INTERPRETIVE GUIDELINES FOR REPORTING UNUSUAL EVENTS

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TABLE OF CONTENTS

		Page
	INTRODUCTION	**i**
	GENERAL INFORMATION	**ii**
SECTION A – Brief Summary		
	INCLUDES/EXCLUDES LIST	**6-15**
SECTION B - Forms		
	UNUSUAL EVENT REPORT FORM	**17**
	MEDICATION OCCURRENCE SUPPLEMENT FORM	**18**
	ANALYSIS FORM	**19-21**
SECTION C – Interpretive Guidelines		
	DEFINITIONS	
Occurrence Code	**Specific Categories**	**Page**
108-110	**Medication Errors**	**23-24**
201	**Aspiration**	**25**
300-303	**Intravascular Catheter Related**	**26-28**
403-404	**Blood Transfusion Reactions**	**29**
600s	**Perioperative/Periprocedural Related**	**30-32**
701	**Burns**	**33**
751	**Falls**	**34**
800s	**Procedure Related**	**35-48**

- **regardless of setting**
- **within 30 days of the procedure**
- **include readmissions**

900s General Categories 49-71

- **901 All occurrences not covered by other codes 49-50**
- **911 Wrong Patient, Wrong Site 51**
- **913 Unintentionally retained foreign body 52**
- **915 Death 53**
- **917 Loss of limb organ 54**
- **918 Impairment of limb 55**
- **921 Crime 56**
- **922 Suicides and attempted suicides 57**
- **923 Elopement from the facility 58**
- **931 Strike by facility staff 59**
- **932 External disaster 60**
- **933 Termination of any services vital to the continued safe operation of the facility 61**
- **934 Poisoning occurring with facility 62**
- **935 Facility fire disrupting patient care 63**
- **936 All other fires 63**
- **961 Infant Abduction 64**
- **962 Adult Abduction 65**
- **963 Rape of a Patient or Resident 66**
- **964 Resident to Resident Altercations 66**
- **966 Restraint related incident 66**
- **967 Infant discharged to wrong family 67**
- **968 Physical Abuse 66**
- **969 Sexual Abuse …….. 66**
- **970 Verbal Abuse ……. 66**
- **971 Neglect or Self-Neglect …….. 66**
- **972 Misappropriation of Funds …… 66**

INTRODUCTION

The purpose of this manual is to offer clarification and guidance in specific reporting categories. It provides additional detail to the includes/excludes list. This section contains the intent of the occurrence codes, definitions, notes and examples. It will also give direction on specific coding policy.

General Information

- Definition of Unusual Event:

  "Unusual event" is an unexpected occurrence or accident resulting in death, life-threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition. An unusual event also includes an incident resulting in the abuse of a patient.

  The Department uses the following definitions as a guide for determining what needs to be reported:

  - "Serious injury", "life threatening", "or harm" requires the patient to undergo significant additional diagnostic or treatment measures.

  - Please refer to the examples for guidance in deciding which incidents are reportable to the Department.

- When you identify more than 2 occurrence codes per event (codes in the 100-800 series) select the two that had the most significant impact on the patient. If you wish to provide additional detail, provide it in the narrative.

- If more than one detail code (codes in the 900 series) applies, select the one that describes the most severe outcome.

- Any repetitive occurrence must be reported as separate submissions (e.g., if a patient is returned to surgery more than once related to the primary procedure, a submission for each return is required).

- Codes that will automatically trigger a visit from the Department.

  Any unusual event associated with a complaint.

  All deaths of reportable unusual incidents

SECTION A

SUMMARY OF INCLUDES/EXCLUDES LIST

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Medication Errors: **Topical, Injectables, IV, PO** **Treatment Medications, Contrasts, Chemotherapy**	108. 109. 110.	A medication error occurred that resulted in permanent patient harm. A medication error occurred that resulted in a near-death event (e.g., an aphylaxis, cardiac arrest). A medication error occurred that resulted in a patient death.	108-110. Any adverse drug reaction that was not the result of a medication error. An allergic reaction in a case where patient did not know of allergy prior to administration of the pharmaceutical agent.
Aspiration	201.	Aspiration pneumonitis/pneumonia in a non-intubated patient related to conscious sedation.	201. Patients intubated on ventilation, or with known history of chronic aspiration.
Intravascular Catheter Related	301.	Necrosis or infection requiring repair (incision and drainage (I&D), debridement, or other surgical intervention), regardless of the location for the repair (e.g., at the bedside, in a treatment room, in the OR).	301. Any infiltration or infection treated exclusively with cold or warm packs, wound irrigation, IV change, and/or medication use (e.g., IV, PO, topical), AV fistula revisions (renal dialysis).
	302.	Volume overload leading to pulmonary edema.	302. Pulmonary edema clearly secondary to acute myocardial infarction. Pulmonary edema occurring in patients with previously known, predisposing conditions such as CHF, cardiac disease, renal failure, renal insufficiency or hemodynamic instability in critically ill patients.
	303.	Pnuemothorax, regardless of size or treatment (including pneumothoraces resulting from a procedure performed through an intravascular catheter, e.g., temporary pacemaker insertion).	303. Non-intravascular catheter related pneumothoraces such as those resulting from lung biopsy, thoracentesis, permanent pacemaker insertion, etc.

