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# State of Wyoming



## Department of Health

# **ADVERSE HEALTH EVENTS IN WYOMING HEALTHCARE FACILITIES: Second Annual Report 2006-2007**

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**The Wyoming Department of Health  
Preventative Health and Safety Division  
Report to the Governor, Wyoming Healthcare Commission and  
Joint Labor, Health, and Social Services Interim Committee**

**Second Annual Report on  
Adverse Health Events in  
Wyoming Healthcare Facilities**

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## Background

In 2000, the Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System*<sup>1</sup>. This report introduced many Americans to the idea that medical errors in hospitals kill between 44,000 and 98,000 people each year, making medical errors the 8<sup>th</sup> leading cause of death in this country<sup>1</sup>. The data presented in the aforementioned report did not come as a surprise to most healthcare professionals; however, the IOM report helped to focus the efforts of healthcare workers to address the systemic causes of medical errors.

Medical errors, as the IOM confirmed, were largely the result of failures within complex systems and processes in healthcare rather than the careless actions of any one healthcare provider. According to the report, "People working in health care are among the most educated and dedicated in the workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer."<sup>1</sup>

The IOM concluded that the most effective way to redesign the system for improved patient safety was to learn more about preventable adverse events. They recommended the implementation of a mandatory reporting system in which the most serious events would be reported, persistent safety problems would be identified, and action would be taken to prevent these errors<sup>1</sup>. Wyoming was one of many states to respond to this recommendation with legislation to implement an adverse events reporting system.

In 2005, the Wyoming Legislature enacted Wyoming Statute 35-2-912: Mandatory Reporting of Safety Events. The statute mandates that licensed healthcare facilities report any occurrence in a defined set of patient safety events to the Wyoming Department of Health. Each licensed facility is also required to designate a Patient Safety Officer who is responsible for reporting such adverse events. (For more information on the mandatory reporting of adverse events in Wyoming, see Appendix B.)

Events reported to the Wyoming Department of Health are part of a passive surveillance system to monitor and learn from adverse events occurring within Wyoming healthcare facilities. The Wyoming Department of Health is required to complete a number of activities related to the adverse event reports including:

- Tracking, assessing, and analyzing incoming adverse event reports and findings
- Publishing an annual report of events including a trend analysis and recommendations for systemic improvements that are likely to enhance patient safety and healthcare
- Providing feedback to Wyoming healthcare agencies, healthcare facilities, and the governor with the purpose of continuously improving patient safety within the state

This is the second year of implementation of the Mandatory Reporting of Safety Events System, and the analysis and feedback process is still in its beginning phase. The following report describes the events reported during the second year (July 2006 through June 2007) and this information will be compared to last year's data. In congruence with the statute, and in order to create a culture of safety and to encourage the accurate reporting of adverse events, no one facility has been identified in this report and all data has been aggregated. Tables with overall, state-wide information as well as tables containing event-specific information begin on page four (4).

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<sup>1</sup> L.T. Kohn, J.M. Corrigan and M.S. Donaldson, Editors, *To Err is Human: Building a Safer Health System*, National Academies Press, Washington, DC (2000).

## How to Use This Report<sup>2</sup>

Patient safety advocates should understand that events listed in this report represent a fraction of all of the procedures and admissions in Wyoming hospitals and healthcare facilities. With relatively low occurrence of adverse events, it is important to recognize that the number of reports from Wyoming facilities may differ from year to year for a variety of reasons. Wyoming hospitals and healthcare facilities vary in size and scope of medical practice. There is also variation in the number of admissions and in the number and types of procedures performed from year-to-year.

In addition, the variations may stem from differences in reporting procedures, interpretation of the law, and the quality or safety of a hospital in general. As clearly and concisely as Wyoming law is written, there will be variation in what gets reported based on interpretation of which events are reportable. Also, the level of awareness of healthcare staff in identifying potentially harmful situations and reporting them will cause variance in reporting. The Wyoming Department of Health, hospitals, and other patient safety stakeholders continue to work to reduce this disparity in interpretation and application of the law.

