SECTION 2:

CLINICAL DEFINITIONS
MANUAL
NYPORTS COUNCIL TRACKABLE EVENTS - 2005 NO RCA:

<table>
<thead>
<tr>
<th>OCCURRENCE CODE 401</th>
<th>INCLUDES</th>
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<tbody>
<tr>
<td>Thromboembolic Disorder</td>
<td>New Acute Pulmonary Embolism (PE) confirmed or suspected and treated.</td>
<td>• Acute pulmonary embolism present on admission (patient would not have had a hospitalization in the past 30 days).</td>
</tr>
<tr>
<td>Include Readmissions Within 30 days</td>
<td>• PE occurring during a hospital stay or,</td>
<td>• New, acute pulmonary embolism is suspected cause of sudden death but there is no autopsy to confirm (consider for 915 reporting).</td>
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<td></td>
<td>• Patients readmitted with a PE within 30 days of a discharge.</td>
<td>• End of life care patients who are intentionally not prophylaxed (e.g., comfort care, and hospice).</td>
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</tbody>
</table>

NOTE:
• Consider codes 915 or 916 in addition to code 401 if death or cardiac arrest occurs.

EXAMPLES:

Include:
• Patient hospitalized or readmitted within 30 days of hospital discharge and VQ scan shows low probability for pulmonary embolism, patient is treated anyway.
• New, acute pulmonary embolism is suspected, diagnostic test not done, patient is treated anyway.
• During any medical/surgical admission the patient develops a PE.

Exclude:
• Patient admitted with chest pain and shortness of breath, work up reveals acute pulmonary embolism (patient would not have had prior admit within past 30 days). Patient is admitted for comfort care only (end stage cancer), thromboprophylaxis medication is omitted intentionally and patient develops a PE.
<table>
<thead>
<tr>
<th>OCCURRENCE CODE 402</th>
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<tbody>
<tr>
<td>Thromboembolic Disorder</td>
<td>New Documented Deep Vein Thrombosis (DVT) at any site.</td>
<td>Superficial thrombophlebitis.</td>
</tr>
<tr>
<td>- Include Readmissions Within 30 days</td>
<td>- DVT occurring during a hospital stay or,</td>
<td>- New documented DVT present on admission (patient would not have had a hospitalization in the past 30 days).</td>
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<td></td>
<td>- Patients readmitted with a DVT within 30 days of a discharge regardless of the reason for the previous hospital stay.</td>
<td>- Patients who are admitted through the ED with a rule out DVT diagnosis and receive treatment (medical record must support the R/O DVT diagnosis).</td>
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<td><strong>NOTE:</strong> If DVT were confirmed, it would not be excluded if the patient had a previous hospitalization in the past 30 days.</td>
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<td></td>
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<td>- End of life care patients who are intentionally not prophylaxed (e.g. comfort care, and hospice).</td>
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**EXAMPLES:**

Sites include but are not limited to central line and the following:

**Lower Extremity**
- Superficial and deep Femoral (note- the superficial femoral vein is anatomically a deep vein)
- Iliofemoral
- Femoral popliteal
- Popliteal
- Tibial
- Proximal portion of Great Saphenous at junction of the Femoral vein

**Upper Extremity**
- Proximal Brachial
- Axillary

**Abdominal**
- Iliac
- Portal
- Renal
- Splenic
- Inferior Vena Cava
- Mesenteric
EXAMPLES OF DEEP VEIN THROMBOSIS:

Include:

- During the course of a hospital stay for pneumonia, an elderly patient developed a PE despite appropriate prophylaxis.
- 20 days following an outpatient surgery at an extension facility under the hospital’s operating certificate, the patient was readmitted (inpatient) for the treatment of a femoral DVT.
- A patient is admitted to the orthopedic unit following hip replacement surgery. Despite prophylaxis to prevent a DVT, the patient was diagnosed with a popliteal DVT during the hospital stay.
- Immediately following an outpatient colonoscopy at an outpatient extension facility under the hospital’s operating certificate, the patient complained of severe abdominal pain. The patient was transferred to the hospital and a mesenteric DVT was diagnosed and treated.
- A patient was discharged from the hospital status post stroke. The patient was readmitted 21 days later (inpatient) for findings of a DVT in the right lower extremity.

Exclude:

- 5 days after a patient had outpatient surgery (at a D&TC under its own operating certificate) for pin replacement to left leg fracture (motor vehicle accident related), the patient came to the hospital emergency department complaining of pain and swelling of the upper arm. A DVT was diagnosed at the proximal brachial vein, the patient was treated with Lovenox and sent home two days later with instruction for follow up with her orthopedist.
- 2 days following a hospitalization for right leg pain and peripheral vascular disease of the right lower extremity, the patient was readmitted for treatment of superficial thrombophlebitis of the right lower leg.
- A patient was admitted through the emergency department with complaints of left calf pain, swelling and redness. The chart reflects rule out diagnosis of DVT. The patient was treated with Lovenox and a doppler study of the left leg confirmed DVT (the patient did not have a hospital encounter within the past 30 days).
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<tbody>
<tr>
<td>604</td>
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<tr>
<td>Perioperative Or Endoscopic Related AMI</td>
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<tr>
<td>• Occurring the same day as, or on the 1st or 2nd day after a procedure</td>
<td>Acute Myocardial Infarction (AMI) unrelated to a cardiac procedure.</td>
<td>• Cardiac diagnostic or interventional procedure occurrences (complications) reported to the Cardiac Services Reporting System (CSRS), (e.g., bypass or other structural cardiac repairs such as aortic repair within the thoracic cavity, cardiac catheterization).</td>
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<tr>
<td>• Include readmissions occurring the same day as, or on the 1st or 2nd day after a procedure</td>
<td>• Operative procedures done in the operating room or ambulatory surgery suite.</td>
<td>• Multiple trauma, AAA rupture known at time of surgery.</td>
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<td></td>
<td>• Endoscopy procedures.</td>
<td>• ESRD (end stage renal disease) patients during and post dialysis treatment.</td>
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**EXAMPLES**

**Include:**
- Elective laparoscopic cholecystectomy, cardiac clearance obtained. Post-operatively (2nd day after procedure) patient was diagnosed with acute non Q-wave myocardial infarction.
- During elective diagnostic colonoscopy patient developed hypotension immediately post procedure followed by acute myocardial infarction.
- Following a scheduled descending aortic repair (below the diaphragm), patient was diagnosed with AMI the day after the procedure.

**Exclude:**
- Patient taken to surgery for internal bleeding following a motor vehicle accident. Post-operatively patient developed non Q wave myocardial infarction.
- Scheduled coronary bypass, patient developed AMI the second day after surgery.
- Scheduled ascending aorta repair (aortic arch immediately off the aortic valve) or descending aorta repair (above the diaphragm); patient had AMI the day after the procedure.
- 4 days after a colonoscopy, patient diagnosed with acute myocardial infarct.
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<tr>
<th>OCCURRENCE CODE 701</th>
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<tr>
<td>Burns</td>
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<td>• 2&lt;sup&gt;nd&lt;/sup&gt; and/or 3&lt;sup&gt;rd&lt;/sup&gt; degree burns occurring during inpatient or outpatient service encounters.</td>
<td>• Burn present on admission.</td>
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<td>NOTE:</td>
<td>• 1&lt;sup&gt;st&lt;/sup&gt; degree burns (see definitions).</td>
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<td>Consider 900 codes when applicable.</td>
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**NOTE:**
A burn is any injury to the tissues of the body caused by heat, chemicals, electricity, radiation or gases.

**BURN DEGREE DEFINITIONS:**
- 1<sup>st</sup> degree burn – tissue injury that is generally characterized by redness and warmth.
- 2<sup>nd</sup> degree burn – tissue injury that is generally characterized by reddened skin with blisters and/or superficial, open, weeping lesions.
- 3<sup>rd</sup> 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.

**EXAMPLES:**

**Include:**
- Second degree burn (2” x 1/2”) left flank due to grounding pad malfunction (would include detail code of 938).
- Bovie cautery device made contact with patient’s left lateral thigh during a hysterectomy, patient sustained a blistered 2 cm reddened area.
- Patient had extravasation of IV chemotherapy and sustained a 3 cm stage 2 burn on left arm.