Blood Transfusion Reactions	403. 404.	Blood transfusion reactions related to wrong type of blood. Blood transfusion related to outdated blood, wrong patient.	
Perioperative/ Periprocedural Related • **within 48 hours**	600s category 601.	Any new central neurological deficit (e.g., TIA, stroke, hypoxic/anoxic encephalopathy).	ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.) 601. Central neurological deficits due to direct procedures on the central nervous system (e.g., tumor dissection or removal, Transient metabolic encephalopathy, ASA 4 and 5, and previously documented potential high risk outcome).
	602.	Any new peripheral neurological deficit (e.g., palsy, paresis) with motor weakness.	602. Deficits due to operative or other procedure on a specific nerve (e.g., procedures involving neuorfibroma, acoustic neuroma, Sensory symptoms or deficits without motor weakness, numbness or tingling, alone, ASA 4 and 5, previously documented potential high risk outcome). NOTE: Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Burns	701.	2nd and/or 3rd degree burns	1st degree burns. Sunburns of 1st and 2nd degree of cognitively alert and physically capable patients.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Falls	751.	Falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma (e.g., hepatic or splenic injury).	Falls resulting in soft tissue injuries. Fractures resulting from prior pertinent pathological conditions.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions**	800s category		Non-serious injuries of known or unknown origin such as laceration, skin tears, or bruising. NOTE: Consider the 911-963 codes, when applicable.
	801.	Procedure related injury requiring repair or removal of an organ. **Any** procedural injury to liver or spleen, including injury associated with lysis of adhesions or manipulation of the organ.	801. Procedure related injuries which do not penetrate, perforate or enter a lumen, require only a suture(s) to serosal/muscular layers to repair, or which do not require removal of an organ. Procedure related injuries resulting from intended, direct operation on an organ or other anatomical structure based on disease process or lack of an alternative approach available to address the presenting surgical condition.
	803.	Hemorrhage or hematoma requiring drainage, evacuation or other procedural intervention or results in serious injury or death.	803. Expected non-symptomatic blood loss related to the procedures • post = cardio pulmonary by-pass blood deperasis • related to disease process
	806.	Displacement, migration or breakage of an implant, device, graft, or drain, whether repaired, intentionally left in place or removed.	806. Occurrences reported in 913 (retained foreign body) or occurrences due to equipment malfunction or defective product reported in 937 or 938.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
	808.	Post-op wound infection following clean or clean/contaminated case. ASA class is required to be noted.	808. Contaminated or dirty case procedure.
	819.	Any unexpected operation or reoperation (RTOR) related to the primary procedure, regardless of setting of primary procedure. (If occurrence involves 801 or 803-808, enter 801 or 803-808 in the 1st occurrence code field, followed by 819 in the 2nd occurrence code field.)	819. Non-anesthesia procedural interventions (e.g., ERCP) usually performed in special procedure rooms in larger hospitals but which are performed in the OR in a smaller hospital simply due to lack of specialized facilities. Procedures that are commonly sequential or repeated (skin flaps, colostomy closure, 2nd look trauma, biopsy follow-up, documented planned 2nd look for ischemia after bowel resection or whenever intestinal ischemia is expected. Also lap 2nd look post oncologic procedure when post-op adjuvant therapy was given (ovarian cancer, Hodgkin's' and non-Hodgkin's lymphoma). Excludes debridement, vascular cases where conservative approach tried first (thrombectomy, fem-pop bypass) but ultimately fails (BKA done as last resort).
	851.	Hysterectomy in a pregnant woman	
	853.	Ruptured uterus	
	854.	Circumcision requiring repair	

	855.	Incorrect procedure or incorrect treatment that is invasive.	855. Venipuncture for phlebotomy, diagnostic tests without contrast agents.

Other Serious Events	900's category		915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission).
	901.	All other unusual incidents or accidents warranting DOH notification, not covered by codes. (Includes falls that do not Result in fracture, but require sutures or staples for laceration.)	
	911.	Wrong Patient, Wrong Site-Surgical Procedure	
	913.	Unintentionally retained foreign body due to inaccurate surgical count or break in procedural technique (sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles, etc.)	913. Foreign bodies retained due to equipment malfunction or defective product (report under 937 or 938) or those reported under 806.
	915.	Death (e.g., brain death). <u>Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in:</u>	915-919. <u>Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission including cardiac diseases and Dementia DX.</u> Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.
	917.	Loss of limb or organ.	

Other Serious Events	918.	Impairment of limb (limb unable to function at same level prior to occurrence) and impairment present at discharge or for at least 2 weeks after occurrence if patient is not discharged.	918.	Limb functions at the same level as prior to the occurrence, impairment resolves by discharge or within two weeks if not discharged. Excludes positioning parathesias.
	921.	Crime resulting in death or serious injury to a patient, as defined in 915-919.		
	922.	Suicides and attempted suicides with serious injury as defined in 915-919.		
	923.	Elopement from the facility resulting in death or serious injury as defined in 915-919.	923.	Cases in which the patient outcome would have been the same whether or not the elopement occurred (cancer death, etc.)
	931.	Strike by facility staff.		
	932.	External disaster outside the control of the facility which affects facility operations.	932.	Situations that are related to termination of service should be reported under 933.
	933.	Termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.		
	934.	Poisoning occurring within the facility (water, air, food or ingestion).		

Other Serious Events	935.	Facility fire disrupting patient care or causing harm to patients or staff.	
	936.	All other fires.	
	961.	Infant Abduction.	
	962.	Adult Abduction.	
	963.	Rape by another patient or staff.	
	964.	Resident to resident altercations (nursing homes, homes for the aged, ACLF, A&D facilities would only report those requiring physician interventions).	964. Resident/Patient to Resident/Patient with non-physician interventions and appropriate facility intervention
	966.	Restraint related incident.	
	967.	Infant discharged to wrong family.	
	968.	Physical Abuse.	
	969.	Sexual Abuse.	
	970.	Verbal Abuse.	
	971.	Neglect or Self-Neglect.	
	972.	Misappropriation of Funds.	

