LEGISLATIVE REPORT TO THE GENERAL ASSEMBLY
Adverse Event Reporting

General Statutes of Connecticut
Section 19a-127l-n

QUALITY OF CARE PROGRAM

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EXECUTIVE SUMMARY

Under the current event definitions, the most common adverse events among 1,224 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" becomes reportable. After screening 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.

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).[2] The NQF 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.

In July 2009, the DPH Commissioner completed the annual review required by CGS 19a-127 and approved an additional Connecticut-specific category, while continuing the five current Connecticut-specific adverse event categories, as recommended by the Quality in Health Care

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

Advisory Committee's Subcommittee on Best Practices and Adverse Events. The additional category (7G) is "Patient death or serious disability associated with surgery."

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 medical 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, 2009 DPH report on Connecticut's Quality of Care Program[3]).

ADVERSE EVENT DATA

As of September 8, 2009, the DPH electronic database contained 1,224 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 from number of reports or fluctuations in the number of reports. For these reasons, no facility-level data are presented.

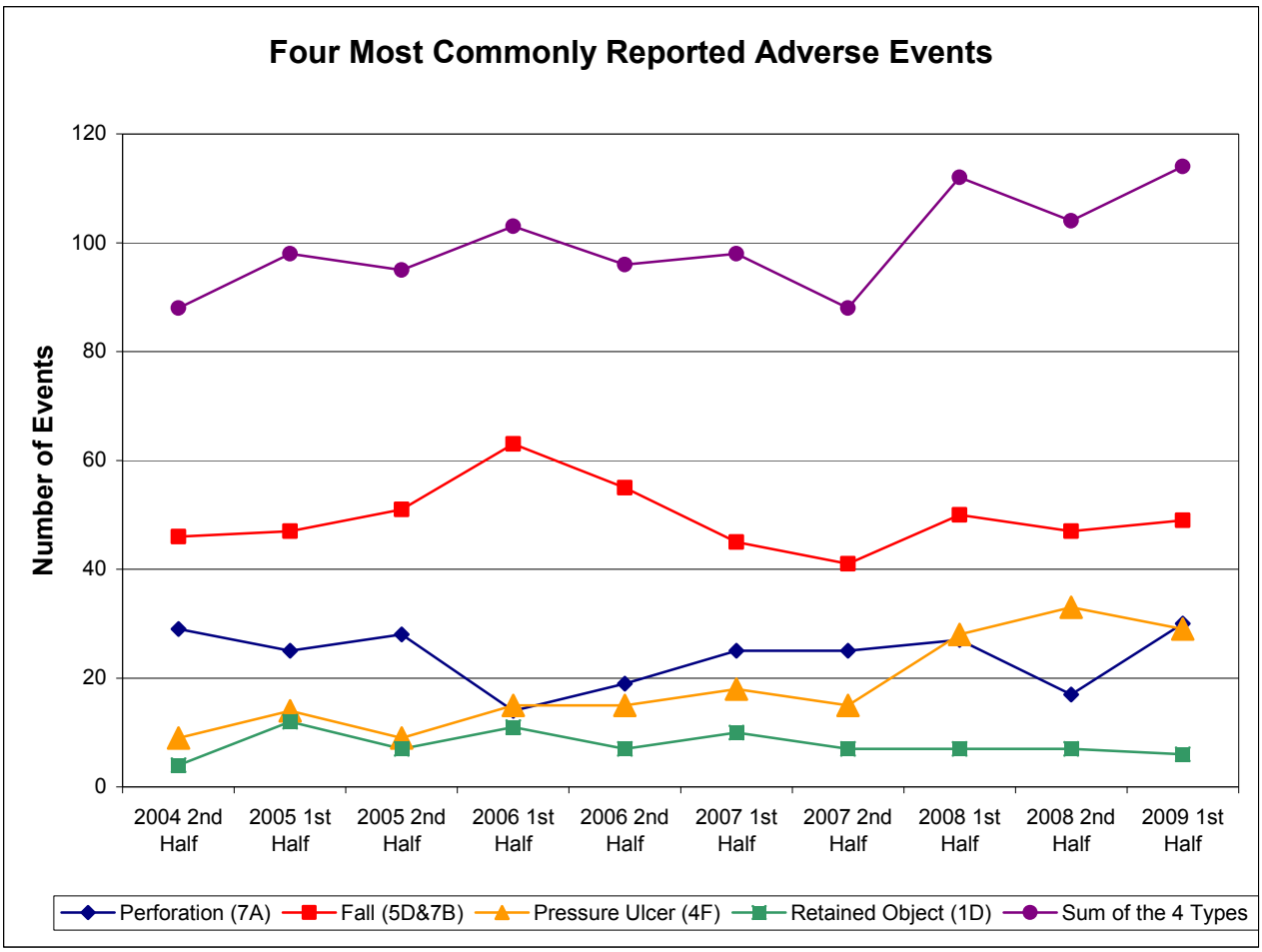
Acute care or children's hospitals submitted 1,070 (87%) of the 1,224 adverse event reports; chronic disease hospitals, 67; hospitals for the mentally ill, 52, and outpatient surgical facilities, 35. Forty-five percent of reported adverse events occurred in males and 55% in females. The majority of reports 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 sixteen 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 the NQF events (1A-6D) and Connecticut-specific events (7A-F). For some types of events,