**Exclude:**
- Superficial reddened 3 cm area to chest following radiation therapy session.
- Reddened abrasion to the left thigh noted after removing tape from wound dressing.
- 2 cm pink warm area noted on left abdomen following use of warming blanket.
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<tr>
<td>751 Falls</td>
<td>Falls Resulting in x-ray proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma (e.g., hepatic or splenic injury).</td>
<td>Falls resulting in soft tissue injuries (bruising reddened areas). Falls with no harm identified. Dislocations (consider for code 918).</td>
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<tr>
<td></td>
<td>• Consider 900 codes when applicable</td>
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**EXAMPLES**

**Include**
- Patient fell to floor while ambulating in the MRI waiting area. X-ray revealed fracture of the right hip.
- Patient found supine on floor next to his bed, sustained cerebral contusion.

**Exclude**
- Patient fell while ambulating to the smoking shelter and sustained a 3-cm abrasion to the left elbow.
- Patient, found in bathroom, stated she hit the back of her head on bathroom door. CT negative for hematoma or fracture.
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<tr>
<th>OCCURRENCE CODE 808</th>
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<tr>
<td><strong>Surgical Related Infection:</strong></td>
<td><strong>Post-op surgical wound Infection:</strong></td>
<td><strong>Contaminated or dirty case procedure.</strong></td>
</tr>
<tr>
<td>• Within 30 Days Of Surgical Procedure While Hospitalized.</td>
<td>• Following clean or clean/contaminated case that requires incision and /or drainage or IV antibiotics during the hospitalization.</td>
<td>• Wound opening for therapeutic measures to enhance/promote healing process.</td>
</tr>
<tr>
<td>• Include Readmission Within 30 Days Of Surgical Procedure.</td>
<td>• <strong>Performed in the operating room or surgical suite only.</strong></td>
<td>Allograft site infection reportable to Blood and Tissue Resources Program (BTRP).</td>
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<td></td>
<td>• <strong>ASA class is required</strong> to be noted on the NYPORTS short form report.</td>
<td>• Sepsis related to central line insertion (reportable to the DOH Infection Control Program when facility thresholds are exceeded).</td>
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<td></td>
<td>• Infections related to the same surgical intervention, which may not be located at the primary surgical wound site (e.g., external drain site, associated internal tissue).</td>
<td><strong>Exclude cardiac surgery related infections (occurring in approved cardiac surgical centers only) meeting the following definitions:</strong></td>
</tr>
<tr>
<td></td>
<td>• Patients readmitted within 30 days of a surgical procedure with a post-op wound infection.</td>
<td><strong>For Adult Cardiac Surgery Reporting System (CSRS)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>I. <strong>Deep Sternal Wound Infection:</strong> (Involvement of bone with drainage of purulent material from the sternotomy wound and instability of the sternum).</td>
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<td></td>
<td>II. <strong>Sepsis:</strong> (Fever and positive blood cultures related to the procedure).</td>
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<td>III. <strong>Endocarditis</strong> (Two or more positive blood cultures without obvious source, demonstrated valvular vegetation or acute valvular dysfunction cause by infection).</td>
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<td></td>
<td><strong>For Pediatric Cardiac Surgery Reporting System (PED CSRS)</strong></td>
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<td>IV. Any sternal wound infection (drainage of purulent material from the sternotomy wound).</td>
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<td>V. <strong>Clinical sepsis/positive culture</strong> (with temp&gt;101 and increase WBC or temp&lt;98.6 and decreased WBC).</td>
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POST-OP SURGICAL WOUND EXAMPLES (Code 808):

Include:

- Patient readmitted to facility eight days following major abdominal surgery for diffuse colon cancer. Surgical stab wound site with abscess requiring debridement and IV antibiotics.
- Endometritis after a C-section requiring IV antibiotics.
- *Superficial* sternotomy wound infection fifteen days after cardiac bypass surgery of adult.
- Patient required readmission for incision and drainage of infected left hip suture line two weeks after a hip replacement.

Exclude:

- Surgical site of right ring finger reddened with scant purulent drainage, oral antibiotics and increased dressing changes instituted.
- Return to ED for infected chest tube site (placed in ED). Site draining purulent drainage, incision and drainage performed in special procedure room. Oral antibiotics ordered, patient discharged.
- Deep sternal wound infection post cardiac bypass surgery of adult (report to CSRS).
- Patient required readmission for incision and drainage of left hand wound 31 days after ED visit for left-hand laceration.
AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) SCORE

An assessment of a patient’s preoperative physical condition that uses the ASA Classification of Physical Status schema from the American Society of Anesthesiologists.

This classification may be used in referring to the severity of systemic disease for surgical and medical patients. It is intended to give practitioners a common language in referring to the severity of systemic disease in various patients.

Definitions of classification codes are as follows:

I. **Normally healthy patient.**
   No systemic disease.

II. **Patient with mild systemic disease.**
   A patient with mild systemic disease that results in no functional limitations (e.g., hypertension, diabetes mellitus, chronic bronchitis, morbid obesity, extremes of age).

III. **Patient with severe systemic disease.**
   A patient with severe systemic disease that results in functional limitations (e.g., poorly controlled diabetes mellitus with vascular complications, angina pectoris, prior myocardial infarction, pulmonary disease that limits activity).

IV. **Patient with an incapacitating systemic disease that is a constant threat to life.**
   A patient with severe systemic disease that is a constant threat to life (e.g., unstable angina pectoris, advanced pulmonary, renal or hepatic dysfunction)

V. **Moribund patient who is not expected to survive for 24 hours with or without operation or medical therapy.**
   A moribund patient who is not expected to survive without the operation (e.g., ruptured abdominal aortic aneurysm, pulmonary embolus, and head injury with increased intracranial pressure).

**NOTE:** Adding an E after the roman numerals above indicates the procedure was emergent.
WOUND CLASSIFICATION DEFINITIONS

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:

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<tbody>
<tr>
<td>• 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.</td>
<td>• 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.</td>
</tr>
</tbody>
</table>

• 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, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.

• 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 infection are present in operative field before operation.
WOUND CLASSIFICATION DEFINITIONS

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. Infection site definitions are as follows:

NOTE: NYPORTS (code 808) includes only those wound infections that require incision and/or drainage or IV antibiotics during the hospitalization (this code does include readmissions within 30 days).

Infection Site: Surgical site infection (superficial incisional)
Definition: A superficial SSI must meet the following criterion: Infection occurs within 30 days after the operative procedure, appears to be related to the operative procedure, 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 symptoms 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 30 days after the operative procedure, appears to be related to the operative procedure, 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 dehiscence 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 within 30 days after the operation 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 is 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: Post hysterectomy patient has purulent drainage from the vaginal cuff.
Criterion 2: Post hysterectomy patient has an abscess at the vaginal cuff.
Criterion 3: Post hysterectomy patient has pathogens cultured from fluid or tissue obtained from the vaginal cuff.
STATUTORILY MANDATED CODES REQUIRING RCA
PUBLIC HEALTH LAW 2805-L

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<th>OCCURRENCE CODE</th>
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<tr>
<td>900’s categories (excludes code 901)</td>
<td>Unexpected adverse occurrence in circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnoses or an omission of care) in accordance with generally accepted medical standards.</td>
<td>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).</td>
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</table>

Root Cause Analysis Is Required For Certain Statutorily Mandated Codes.

• Unexpected adverse occurrence in circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnoses or an omission of care) in accordance with generally accepted medical standards.

NOTE:
All 900 codes except code 901 are to be reported within 24 hours or one business day of the “date of awareness” (date facility determines that an occurrence meets NYPORTS reporting criteria).

Submission of a 900 code does not necessarily indicate a mistake or error on the part of the facility. The focus of NYPORTS continues to be analysis of data for quality improvement, risk reduction, lessons learned and process improvements.

• If more than one detail code (codes in the 900 series) applies, select the one that describes the most severe outcome or has more direct relationship, for example:
  • Cardiac arrest occurs that results in a death, use code 915 (unexpected death) as opposed to code 916 (cardiac arrest).
  • Malfunction of cardiac monitor resulting in death, code as 938.
  • Adverse occurrences are not automatically dismissed from reportability because a patient develops a known complication to a procedure or treatment.
  • Adverse occurrences are not dismissed from reportability in a patient without underlying illness or condition simply because they are elderly.
  • When making a determination for submission as an unexpected death (code 915), arrest (code 916), or impairment (code 917-918), consider the question “Did you think the patient was likely to die, arrest, or suffer this impairment when admitted to the hospital?”
**OCCURRENCE CODES 108-110**

Medication Errors: Report Within 24 Hours Of Date Of Awareness.