SECTION B

FORMS

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501, HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
TELEPHONE (615) 741-7221
FAX (615) 253-4356

UNUSUAL EVENT REPORT

Facility Name: _____ License No: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Fax: _____

π Not Patient Specific **Date of Occurrence:** _____ **Time:** _____ ___ **AM** ___ **PM**

Patient Information: Age: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Race: ☐ 1 - American Indian or Alaska Native ☐ 2 – Asian ☐ 3 – Black or African-American ☐ 4 – Hispanic or Latino ☐ 5 - Native Hawaiian or Pacific Islander ☐ 6 – White ☐ UK – Unknown

MR # _____ **Sex:** ☐ Male ☐ Female

Occurrence Code: _____ _____ _____

Diagnosis: (max. number 4)
_____ Alzheimer/Dementia
_____ Cerebral Vascular Injury/Disease
_____ Diabetes
_____ Gastrointestinal Disorders
_____ Genitourinary Disorders
_____ Heart Disease
_____ Hypertension
_____ Infectious Disease
_____ Malignant Neoplasm/Blood Disorders
_____ Neurological
_____ Neurotic/Personality Disorders
_____ Orthopedic Injury/Condition
_____ Parkinson's Disease
_____ Renal Failure
_____ Respiratory Illness
_____ Vascular Diseases
_____ Other

Procedure: (max. number 4)
_____ Cardiovascular
_____ Cosmetic
_____ EENT
_____ Gastroenterology
_____ Neurologic
_____ OB/GYN
_____ Oncology
_____ Orthopedic
_____ Respiratory
_____ Urology

Brief Summary of Incident: _____

Report Date: _____ Reporter: _____

TENNESSEE DEPARTMENT OF HEALTH
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227 FRENCH LANDING, SUITE 501, HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
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FAX (615) 741-7051

Medication Occurrence
Unusual Event Supplement
Facility Document

Type of Occurrence *Check All That Apply*	**Where in the process did the error occur?** *Check All That Apply*
☐ Wrong Patient ☐ Wrong Drug ☐ Wrong Dose ☐ Wrong Route ☐ Wrong Frequency ☐ Wrong Time ☐ Omission ☐ Administration After Order Discont'd/Expired ☐ Wrong Diluent/Concentration/Dosage Form ☐ Monitoring Error ☐ Other	☐ Prescribing -- Written order -- Verbal order ☐ Transcription onto: -- Medication Administration Record -- Other Documentation ☐ Dispensing -- Delay -- Error -- Not Available ☐ Administration Process ☐ Documentation On Med Administration Record

Medication Regimen

Generic Name of Medication Given:	**Dose Given:**	**Route Medication Administered:**	**Frequency Given:**
Generic Name of Medication Prescribed to be Given:	**Prescribed Dose:**	**Prescribed Route:**	**Frequency Prescribed:**

Categories of all Staff Involved in the Occurrence (*check all that apply)*

☐ LPN ☐ RN ☐ PA ☐ Pharmacist ☐ Respiratory Therapist
☐ MD Resident ☐ Attending MD ☐ NP ☐ Unit Secretary
☐ Student (specify type) _____ ☐ Other Staff (specify type) _____

Discovery Date/Time:

How was the occurrence discovered?

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501, HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
TELEPHONE (615) 741-7221
FAX (615) 741-7051

Framework for An Analysis In Response to an Unusual event

INSTRUCTIONS

For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, title of responsible person for implementation and associated measure of effectiveness. If, after consideration of such a finding, a decision is made not to implement as associated strategy, indicate the rationale for not taking action.

Assure that the selected measure will provide data to assess effectiveness of the action.

Consider pilot testing of a planned improvement.

Improvement to reduce risk should be implemented in all areas where applicable, not just where the event occurred. Identify where the improvement will be implemented.

Root Cause Analysis	**Narrative Description**				**Action Plan**			
What happened? Adverse Occurrence What are the details of the event? (Brief description) Include date, day of week, time and the area/service involved.	(Write statement on attachment.)							
Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, including Root Cause(s)** Consider each aspect for analysis Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES**	**NO**		**Risk Reduction Strategies**	Implemented **YES**	**DATE**	**Measures of Effectiveness**
Policy or Process (System) in which the event occurred.	The system in place related to the event is effective.				Action:			Measure:
	The system in place related to the event was carried out as intended.							
	An effective policy is in writing.							
	The policy was effectively communicated.							
	An effective procedure is in place.							

Framework for Root Cause Analysis and Action Plan In Response to an Unusual event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies.			**Risk Reduction Strategies**	Implemented		Measures of Effectiveness
		YES	**NO**			**YES**	**DATE**	
Human Resources. (factors & issues)	Staff are properly qualified.				Action:			Measure:
	Staff are currently assessed as competent to carry out their responsibilities.							
	Staffing level plans were in place.							
	Staffing level plans were appropriate.							
	Staff level plans were implemented.							
	Staff performance in the relevant processes is evaluated.							
	Orientation & in-service training are in place							
	Human error did not contribute to the outcome.							
Environment of Care. (including equipment & other related factors)	The physical environment was appropriate for the processes/treatments being carried out.							
	A system is in place to identify environmental at risk.							
	Emergency and failure-mode responses have been planned.							
	Emergency and failure-mode responses have been tested.							
	Controllable equipment factors did not contribute to the event.							
	Controllable environmental factors did not contribute to the event.							
	Uncontrollable external factors, (natural disaster, power outages, etc.) were not a factor in this case.							

Framework for Root Cause Analysis and Action Plan In Response to an Unusual event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies**	Implemented **YES**	**DATE**	Measures of Effectiveness
Environment of Care (Continued)	An emergency preparedness plan is in place.							
Information Management & Communication Issues	Necessary information was available.							
	Necessary information was accurate.							
	Necessary information was complete.							
	Necessary information was clear and unambiguous.							
	Communication among participants was effective.							
	No barriers to communication were identified.							
Standard of Care	The quality of care and services met generally accepted community standards.							
Leadership: Corporate culture	Leadership is involved in the evaluation of adverse patient care occurrences,.							
Other	Note other factors that influenced or contributed to this outcome? Note other areas of service impacted.							

