



Colorado Department
of Public Health
and Environment

Health Facilities &
Emergency Medical Services Division
(HFEMSD)

REPORTABLE OCCURRENCE EXAMPLES

AMBULATORY SURGICAL CENTERS (ASC)

Revised September 2012

OCCURRENCE REPORTING MANUAL:

www.healthfacilities.info

HEALTH FACILITIES INTERNET PORTAL

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Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

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PHYSICAL ABUSE EXAMPLES

"Any occurrence involving physical... abuse of a patient or resident, as described in section 18-3-202, 18-3-203, and 18-3-204... C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." 25-1-124 (2)(d), C.R.S.

2 Elements Needed:

- Intent OR knowingly OR recklessly
- Bodily injury and/or serious bodily injury, and/or Unreasonable confinement or restraint (26-3.1-101 (4)(a)(II) C.R.S.)

Note: "Bodily injury means physical pain, illness, or any impairment of physical or mental condition" 18-1-901 (3)(c) C.R.S.

Note: Serious bodily injury is defined as "bodily injury, which involves a substantial risk of death, a substantial risk of serious permanent disfigurement, or a substantial risk of protracted loss or impairment of the function of any part or organ of the body." 18-1-901 (3)(p), C.R.S.



If the elements are met for physical abuse, you have the duty to report the occurrence to law enforcement also. That statute can be found on the last page of our Occurrence Reporting Manual. The police must be contacted immediately, not after you have investigated to see if you believe that the allegation is substantiated. We expect you to follow any directions or instructions given to you by the police.



All patients, not just the victim, must be protected from an alleged assailant pending the outcome of your investigation. For example, staff members might be suspended, family or visitors escorted off the premises, or only allowed to be in the facility in an area where they can be supervised and observed.



A thorough investigation must be conducted. If you determine that the allegation is not substantiated, you will note that conclusion in your final occurrence report.

1. A patient alleges that when she was trying to get out of the recliner to go to the bathroom, a nurse pushed her back down into the recliner, causing her pain due to arthritis in her back and hips.

This is reportable due to "recklessly" and "injury" elements being met. The police must be contacted. All patients must be protected from the alleged assailant pending the outcome of your investigation.

2. **A patient was just coming out of anesthesia and slapping at the nurse. The nurse slapped the patient back.**

This is reportable due to the elements of "intent" and "injury" being met. The police must be contacted. All patients must be protected from the alleged assailant pending the outcome of your investigation.

3. **A patient was being combative and her husband slapped the patient in an attempt to make the patient stop.**

This is reportable due to "intent" and "injury" being met. An assailant is anyone; staff, family, visitor, etc. However, a victim always has to be a patient in order for an occurrence to be reportable. **It is not reportable if a patient hits a staff person.** The ASC must contact the police, and in some cases, report to Adult Protective Services (APS). The patient must be protected from the alleged assailant.

4. **A patient became unresponsive during an outpatient procedure and was emergently transported to the nearest hospital. Upon admission, staff at the hospital noted what appeared to be fresh bruises to the patient's forearms. The hospital contacted the ambulatory surgical center to report an allegation of possible physical abuse of the patient while in the ASC.**

The allegation is reportable. The ASC must conduct an investigation to rule out abuse of the patient while under their care.

5. **While in the Post Anesthesia Care Unit (PACU)/Recovery Room, a patient awoke from anesthesia, violently thrashing and trying to get off the gurney, which would result in injury to him. The recovery nurses had to lie on top of the patient and restrain him, in order to prevent him from self-injury.**

This is reportable under physical abuse for unreasonable confinement or restraint. Staff should be trained on appropriate methods to handle a patient such as this.

6. **The patient was scheduled for a colonoscopy. Her husband accompanied her. When she was taken to the procedure room, her husband went to the waiting area. As the patient was being positioned for the procedure, the nurse noted a large bruise on her upper arm. The nurse asked the patient how she received the injury and the patient responded that her husband had grabbed her and pinched her "very hard". This occurred in the patient's home, before she came to the surgery center. The patient reported that her husband had been very frustrated lately, and that they were looking for a marriage counselor.**

This is not reportable because it did not happen in the facility. The facility should consider contacting APS and/ or the police.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

SEXUAL ABUSE EXAMPLES

"Any occurrence involving sexual ...abuse of a patient or resident, as described in section ...18-3-402, 18-3-403, 18-3-404, or 18-3-405 C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." 25-1-124 (2)(d) C.R.S.