CODES 108-110 Require:
- Associated 900 Detail Code
- Completion Of The Medication Supplement Form
- Root Cause Analysis.

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<tr>
<td>108. A medication error occurred that resulted in permanent patient harm. <strong>NOTE:</strong> NYPORTS defines permanent harm for code 108, as an impairment meeting codes 916-918 reporting criteria (see examples).</td>
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<tr>
<td>109. A medication error occurred that resulted in a near-death event (e.g., cardiac or respiratory arrest requiring advanced cardiopulmonary life support (ACLS)).</td>
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<tr>
<td>110. A medication error occurred that resulted in a patient death.</td>
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<tr>
<td>108-110. Any adverse drug reaction that was not the result of medication error.</td>
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<tr>
<td>108. Medication error that resulted in the need for treatment, intervention, initial or prolonged hospitalization and caused temporary harm.</td>
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<tr>
<td>109. Medication error that resulted in cardiac or respiratory arrest that required the need for basic life support only.</td>
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<tr>
<td>110. Death that is not the direct result of a medication error (consider code 915).</td>
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**NOTE:**

**Special Requirements for Medication Error Codes:**

- Codes 108-110 (medication errors) represent a special category since they are defined as resulting in permanent harm, a near death event or death. A system force function requires an associated detail code of 915-918 be entered and an RCA be submitted.

- All medication reports require a medication supplement page to be completed, which collects specifics related to the error.

Additional medication events may be submitted to the DOH for analysis by the NYPORTS Medication Panel using code 901. Use the term “medication error” or “potential medication error” in the narrative, so the event can be easily abstracted for analysis.
DEFINITIONS:

- In general, **permanent harm** is harm that is enduring and cannot be rectified by treatment.

- **For the purpose of NYPORTS**, NCC-MERP index for categorizing medication errors defines harm as impairment of the physical, emotional, psychological function or structure of the body and/or pain resulting therefrom.
  - When identifying a medication error that has the potential for permanent harm (code 108), and permanent harm is not obvious, the facility may await the allotted time period noted in codes 917-918 to report the event using this date as the day of awareness.
  - If the facility becomes aware that an impairment meeting the definition of “permanent impairment for NYPORTS” is resolved within 2 weeks during the hospitalization or by discharge, they may request deletion of the occurrence.

- **Advanced Cardiopulmonary Life Support (ACLS)**

ACLS is a detailed medical protocol for the provision of life saving cardiac care in settings ranging from the pre-hospital environment to the hospital setting.

ACLS is the appropriate medical response to cardiac arrest and is continued until the person is revived or declared dead by a competent medical authority. The standards for ACLS in the United States are administered by the American Heart Association.

ACLS consists of the provision of advanced cardiac drugs, defibrillation and intubation.

For witnessed or monitored arrests, ACLS also indicates a single precordial thump.

ACLS is resuscitation that requires skills greater than those for basic life support which may include but not be limited to:

- Use of conventional defibrillator/monitors for defibrillation and cardioversion
- Use of transcutaneous pacing devices
- Advanced airway management, including the use of Combitube, Laryngeal mask airway, and tracheal tube
- Recognition of cardiac arrest rhythms and the most common bradycardias and tachycardias
- Recognition of the 12 lead ECG signs of acute injury and ischemia
- Initiation of intravenous (IV) access or endotracheal routes to provide life saving medications
- Open heart massage
MEDICATION CODE EXAMPLES

CODE 108

Include:
- Patient with hypopituitarism on long term steroid therapy, steroid omitted when transferred to another unit, patient developed hypotension, hypoglycemia and coma.
- Patient admitted for fracture, thromboprophylaxis medication ordered incorrectly, given treatment dose; sustained brain infarct, slurred speech and left sided paralysis.
- Patient given wrong eye drops and developed impaired vision. Patient’s vision not corrected by discharge.

Exclude:
- Patient received excess IV gentamycin, lab results show increased creatinine. IV fluids increased creatinine level within normal limits by discharge.
- Patient given excessive dose of insulin and became very lethargic, blood glucose level 28, IV dextrose administered, and blood glucose returned to normal.
- Patient given 15 mg morphine for pain instead of 10 mg, shortly after became unconscious, IV narcan administered, patient responded quickly.

CODE 109

Include:
- Patient received succinylcholine in lieu of morphine and required rescue medications and intubation for respiratory demise, ACLS successful.
- Patient redigitalized for atrial fibrillation despite rising creatinine levels, developed ventricular arrhythmias and cardiopulmonary arrest. Patient resuscitated and given cardiac rescue medications IV, successfully ACLS resuscitated.
- Pediatric patient given 10 times recommended dose of narcotic, O2 saturation dropped precipitously, became bradycardic and arrested, ACLS resuscitated and treated successfully with IV narcan.
- Patient given 10 times the ordered dose of morphine, went into respiratory arrest, ACLS successful.
CODE 109 CONTINUED

Exclude:
• Patient received roommate’s medications for cardiac diagnosis, developed arrhythmias and coded, BLS successful, transferred to MICU.
• During surgery on right shoulder, patient’s wound site was irrigated with epinephrine/NaCl solution, fluid flushed and evacuated. The patient developed sudden increase in B/P and sinus tachycardia, responded promptly to labetalol IV.
• Patient received in ER with violent behavior, urine toxicology positive for cocaine and alcohol, heavily sedated (Ativan, Haldol, Benadryl), developed respiratory distress, inspiratory stridor, transferred to MICU for close monitoring, stabilized and transferred to Psych unit. (consider code 901).

CODE 110
Include:
• Patient diagnosed with aspiration pneumonia, admission antibiotic orders and blood work not noted or followed through, patient developed sepsis and expired the following day.
• Diltiazem drip and IV normal saline infusing as ordered. Order received to administer antibiotic piggybacked to normal saline IV as well as increase rate of this IV. Rate of diltiazem increased instead, patient had cardiac arrest and expired.
• Surgical patient with past medical history of sleep apnea given excessive dose of epidural fentanyl and expired following cardiac arrest despite ACLS intervention.
**DEFINITIONS:**

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<th>Medication Error</th>
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<tbody>
<tr>
<td>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. (American Society of Hospital Pharmacists)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Omission</th>
</tr>
</thead>
<tbody>
<tr>
<td>The failure to administer an ordered dose.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrong Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of medication outside a predefined time interval (established by each institution) from its scheduled administration time (e.g., late or early doses).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administration after order discontinued/Expired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of a medication no longer authorized by the prescriber.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrong dose</th>
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</thead>
<tbody>
<tr>
<td>Administration of a dose that is greater or less than the amount ordered.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrong route</th>
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</thead>
<tbody>
<tr>
<td>Administration by a route other than that prescribed.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrong diluent/concentration/dosage form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug incorrectly formulated or manipulated before administration OR inappropriate procedure or technique in administration of the drug.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring error</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wrong patient</th>
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<tbody>
<tr>
<td>Administration of a medication to a patient other than the one for whom it was prescribed.</td>
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</table>

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<tr>
<th>Wrong drug</th>
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<tr>
<td>Administration of a medication not prescribed for that patient.</td>
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<tr>
<th>Wrong frequency</th>
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<tbody>
<tr>
<td>Administration of a medication at a frequency not authorized by the prescriber.</td>
</tr>
<tr>
<td>OCCURRENCE CODE 911</td>
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<tr>
<td>---------------------</td>
</tr>
</tbody>
</table>
| Root Cause Analysis Required | Wrong Patient, Wrong Site Surgical Procedure  
- Surgical procedures performed in the operating room or ambulatory surgery suite only.  
- Surgery that proceeds to surgical incision or beyond. |  
- Surgery that proceeds with the administration of anesthesia only and is stopped or rescheduled (code as 912).  
- Procedures usually done outside the O.R (e.g., Endoscopy, Interventional Radiology, Nursery, bedside, E.D.). |
| Report Within 24 Hours Of Date Of Awareness. | | |

**EXAMPLES**

**Include:**
- Patient identified herself as someone else and was taken into ambulatory surgical center for eye surgery, surgery completed before it was discovered that the wrong patient was operated on.
- Two patients’ radiological films mixed up (same last name). Wrong patient taken to OR, an incision was made into skin before the surgeon realized the wrong patient was being operated on.
- Knee replacement performed in the OR on the wrong side, draping covered the marked site.
- Bone scan positive for osteomyelitis of left foot, patient taken to OR for left bone biopsy, right bone biopsy performed.