Results of literature review (include key citation(s)):

Executive Summary of the Analysis (note critical findings):

- List titles of Root Cause Analysis participants i.e., Director of Nursing

SECTION C

INTERPRETIVE GUIDELINES
&
DEFINITIONS MANUAL

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Medication Errors: **Topical, Injectables, IV, PO** **Treatment Medications, Contrasts, Chemotherapy**	108. 109. 110.	A medication error occurred that resulted in permanent patient harm. A medication error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest). A medication error occurred that resulted in a patient death.	108-110. Any adverse drug reaction that was not the result of a medication error. An allergic reaction in a case where patient did not know of allergy prior to administration of the pharmaceutical agent.

INTENT:

- Whenever code 108, 109, or 110 is reported a detail code in the 900 series may also be submitted.

DEFINITIONS:

Medication Error	A medication error is any preventable event that may cause or lead to inappropriate medication use and patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use. (National Coordinating Council for Medication Error Report and Prevention 1998)
Omission	The failure to administer an ordered dose.
Wrong Time	Administration of medication outside a predefined time interval (established by each institution) from its scheduled administration time (e.g., later or early dose) if error causes patient discomfort or jeopardizes patient's health and safety as stated in long term care guidelines.
Administration after order discontinued/expired	Administration of a medication no longer authorized by the prescriber.
Wrong dose	Administration of a dose other than that prescribed by the prescriber.
Wrong route	Administration by a route other than that prescribed.
Wrong diluent/concentration dosage form	Drug incorrectly formulated or manipulated before and/or after administration OR inappropriate procedure or technique in administration of the drug.
Monitoring error	Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of response to prescribed therapy.
Wrong Patient	Administration of a medication to a patient other than the one for whom it was prescribed.
Wrong drug	Administration of a medication not prescribed for that patient.
Wrong frequency	Administration of a medication at a frequency not prescribed.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Aspiration	201.	Aspiration pneumonitis/pneumonia in a non-intubated patient related to conscious sedation.	201. Patients intubated on ventilation, or with known history of chronic aspiration.

DEFINITION:

Aspiration: New infiltrates on chest x-ray and/or reductions of 10% or more in p02 or 02 saturation (compared to baseline, which should have been recorded as part of the conscious sedation monitoring process) or requiring new oxygen therapy or mechanical ventilation (in those cases where baseline values were not recorded).

NOTE:

Aspiration will be limited to those occurrences related to conscious sedation.

Definition of conscious sedation:

conscious sedation[1] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or nonpharmacological method or a combination thereof. In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Futher, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

combination inhalation-enternal conscious sedation (combined conscious sedation) – conscious sedation using inhalation and enteral agents.

When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of combination inhalation-enteral conscious sedation does not apply.

Nitrous oxide/oxygen when used in combination with sedative agents may produce anxiolysis, conscious or deep sedation or general anesthesia.

deep sedation – an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation *or* verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	301.	Necrosis or infection requiring repair (incision and drainage (I&D), debridement, or other surgical intervention), regardless of the location for the repair (e.g., at the bedside, in a treatment room, in the OR).	301. Any infiltration or infection treated exclusively with cold or warm packs, wound irrigation, IV change, and/or medication use (e.g., IV, PO, topical). AV fistula revisions (renal dialysis).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	302.	Volume overload leading to pulmonary edema.	302. Pulmonary edema clearly secondary to acute myocardial infarction. Pulmonary edema occurring in patients with previously known, predisposing conditions such as CHF, cardiac disease, renal failure, renal insufficiency or hemodynamic instability in critically ill patients.

INTENT:

- To capture iatrogenic volume overloads in patients who are not predisposed to pulmonary edema. The intent is not to capture patients who are at high risk for pulmonary edema due to previously known, predisposing conditions. Predisposing conditions may include but are not limited to: CHF, cardiac disease, renal insufficiency, renal failure, or hemodynamic instability in critically ill patients.

NOTES:

- Pulmonary edema may be diagnosed radiologically, or clinically (based on S&S).

EXAMPLES:

Include:

- Pulmonary edema occurs intra- or post-operatively in a patients with no predisposing conditions, etiology is unclear, volume overload is possible factor.

Exclude:

- Elderly patient with history of CHF, COPD, CAD, etc., admitted with fracture of humeral head and neck, receives IV fluids at 100cc/hr, requires transfer to ICU for acute pulmonary edema likely due to volume overload.
- Patient develops right-sided CHF from volume overload and the CHF does not progress to pulmonary edema.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	303.	Pneumothorax, regardless of size or treatment (including pneumothoraces resulting from a procedure performed through an intravascular catheter, e.g., temporary pacemaker insertion).	303. Non-intravascular catheter related pneumothoraces such as those resulting from lung biopsy, thoracentesis, permanent pacemaker insertion, etc.

NOTE:

- Enter the procedure code (Proc) corresponding to the type of intravascular catheter inserted (e.g., Swan Ganz catheter insertion) or the procedure directly involving the use/insertion of the intravascular catheter (e.g., temporary pacemaker insertion procedure).

INTRAVASCULAR CATHETER CODES:

- 37.71 Initial Insertion of Transvenous Lead (Electrode) into Ventricle
- 37.72 Initial Insertion of Transvenous Leads (Electrodes) into Atrium and Ventricle
- 37.73 Initial Insertion of Transvenous Lead (Electrode) into Atrium
- 38.91 Arterial Catheterization
- 38.92 Umbilical Vein Catheterization
- 38.93 Central Venous Catheter (e.g., triple lumen, Hickman)
- 38.94 Venous Cutdown
- 86.06 Insertion of Infusion Pump
- 86.07 Insertion of Totally Implantable Vascular Access Device
- 89.64 Swan Ganz (to monitor pulmonary distal branch pressure)
- 89.68 Monitoring of Cardiac Output

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES	
Blood Transfusion Reactions	403. 404.	Blood transfusion reactions related to wrong type of blood. Blood transfusion reactions related to outdated blood, wrong patient.	403-404	Blood transfusion reactions related to fever and chills. Minor reactions controlled with medication or palliative therapy.

NOTE:

Consider the 900 category codes in addition to the 400 category code when applicable.