[3] Quality of Health Care Reports are available at www.ct.gov/dph under "Health Care Quality".

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). As noted above, 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. Five hundred two falls comprised 41% of all 1,224 adverse events reported. The second most commonly reported events were perforations during open, laparoscopic, and/or endoscopic procedures, with 247 reports (20%).[4] 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% of reports overall. The number of reports in these four types and the proportion of all adverse events that they comprise have been fairly stable throughout five years of reporting.



[4] 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 of Health Care Program).

The number of pressure ulcer reports increased starting in 2008.[5] However, reporting of in-hospital falls, perforations, or objects left in patients after surgery did not change.[6] Ninety-four percent (94%) of 194 pressure ulcer reports for 2004-2009 were submitted by acute care or children's hospitals, 6% by chronic disease hospitals; 62% of involved patients were male; 49% were 65 years or older, 35% were ages 45-64, 14% were ages 15-44, and 2% were less than 15 years old; 63% of reports identified the time of occurrence between midnight and 8 am. The leading location of occurrence for ulcers, within the hospital, was adult medical (though falls were the leading adverse event there), followed by medical intensive care.

Summary of the 94 pressure ulcer cases in 2007-2008

Locations were: sacrum/coccyx (64), buttocks (10), hip (6), heel (4), upper back (3), tracheotomy site (2), forefoot (1), mandible (1), nose (1), thigh (1). Some notes mentioned multiple locations. The following were mentioned in the electronic adverse event report to DPH: special bed (29); debridement of wound (23); wound care nurse or specialist saw the patient (22); use of dressing/cream/duoderm/enzyme (20); nutritional therapy (10); skin consult (10), ulcer slough (6); patient incontinence (6); Braden ulcer score (4); foul wound smell/exudate/antibiotics (3); staff unable to reposition patient (3); surgery consult (1); patient refused special bed (1).

Of the 33 pressure ulcer reports for events during 2007, 30 were determined from the description in the electronic record to have developed during the hospital stay. Three could not be classified from the electronic record of the adverse event report to DPH. In one unclassifiable case the ulcer was documented as stage 2 and a week later a "skin integrity plan of care was documented" but without mention that the stage had progressed. In a second case the patient was stated to have multiple risk factors for development of decubitus ulcers, but no ulcer description was provided. In a third case the patient underwent a coronary bypass and on the first post-op night was documented to have a stage 4 ulcer, suggesting that it was present on admission.

Of the 61 pressure ulcer reports for events during 2008, 51 were determined from the description in the electronic record to have developed during the hospital stay. Three were documented as present on admission. Seven could not be classified from the electronic record of the adverse event report to DPH. In the first case the patient was assessed on admission as having no pressure ulcer but as having deep tissue injury, osteomyelitis and spinal epidural abscess. Upon debridement down to the deep tissue injury the patient was stated to have a stage 4 ulcer resulting from surgery. In the second case the ulcer stage at admission was omitted, subsequently described as unstageable, and later was surgically debrided to the bone (stage 4). The third case was noted to be unstageable, but from the description was serious. In the fourth

[5] Minnesota's January 2009 adverse event report reflects a large increase in pressure ulcer reporting during October 7, 2007-October 6, 2008 compared with the previous year, as unstageable ulcers became reportable. The number of stage 3-4 ulcers actually decreased there. http://www.health.state.mn.us/patientsafety/ae/09ahereport.pdf.