**Exclude:**
- Patient in ED had chest tube insertion on the wrong side (code as 912).
- Patient was taken to the OR for knee surgery, the wrong knee component was cemented before it was discovered that it was not the intended equipment (code as 912).
- Nursing transferred wrong infant to physician for circumcision in the nursery (code as 912).
- Patient was taken to ambulatory surgical suite for eye surgery and received anesthesia block only before it was noted that the wrong patient was on the table. Surgery was stopped and rescheduled (code as 912).
- Patient taken to endoscopy for removal of cancerous polyp. Lab results were for another patient, no cancerous lesion noted, no polyps noted (code as 912).
<table>
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<tr>
<th>OCCURRENCE CODE 912</th>
<th>INCLUDES</th>
<th>EXCLUDES</th>
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</table>
| Root Cause Analysis Required Report Within 24 Hours Of Date Of Awareness. | Incorrect Procedure or Treatment - Invasive | • Venipuncture for Phlebotomy  
• Diagnostic tests without contrast agents.  
• Transfusion related occurrences are to be reported to Blood & Tissue Resources Program (BTRP) only. |

Some O.R. occurrences that are not wrong patient or site, such as:

a. inserting the wrong surgical implant (e.g., lens or total knee components).

b. surgical procedures that involve the administration of anesthesia only prior to commencement of a surgical incision.

c. wrong treatment or procedure performed on a patient related to error of omission, laboratory or radiological findings.

**NOTE:**
Includes scopic procedures and procedures from all other settings (e.g., Endoscopy, Interventional Radiology, Nursery, bedside and E.D.).

**DEFINITION**
**Invasive:** Involving puncture or incision into the skin, insertion of an instrument or foreign material into body vessels, organs or a body orifice.

**EXAMPLES:**

**Include:**

- Patient in ED had chest tube insertion on the wrong side.
- Patient was taken to the OR for knee surgery, the wrong knee component in cemented before it was discovered that it was not the intended equipment.
- Patient had ureteral stent placed in the OR.

**Exclude:**

- Patient identified herself as someone else and was taken into ambulatory surgical center for eye surgery, surgery completed before it was discovered that the wrong patient was treated (code as 911).
- Knee replacement performed in the OR on the wrong side, draping covered the marked site (code as 911).
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<tr>
<th>OCCURRENCE CODE</th>
<th>INCLUDES</th>
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<tr>
<td>913</td>
<td>Unintentionally Retained Foreign Body (e.g., sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles)</td>
<td>- Foreign bodies retained due to equipment malfunction or defective product (report under code 937 or 938).</td>
</tr>
<tr>
<td></td>
<td>- Retained foreign body discovered after wound closure while still in O.R.</td>
<td>- Intentionally leaving a foreign body it should be assessed on a case by case basis (e.g., foreign body left for treatment reasons).</td>
</tr>
</tbody>
</table>

**EXAMPLES**

**Include:**
- Post surgical sponge count correct, patient goes home following abdominal surgery. A few days later patient returns to ED for complaints of severe abdominal pain, diagnostics reveal a retained surgical sponge, patient goes back to OR for removal.
- Surgeon staples the surgical site closed before equipment count complete, count reveals missing needle, x-ray confirms, incision reopened for removal before leaving the OR.
- Post delivery patient returns to ED with signs of infection, speculum examination reveals a purulent surgical gauze left in the vaginal canal.

**Exclude:**
- Bovie cautery knife used to achieve hemostasis in a patient with hemorrhage during surgery. A piece of the knife breaks off and falls into the surgical wound but is easily retrieved by the surgeon (report as 937).
- Prior to closure of abdominal surgical site, x-ray is performed due to miscount of surgical sponges. Missing sponge located and retrieved, wound closure completed.
- Post orthopedic procedure titanium drill bit breaks in bone, left in place intentionally (because broken bit would not cause harm).
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<thead>
<tr>
<th>OCCURRENCE CODE 915</th>
<th>INCLUDES</th>
<th>EXCLUDES</th>
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<tbody>
<tr>
<td>Root Cause Analysis Required</td>
<td><strong>Unexpected Death</strong> (e.g., brain death). In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnosis or an omission of care) in accordance with generally accepted medical standards.</td>
<td>• End of life care such as DNR with comfort care only, Hospice Patients.</td>
</tr>
<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
<td>• Death of fetus/neonate meeting all of the following criteria:</td>
<td>• Emergent and unplanned surgical patients with significant mortality category (ASA 4 or 5) if the occurrence is not related to deviation from the standard of care, medication error, omission, delay, or iatrogenic event.</td>
</tr>
<tr>
<td></td>
<td><strong>For live Or Still Birth:</strong></td>
<td>• Patients admitted with severe illness/ incapacitating systemic disease that is a constant threat to life or moribund and not expected to survive for 24 hours with or without an operation.</td>
</tr>
<tr>
<td></td>
<td>a. Greater than or equal to 28 weeks gestation</td>
<td>• Death of fetus/neonate with presence of congenital anomalies incompatible with life (e.g., Anencephalus, Trisomy 13,18, Tracheal or Pulmonary Atresia, Multiple life threatening congenital anomalies).</td>
</tr>
<tr>
<td></td>
<td>b. Greater than or equal to 1000 grams of weight</td>
<td>• Sepsis related to opportunistic infection following required antibiotic therapy (e.g., C. Difficile) resulting in death.</td>
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<tr>
<td></td>
<td>• Any iatrogenic occurrence resulting in death at any gestation/weight</td>
<td>• Transfusion related death, report to Blood and Tissue Resources Program (BTRP) only.</td>
</tr>
<tr>
<td></td>
<td>• All maternal deaths</td>
<td>• Malfunction of equipment resulting in death or loss of limb or organ should be reported under 938.</td>
</tr>
</tbody>
</table>
NOTE:
Report an unexpected death within 24 hours (one business day) of the “date of awareness” (date a facility determines that an occurrence meets NYPORTS reporting criteria).

- Use ASA risk classification for medical and surgical patients when determining unexpected death reportability.
- Exclude cases from code 915, when the ASA classification of a patient is either IV or V and there has not been deviation from the standard of care, medication error, omission or delay, or iatrogenic event.

AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) SCORE
An assessment of a patient’s preoperative physical condition that uses the ASA Classification of Physical Status schema from the American Society of Anesthesiologists. The classification is intended to give practitioners a common language in referring to the severity of systemic disease in various patients. Each patient should be given the proper ASA classification as part of the routine pre procedure screening.

I. Normally healthy patient
   No systemic disease.

II. Patient with mild systemic disease.
   A patient with mild systemic disease that results in no functional limitations. (e.g., hypertension, diabetes mellitus, chronic bronchitis, morbid obesity and extremes of age).

III. Patient with severe systemic disease.
   A patient with severe systemic disease which results in functional limitations (e.g., poorly controlled diabetes mellitus with vascular complications, angina pectoris, prior myocardial infarction, or pulmonary disease that limits activity).

IV. Patient with an incapacitating systemic disease that is a constant threat to life.
   A patient with severe systemic disease that is a constant threat to life (e.g., unstable angina pectoris, advanced pulmonary, renal or hepatic dysfunction).

V. Moribund patient who is not expected to survive for 24 hours with or without operation or medical therapy.
   A moribund patient who is not expected to survive without the operation (e.g., ruptured abdominal aortic aneurysm, pulmonary embolus, and head injury with increased intracranial pressure).

NOTE: Adding an E after the roman numerals above indicates the procedure is emergent.
REPORT:

- All maternal deaths not directly related to trauma (e.g., gunshot wound, stabbing, motor vehicle accident) are reportable as a 915.

- Death of fetus/neonate is unexpected when meeting the following criteria for live or still birth and is not associated with the presence of congenital anomalies incompatible with life (e.g., anencephalus, trisomy 13,18, tracheal or pulmonary atresia, multiple life threatening anomalies:
  a. greater than or equal to 28 weeks gestation
  b. greater than or equal to 1000 grams weight

- **Report unexpected stillbirth meeting the following scenarios:**
  a. Mom is admitted to the hospital with a viable fetus meeting the above criteria and has fetal demise/stillbirth during the hospital stay.
  b. Stillbirth on admission, when the mom has been seen at an OB related extension clinic/facility listed on the hospitals operating certificate within the past 72 hours and deemed to have a viable fetus.