3 Elements Needed:

- Knowingly
- Consent not given
- Sexual intrusion or penetration or, touching intimate parts or the clothing covering the intimate parts or, examines or treats resident/patient for other than bona fide medical purposes or, observes or photographs another person's intimate parts or, physical force/threat.

 ***If the elements are met for sexual abuse, you have the duty to report the occurrence to law enforcement also. That statute can be found on the last page of our Occurrence Reporting Manual. The police must be contacted immediately, not after you have investigated to see if you believe that the allegation is substantiated. We expect you to follow any directions or instructions given to you by the police.***

 ***All patients, not just the victim, must be protected from an alleged assailant pending the outcome of your investigation. For example, staff members might be suspended, family or visitors escorted off the premises, or only allowed to be in the facility in an area where they can be supervised and observed.***

 ***A thorough investigation must be conducted. If you determine that the allegation is not substantiated, you will note that conclusion in your final occurrence report.***

1. A female patient complained that a male nurse touched her inappropriately by touching her breast with his stethoscope while listening to her chest over her gown.

This is reportable because the allegation meets all three elements.

2. A female patient alleged that her GI physician verbally, physically, and sexually abused her during her endoscope and colonoscopy. She stated that he refused to sedate or medicate her and she was awake. She stated that she requested him to stop "many times" and he refused. She stated that the physician "raped her with the scope in her rectum."

This is reportable because the allegation meets all three elements.

3. A facility received a letter from a former patient who stated that he had been sexually abused when he was a patient 6 months ago. He stated that the nurse had stroked his leg,

and that he was worried about what might have happened when he was under anesthesia. The nurse was put on administrative leave pending the outcome of the investigation, and the police were contacted.

This is reportable because the allegation meets all three elements.

4. **A staff person was sharing pictures with other staff members of a tattoo on a patient's upper buttocks that the staff person had taken with her cell phone. The patient was being positioned for a procedure at the time, and was under conscious sedation, and had no idea that the picture had been taken.**

This allegation meets all three elements, including "observes or photographs a person's intimate parts.

5. **A female patient alleged a staff member touched her inappropriately. She stated that she was groggy, just waking up from anesthesia. She alleged that a male nurse was in the room and had his hand on her left breast. All patients present in the ASC were interviewed and all said the nurse was professional and appropriate. Staff interviews concurred. The nurse denied the allegation. The ASC did not substantiate the allegation.**

This is reportable because the allegation meets all three elements.

6. **The facility sends patients a questionnaire after undergoing a procedure, via mail, asking about their experience. An anonymous female patient returned the questionnaire, alleging that a nurse had fondled her on both breasts. The anonymous patient stated that the nurse was an older woman, with light hair, and glasses. This could have been several nurses. Nurses who worked during that time period were interviewed, but no one knew anything about an incident of this nature. The facility was advised by their legal personnel that they didn't have to report this unless the patient filed a complaint. A month later, the patient did file a complaint with the ASC. Another investigation was initiated. The facility did not contact the police until the complaint was received.**

The allegation was reportable at the time that the facility received the questionnaire. The facility did initiate an investigation based on the information provided, and were not able to substantiate the allegation at that time. The police should have been contacted at the time the questionnaire was received. The facility would receive a deficiency for reporting the occurrence late because it should have been reported when the facility received the questionnaire.

7. **A surgical technologist alleged that a surgeon touched him inappropriately as he was walking down an isolated hallway between the operating rooms.**

This is not reportable as an occurrence. **The victim has to be a patient.** However, the facility may want to initiate and complete an investigation to determine if the allegation is substantiated and if measures need to be taken with the surgeon. If the allegation is valid, issues of patient safety must be addressed.

- 8. A patient alleged that she had been sexually assaulted by all the surgical staff during her surgery. An anesthesia agent used during the procedure may cause abnormal dreams, euphoria, and hallucinations that can be sexual in nature.**

Given the side-effects of the anesthesia agent, if there was always more than one staff member around the patient, and if she was never alone at any time, the facility would not have to report this as an occurrence. However, if the patient had been alone, or if there was a time when only one staff member was present, the facility would report this allegation and carry out a thorough investigation.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

VERBAL ABUSE EXAMPLES

"Any occurrence involving ...verbal abuse of a patient or resident, as described in section ...18-3-206...C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." 25-1-124 (2)(d), C.R.S.

