HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: XVI-102 ADVERSE EVENT REPORTING TO THE STATE DEPARTMENT OF PUBLIC HEALTH	**POLICY #**: 1037 **VERSION:** 1
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DATE APPROVED: 11/17/2017	

PURPOSE: To comply with the mandated reporting requirements of Health and Safety Code § 127931 (b) and to support the improvement of patient safety and quality improvement initiatives.

POLICY: The Ambulatory Surgical Center (ASC) shall report adverse events defined within Health and Safety Code § 1279.1, to the California Department of Public Health (CDPH): 1. no later than 5 days after the event has been detected; or, 2. if the event poses an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected.

DEFINITIONS:

"Adverse event" includes any of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent to preclude 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.
5. Death during or up to 24 hours after induction of anesthesia and/or 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.
6. Patient's death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

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7. Patient's 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 is intended. For purposes of this policy "device" includes, but is not limited to, catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. A patient's death or serious disability associated with a medication error including, but not limited to, 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.
9. Patient's death or serious disability related to hypoglycemia, the onset of which occurs while being cared for in the health facility.
10. Patient's death or serious disability associated with electric shock while being cared for in a health facility.
11. 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 a toxic substance.
12. A patient's death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
13. A patient's death associated with a fall.
14. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
15. The sexual assault on a patient within or on the grounds of the facility.
16. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds.
17. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

PROCEDURE:

1. The ASC staff will inform the ASC Medical Director and Administration of the adverse event.
2. The ASC Medical Director or designee will report adverse events using the "DHS Reporting Form – Adverse Events." The report shall be sent concurrently to:

   a. CDPH

   b. DHS Director of Quality Improvement and Patient Safety by e-mailing as a PDF file to QIPS@dhs.lacounty.gov or faxing it to (213) 250-5136 and include a brief narrative describing the event and a Safety Intelligence (SI) identification number on the QIPS copy.
3. The report to CDPH must **not** be placed in the patient's medical record.
4. The patient, or the party responsible for the patient, will be notified of the nature of the adverse event by the time the report to the CDPH/DHS is made. Such disclosure shall be reflected in the patient's record.

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5. Following the event, an intensive investigation will be conducted, by High Desert Health System Risk Management, for evaluation and improvement of the quality of care. The investigation will be completed in 45 days from the date the facility was first made aware or notified of the event.

SOURCE: DHS Policy 311.202 Adverse Event Reporting

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