Healthcare providers in Wyoming hospitals are watching for potentially dangerous situations and subsequently reporting them with the intent to learn and prevent harm to patients. This reality is a major step forward in patient safety. Consumers should use this report to identify situations of interest to them and ask their hospital or healthcare provider what is being done in their facility to prevent these types of events from occurring.

Patients and families are a vital part of the healthcare team and play an important role in ensuring safe healthcare. Many resources are available for patients interested in what they can do to help make their healthcare safer. One such resource is the Federal Agency for Health Research and Quality (AHRQ). AHRQ has compiled research pertaining to patient safety and has developed many tips for patients that can be found at <http://www.ahrq.gov/qual/>. Some of these tips are highlighted in this report, and can be found on page eight (8).

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<sup>2</sup> MDH Adverse Health Events in MN Hospitals, 2005

**Table 1: Categories of Reportable Events as Defined by Law\***

<b>SURGICAL EVENTS</b>
• Surgery performed on a wrong body part;
• Surgery performed on the wrong patient;
• The wrong surgical procedure performed on a patient;
• Foreign objects left in a patient after surgery; or
• Death during or immediately after surgery of a normal, healthy patient.
<b>PRODUCT OR DEVICE EVENTS</b>
<b>Patient death or serious disability associated with:</b>
• The use of contaminated drugs, devices, or biologics;
• The use or malfunction of a device in patient care; and
• An intravascular air embolism.
<b>PATIENT PROTECTION EVENTS</b>
• An infant discharged to the wrong person;
• Patient death or serious disability associated with patient disappearance; and
• Patient suicide or attempted suicide resulting in serious disability.
<b>CARE MANAGEMENT EVENTS</b>
<b>Patient death or serious disability:</b>
• Associated with a medication error;
• Associated with a reaction due to incompatible blood or blood products;
• Associated with labor or delivery in a low-risk pregnancy;
• Directly related to hypoglycemia (low blood sugar);
• In newborn infants during the first 28 days of life associated with hyperbilirubinemia;
• Due to spinal manipulative therapy; and
• Stage 3 or 4 ulcers (very serious pressure sores) acquired after admission to a facility.
<b>ENVIRONMENTAL EVENTS</b>
<b>Patient death or serious disability associated with:</b>
• An electric shock;
• A burn incurred while being cared for in a facility;
• A fall while being cared for in a facility;
• The use or lack of restraints or bedrails while being cared for in a facility; and
• 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.
<b>CRIMINAL EVENTS</b>
• Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;
• Abduction of a patient of any age;
• Sexual assault on a patient within or on the grounds of a facility; and
• Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

\*Detailed definitions are included in Appendix C

## Events Reported in Wyoming Healthcare Facilities

**Table 2: Summary of Adverse Health Events Reported (July 2005 – June 2007)**

2. Total Events												
	Severity Details											
	Frequency (# Events)			Percentage (%)			Disability			Death		
	2005-2006	2006-2007	% Change	2005-2006	2006-2007	% Change	2005-2006	2006-2007	% Change	2005-2006	2006-2007	% Change
Surgical	6	4	-33.3	10.3	9.3	-9.7	0	0	-	1	0	-100
Products or devices	3	0	-100	5.2	2.3	-55.8	0	0	-	0	0	-
Patient Protection	0	0	-	0.0	0.0	-	0	0	-	0	0	-
Care Management	19	14	-26.3	32.8	32.6	-0.6	4	0	-100	1	2	100.0
Environmental	25	25	-	43.1	58.1	34.8	19	20	-5.3	4	2	-50.0
Criminal	5	0	-100	8.6	0.0	-100	0	0	-	0	0	-
<b>Total</b>	<b>58</b>	<b>43</b>	<b>-25.9</b>	<b>100</b>	<b>100</b>	<b>-</b>	<b>23</b>	<b>20</b>	<b>-13.0</b>	<b>6</b>	<b>4</b>	<b>-33.3</b>

In fiscal year 2006-2007, 43 adverse health events were reported; 20 of the events resulted in serious disability, and four resulted in death. For the second consecutive year, care management and environmental events comprised the largest percentage of reported events (32.6% and 58.1%, respectively). There was an overall decrease in the number of events reported during 2006-2007 fiscal year compared to the 2005-2006 fiscal year. Detailed events stratified by category are presented in Tables 3A-3F, below.