*"A person commits the crime of menacing if, by any threat or physical action, he knowingly places or attempts to place another person in fear of imminent, serious bodily injury."
18-3-206, C.R.S.*

3 Elements needed:

- Knowingly
- Threat OR Physical Action (includes threatening gesture)
- Fear of imminent, serious bodily injury

Note: "Serious Bodily Injury" is defined as "bodily injury which involves a substantial risk of death, a substantial risk of serious permanent disfigurement, or a substantial risk of protracted loss or impairment of the function of any part or organ of the body." 18-1-901(3)(p), C.R.S.



If the elements are met for verbal abuse, you have the duty to report the occurrence to law enforcement also. That statute can be found on the last page of our Occurrence Reporting Manual. The police must be contacted immediately, not after you have investigated to see if you believe that the allegation is substantiated. We expect you to follow any directions or instructions given to you by the police.



All patients, not just the victim, must be protected from an alleged assailant pending the outcome of your investigation. For example, staff members might be suspended, family or visitors escorted off the premises, or only allowed to be in the facility in an area where they can be supervised and observed.



A thorough investigation must be conducted. If you determine that the allegation is not substantiated, you will note that conclusion in your final occurrence report.

1. A family member who was with a patient in the recovery area, alleged that a staff person was verbally abusive to the patient. The patient was moaning loudly, and the staff person told the patient that if she didn't shut up, he'd give her something to moan about.

This is reportable. The allegation meets all three elements.

2. **This patient reported that a nurse "got in her face and pointed her finger at her." The patient reported that this made her feel very threatened. There was no physical contact or verbal threats of physical contact. The patient admitted that she was not being very nice but she still felt threatened by this nurse.**

This is reportable because the nurse made a threatening gesture, and the patient reported that she felt threatened.

3. **Patient reported that her surgeon screamed at her in the pre-op holding area when he found out she had had something to eat prior to surgery. His behavior was intimidating and scared the patient.**

This is reportable because the surgeon exhibited threatening behavior and the patient reported being afraid.

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BRAIN INJURY EXAMPLES

*"Any occurrence that results in any of the following serious injuries to a patient or resident: (I) Brain ...Injuries...".
25-1-124 (2)(b)(I) C.R.S*

2 Elements needed:

- Result of occurrence
AND
- Change in level of consciousness and/or loss of bodily function OR diagnostic test which shows brain injury

1. A patient, who was waiting for his procedure to begin, stated he had to use the restroom. Staff assisted him up and showed him where the restroom was located. Staff then heard a crash in the bathroom, and found the patient lying on the floor. He had a laceration to his head, and had a momentary loss of consciousness. 911 was called and the patient was transported to the local ER.

This is reportable due to element of result of an occurrence (the fall) and the change in consciousness.

2. A patient was leaving the facility after a full recovery. It was snowing outside, and the family member accompanying the patient came back into the facility to tell them that the patient had fallen and had hit his head on the sidewalk. The patient was dazed and reported he couldn't hear anything for a few seconds after it happened. The facility called 911 and the patient was transported to the ER.

This would be reportable because the patient is still on the facility's property. The facility staff should be accompanying a patient to their car.

3. A patient arrested during a procedure and was unresponsive. 911 was called and the patient was transported to the ER by paramedics. Information subsequently received from the hospital was that the patient had suffered an MI that was unrelated to the procedure. A thorough H & P had been completed prior to the procedure, and the patient did not have a history of cardiac disease. The ASC reported this as a brain injury due to possible anoxic brain injury, and because they didn't know if the procedure or anesthesia had anything to do with the patient arresting.

Once the final report was received by the ASC, and the cause of the arrest was determined not to have anything to do with the procedure, this occurrence would be deactivated.

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BURN EXAMPLES

"Any occurrence that results in any of the following serious injuries to a patient or resident: ..Second-or third-degree burns involving twenty percent or more of the body surface area of an adult patient/resident, or fifteen percent or more of the body surface area of a child patient/resident." 25-124-(2)(b)(III) C.R.S.

2 Elements Needed:

- Second or third degree burns
- 20% or more of body surface in an adult or 15% or more of body surface in a child



See the Burn Size Chart in the Occurrence Reporting Manual.