Excludes:

Minor reactions controlled with minimum amounts of medication or blood transfusion where reactions are controlled with minimum amounts of medication or palliative therapy.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**	600s category		ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.) 601 – 602 Multiple trauma, AAA rapture known at time of surgery, ASA category 4 and 5.

INTRODUCTION TO THE 600S CATEGORY

INTENT:

- To capture any perioperative and periprocedural occurrences occurring in any setting which falls under the control or provider number of the facility (e.g., off-site facility such as an outpatient clinic, lab, or ASTCs).

NOTE:

- The perioperative/periprocedural timeframes begins with either the induction of anesthesia (regardless of type) or, when no anesthesia is involved, the initiation of the procedure, and ends 48 hours later.
- Consider the 900 category codes in addition to the 600 category code, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**			ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.)
	601.	Any new central neurological deficit (e.g., TIA, stroke, hypoxic/anoxic encephalopathy).	601. Central neurological deficits due to direct procedures on the central nervous system (e.g., tumor dissection or removal). Transient metabolic encephalopathy.

INTENT:

- To capture central nervous system (CNS) deficits that are unexpected in relation to the type of procedure performed. It is NOT intended to capture occurrences involving postoperative confusion, disorientation, hallucination, etc., due to transient metabolic encephalopathy from effects of medications, anesthesia, electrolyte disturbance, etc.

NOTE:

- Consider code 919 in addition to code 601 if deficit persists for 2 weeks or is present at time of discharge.

EXAMPLES:

Include:

- Elderly patient exhibits transient postoperative aphasia, hemiparesis (TIA).
- ESRD patient suffers a stroke during dialysis treatment.

Excludes:

- Elderly patient exhibits transient postoperative confusion due to hyponatremia.
- ESRD patient suffers a stroke following completion of dialysis treatment and has left the dialysis area.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**			ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.)
	602.	Any new peripheral neurological deficit (e.g., palsy, paresis) with motor weakness.	602. Deficits due to operative or other procedure on a specific nerve (e.g., procedures involving neurofibroma, acoustic neuroma). Sensory symptoms or deficits without motor weakness (e.g., numbness or tingling, alone). NOTE: Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601.

INTENT:

- To capture injuries (e.g., due to pressure, stretching, positioning, laceration, hematoma, ischemia) to peripheral nerves related to procedures not directly performed on the affected nerve. The intent is NOT to capture peripheral neurological deficits that result from procedures performed directly on the affected nerve.

NOTE:

- Cranial nerves are included in the peripheral nerve category.
- Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601, not as 602.
- Consider code 918 in addition to code 602 if deficit persists for 2 weeks or is present at time of discharge.

EXAMPLES:

Include:

- Footdrop following an orthopedic procedure.

Exclude:

- Facial nerve deficit following surgery for an acoustic neuroma.
- Left-sided hemiparesis in connection with a postoperative stroke following a fractured hip repair (the stroke is submitted as a 601).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Burns	701.	2nd and/or 3rd degree burns	1st degree burns. Sunburns of 1st and 2nd degree of cognitively alert and physically capable patients.

INTENT:

- To capture all 2nd or 3rd degree burns occurring during inpatient or outpatient service encounters.

NOTE:

- A burn is any injury to the tissues of the body caused by heat, chemicals, electricity, radiation or gases.
    - 1st degree burn – tissue injury that is generally characterized by redness and warmth.
    - 2nd degree burn – tissue injury that is generally characterized by reddened skin with blisters and/or superficial, open, weeping lesions.
    - 3rd degree burn – tissue injury that is generally characterized by stiff, ischemic or necrotic tissue which is black or white in color, depending on the etiology of the burn.
- Consider the 915-938 codes in addition to code 701, when applicable.

EXAMPLES:

Exclude:

- Burn present on admission.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Falls	751.	Falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma (e.g., hepatic or splenic injury).	Falls resulting in soft tissue injuries. Fracture resulting from prior pertinent pathological conditions.

NOTE:

- Consider the 915-919 codes in addition to code 751, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	800s category		NOTE: Consider the 911-963 codes, when applicable. Non-serious injuries of known or unknown origin such as laceration, skin tears, or bruising.

INTENT:

- To capture procedure-related occurrences occurring in any setting which falls under the control or provider number of the facility.

NOTE:

- Procedures to be reported include but are NOT LIMITED to the following:
    - Urinary catheter insertion
    - Central line insertion
    - Endoscopic procedures
    - Operative procedures (including obstetrical-related)
    - Invasive radiological procedures
    - Intubation
    - Dialysis
    - Circumcision
    - Vaginal delivery
- Obstetrical occurrences involving the mother are captured in the 801-819 category code range, whenever applicable. Additional specific mother-related obstetrical occurrences are identified in 851-853 category code range.
- Birth-related occurrences involving the fetus/neonate/newborn that are **not required** to be reported:
    - Neonatal deaths associated with congenital anomalies,
    - Congenital anomalies,
    - Newborn lacerations occurring at the time of delivery,
    - Low Apgar scores,
    - Low Apgar scores and meconium aspiration,
    - Low Apgar scores and seizures,
    - Seizure activity,
    - Transfer of a neonate to another hospital for a higher level of care,
    - Multiple complications in high risk pregnancy, and
    - Stillborn. (see 900 codes)

- Birth related occurrences involving the fetus/neonate//newborn that **<u>are required</u>** to be reported:

  - Newborn fractures occurring at the time delivery
  - Shoulder dystocia and resulting palsy (brachial plexus or Erb's)

- Whenever a 801 or 803 occurrence involves an unexpected operation or return to OR (RTOR) (819) following completion of the original procedure regardless of setting, in the following manner:

  1) enter 801, 803, or 808 in the 1st **occurrence code field**

  2) enter 819 in the 2nd **occurrence code field**

- Whenever an unexpected operation or RTOR (819) is not associated with an occurrence in the 801-808 range, enter the 819 in the first occurrence field and include an explanation in the narrative of the cause for the return or a detail code in the 900 range.