**Table 3 (A-F): Statewide Reports by Category (July 2006 - June 2007)**

<b>3A. Surgical</b>						
	<b>Wrong body part</b>	<b>Wrong patient</b>	<b>Wrong procedure</b>	<b>Foreign object</b>	<b>Intra/Post-op death</b>	<b>Total</b>
Frequency	1	0	0	3	0	4
Severity details						
	Disability	-	-	-	0	0
	Death	-	-	-	0	0
* For the second consecutive year, retention of a foreign object was associated with the most adverse events in this category.						

<b>3B. Products or Devices</b>				
<b>Patient death or serious disability associated with:</b>				
	<b>Contaminated drugs, devices, or biologics</b>	<b>Misuse or malfunction of device</b>	<b>Intravascular air embolism</b>	<b>Total for Products or devices</b>
Frequency	0	0	0	0
Severity details				
	Disability	-	-	0
	Death	-	-	0
* No events were reported in this category for 2006-07.				

<b>3C. Patient Protection</b>				
	<b>Wrong discharge of infant</b>	<b>Patient disappearance</b>	<b>Suicide or attempted suicide</b>	<b>Total for Patient Protection</b>
Frequency	0	0	0	0
Severity details				
	Disability	-	-	0
	Death	-	-	0
* No events were reported in this category for 2006-07.				

<b>3D. Care Management</b>								
Patient death or serious disability associated with:								
	Medication Error	Hemolytic Reaction	During low-risk pregnancy, labor, or delivery	Hypo-glycemia	Failure to treat hyperbilirubinemia	Stage 3 or stage 4 pressure ulcers acquired after admission	Spinal manipulation	Total for Care Mgmt
Frequency	6	0	0	0	0	8	0	14
Severity details								
Disability	0	-	-	-	-	0	-	0
Death	1	-	-	-	-	1	-	2
* Four of the six reported medication errors were due to improper dosage administration to a patient as a result of transposing numbers or misinterpreting units. For example, 50 mg of a medication was given to a patient instead of 5 mg, as prescribed.								

<b>3E. Environmental</b>						
Patient death or serious disability associated with:						
	Electric shock	Wrong gas or contamination in patient gas line	Burns	Injury associated with a fall*	Restraints	Total for Environmental
Frequency	0	0	0	25	0	25
Severity details						
Disability	-	-	-	20	-	20
Death	-	-	-	2	-	2
* Eighty-four percent of the falls reported resulted in a fractured or broken bone.						

<b>3F. Criminal</b>					
	Care ordered by someone impersonating a physician, nurse, or other provider	Abduction of patient	Sexual assault of a patient	Death or injury of patient or staff from physical assault	Total for Criminal
Frequency	0	0	0	0	0
Severity details					
Disability	-	-	-	-	0
Death	-	-	-	-	0
* No events were reported in this category for 2006-07.					