1. During a surgical procedure the surgeon was using an electrosurgical unit when an unexpected malfunction of equipment occurred. An arc of electric current occurred from the bovie tip insertion point, where the bovie tip inserts into the hand piece, to the tip of the bovie tip and the patient's skin. A 1 cm burn occurred on the patient's skin at the incision.

This is not reportable as a burn because the burn area does not equal 20% or more of body surface. **This is reportable** as a malfunction of equipment, or possibly neglect would be the appropriate category.

2. A female patient was undergoing cystoscopy. During the procedure, an Operating Room staff-member did not place the electrocautery wand into its holder, and it was left on the patient's chest. This caused a 1/4 inch burn on the patient's right chest, about 1 inch below the breast.

This is not reportable as a burn due to the size of the burn, but **this is reportable** as misuse of equipment, or neglect.

3. During endoscopic sinus surgery, there were complications with the camera and scope. While changing them out, the light source was removed from the scope and came in contact with the plastic drape and melted through and burned the patient's skin. The patient received a small cigarette size burn on the forearm. The light source was laid on the drape over the patient and not coiled on the mayo stand.

This is not reportable as a burn due to the size of the burn, but **this is reportable** as misuse of equipment, or neglect.

- 4. A patient sustained a chemical burn to his cornea when a technician was checking the patient's intraocular pressure. The technician was not aware that there was a crack in the tip of the tonometer. While using it on the patient, bleach solution leaked out of the tonometer via the crack, causing the chemical burn to the patient's eye.**

Reportable as equipment malfunction as the area is not large enough to be reportable as a burn.

- 5. A patient returned for a second therapy session of electrical stimulation to her lower left lumbar sacral area. At that time superficial 2nd degree burns at two previous electrode sites were noted.**

The area is not large enough to be reportable as a burn. Equipment malfunction/misuse or neglect should be considered.

- 6. An alcohol preparation had been used on a patient's face and was a product that was not intended for this use. During the procedure using electrocautery the alcohol preparation caught fire. The patient only sustained singed hair, no burns.**

This is reportable as neglect, not as a burn. The elements for a burn are not met.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

DEATH EXAMPLES

"Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the Coroner pursuant to Section 30-10-606, C.R.S., as arising from an unexplained cause or under suspicious circumstances." 25-1-124(2)(a), C.R.S.

2 Elements Needed:

- Occurrence (event) resulting in death
- Reportable to the coroner as unexplained or suspicious (unexplained)

1. **A patient had right cataract surgery at the ASC, without any complication. A post-op call from the ASC was made the next day, and the patient reported that he was "very weak". The ASC business office received a phone call the following day from the surgeon's office that the patient had passed away that morning. The ASC contacted the coroner who did take the case. This death was unexpected.**

Because the cause of death was unknown, unexpected, and reportable to the coroner, this was a reportable death. The cause of death was determined by the coroner to be coronary artery disease and pulmonary hypertension. Upon completion of the facility's investigation, and the results of the coroner report, the state was able to determine this was not a reportable death, and therefore the occurrence was deactivated.

2. **A patient expired after undergoing laparoscopic gastric banding. During the surgery, a trochar was inserted and hit a vessel. The patient began bleeding and staff was unable to stop the bleeding. The patient was transferred to the hospital where she expired.**

This became a reportable death when the hospital notified the ASC that the patient had expired. The coroner ruled that the death was the result of the vessel being punctured.

3. **The domestic partner of patient was found unresponsive in the waiting room when the nurse went to get her to see the patient following the conclusion of surgery. Emergency resuscitation efforts commenced and 911 was called. After 20 minutes the medical team was unable to revive the victim.**

This is not reportable because the deceased was not a patient of the ASC

4. **A female patient was admitted for an elective reverse total shoulder surgery. The patient was at the end of her surgery which was a long surgery when her blood pressure (BP) became volatile and the patient became unresponsive with no pulse or respirations. 911 was called and ASC staff initiated CPR (cardiopulmonary resuscitation). When paramedics**

arrived, the patient was transported to an acute care hospital where the patient was pronounced dead.

This is a reportable occurrence because it was unexpected and reportable to the coroner. Deactivation or summarization would be determined by the Department after the coroner determined the cause of death.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

DIVERTED DRUG EXAMPLES

"Any occurrence in which drugs intended for use by patients or residents are diverted to use by other persons"
25-1-124 (2) (g) C.R.S.