- The purpose for the order in which the codes are entered is important for data analysis. To analyze unexpected operations or reoperations: one query for the 819 code alone in the 1st occurrence code field, and a second query for those occurrence codes 801 and 803-808 in the 1st occurrence code field which also have the 819 code in the 2nd occurrence code field.

- Consider the 900 category codes in addition to the 800 category codes when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	801.	Procedure related injury requiring repair or removal of an organ. **Any** procedural injury to liver or spleen, including injury associated with lysis of adhesions or manipulation of the organ.	NOTE: Consider the 911-963 codes, when applicable. 801. Procedure related injuries which do not penetrate, perforate or enter a lumen, require only a suture(s) to serosal/muscular layers to repair, or which do not require removal of an organ. Procedure related injuries resulting from intended, direct operation on an organ or other anatomical structure based on disease process or lack of an alternative approach available to address the presenting surgical condition.

NOTE:

- Bleeding that is not attributable to a specific intraoperative injury is submitted as an 803. Injuries that occur during laparoscopic procedure and result in unplanned conversion to open procedure.

- **Intraoperative or intraprocedural injuries** include any cut, laceration, tear or nick to an organ or other anatomical structure (e.g., duct, major blood vessel, nerve, ureter, tendon) which results in any of the following:

    - Penetration, perforation or any other type of entry into its lumen
    - Need for repair (exceeds simply placing sutures in the serosal/muscular layer) or other procedural intervention
    - Need for organ removal

- **Repair** can include but is NOT LIMITED to the following:

    - Repair of a major blood vessel
    - Closure of a perforation
    - Bowel or organ resection
    - Anastomosis
    - Revision or reconstruction

- **Other procedural interventions** include but are NOT LIMITED to the following:

    - Control of bleeding in the liver or spleen
    - Placement of stent, drain, catheter, or tube (e.g., T-tube, chest tube, nephrostomy tube, gastrostomy tube)
    - Any scopic examination (e.g., laparoscopy, endoscopy, colonoscopy, bronchoscopy)
    - Operative procedure
    - Examination under anesthesia (EUA)
    - Repeat of the initial procedure
    - Angioplasty
    - Other invasive procedure
    - Resuscitative measures

- Any intraoperative or intraprocedural injury which fits the above definition, even if it is referred to as an "incidental" nick or injury, is to be captured as an 801.

- An 801 occurrence may require an 819 secondary entry. Please reference general instructions.

EXAMPLES:

Include:

- Esophageal tear occurs during intubation. No repair but 10 days later patient develops retropharyngeal and mediastinal abscesses and pharyngeal fistula; patient requires gastrostomy tube, thoracotomy and chest tub (examples of other procedural interventions).
- A tear to the small bowel while lysing adhesions during hysterectomy results in a need for a small bowel resection.
- "Incidental nick" results in entry into the bladder which requires placement of suture(s).

Exclude:

- Tear to only the serosa in the small bowel requiring suture(s).
- Patient requires RTOR for hemorrhage; diffuse oozing not due to any injury is identified and controlled.
- Bile leak occurs in connection with excision of a hepatoma, repair is required (the injury occurred during direct operation on the liver).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	803.	Hemorrhage or hematoma requiring drainage, evacuation or other procedural intervention or results in serious injury or death.	Expected non-symptomatic blood loss related to the procedures. • Post-cardiopulmonary bypass blood deperasias • Related to disease process

NOTE:

- Bleeding that is attributable to a specific **intraoperative or intraprocedural** injury is submitted as an 801. Bleeding that occurs during laparoscopic procedure and results in unplanned conversion.

- **Other procedural interventions** include but are NOT LIMITED to the following:

    - Blood transfusions
    - Control of bleeding in a procedure room or operating room
    - Placement of stent, drain, catheter, or tube (e.g., T-tube, J-tube, chest tube, nephrostomy tube, gastrostomy tube)
    - Any scopic examination (e.g., laparoscopy, endoscopy, colonoscopy, bronchoscopy)
    - Operative procedure
    - Examination under anesthesia (EUA)
    - Repeat of the initial procedure
    - Angioplasty
    - Other invasive procedure
    - Resuscitative measures

- Repetitive occurrences (e.g., multiple occurrences involving hemorrhage or hematoma in connection with a previous procedure) each need to be submitted.

If the drainage, evacuation or other procedural intervention occurs in the operating room, regardless of the setting of the original procedure, enter 803 in the 1st occurrence code field and add 819 in the 2nd occurrence code field.

“Serious Injury”, “life threatening”, or “harm” requires the patient to undergo significant additional diagnostic or treatment measures.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	806.	Displacement, migration or breakage of an implant, device, graft, or drain, whether repaired, intentionally left in place or removed.	806. Occurrences reported in 913 (retained foreign body) or occurrences due to equipment malfunction or device product reported in 937 or 938.

NOTE:

Device includes but NOT LIMITED to:

- Catheter
- Wire
- Screw

Hip prosthesis dislocation should be reported as 806.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	808.	Post-op wound infection following clean or clean/contaminated case. ASA class is required to be noted.	808. Contaminated or dirty case procedure.

NOTE:

- Wound Class

  Assessment of likelihood and degree of microbial contamination of surgical wound at time of operation. National Nosocomial Infection Surveillance (NNIS) wound class is the Centers for Disease Control and Prevention's adaptation of the American College of Surgeons' wound classification schema. Definitions of the four wound classes are as follows:

- Clean (I): Uninfected operative wounds in which no inflammation is encountered and respiratory, alimentary, genital, or uninfected urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet criteria.

  - Clean-contaminated (II): Operative wounds in which respiratory, alimentary, genital or uninfected urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving biliary tract, elective appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.

  - Contaminated (III): Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from gastrointestinal tract, and incisions in which acute, nonpurulent inflammation is encountered are included in this category.