- Report any iatrogenic occurrence resulting in death at any gestation/weight.

NOTE:

- To submit a stillbirth occurrence, use the mother’s information on the short form, with the exception of the birthdate (use the day of the stillbirth for the date of birth) and describe the occurrence of stillbirth in the narrative description.

- The unexpected adverse occurrence does not imply that it is necessarily procedure or treatment related.

- All unexpected cardiac diagnostic or interventional related deaths are reportable as a 915, as long as they are not directly related to the natural course of illness, disease or underlying condition.
UNEXPECTED DEATH EXAMPLES (Code 915):

Include:
- Elderly patient fell out of bed, sustained an epidural hematoma requiring craniotomy. Post-op the patient was admitted to critical care unresponsive, patient made DNR per family, expired 5 days later.
- Patient on Cardiazem IV drip, received overdose of Cardiazem as a result of IV pump programming error. The patient, who had end stage lung cancer, expired shortly after.
- Patient discharged ambulatory from ED after seen S/P fall for suturing of lip laceration and multiple broken teeth. Found unresponsive with reported seizures and brought back to ED. Head CT shows subdural hematoma. Patient expired during surgical intervention.
- Baby found ashen, limp, no heart rate or respirations beneath breastfeeding mother on routine checks, ACLS resuscitation code unsuccessful.
- Patient receiving IV potassium chloride for dehydration, potassium level 5.5 on admission. Patient became restless with change in status, transferred to critical care. Potassium level upon rechecking was 7.4, patient had cardiac arrest, ACLS resuscitative measures unsuccessful.
- Patient found sitting on floor after possible fall, pulse irregular, EKG and bloodwork suggestive of MI. While awaiting transfer to CCU patient became unresponsive, code called, unable to be resuscitated.
- Patient with IUP at 37 weeks in early labor was seen in labor and delivery and discharged home at 7:30 pm with instructions to return. Returned at 10:30 PM with absence of fetal heart rate, delivered stillborn infant.
- Elderly patient found in bed with vascular catheter dislodged, bleeding profusely, emergency measures including ACLS initiated, expired despite efforts.

Include: (Specific Examples of unexpected deaths due to delay or omission)
- Patient was admitted for elective surgery. Pre-operative test reports demonstrated significant cardiac disease. Elective surgery was performed without cardiac disease being addressed. Patient found unresponsive 12 hours post-op. ACLS initiated but unsuccessful and patient expired. Autopsy revealed cause of death was due to underlying cardiac condition.
- Patient arrived in ED with infection. Sepsis is not immediately recognized and critical care and IV antibiotics were delayed. Patient expired.
- Patient with head trauma presented at ER; no x-ray or CAT scan done. Discharged; told to take aspirin. Readmitted in coma from cranial bleed and expired.
- Psychiatric patient developed lower extremity swelling, medical consult done, ultrasound performed (results limited), no further action was taken, patient expired next morning, autopsy confirmed DVT and PE.
- Bariatric patient discharged after gastric banding. Readmitted three days later to surgical floor with nausea, vomiting and abdominal pain. Patient found unresponsive in bed six hours later and expired despite ACLS. Autopsy revealed intra-abdominal bleed.
UNEXPECTED DEATH EXAMPLES CONTINUED (Code 915):

Exclude:
- Patient admitted through ED following motor vehicle accident with multiple head trauma, taken for emergent surgery, expired during surgery despite aggressive medical management.
- Elderly patient admitted for multiple infected pressure ulcers of right foot, history of CAD, HTN, IDDM, PVD, gout, renal failure (ASA IV). Treated with IV antibiotics and whirlpool. Ulcers improved slowly, found unresponsive day #8.
- Patient with 40 week IUP admitted in active labor, baby born with severe pulmonary atresia, rescue efforts unsuccessful.
- Patient admitted with massive pulmonary embolus, patient expired despite lysis therapy and ACLS resuscitation.
- Patient admitted with history of CABG following MI two years ago, CAD, IDDM, left AKA and with complaints of heaviness in chest and SOB. EKG positive for non Q wave MI, patient went into full arrest despite cardiac drug intervention and was not resuscitated due to DNR order.
- Patient transferred to the facility for scheduled ORIF following fall with fracture from another hospital. Upon admission, strong suspicion of pulmonary embolus, patient immediately slumped over in bed and arrested. ACLS unsuccessful.
- Patient admitted with complaints of severe abdominal and back pain over past hour, taken to radiology for abdominal CT, large abdominal aortic aneurysm. Patient taken to OR for urgent intervention, expired during induction despite ACLS and massive blood transfusions and surgical intervention (ASA V).
- Patient admitted with end stage lung cancer and pneumonia. Admitted to hospice care, expired following morning.
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<tr>
<th>OCCURRENCE CODE</th>
<th>INCLUDES</th>
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<tbody>
<tr>
<td>916</td>
<td><strong>Cardiac And/Or Respiratory Arrest Requiring ACLS Intervention.</strong> In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnosis or an omission of care) in accordance with generally accepted medical standards</td>
<td>• Events not requiring ACLS intervention.</td>
</tr>
</tbody>
</table>

**NOTE:**
- The unexpected adverse occurrence does not infer that it is necessarily procedure or treatment related.
- If the patient subsequently expires as result of an arrest, the occurrence should be re-coded as a 915 (if it has not already been submitted as a 915). If the report is closed the facility will have to contact the regional DOH NYPORTS coordinator to reopen the report, so the code can be changed to reflect the more severe outcome.
CODE 916: CARDIAC AND/OR RESPIRATORY ARREST REQUIRING ACLS EXAMPLES

Include:

- Patient admitted to CCU with acute anterior wall MI. Lopressor 5 mg IV ordered for sinus tachycardia, inadvertently given 20 mg IV Lopressor with immediate cardiac arrest requiring ACLS resuscitation (code as 109 and 916).
- Patient admitted to ED with extreme agitation. Order received for Ativan 2 mg IV, patient given Atracurium 50 mg IV. Patient sustained respiratory and cardiac arrest within 5 minutes requiring ACLS resuscitation. Resuscitation efforts successful (code as 109 and 916).
- Patient S/P hemicolecotomy for colon cancer, started on coumadin for chronic a-fib three days post-op. Patient developed abdominal distension, pain, diaphoresis and tachycardia. Full arrest with successful ACLS resuscitation. Patient taken to OR for evacuation of retroperitoneal bleed.
- Patient admitted with diagnosis of gallstone pancreatitis and scheduled for laparoscopic cholecystectomy. Pre-op work up revealed no apparent contraindications to surgery. Upon surgical intervention, patient exhibited a 10 second sinus pause with no cardiac activity. Rhythm and blood pressure spontaneously resumed with administration of atropine and chest compressions. Surgery abandoned.
- Patient to OR for D&C, exhibited bradycardia and asystole in recovery room. Chest compressions and atropine effective.
- Patient with history of MI, age 22, admitted for vaginal delivery for fetal demise. Patient became SOB, lost consciousness and cardiac arrested. ACLS resuscitation successful. Still born fetus delivered. Transferred to ICU, cardiac consult ordered.

Exclude:

- Patient admitted to surgical floor following left hip surgery. Patient accidentally given double dose of morphine, respiratory rate decreased to 8/min, O₂ saturation 88%, Narcan given IV with immediate improvement in respiratory status.
- Obese patient admitted for pneumonia. Found unresponsive, ashen, flat in bed with decreased respirations, O₂ saturation 86%. Patients’ HOB up 90 degrees, 100% O₂ applied via mask with immediate improvement.
- Patient underwent gastric bypass two weeks prior to readmission for suspected GI bleed. Patient taken to GI lab for procedure, during endoscopy became unresponsive, CPR successful, taken to OR for repair of bleed.
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<tbody>
<tr>
<td>917</td>
<td>Loss Of limb Or Organ.</td>
<td>• Malfunction of equipment resulting in death or loss of limb or organ should be reported under 938.</td>
</tr>
<tr>
<td>Root Cause Analysis Required</td>
<td>In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnosis or an omission of care) in accordance with generally accepted medical standards.</td>
<td>• Procedure related injuries resulting from intended direct operation on an organ or anatomical structure based on disease process or lack of alternative approach to address the surgical condition.</td>
</tr>
<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
<td>• Impairment must be present at discharge or for at least 2 weeks after occurrence if patient is not discharged.</td>
<td>• Vascular cases where conservative approach tried first (e.g., thrombectomy or fem-pop bypass), but ultimately fails (below knee amputation done as last resort).</td>
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<td>• Ruptured uterus requiring hysterectomy following VBAC.</td>
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**EXAMPLES**

**Include:**
- Patient with femoral arterial line found to have loss of popliteal and pedal pulses with mottling of extremity. Taken emergently to OR, revascularization of femoral artery unsuccessful, AKA required.
- Patient admitted 40 weeks gestation in active labor, history of one prior C-Section. Planned VBAC delivery but patient unable to progress. Complaints of severe abdominal pain, fetal decelerations noted, urgently taken to OR. Hysterectomy performed (after live birth) for rupture of uterus.
- Patient underwent right foot bunionectomy and hammer toe repair, post-op day 4 noted to have purulent drainage of surgical site, cultures positive. Despite antibiotic therapy and wound care, the patient developed a gangrenous right foot and required amputation of right toe. Patient discharged home with orthopedic shoe, crutches, nursing and PT services.