1 Element needed:

- Deliberate



Please keep in mind that drug diversion perpetrators aren't always using the drugs themselves, and wouldn't test positive during drug testing. They might be selling, or taking medications for family or friends who can't afford their medications.

1. Two staff members discovered numerous narcotics were missing after conducting a medication count on Monday. The missing medications were Valium, morphine sulfate, and cocaine. The medication count was correct when counted on Friday before the weekend. The medication area is secured and is accessed with a swipe card. The swipe log showed no activity over the weekend. Employees who were in the building over the weekend were drug tested and all results were negative. No perpetrator can be identified, and the facility isn't able to determine that the missing narcotics were deliberately diverted.

This is reportable. The facility has not come up with a reasonable conclusion as to where the medications might be, or what might have happened to them.

2. The facility began an investigation related to a ketamine count discrepancy and discovered missing Sufentanil and Versed. A search of the facility was authorized and a vial of Versed was found in a staff person's locker.

This is reportable.

3. A physician who was on staff at a surgical center was found down in a parking lot. He was treated by the ER and admitted to the hospital. Police found drugs in the physician's vehicle that matched lot numbers purchased by the surgical center.

This is reportable.

4. A staff member became suspect for a Fentanyl drug diversion when she said that she wasted a vial of Fentanyl into a sharps container. However, the sharps container did not contain an empty vial of Fentanyl. The staff member was tested and found positive for Fentanyl.

This is reportable.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

LIFE-THREATENING COMPLICATIONS OF ANESTHESIA

"Any occurrence that results in any of the following serious injuries to a patient or resident: Life-threatening complications of anesthesia..." 25-124-(2)(b)(II) C.R.S.

2 Elements Needed:

- Occurrence as a result of Anesthesia
- Life-threatening complication/reaction

1. **A male patient in his teens had a reaction to anesthesia called malignant hyperthermia. During the surgery, the anesthesiologist noted an increase in carbon dioxide, a temperature spike and increased heart rate. Medical interventions were made and the symptoms improved. He was monitored continuously until the procedure was completed and transferred to an ER.**

This example is reportable.

2. **A female patient had an admitting BP of 156/79, and a history of hypertension. Several minutes into the procedure, she went into V-Fib. She converted after 60 seconds of chest compressions and defibrillation was not necessary. She was transported to the ER.**

This example is reportable. In some cases, these situations are reported because the cause for the symptoms has not been determined, but anesthesia is a probable cause. If analysis determines a different cause, the occurrence can be deactivated.

3. **While a female patient was connected to a BP cuff, cardiac monitor and a pulse oximeter, a test dose of anesthesia medication was administered. The patient had received the same medications during previous procedures without any complications. Minutes following the test dose, the remainder of the dose was administered. The patient began exhibiting changes in her vital signs, cardiac status, and breathing. The patient was transferred to the ER.**

This example is reportable. In some cases, situations are reported because the cause for the symptoms has not been determined, but anesthesia is a probable cause. If analysis determines a different cause, the occurrence can be deactivated.

4. **A patient was returned to the recovery area following a procedure. She complained of nausea and vomited four times. When the nurse checked on her later, she found the patient had huge welts all over her body. The patient complained of itching all over.**

These are the beginning signs of a serious reaction and need to be reported.

- 5. A patient suffered a cardiac arrhythmia in the OR after induction. It was not immediately known why. At the time it was reported, there was a possibility it was a reaction to anesthesia. The patient was transported to the local hospital.**

This example is reportable. In some cases, these cases are reported because the cause for the symptoms has not been determined, but anesthesia is a probable cause. If analysis determines a different cause, the occurrence can be deactivated.

- 6. The patient was admitted for a procedure. She had a history of a Lidocaine allergy that was noted by the nurses upon admission, but not noted by the anesthetist. Propofol IV and Lidocaine IM were given. The procedure was uneventful and completed without incident. When the patient was in recovery, she complained of chest tightness, and upon examination had bilateral wheezing. The patient was treated with albuterol, Solu-Medrol, and Fentanyl, and transported to the emergency room via ambulance.**

This is reportable as an anesthesia complication, but could also be reportable as neglect.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

LIFE-THREATENING TRANSFUSION ERRORS OR REACTIONS

"Any occurrence that results in any of the following serious injuries to a patient or resident: ...life-threatening transfusion errors or reactions" 25-1-124 (2)(b)(II) C.R.S.