  - Dirty/infected (IV): Old traumatic wounds with retained devitalized tissue and those wounds that involve existing clinical infection or perforated viscera. This definition suggests that organisms causing postoperative field before operation.

- American Society of Anesthesiology (ASA) Score

An assessment by the anesthesiologist of a patient's preoperative physical condition that uses the ASA Classification of Physical Status schema. Definitions of classification codes are as follows:

1. Normally healthy patient.
2. Patient with mild systemic disease.
3. Patient with severe systemic disease.

4. Patient with an incapacitating systemic diseases that is a constant threat to life.
5. Moribund patient who is not expected to survive for twenty-four (24) hours with or without operation.

- Infection Site: Surgical site infection (superficial incisional)

Definition: A superficial SSI must meet the following criterion: Infection occurs within thirty (30) days after the operative procedure and involves only skin and subcutaneous tissue of the incision and patient has at least one of the following:

a. purulent drainage from the superficial incision
b. organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision
c. at least one of the following signs or symptons of infection: pain or tenderness, localized swelling, redness or heat, and superficial incision is deliberately opened by surgeon, unless incision is culture-negative.
d. Diagnosis of superficial incisional SSI by the surgeon or attending physician.

Infection Site: Surgical site infection (deep incisional)

Definition: A deep incisional SSI must meet the following criterion: Infection occurs within thirty (30) days after the operative procedure if no implant is left in place or within one year if implant is in place an the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision and patient has at least one of the following:

a. purulent drainage from the deep incision but not from the organ/space component of the surgical site.
b. a deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (>38°C or 100.4°F), or localized pain or tenderness, unless incision is culture-negative.
c. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
d. diagnosis of a deep incisional SSI by a surgeon or attending physician.

Infection Site: Surgical site infection (organ/space)

Definition: An organ/space SSI involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure. Specific sites are assigned to organ/space SSI to further identify the location of the infection.

An organ/space SSI must meet the following criterion: Infection occurs when thirty (30) days after the operative procedure if no implant is left in place or within one year if implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and infection involves any part of the body, excluding the skin incision, fascia or muscle layers, that is opened or manipulated during the operative procedure and patient has at least one of the following:

a. purulent drainage from a drain that is placed through a stab wound into the organ/space.
b. Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
c. An abscess or other evidence of infection involving the organ/space that found on direct examination, during reoperation, or by histopathologic or radiologic examination
d. Diagnosis of an organ/space SSI by a surgeon or attending physician.

Infection Site: Vaginal Cuff

Definition: Vaginal cuff infections must meet at least one of the following criteria:

Criterion 1: Posthysterectomy patient has purulent drainage from the vaginal cuff.
Criterion 2: Posthysterectomy patient has an abscess at the vaginal cuff.
Criterion 3: Posthysterectomy patient has pathogens cultured from fluid or tissue obtained from the vaginal cuff.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	819.	Any unexpected operation or reoperation (RTOR) related to the primary procedure, regardless of setting of primary procedure. (If occurrence involves 801 or 803-808, enter 801 or 803-808 in the 1st occurrence code field, followed by 819 in the 2nd occurrence code field.)	Non-anesthesia procedural interventions (e.g., ERCP) usually performed in special procedure rooms in larger hospitals but which are performed in the OR in a smaller hospital simply due to lack of specialized facilities. Procedures that are commonly sequential or repeated (skin flaps, colostomy closure, 2nd look for ischemia after bowel resection or whenever intestinal ischemia is expected. Also lap 2nd look post oncologic procedure when post-op adjuvant therapy was given (ovarian cancer, Hodgkin's and non-Hodgkins lymphoma). Excludes debridement, vascular cases where conservative approach tried first (thrombectomy, fem-pop bypass) but ultimately fails (BKA done as last resort).

INTENT:

To capture any **unexpected visit to the OR** for an operation or reoperation in connection with a previous procedure, regardless of the setting of the previous procedure (e.g., Radiology Department, special procedure room or outpatient clinic treatment room).

NOTE:

Whenever an 801-808 occurrence involves an unexpected operation or RTOR (819) following completion of the original procedure regardless of setting, the report should be completed in the following manner:

1) enter 801, 803, 806, or 808 in the 1st occurrence code field
2) enter 819 in the 2nd occurrence code field

Whenever an unexpected operation or RTOR (819) is not associated with an occurrence in the 801-808 range, enter the 819 in the first occurrence field and include an explanation in the narrative of the cause for the return or a detail code in the 900 range.

The purpose for the order in which the codes are entered is important for data analysis. To analyze unplanned or unexpected operations or reoperations: one query for the 819 code alone in the 1st occurrence code field, and a second query for those occurrence codes 801 and 803-808 in the 1st occurrence code field which also have the 819 code in the 2nd occurrence code field.

Consider the 900 category codes in addition to the 800 category codes, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	851.	Hysterectomy in a pregnant woman	

NOTE:

- All other obstetrical occurrences should be tracked or reported through existing categories. For example, maternal deaths would be reported as code 915.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	853.	Ruptured uterus	

NOTE:

- All other obstetrical occurrences should be tracked or reported through existing categories. For example, maternal deaths would be reported as code 915.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	854.	Circumcision requiring repair	854. Planned suture during procedure.

NOTE:

- Wrong infant circumcised would be coded as 911 “Wrong patient-wrong site”.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	855.	Incorrect Procedure or incorrect Treatment that is Invasive	855. Venipuncture for phlebotomy, diagnostic tests without contrast agents.

NOTE:

- Invasive procedures or treatment – involves puncture or incision of the skin or insertion of an instrument or foreign material into the body.

- Medication errors resulting in adverse outcomes should be reported under 108-110 and corresponding 900 code category (915-919).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	900s category		915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission).

NOTE:

- **When making a determination for submission as an unexpected death, consider the question "Did you think the patient was likely to die when admitted to the facility"?**

- If more than one detail code (codes in the 900 series) applies, select the one that describes the most severe outcome or issue (e.g., if a cardiac arrest occurs that results in a death, use code 915 (death).