**Exclude:**
- Patient admitted to ED following auto accident, abdomen hard and distended, taken urgently to OR, splenectomy required for ruptured spleen.
- Patient with history of IDDM, HTN, severe PVD with multiple ulcerations to toes requiring greater toe amputation. Found to have absent popliteal pulse and ischemic incisional site post-op day 8. Returned to OR for left AKA.
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<tbody>
<tr>
<td>918</td>
<td>Impairment Of Limb, Organ or Body Functions. (limb, organ or body function is not at the at same level as prior to occurrence). In circumstances other than those related to the natural course of illness, disease or proper treatment (e.g., delay in treatment, diagnosis or an omission of care) in accordance with generally accepted medical standards.</td>
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<tr>
<td>Root Cause Analysis Required Report Within 24 Hours Of Date Of Awareness.</td>
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<tr>
<td></td>
<td>• Impairments present at discharge or for at least 2 weeks after occurrence if patient is not discharged.</td>
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<tr>
<td></td>
<td>• Body function (e.g., sensory, motor, communication or physiologic function diminished from level prior to occurrence).</td>
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<tr>
<td></td>
<td>• Procedure related function loss resulting from direct operation on an organ or other anatomical structure based on disease process or lack of an alternative approach to address the present surgical condition.</td>
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<tr>
<td></td>
<td>• Limb or body functions at the same level as prior to the occurrence, impairment resolves by discharge or within two weeks if not discharged.</td>
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<tr>
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<td>• Positioning parathesias.</td>
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<td></td>
<td>• Any case involving malfunction of equipment resulting in impairment should be reported under 938.</td>
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<td>• Surgical nick to bladder requiring foley catheter to promote healing.</td>
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</table>
CODE 918: IMPAIRMENT LIMB, ORGAN, BODY FUNCTION

EXAMPLES

Include

- Patient undergoes hemicolecctiony procedure, returns to the O.R. three days later due to an anastomotic leak, permanent colostomy required.
- Following extubation after coronary artery bypass x3 and mitral valve annuloplasty, patient became increasingly distressed with worsening arterial blood gases and vital signs. Upon reintubation patient went into respiratory arrest. The chest was opened, cardiac massage rendered and IABP placed. Patient reintubated and placed on vent. Despite ACLS measures patient sustained severe and irreversible brain damage.
- Elderly patient with a PMH of asthma and essential tremors admitted for a right total hip replacement. Post–op treatment included plexipulse boots and prophylactic ASA. On post-op day 4, the patient developed new weakness of right lower extremity. Discharged home day 5 with physical therapy.

Exclude:

- Patient has vacuum assisted vaginal delivery and required foley catheter due to post treatment swelling/dysuria.
- Patient admitted with fractured hip to OR for ORIF left hip. Post-op patient developed foot drop of the left foot which resolved by discharge.
- Patient in for scheduled hysterectomy, bladder is nicked during the surgery and foley catheter is required for healing. Patient discharged home with foley catheter.
- Patient in for surgery of cancerous tumor of right upper arm. During surgery dissection is complicated by the involvement of nerve and vascular tissue. The patient is noted to have significant right arm weakness post procedure that does not resolve by discharge.
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<thead>
<tr>
<th>OCCURRENCE CODE 938</th>
<th>INCLUDES</th>
<th>EXCLUDES</th>
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<tbody>
<tr>
<td>Root Cause Analysis Required</td>
<td>Malfunction Of Equipment during treatment or diagnosis, or a defective product Resulting In Death Or Serious Injury (as described in 915-918) to patient or personnel</td>
<td></td>
</tr>
<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
<td>Please include: a. equipment/device name b. malfunction c. model # d. serial #</td>
<td></td>
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</tbody>
</table>

**NOTE:**

The Food and Drug Administration (FDA) requires that any malfunction of equipment resulting in harm requiring medical or surgical intervention is reported.

For the purposes of NYPORTS code 938 resulting in serious injury is defined to include codes 916-918 (e.g., cardiac or respiratory arrest requiring ACLS, loss of limb or organ, or impairment of limb, organ or body function).

All other serious injury occurrences may be reported using code 901.
CODE 938: MALFUNCTION OF EQUIPMENT RESULTING IN SERIOUS INJURY OR DEATH
EXAMPLES

Include:

- Following a cardiac bypass, pacemaker dependent patient transported to SICU. Within 5 minutes of admission the patient became agitated, all pacemaker connections were verified as tight and securely taped per protocol, the patient’s rhythm and pressure tracings were noted to go flat on the monitor. Code called, rescue medications given and resuscitation successful. The pacemaker cable and alligator connecting wires were replaced with another pacemaker, cable and alligator connecting wires. The pacer began to capture immediately. Equipment was sent for analysis.

- Patient on dopamine drip 7 mcg/kg/hour, status post ruptured aortic aneurysm repair. IV pump malfunctioned and delivered the entire 400 mg IV bag. Patient sustained cardiac arrest with successful ACLS resuscitation. Severe encephalopathy post arrest maintained on ventilator.

- Patient had venous duplex study two days after surgery. Diagnosed with DVT of right gastrocnemius vein. Patient underwent attempted placement of retrievable IVC filter via right common femoral vein. The filter did not engage properly and migrated to just above the renal veins. Retrieval was unsuccessful. The filter migrated to the heart and lodged in the right ventricle. Patient sustained ventricular-fibrillation, arrested. ACLS unsuccessful.

Exclude:

- Telemetry monitoring capability was lost due to hard drive failure, 12 patients affected. All attending physicians notified and orders received to discontinue monitoring. Determined that patients could endure brief interruption of telemetry during installation of new hard drive. No patient harm (report as 937).

- A ventilator began making a high pitch humming noise with each cycle while in use for a patient. The patient’s SAO₂ was noted to drop from 98 to 90. The patient was bagged with 100% O₂ and new vent applied immediately. Malfunctioning ventilator pulled from service. No harm to patient (report as 937).

- During left heart catheterization and PTCA of right coronary artery, stent came off balloon and traveled to left iliac. Stent was retrieved with snare. No harm to patient (report as 937).
### D&TC UNDER ITS OWN OPERATING CERTIFICATE

<table>
<thead>
<tr>
<th>OCCURRENCE CODE 902</th>
<th>INCLUDES</th>
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<tbody>
<tr>
<td>This Code Is Applicable To Article 28, Diagnostic And Treatment Centers (D&amp;TC) In Compliance With Section 751 Of DOH Regulations.</td>
<td>Specific Patient <strong>Transfers</strong> to the hospital from an Article 28 diagnostic and treatment center, in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards (e.g., delay in treatment, delay in diagnosis, iatrogenic event, severe reaction or complication, omission of care).</td>
<td>• Occurrences in an extension clinic under a hospital’s operating certificate.</td>
</tr>
</tbody>
</table>
| Report transfers by ambulance within 24 hours of the Date Of Awareness | Including The Following Reasons:  
  a. Patient required CPR or other life sustaining effort.  
  b. Adverse occurrence resulting in unexpected impairment of body function.  
  c. Adverse Occurrence during OB/GYN procedure.  
  d. Adverse Occurrence while patient treated in an ambulatory surgical center. | • Patients transferred to hospital for additional work up or tests in the normal process of follow up. |
| Report electronically into the NYPORTS system (on the HPN) using the NYPORTS shortform. | | • Patient transferred to hospital for diagnostic tests not available at the D&TC (e.g., MRI). |
| Investigation reports must be submitted within 30 days of The Date Of Awareness. | | • Patients in dialysis (ESRD) center that require transfer to hospital for shunt repair or treatment of thrombosed shunt sites. |