2 Elements Needed:

- Errors or reaction from transfusion of blood or blood products
- Life-threatening

1. The surgeon nicked an artery causing the need for emergent blood. The patient received 4 units of packed red blood cells. Monitoring was appropriate during the transfusion, and VS were stable. After the 4th unit was transfused, the patient complained of a rash. His VS were stable. The patient was treated with Benadryl, and then became tachycardic and remained hypotensive. His rhythm converted to an atrial fibrillation.

This is reportable because it is a reaction to the transfusion and life-threatening.

2. During a vaginal hysterectomy, the patient began having uncontrolled bleeding. The patient received packed red blood cells emergently. The patient became tachycardic (155 beats per minute), hypoxic (oxygen saturations 70%), and febrile (37.4°C up to 39.5°C). The transfusion was immediately stopped and the patient was transported to a local ED.

This is reportable because it is a reaction to the transfusion and life-threatening.

3. The patient had a transfusion and went into respiratory distress. The patient was sent to an ED. It has been determined that the reaction was the result of a contaminated blood transfusion. The contaminant was a bacteria, pseudomonas. This was not the result of error in cross-typing or processing, but was probably secondary to an ineffective skin prep.

This is reportable because it was a life-threatening reaction and life-threatening.

4. The patient had a transfusion and went into respiratory distress. The patient was sent to an ED. It has been determined that the reaction was the result of the blood bank sending over the wrong blood type.

This is reportable because it involves a transfusion error and life-threatening.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

MALFUNCTION/MISUSE OF EQUIPMENT (*Also see burn examples)

"Any occurrence involving the malfunction or intentional or accidental misuse of patient or resident care equipment that occurs during treatment or diagnosis of a patient or resident and that significantly adversely affects or if not averted would have significantly adversely affected a patient or resident of the facility." 25-1-124 (2) (h), C.R.S.

3 Elements Needed:

- Malfunction or intentional or unintentional misuse
- Significant adverse affects or potentially-adverse affects
- Occurring during treatment or diagnosis

➔ ***The following examples would all be reportable as malfunction due to the adverse or potentially adverse effects for patients occurring during treatment or diagnosis. Along with actual injury to the patient, we would consider the following as adverse effects:***

- ✓ ***Increased time under anesthesia***
- ✓ ***Having to be moved out of a sterile environment to another area during an open procedure***
- ✓ ***Incision having to be re-opened after closure***
- ✓ ***Resulting in additional procedure(s)***

This list is NOT all inclusive

➔ ***Burns are rarely reportable due to the large size (20% of body area) that must be met. However, most burns have been reportable due to equipment malfunction/misuse or neglect.**

- 1. During a procedure on a male patient, the screen on the video monitor failed to display the procedure. A second scope was tried in another room, and also failed. The patient was moved to a third room and this equipment functioned properly.**

This would be reportable if the scope was already inserted in the patient. The patient would be at increased risk being moved from a sterile environment to another. If the scope had not been inserted yet, the risk to the patient would not be significant and this would not be reportable.

2. **The facility determined that improper software for a new high-level disinfectant had been sent by the vendor. As a result, endoscopes were chemically processed according to the wrong specifications. Three patients were exposed to scopes that had not been disinfected appropriately.**

This is reportable.

3. **A female patient was scheduled to undergo an endometrial ablation. In pre-op, an IV was attempted in the wrist with a Braun #22 gauge angiocath. A small amount of blood was returned and then stopped. It was decided to stop the IV. When the nurse attempted to pull the angiocath back, she experienced some resistance. When the angiocath was removed and inspected it was noted that the catheter was split from the needle. There were no missing parts of the angiocath but there was the potential that the catheter could have broken off in the patient.**

This is reportable due to the potential for significant adverse effects or potentially adverse effects.

4. **During a surgical procedure a surgeon was inserting a k-wire. No misuse of the equipment was noted. An unexpected malfunction of the equipment occurred when a piece of the k-wire broke off in the surgical site. A second incision was made to retrieve and remove the piece of k-wire. The pieces of k-wire were inspected and it was determined that all pieces of the k-wire were accounted for.**

This is reportable due to the potential for significant adverse effects or potentially adverse effects.

5. **During a procedure, a trochar broke off in a patient's hip. The case was aborted and the patient was taken to the PACU in stable condition. The patient was then transferred to a local hospital and had a subsequent procedure to remove the trochar by a surgeon the following day.**

This is reportable because the patient had to undergo a second procedure.