[6] Medicare required hospitals to report whether adverse events in ten categories, including pressure ulcer, fall, and surgical object left in patient, were present on admission, beginning October 2007. Starting October 2008 Medicare will not pay a hospital extra to treat any adverse event on the list unless it was present on admission. The preventability of adverse events on the Medicare list varies considerably. Pronovost PJ, Goeschel CA, Wachter RM. The wisdom and justice of not paying for 'preventable complications.' JAMA 2008;299(18):2197-2199. Averill RF, Hughes JS, Goldfield NI, McCullough EC. Hospital complications: linking payment reduction to preventability. Joint Comm J Qual Pt Safety 2009;35(5):283-285.

case the patient had a tibeal fracture and history of ulcer, but the note did not record a current ulcer. The fifth case was a patient with many co-morbid conditions who developed an unstageable ulcer. The sixth case was an unstageable ulcer which upon debridement was deemed stage 4. The seventh case did not have the stage stated but appeared serious from the description.

In 2008 there were more reports of ulcers being present on admission, of being unstageable (and, by the adverse events reporting requirements, not reportable), or becoming ulcers upon surgical debridement, compared with 2007. Factors that could contribute to a greater number of ulcer reports include greater ulcer prevalence in the population being served, changes in care, greater awareness of ulcers among care providers, or increased willingness to report ulcers in 2008.

The National Quality Forum specifications for reportable pressure ulcers (adopted by Connecticut in 2004) exclude "progression from stage 2 to stage 3 if stage 2 was recognized upon admission." The class 4F adverse event reports during 2007-2008 suggest that facilities understand this exclusion. Patients with stage 2 ulcers at admission were only mentioned in reports if they developed stage 4 ulcers.

CURRENT ACTIVITIES AND FUTURE PLANS

Revision of Reportable Adverse Events List

DPH is consulting with internal experts, with the Connecticut Hospital Association (CHA), and with hospitals to develop additional specifications and implementation guidance for the new Connecticut-specific event category (7G), "Patient death or serious disability associated with surgery." DPH, plans to post the revised reportable adverse events list and instructions to its website under "Forms". The anticipated effective date for using the revised list is early 2010.

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 screening 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 are 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 medical 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 patient or family is contacted during and after completion of the investigation. The results of completed investigations are public, and may be obtained upon request, under the Freedom of Information 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,[7] 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.

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

Appendix A. Demographic Data from 1,224 Adverse Event Reports in the Electronic Database, July 1, 2004-September 8, 2009

Measure	Frequency	Percent	Most Common Event
Facility Type (n=1224)			*Facility's Leading Event (n)*
Acute Care or Children's Hospital	1070	87.4	Fall (420)
Chronic Disease Hospital	67	5.5	Fall (54)
Hospital for Mentally Ill Persons	52	4.3	Fall (28)
Outpatient Surgical Facility	35	2.9	Perforation (25)
Patient Gender (n=1209)			
Male	546	45.2	
Female	663	54.8	
Patient Age (n=1224)			*Age Group's Leading Event*
0-14	50	4.1	Retained Object (11)
15-44	183	15.0	Perforation (37)
45-64	267	21.8	Fall (71)
65 and older	724	59.2	Fall (409)
Event Hour (n=1190)			
Midnight-3:59 am	355	29.8	
4 am-7:59 am	203	17.1	
8 am-11:59 am	318	26.7	
12 noon-3:59 pm	176	14.8	
4 pm-7:59 pm	93	7.8	
8 pm-11:59 pm	45	3.8	
Location of Event (n=951)			*Location's Leading Event*
Adult Medical	330	27.4	Fall (242)
Adult Surgical	92	7.6	Fall (50)
Ambulatory Surgical	27	2.2	Perforation (14)
Cardiac Care	47	3.9	Fall (31)
Cardiac Cath Lab	8	0.7	--
Diagnostic Services	42	3.5	Perforation (28)
Dialysis	1	0.1	--
Emergency Department	44	3.7	Fall (26)
Medical ICU	75	6.2	Stage 3-4 Ulcer (51)
Neonatal ICU	2	0.2	--
Obstetrical/Gynecological	38	3.2	Obstetric Event (19)
Operating Room	121	10.1	Perforation (59)
Other	137	11.4	Perforation (64)
Outpatient Services	57	4.7	Perforation (44)
Pediatrics	4	0.3	--
Psychiatric	118	9.8	Fall (83)
Rehabilitative Services	20	1.7	Fall (13)
Surgical ICU	41	3.4	Stage 3-4 Ulcer (26)
Patient Expired (n=1114)	116	10.4	