**This code is not applicable to hospital extension clinics and pertains specifically to D&TC centers under their own Article 28 operating certificate.**

**This code is not applicable to hospital extension clinics and pertains specifically to D&TC centers under their own Article 28 operating certificate.**

- All D&TC reports are to be entered on the NYPORTS shortform and submitted electronically to the NYPORTS system via the HPN. The shortform may be faxed to the Regional DOH office if computer issues prevent electronic reporting.
- Code 902 pertains to **transfers only**. Center NYPORTS coordinators should report all other D&TC reportable occurrences under the respective NYPORTS code it is associated with, for example:

<table>
<thead>
<tr>
<th>Occurrence Type</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Unexpected death occurring in the facility</td>
<td>Code as 915</td>
</tr>
<tr>
<td>Fires or other internal disasters</td>
<td>Code as 935</td>
</tr>
<tr>
<td>Equipment malfunction</td>
<td>Code as 938</td>
</tr>
<tr>
<td>Unscheduled termination of vital services</td>
<td>Code as 933</td>
</tr>
<tr>
<td>Strikes by center staff</td>
<td>Code as 931</td>
</tr>
<tr>
<td>Disasters or other emergent situations/external</td>
<td>Code as 932</td>
</tr>
<tr>
<td>Voluntary /Serious occurrence</td>
<td>Code as 901</td>
</tr>
</tbody>
</table>
EXAMPLES OF DIAGNOSTIC AND TREATMENT CENTER TRANSFER (Code 902):

Include:
- Patient treated at D&TC dialysis center. During the session the patient complained of tightness in chest and then sustained a cardiac arrest, CPR initiated and patient sent to nearest hospital via ambulance.
- Patient with 40 week intrauterine pregnancy (IUP) admitted to birthing center in active labor. Labor complicated with unmanageable hemorrhage requiring transfer to hospital.
- Patient scheduled for outpatient knee surgery. Following surgery the patient was noted to have slurred speech and left sided weakness, stabilized and transferred via ambulance to the nearest hospital for treatment.
- During extubation following outpatient shoulder surgery, patient vomited and was noted to have decreased breath sounds at bases with moist cough. Patient was transferred via ambulance to nearest hospital and admitted for observation.
- Patient to outpatient ambulatory surgical center for elective intercostal nerve block. Upon completion of procedure, patient complained of sharp pain to left chest. Chest x-ray positive for pneumothorax. Patient transferred via ambulance to nearest hospital.
- Patient scheduled for routine colonoscopy. After procedure the patient complained of severe abdominal pain. The patient was transferred by ambulance to ED of nearest hospital for treatment of bowel perforation.
- Patient with history of cardiac disease complained of chest pain ten minutes post dialysis. Patient sent to nearest hospital for evaluation.

Exclude:
- Patient arrived at D&TC with abdominal pain, following evaluation the patient was transferred to the hospital for a spiral CT not available at D&TC.
- Patient sustained a fall at home and missed her scheduled dialysis session at the D&TC. The following day the patient arrives at the center and complains of weakness, the physician determines that patient would be transferred via ambulance to ED for evaluation of injuries.
- Patient arrives at outpatient ambulatory surgical center for scheduled surgery. Admission assessment reveals unstable angina and the patient in transferred to nearest ED for evaluation.
STATUTORILY MANDATED CODES - NO RCA REQUIRED UNLESS SPECIFICALLY REQUESTED BY THE DOH

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<thead>
<tr>
<th>OCCURRENCE CODE</th>
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<tbody>
<tr>
<td>914</td>
<td>914. Misadministration Of Radiation Or Radioactive Material (as defined by BERP, Section 16.25, 10NYCRR).</td>
<td>Misadministration involving diagnostic or therapeutic use or ionizing radiation (radioactive materials, x-rays and electrons)</td>
</tr>
</tbody>
</table>

Submit Short Form Only

Root Cause Analysis Not Required except as defined above

Report Within 24 Hours Of Date Of Awareness.

As defined by Bureau of Environmental Radiation Protection (BERP), Section 16.25, 10 NYCRR:

16.25 Misadministration

   (a) A medical misadministration shall be the administration of:

   1. A radiopharmaceutical or radiation from a source other than the one ordered;
   2. A radiopharmaceutical or radiation to the wrong person;
   3. A radiopharmaceutical or radiation by a route of administration or to a part of the body other than that intended by the ordering physician;
   4. An activity of a radiopharmaceutical for diagnostic purposes that differs from the activity ordered by more than 50%;
   5. An activity of a radiopharmaceutical for therapeutic purposes that differs from the activity ordered by more than 10%;
   6. A therapeutic radiation dose from any source other than a radiopharmaceutical or brachytherapy source such that errors in computation, calibration, time of exposure, treatment geometry or equipment malfunction result in a calculated total treatment dose differing from the final total treatment dose ordered by more than 10%; or
   7. A therapeutic radiation dose from a brachytherapy source such that errors in computation, calibration, treatment time, source activity, source placement or equipment malfunction result in a calculated total treatment dose differing from the final total treatment dose ordered by more than 10%; or
   8. A therapeutic radiation dose in any fraction of a fractionated treatment such that the administered dose in the individual treatment or fraction differs from the dose ordered for that individual treatment or fraction by more than 50%, except when the administered dose is lower than the dose ordered by more than 50% due to machine interruption, or due to patient inability or decision to not finish the treatment.
(b) Records and Reports of Misadministrations.

1. **Diagnostic** misadministrations.

   (i) Records of misadministrations as defined in subdivision (a) of this section which involve diagnostic procedures, and the corrective actions taken pursuant to subparagraph (ix) of paragraph (1) of subdivision (a) of section 16.23, shall be retained for three (3) years; and

   (ii) If such a misadministration results in a dose to the patient exceeding 5 rem to the whole body or 50 rem to any individual organ, or the administration of iodine-131 or iodine-125 in the form of iodide, and in a quantity greater than 30 microcuries, the licensee or registrant shall notify the department in writing within 15 days and make and retain a record pursuant to paragraph (3) of this subdivision.

2. **Therapy** misadministrations.

   (i) When a misadministration described in paragraphs (5), (6), or (7) of subdivision (a) of this section, in which the percentage of error is equal to or less than 20 per cent is discovered the licensee or registrant shall immediately investigate the cause and take corrective action; and

       (a) The licensee shall make and retain a record of all therapy misadministrations described in this subparagraph. The record shall contain all the information called for in paragraph (3) of this subdivision and shall be retained for six years.

   (ii) When a therapy misadministration described in paragraphs (1), (2), (3) or (8) of subdivision (a) of this section is discovered; or when a misadministration described in paragraphs (5), (6) or (7) of subdivision (a) of this section in which the percentage of error is greater than 20 per cent is discovered; the licensee or registrant shall notify the department by telephone. The licensee or registrant shall also notify the referring physician of the affected patient and the patient, of any therapy misadministration described in this subparagraph, with the exception of misadministrations described in paragraphs (a)(1) and (8) of this section. When it is not medically advisable to give such information to the patient the information shall be made available to the patient's responsible relative or guardian on the patient's behalf. These notifications must be made within 24 hours after the misadministration is discovered. If the referring physician, patient, or the patient's responsible relative or guardian can not be reached within 24 hours, the licensee or registrant shall notify them as soon as practicable. It is not required that the patient be notified without first consulting the referring physician; however, medical care for the patient shall not be delayed because of this.
(iii) Within 7 days after an initial therapy misadministration report, the licensee or registrant shall send a written report to the department. The written report must contain the name of the licensee or registrant; the information called for in paragraph (3) of this subdivision; and whether the licensee or registrant notified the patient or the patient's responsible relative or guardian. A separate report is not required when an incident report containing all the aforesaid information is submitted to the department pursuant to Part 405 of this Title.

3. Each licensee or registrant shall maintain a record of each reportable misadministration for six years. The record must contain the names of all individuals involved in the event (including the treating physician, allied health personnel, the patient, and the patient's referring physician), the patient's social security number or identification number if one has been assigned, a brief description of the event, the effect on the patient, and actions taken to prevent recurrence.