6. **During a knee arthroscopy procedure, a surgeon was using an arthroscope probe instrument when the tip of the probe broke off in the surgical site. No misuse of the instrument was noted. The fragment was removed through an incision using fluoroscopic guidance, and the entire instrument was accounted for. (See answer for #7.)**

This malfunction might not have caused an adverse effect for this patient, however there could be significant adverse effects for other patients when the same type or make of equipment is used in the future.

7. **A surgeon was drilling a patient's toe while performing a bunionectomy with osteotomy, when the tip of the drill bit broke off in the bone. The surgeon decided not to remove the piece as he determined that there was more potential for harm in removing it.**

This malfunction might not have caused an adverse effect for this patient, however there could be significant adverse effects for other patients when the same type or make of equipment is used in the future.

8. **A surgeon was inserting a canulated screw through a patient's bone and when completing the final tightening, the head of the screw broke off. The surgeon determined to leave the screw in place instead of trying to remove it as she determined there was more potential for harm in trying to remove the screw.**

This is reportable due to the potential for the procedure to fail and the patient then needing more surgery.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

MISAPPROPRIATION OF PROPERTY

"Any occurrence involving misappropriation of a patient's or resident's property. For purposes of this paragraph (f), "Misappropriation of a patient's or resident's property" means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a patient's or resident's belongings or money without the patient's or resident's consent" 25-1-124 (2)(f), C.R.S.

2 Elements Needed:

- Deliberate misplacing, exploiting, or wrongful use of a patient's or resident's property or a pattern of misplacing, exploiting, or wrongful use of a patient's or resident's property
- AND
- Patient/Resident consent not given

1. A female patient underwent a procedure. She later notified the facility that she was missing her credit card and that someone had charged \$700.00 of unauthorized items on it. The patient's belongings had been placed in a secure locker prior to her entering the operating room. Following recovery, her belongings were returned to her. The patient reported that the credit card had been in her jacket pocket and was missing the following morning.

The allegation made by the patient meets the elements and is reportable.

2. A male patient had all his personal belongings, including a watch and wedding ring, bagged and placed under the gurney. Patients are advised to leave valuables at home. When the patient was ready to get dressed, he realized that his watch was missing. There were many people in the facility that day including staff, other patients, and other family members or friends.

The allegation is reportable. Even though the facility advises patients not to bring valuables, the watch was taken while the patient was under the care of the facility. The investigation did not identify a perpetrator due to all of the people that had been in and out and around during the course of the patient's procedure.

3. **A patient contacted the surgical center three days after having a procedure done. She had paid for the procedure via a credit card, and had been notified by the credit card company that several large ticket items had been charged on her account. She stated that the surgical center personnel were the only individuals that had access to her account number information.**

This is a reportable allegation. If the police were notified, they might be able to work with the credit card company.

4. **A facility suspects that drugs have been stolen.**

This is reportable as drug diversion, not misappropriation.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

MISSING PERSONS

"Any time that a resident or patient of the facility cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility and there are circumstances that place the resident's health, safety or welfare at risk or, regardless of whether such circumstances exist, the patient or resident has been missing for eight hours." 25-1-124 (2)(c), C.R.S.

1 Element Needed:

- At risk and missing after search conducted
OR
- Missing more than eight hours, regardless of risk

1. **A patient with a history of traumatic brain injury, was last seen by ASC staff recuperating in the recovery room after a procedure. A staff person noticed that the patient was no longer in the recovery room. A search of the building was conducted, and the patient was not found. Staff started to search around the building, and the patient was found dressed, sitting at a bus stop at the corner. The patient said he was "going home".**

This is a reportable occurrence. The patient was at risk due to his TBI diagnosis, and was not found during a search of the building or grounds. If the patient was not at risk, and was located within 8 hours, it would not be reportable.

2. **A patient was seen by staff recuperating in the recovery room after a procedure. The patient's spouse was waiting with him. A few minutes later, the patient, his spouse, and his clothes and belongings were gone. The building and grounds were searched, and the patient was not located. Calls to the patient's home were unanswered. The patient's surgeon notified the facility a couple of days later that he had kept a post-op appointment and was okay.**

This is reportable because even if the patient was not at risk, he was missing longer than 8 hours. Had the patient been alone, and had not been assessed as able to drive himself home yet, he would have been at risk, and this would be reportable regardless of how soon he might have been located.