**Table 4: Statewide Numbers for Facility Type (July 2006 - June 2007)**

4. Type of Facility	Current Statewide Number
Hospitals	26
Hospices	20
Home Health Agencies	46
Nursing Home Facilities	39
Assisted Living Facilities	20
Adult Daycare Facilities	9
Residential Facilities (Boarding Homes)	15
Behavioral Health/Developmental Disabilities	4
Dialysis Centers	9
Surgical Centers	17
	<b>205</b>

**Table 6: Events by Facility Type (July 2005 - June 2007)**

5. Facility Type	Number of Reports 2005-2006	Number of Reports 2006-2007	Percent Change
Hospitals	18	14	- 22.2
Home Health Agencies	1	2	100.0
Nursing Home Facilities	30	10	- 66.7
Assisted Living Facilities	5	10	100.0
Residential Facilities (Boarding Homes)	2	5	150.0
Surgical Centers	1	2	100.0
Behavioral Health/Developmental Disabilities	1	0	- 100.0
	<b>58</b>	<b>43</b>	<b>- 25.9</b>

- During the first year (2005-2006), 19 facilities out of 199 (9.5%) reported a total of 58 adverse health events, of which 23 events resulted in serious disability and six resulted in death. Although 19 facilities reported events, it is likely that reporting is incomplete, and these events are not representative of all adverse events occurring within the state.
- During the second year (2006-2007), 21 facilities out of 205 (10.2%), Table 2, facilities reported a total of 43 adverse health events, of which 20 events resulted in serious disability and four resulted in death. Although 21 facilities reported events, it is likely that reporting is incomplete and these events are not representative of all adverse events occurring in the state.

## Selected Safety Tips from the Agency for Health Quality and Research (AHQR)<sup>3</sup>

### Be Involved in Your Healthcare

1. The single most important way you can help to prevent errors is to be an active member of your healthcare team. This means taking part in every decision about your healthcare. Research shows that patients who are more involved with their care tend to get better results.

### Medicines

2. Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you receive them:

- What is the medicine for?
- How am I supposed to take it, and for how long?
- What side effects are likely? What do I do if they occur?
- Is this medicine safe to take with other medicines or dietary supplements I am taking?
- What food, drink, or activities should I avoid while taking this medicine?

### Hospital Stays

3. If you have a choice, choose a hospital at which many patients have the procedure or surgery you need. Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.

4. If you are in a hospital, consider asking all healthcare workers who have direct contact with you whether they have washed their hands. Hand washing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether healthcare workers washed their hands, the workers washed their hands more often and used more soap.

5. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

### Surgery

6. If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done. Doing surgery at the wrong site (for example, operating on the left knee instead of the right) is rare, but even once is too often. The good news is that wrong-site surgery is one hundred percent preventable. The Academy of Orthopedic Surgeons urges its members to sign their initials directly on the site to be operated on before surgery.

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<sup>3</sup> Agency for Health Quality and Research, Patient Fact Sheet: 20 Tips to Help Prevent Medical Errors Online. Available: <http://www.ahrq.gov/consumer/> [Accessed October 2006]

## Other Steps You Can Take

7. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.
8. Make sure that someone, such as your personal doctor, is in charge of your care. This is especially important if you have many health problems or are in a hospital.
9. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need in order to provide you with proper care.
10. Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.
11. Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
12. If you have a test, don't assume that no news is good news. Ask about the results.
13. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.

## Resources:

National Patient Safety Foundation

<http://www.npsf.org/>

The Agency for Health Quality and Research

<http://www.ahrq.gov/qual/errorsix.htm>

## Recommendations for Healthcare Facilities

Two years has passed since the full implementation of Wyoming's Mandatory Reporting of Safety Events System. Although there was an increase in the number of facilities reporting to the Department of Health this year; the number of reported events declined by approximately twenty-six percent. In order to more accurately describe the patient safety environment, it is important for healthcare facilities to become familiar with the reporting requirements defined by Wyoming law. Accurate and complete reporting of adverse events will allow the Wyoming Department of Health to more accurately describe trends in patient safety and to make recommendations that will ultimately improve patient safety in the state. The following recommendations will serve to increase reporting of adverse events, which is an important step in creating a safer healthcare system. These recommendations should not be seen as all-inclusive, but as a starting point from which to create a culture of safety.

1. If your facility has not already done so, designate a patient safety officer who will be responsible for reporting adverse events;
2. Become familiar with reporting requirements defined in Wyoming law (see appendix); and
3. Complete reports on adverse events and report them to the Wyoming Department of Health in a timely manner.