Appendix B. Connecticut Adverse Events Reports in Electronic Database
September 8, 2009, by Event Code and Half Year of Occurrence
NQF List (1A-6D) and Connecticut-Specific List (7A-7F)

Event Code	Description	Time - Period										Total
		2004	2005		2006		2007		2008		2009	
		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	17
1B	Surgery performed on the wrong patient	0	0	0	0	1	2	0	0	0	0	3
1C	Wrong surgical procedure performed on a patient	0	1	1	0	0	2	2	1	0	0	7
1D	Retention of a foreign object in a patient after surgery or other procedure	4	12	7	11	7	10	7	7	7	6	78
1E	Intraoperative or immediate post-operative death in an ASA class I patient	0	0	0	0	0	0	1	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	2
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	17
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	6
3A	Infant discharged to the wrong person	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
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	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	17

Appendix B continued

Event Code	Description	Time - Period										Total
		2004	2005		2006		2007		2008		2009	
		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	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	6
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	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
4F	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	9	14	9	15	15	18	15	28	33	29	185
4G	Patient death or serious disability due to spinal manipulative therapy	0	1	0	0	0	0	0	0	0	0	1
4H	Artificial insemination with the wrong donor sperm or wrong egg							0	0	0	1	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
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	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	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	49	494

Appendix B continued

Event Code	Description	Time - Period										Total
		2004	2005		2006		2007		2008		2009	
		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	3
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	1
6B	Abduction of a patient of any age	0	0	0	0	0	0	0	0	0	1	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	32
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	7
7A	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	29	25	28	14	19	25	25	27	17	30	239
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	20
7D	Significant medication reactions resulting in death or serious disability	0	1	2	0	1	2	1	1	3	0	11
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	1
7F	Nosocomial infections resulting in death or serious injury	3	1	1	2	1	1	2	3	3	2	19
Total		**106**	**122**	**117**	**127**	**116**	**123**	**104**	**132**	**122**	**125**	**1194**

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, 2009 are not included.
Category 4H was added to the list of reportable adverse events in May 2007.
*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 8, 2009, by Frequency of Occurrence NQF List (1A-6D) and Connecticut-Specific List (7A-7F)

Event	Description	Frequency	Percent
5D & 7B*	Patient death or serious injury associated with a fall while being cared for in a healthcare facility	502	41.0%
7A	Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability	247	20.2%
4F	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	194	15.8%
1D	Retention of a foreign object in a patient after surgery or other procedure	81	6.6%
6C	Sexual assault on a patient within or on the grounds of a healthcare facility	32	2.6%
7C	Obstetrical events resulting in death or serious disability to the neonate	20	1.6%
7F	Nosocomial infections resulting in death or serious injury	19	1.6%
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)	18	1.5%
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	17	1.4%
1A	Surgery performed on the wrong body part	17	1.4%
3C	Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	14	1.1%
7D	Significant medication reactions resulting in death or serious disability	11	0.9%
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	8	0.7%
1C	Wrong surgical procedure performed on a patient	7	0.6%
4C	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	6	0.5%
2C	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	6	0.5%
5C	Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	5	0.4%
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%

Appendix C continued

Event	Description	Frequency	Percent
1B	Surgery performed on the wrong patient	3	0.2%
5E	Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	3	0.2%
2A	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	2	0.2%
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%
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	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		**1224**	**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.