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NEGLECT

(*Also see burn examples)

"Any occurrence involving neglect of a patient or resident as described in Section 26-3.1-101 (4)(b), C.R.S."; [25-1-124(e) C.R.S.]

Caretaker neglect which occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is not secured for the patient or resident (**at-risk adult**) or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise; except that the withholding of artificial nourishment in accordance with the 'Colorado Medical Treatment Decision Act', Article 18 of Title 15, C.R.S., shall not be considered as abuse.

1 Element Needed:

- *Failure to provide any care or services as provided above resulting in actual harm*
OR
- *Staff member has a history in the past 12 months of similar neglect and had been counseled and/or re-educated*
OR
- *Staff member intentionally failed to follow standard of practice and/or facility policy with significant potential for harm*



*Burns are rarely reportable due to the large size (20% of body area) that must be met. However, as a rule, most burns have been reportable due to equipment malfunction/misuse or neglect.

1. **In the sterile processing department, it was discovered that indicators from a previous sterilization cycle were still in the trays and did not show proper (complete) color change. As a result, this indicated a potential for non-sterile scope exposure in the operating area. It was determined that there were two patient exposures, but they could not determine which two of several patients were involved. It was believed that staff missed the fact the color had not changed when they prepped for surgery.**

Only one of the three elements needs to be met to make this reportable. Actual harm would be met due to the non-sterile exposure to two patients. Also, staff failed to follow standard of practice or facility policy when they did not check to make sure that the color had changed on the sterility indicators when they prepped for surgery.

2. **A patient was given one unit of packed red blood cells that was not ordered. The physician only intended a type and screen to be done. The error was discovered when the physician asked why the patient received blood.**

This is reportable because staff did not provide the degree of care that a reasonable person would exercise.

- 3. A patient with a well-documented history of falls was admitted for a procedure. The patient asked to use the restroom and was shown where to go by staff. On the way to the restroom, the patient lost his balance and fell. The patient had hip pain and was transported to the hospital via ambulance. The patient did sustain a hip fracture.**

This is reportable because staff was aware of the patient's fall risk, and allowed the patient to ambulate to the restroom unaccompanied. This resulted in harm to the patient.

- 4. While in the recovery area, a patient had a change in condition. The nurse neglected to properly monitor the patient as ordered and failed to report the change in the patient's condition to the physician in a timely manner. The patient had to be transferred to the ED.**

This is reportable because the nurse failed to provide expected care and service.

- 5. A female patient undergoing a colonoscopy had suspected cecal perforation due to the high power setting on the cautery device. Cautery settings are determined by the manufacturer's recommendations and confirmed by the physician in the room. Further follow up is pending regarding the process followed by the staff member for setting the device and confirming with the physician.**

This is reportable because staff had been trained on appropriate settings, and didn't follow the guidelines. There was harm to the patient.

Please remember, these examples are not all inclusive. Contact the Occurrence Intake Desk, 303-692-2826, if you have questions concerning whether an event or incident is reportable.

SPINAL CORD INJURIES

"Any occurrence that results in any of the following serious injuries to a patient or resident: (I) ...or Spinal Cord injuries..". 25-1-124 (2)(b)(I) C.R.S.

Any trauma to the central nervous system within the spinal column, including the cervical spine, thoracic spine, lumbar spine, and sacral nerves which cause: motor or sensory loss which may be permanent or temporary (HFEMSD guideline).

3 Elements needed:

- Result of an occurrence
- Functional loss consistent with spinal cord injury
- Permanent or temporary

1. A patient underwent a posterior cervical laminectomy with decompression. The patient was taken to the recovery room in stable condition. During phase 1 recovery the patient reported some tingling to her right hand. Later, the patient was discharged from phase 1 recovery into 23-hour observation. At that time she was able to walk without assistance to her room. Over the course of the next few hours the patient experienced an onset of worsening neurological deficits. The surgeon was notified, arrived to examine the patient, and subsequently ordered an emergent transfer to the acute care hospital where an MRI was performed followed by emergency surgery. Post-op the patient exhibited neurological deficits consistent with quadriplegia.

This is reportable as a spinal cord injury due to there being an event that caused or contributed to the injury, there was functional loss consistent with spinal cord injury, and the loss is permanent or temporary. All three elements are met.