To designate a Patient Safety Officer or find out more about the requirements pertaining to Wyoming's Mandatory Reporting of Safety Events system, please visit the Wyoming Department of Health's Patient Safety Website at <http://wdh.state.wy.us/PHSD/ser.html>.

## **APPENDIX A:** **Definitions**

**ADVERSE EVENT** An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a healthcare organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.<sup>4</sup>

**AGGREGATE DATA** Data collected and reported by organizations as a sum or total over a given time period, for example, monthly or quarterly.<sup>6</sup>

**CULTURE OF SAFETY** The product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.<sup>5</sup>

**ERROR** The failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).<sup>6</sup>

**PATIENT SAFETY** Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.<sup>7</sup>

**DISABILITY** "Person with a disability" means an individual who has a mental or physical impairment which substantially limits one or more major life activities.<sup>8</sup>

**SURVEILLANCE** Ongoing monitoring using methods distinguished by their practicability, uniformity, and rapidity, rather than by complete accuracy. The purpose of surveillance is to detect changes in trend or distribution to initiate investigative or control measures. Active surveillance is systematic and involves review of each case within a defined time frame. Passive surveillance is not systematic. Cases may be reported through written incident reports, verbal accounts, electronic transmission, or telephone hotlines, for example.<sup>6</sup>

**PASSIVE SURVEILLANCE** Surveillance in which either available data on reportable diseases are used or reporting is mandated or requested with the responsibility for the reporting often falling on the healthcare provider or facility. The completeness and quality of the data reported thus largely depend on this individual and his or her staff who often take on this role without additional funds or resources. As a result, underreporting and lack of completeness of reporting are likely.<sup>9</sup>

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<sup>4</sup> Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Glossary of Terms, Online. Available at [http://www.jointcommission.org/SentinelEvents/se\\_glossary.htm](http://www.jointcommission.org/SentinelEvents/se_glossary.htm). [Accessed October 2006]

<sup>5</sup> Health and Safety Commission, Third report of the Advisory Committee on the Safety of Nuclear Installations - Organizing for Safety. 1993.

<sup>6</sup> National Quality Forum, Serious Reportable Events in Healthcare. Washington D.C., 2002.

<sup>7</sup> Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 2000.

<sup>8</sup> Wyoming State Statute 35-13-205. Available at <http://legisweb.state.wy.us/statutes/titles/Title35/T35CH13AR2.htm>. [Accessed October 2006]

<sup>9</sup> Epidemiology. Leon Gordis. Philadelphia, 2004.

## **APPENDIX B:<sup>10</sup>** **Facility Definitions**

**ASSISTED LIVING FACILITY** A non-institutional dwelling operated by a person, firm, or corporation engaged in providing limited nursing care, personal care and boarding home care, but not rehabilitative care, for persons not related to the owner of the facility.

**BOARDING HOME/RESIDENTIAL FACILITY** A dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rental, and providing meals and personal daily living care, but not rehabilitative or nursing care, for persons not related to the owner. Boarding home does not include a lodging facility or an apartment in which only room and board is provided.

**CRITICAL ACCESS HOSPITAL** A hospital which meets the criteria required by the Wyoming State Rural Health Plan and rules for designation of critical access hospitals.

**HOSPICE** A program of care for the terminally ill and their families given in a home or health facility which provides medical, palliative, psychological, spiritual and supportive care and treatment.

**HOSPITAL** An institution or a unit in an institution providing one (1) or more of the following to patients by or under the supervision of an organized medical staff:

- a. Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons;
- b. Rehabilitation services for the rehabilitation of injured, disabled or sick persons;
- c. Acute care;
- d. Psychiatric care;
- e. Swing beds.

**NURSING FACILITY** An institution which is a skilled nursing facility (SNF) or a nursing facility (NF) which is currently licensed and meets the requirements of these rules and regulations.

