B	Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	1	0.1%
4G	Patient death or serious disability due to spinal manipulative therapy	1	0.1%
5B	Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	1	0.1%
6A	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	1	0.1%
1E	Intraoperative or immediate post-operative death in an ASA class I patient	1	0.1%
4H	Artificial insemination with the wrong donor sperm or wrong egg	1	0.1%
6B	Abduction of a patient of any age	1	0.1%
3A	Infant discharged to the wrong person	0	0.0%
3B	Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	0	0.0%
4E	Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	0	0.0%
5A	Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	0	0.0%
Total		**1488**	**100.0%**

*Prior to May 2007 category 5D included only death associated with a fall, while 7B included falls resulting in serious injury. Events formerly classified as 7B are reportable as 5D starting May 2007.