EXAMPLES:

- Sepsis related to opportunistic infection (e.g., C. Difficile) resulting from antibiotic therapy is NOT reportable (e.g., sepsis from C. Difficile infection due to antibiotic therapy for pneumonia, which results in death).

- Adverse occurrences are not automatically dismissed from reportability because a patient is significantly compromised by underlying illness or condition (e.g., if a patient with ESRD and significantly cardiac disease exhibits S&S of hemorrahage s/p hip repair and suffers an MI and expires before the hemorrhage can be controlled, it would be reportable as a 915).

- Adverse occurrences are not automatically dismissed from reportability because a patient develops a known complication to a procedure or treatment. An event would be reportable under codes 915-919 if the known complication is unintended or undesirable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	901.	All other unusual events or accidents warranting DOH notification, not covered by other codes. (Includes falls that do not result in fracture, but require sutures or staples for laceration.)	

NOTE:

- Submissions within this category should be infrequent.

EXAMPLE:

- Kidney intended for transplant erroneously discarded and retrieved from trash. Transplant continued as still within window of opportunity for surgery.

- During delivery, mother kicked obstetrician causing him/her to be pushed away, instruments scattered. Baby expelled to floor.

- Definition of Unusual Incidents:

  An unusual incident is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient or the abuse of a patient.

  The Department uses the following definitions as a guide for determining what needs to be reported:

  - "Serious injury" means injury that is life threatening, results in death, or requires a patient to undergo significant additional diagnostic or treatment measures.

  - "Other serious incidents that seriously affect the health and safety of patients" means incidents that result in serious injury.

  - Please refer to the examples for guidance in deciding which incidents are reportable to the Department.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	911.	Wrong Patient, Wrong Site – Surgical Procedure	

NOTE:

- Surgical procedures include any procedures performed in the operating room or ambulatory surgery center.
- Other invasive procedures performed on wrong patient/wrong site should be reported as 912.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	913.	Unintentionally retained foreign body.	913. Foreign bodies retained due to equipment malfunction or defective product (report under 937 or 938) or those reported under 806.

NOTE:

- Also code the occurrence as an 819 if it requires an unplanned operation (RTOR) to remove or address the retained foreign body.

EXAMPLES:

Inaccurate surgical count or break in procedural technique (sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles, etc.).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	915.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Death (e.g., brain death).	915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission) including cardiac diseases and Dementia Dx. Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.

NOTE:

- The unexpected adverse occurrence does not infer that it has to be procedure or treatment related.

INCLUDE:

- All maternal deaths are reportable.
- All deaths in a full term infant weighing > 2500gms with no congenital anomalies are reportable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	917.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Loss of limb or organ.	915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission, Dementia Dx). Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.

NOTE:

- When making a determination for submission as a loss of limb or organs, consider the question "Did you think the patient was likely to lose a limb or organ when admitted to the facility?"

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CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	918.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Impairment of limb (limb unable to function at same level prior to occurrence) and impairment present at discharge or for at least two (2) weeks after occurrence if patient is not discharged.	915-920. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission including Dementia Dx). Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938. 918. Limb functions at the same level as prior to the occurrence, impairment resolves by discharge or within two weeks if not discharged. Excludes positioning parathesias.

NOTE:

When making a determination for submission as an impairment of a limb, consider the question "Did you think the patient was likely to develop an impairment of a limb when admitted to the facility?"

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	921.	Crime resulting in death or serious injury to a patient, as defined in 915-919.	

NOTE:

- A crime is any action that is legally prohibited or is any serious violation of a public law after law enforcement has made determination.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	922.	Suicides and attempted suicides with serious injury as defined in 915-919.	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	923.	Elopement from the facility resulting in death or serious injury as defined in 915-919.	923. Cases in which the patient outcome would have been the same whether or not the elopement occurred (cancer death, etc.).

The definition of elopement was defined and accepted as “unauthorized exit from the facility property of a cognitively impaired resident without staff awareness”.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	931.	Strike by facility staff.	

Strike is defined as collective work stoppage by facility staff.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	932.	External disaster outside the control of the facility which affects facility operations.	932. Situations that are related to termination of service should be reported under 933.

NOTE:

Reporting under this occurrence code relates specifically to natural or catastrophic disasters.

EXAMPLE:

- Earthquakes
- Bioterrorism
- Bomb Threat

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	933.	Termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.	

NOTE:

Any major equipment failure should be reported under 937, 938 or 932.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	934.	Poisoning occurring within the facility (water, air, food, or ingestion).	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	935.	Facility fire disrupting patient care or causing harm to patients or staff.	
	936.	All other fires.	

NOTE:

- This code should be used to identify any fires which result in cancellation or delay of any patient care services or result in any movement of patients.
- A fire resulting in a patient death or serious injury should be reported under 915-919.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	961.	Infant Abduction.	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	962.	Adult Abduction	

EXAMPLE:

Patient or resident removed from facility without facility knowledge and/or power of attorney and/or medical approval.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Events	963.	Rape of a patient, resident, staff.	964. Non-physician interventions and appropriate facility interventions.
	964.	Resident/Patient to Resident/Patient altercations (nursing homes, Homes for the Aged, ACLF, A&D facilities would only report those that required physician intervention).	
	966.	Restraint related incident.	
	967.	Infant discharged to wrong family.	
	968.	Physical Abuse.	
	969.	Sexual Abuse.	
	970.	Verbal Abuse.	
	971.	Neglect or Self-Neglect.	
	972.	Misappropriation of Funds.	

EXAMPLE:

- Inappropriate contact (sexual) between patient and staff.

NOTE:

Nursing homes should refer to specific definitions under nursing home regulations and Linton Law for resident abuse, neglect, or misappropriation of funds.

Definition of Abuse: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain, or mental anguish.

Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Misappropriation of resident property: The deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	967.	Infant discharged to wrong family.	