**SURGICAL CENTER** A facility which provides surgical treatment to patients not requiring hospitalization and is not part of a hospital or an office of private physicians, dentists or podiatrists.

**HOME HEALTH AGENCY** Any group, public agency, private organization, or any individual person who is primarily engaged in arranging for and directly providing two or more healthcare services to persons at their residence.

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<sup>10</sup> Office of Healthcare Licensing and Surveys, Wyoming Department of Health, Rules and Regulations. Available: <http://wdh.state.wy.us/ohls/licensingcategories.html> [Accessed October 2007]

## **APPENDIX C:**

### **Reportable events as defined in the law**

Below are the events that must be reported under the Mandatory Reporting of Safety Event system. This language is taken directly from Wyoming Statute 35-2-912.

#### **SURGICAL EVENTS**

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
2. Surgery performed on the wrong patient;
3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

#### **PRODUCT OR DEVICE EVENTS**

6. Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices or biologics regardless of the source of the contamination or the product;
7. 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. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

#### **PATIENT PROTECTION EVENTS**

9. An infant discharged to the wrong person;
10. Patient death or serious disability associated with patient disappearance for more than four (4) hours, excluding events involving adults who have decision making capacity; and
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

## **CARE MANAGEMENT EVENTS**

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within forty-two (42) days of post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first twenty-eight (28) days of life. "Hyperbilirubinemia" means bilirubin levels greater than thirty (30) milligrams per deciliter;
17. Stage three (3) or four (4) pressure ulcers acquired after admission to a facility, excluding progression from stage two (2) to stage three (3) if stage two (2) was recognized upon admission; and
18. Patient death or serious disability due to spinal manipulative therapy.

## **ENVIRONMENTAL EVENTS**

19. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric counter shock;
20. 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;
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
22. Patient death or serious injury associated with a fall while being cared for in a facility; and
23. Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

## **CRIMINAL EVENTS**

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;
25. Abduction of a patient of any age;
26. Sexual assault on a patient within or on the grounds of a facility; and
27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

## APPENDIX D: Links and Other Resources

Wyoming's Mandatory Reporting of Safety Events Law:

- <http://legisweb.state.wy.us/2005/Introduced/SF0113.pdf>

Wyoming Department of Health Safety Event Reporting Page, including rules and regulations, instructions for reporting, and event reporting forms.

- <http://wdh.state.wy.us/phsd/phsd/ser.html>

The federal Agency for Healthcare Research and Quality (AHRQ) provides safety and quality tips for consumers. The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans.

- <http://www.ahrq.gov/consumer/>

Institute for Safe Medication Practices (ISMP) provides a *Medication Safety Alerts* for patients and hospitals by distributing a list of frequent medication errors and how to avoid them, general information and advice on medication safety for consumers.

- <http://www.ismp.org/Newsletters/default.asp>

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits more than 15,000 healthcare organizations and programs in the United States. JCAHO's mission is to continuously improve the safety and quality of care provided to the public. JCAHO provides a number of patient safety tips for patients and consumers.

- <http://www.jointcommission.org/PatientSafety/>

Consumers Advancing Patient Safety (CAPS) is a consumer-led nonprofit organization, formed to be a collective voice for individuals, families and healers who wish to prevent harm in healthcare encounters through partnership and collaboration.

- <http://www.patientsafety.org/>

The National Academy for State Health Policy (NASHP) is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. NASHP provides resources to compare patient safety initiatives and approaches across the states.

- <http://www.nashp.org/>

The Leapfrog Group is an initiative driven by organizations that buy healthcare who are working to initiate breakthrough improvements in the safety, quality and affordability of healthcare for Americans. The Leapfrog website provides quality and safety information about hospitals that consumers can search.

- [www.leapfroggroup.org](http://www.leapfroggroup.org)

This list represents only a small fraction of the resources available on patient safety. The websites listed here provide an example of the types of information available. There are additional local and national resources on patient safety that can provide valuable information for patients, consumers, purchasers, and policy-makers.