4. Within seven days after an initial therapy misadministration report made pursuant to subparagraph (ii) of paragraph (2) of this subdivision, the licensee or registrant shall provide the patient a written report with a copy to the patient's referring physician. The report shall contain a brief description of the event, the effect on the patient including any change in the patient's health status which resulted or could result from the misadministration, and recommendations for the appropriate course of treatment or follow-up. If it is not medically advisable to give such information to the patient, the report shall be made available to the patient's responsible relative or guardian on the patient's behalf and documented in the patient's treatment record.
MISADMINISTRATION OF RADIATION OR RADIOACTIVE MATERIAL EXAMPLES (Code 914):

Misadministration involving diagnostic or therapeutic use or ionizing radiation (radioactive materials, x-rays and electrons).

Include:
- Prescription written for radiation treatment to right lung. Following completion of a single treatment it was discovered that the treatment field should have been to the left lung.
- Radiopharmaceutical for parathyroid scan was mistakenly injected into a patient who was to receive a different radiopharmaceutical for a bone scan.
- Miscalculation of therapeutic dose of radiation resulted in an overdose. Patient received a final total treatment dose 15% greater than that intended.
- Bone Scan performed on the wrong patient. Nursing submitted computerized requisition on the wrong patient and the radiology tech did not review the written physician order on the patients chart, prior to injection of a radiopharmaceutical.
- A patient was treated using 9 MV photons rather than the prescribed 6 MV photons.
- A patient’s treatment set-up specified the use of a 30 degree wedge, however a fraction was delivered to the patient without using the specified wedge.

Exclude:
- Patient did not receive the complete therapeutic dose of a fraction treatment ordered due to refusal to complete the treatment.
- Radiation set-up for left breast; just prior to treatment the technician reviewed the physician’s order and changed the field to the correct side.
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<th>OCCURRENCE CODE 921</th>
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<tbody>
<tr>
<td>Submit Short Form Only</td>
<td>Crime Resulting In Death Or Serious Injury. As defined in 915-918 (actual death, or near death event requiring ACLS; unexpected loss of limb or organ, impairment of limb, organ or bodily functions that exists for two weeks during a hospitalization or is present at discharge.</td>
<td>Crimes that result in other serious events not captured by codes 915-918 may be reported under the voluntary code of 901.</td>
</tr>
<tr>
<td>Root Cause Analysis Not Required</td>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
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</tbody>
</table>

NOTE:
- All other serious injuries not captured specifically by this code, may be reported using code 901.

DEFINITION
- A crime is any action that is legally prohibited or is any serious violation of a public law, regardless if charges are involved.

EXAMPLES OF CRIME RESULTING IN DEATH OR SERIOUS INJURY

Include:
- Patient admitted to inpatient psychiatric unit for drug induced psychosis. One week later patient sustained injury to face and left orbit during an altercation with two other patients requiring ENT evaluation and surgical intervention. Two weeks post op the patient continued to have partial blindness to left eye.
- Patient assaulted by another patient on inpatient psychiatric unit causing a right subdural hematoma requiring surgical evacuation. The patient was discharged to rehab with left sided weakness.
- Patient admitted to medical floor for pneumonia, has altercation with roommate who punches patient in left temple. Patient has grand mal seizure and arrests. ACLS resuscitation unsuccessful.

Exclude:
- Patient admitted to surgical floor for rule out appendicitis. Began yelling at roommate to be quiet, nursing came to room as patient struck roommate with television control causing a 4 cm abrasion. Injury resolved by time of discharge.
- Patient wandered into room across the hall and stabbed patient with her dinner fork causing puncture wound to right arm. Wound treated and resolved within 4 days.
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<tr>
<th>OCCURRENCE CODE 922</th>
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<tbody>
<tr>
<td>Submit Short Form Only</td>
<td>Suicides And Attempted Suicides Related To An Inpatient Hospitalization, With Serious Injury. As defined in 915-918 (Actual death, or near death event requiring ACLS. Unexpected loss of limb or organ, impairment/dysfunction of limb or bodily functions that exists for two weeks during a hospitalization or at discharge.</td>
<td></td>
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<tr>
<td>Root Cause Analysis Not Required</td>
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<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
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**EXAMPLES OF SUICIDES AND ATTEMPTED SUICIDES RELATED TO AN INPATIENT HOSPITALIZATION, WITH SERIOUS INJURY:**

**Include:**
- Patient admitted for acute manic state bipolar disorder. Patient had been contracted for no sharps the previous day and placed on 15 minute checks. Patient was given a lighter by a visitor and shortly after an automatic smoke alarm was set off and code red announced. Patient came into hallway engulfed in flames shouting let me die. Immediate staff response included assisting patient to floor, rolling patient and smothering flames with flame retardant blanket. Patient taken immediately to ED via stretcher. Diagnosed with 2nd and 3rd degree burns over abdomen, chest and left arm. Transferred to burn unit after stabilization.

- Patient admitted to inpatient psychiatric unit, diagnosed with bipolar disorder type 2 and borderline personality disorder. Two days post admit patient found unconscious with agonal respirations. Sock with numerous pills found on bedside table. Full ACLS resuscitation with intubation, transferred to MICU for emergent hemodialysis.

**Exclude:**
- Patient with acute manic state bipolar disease admitted to mental health unit for medication stabilization. Discharged after two weeks to home. Facility received call from state police that patient had jumped from apartment building roof to his death.
- Patient discharged from psychiatric unit to halfway house. Patient found hanging by bed sheet from doorframe of room.
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</table>
| 923             | Elopement From The Hospital Resulting In Death Or Serious Injury
|                 | As defined in 915-918 (Actual death, or near death event requiring ACLS. Unexpected loss of limb or organ, impairment/dysfunction of limb or bodily functions that exists for two weeks during a hospitalization or at discharge.) | Cases in which the patient outcome would have been the same whether or not the elopement occurred (cancer death, etc.). |

**EXAMPLES OF ELOPEMENT FROM THE HOSPITAL RESULTING IN DEATH OR SERIOUS INJURY**

**Include:**
- Patient abducted from ED while being treated for assault wounds by husband with current court order of protection. Husband shot patient while out in car. Patient pronounced DOA.
- Elderly patient with alzheimer’s disease wandered off medical unit and out to street. Patient was struck by a car and sustained fractures to both legs and pelvis.

**Exclude:**
- Patient with end stage COPD got on elevator and left facility headed north on route 66. Patient was found by local police and returned to facility unharmed.
- Patient with diagnosis of bipolar disorder followed visitors onto elevator and went to roof. Seen by maintenance worker who was able to coax patient back to unit. No harm to patient.
<table>
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<tr>
<th><strong>OCCURRENCE CODE</strong></th>
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<th><strong>EXCLUDES</strong></th>
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</thead>
<tbody>
<tr>
<td>931</td>
<td>Strike By Hospital Staff.</td>
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</table>

**NOTE:**
It is required that facilities contact their regional DOH program director or designee for any pending strikes they are made aware of. This NYPORTS code is specific for actual Strike.

**EXAMPLES OF STRIKE BY HOSPITAL STAFF**

**Include:**
- Service union (housekeeping, maintenance, laundry, ward secretaries and lab totaling 199 employees) began an economic strike at 7AM on this date. A 10-day notice was provided, strike plan referred and accepted. Several of the workers did not report to work and positions were filled with existing hospital staff and agency staff.
- Strike by hospital staff starting at 7:00 AM on 3/2/02. Participants included the union representing nursing, pharmacy and social service.

**Exclude:**
- Strike notice received on Friday February 10, 2003 (report to the DOH regional office program director or designee).
- Administration received a notice to strike effective 10/5/05, strike averted (report to the DOH regional office program director or designee).
<table>
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<tr>
<th>OCCURRENCE CODE 932</th>
<th>INCLUDES</th>
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</table>
| Submit Short Form Only | External Disaster outside the control of the hospital, which affects facility operations.  
- Natural or catastrophic disasters.  
- Internal facility operations affected directly by a natural or catastrophic disaster. | Facility operations that are affected by an internal disaster not affiliated with a natural or catastrophic disaster.  
(e.g., septic pipe breaks and leak of toxic gases, patients must be transferred to other units in the facility for continuation of care.) code as 935. |

**NOTE:**

Disruption of facility operations that are not the result of a natural or catastrophic disaster, but rather related to termination of services, should be reported under code 933.

**EXAMPLES**

**Natural Disasters:**
- Floods
- Earthquakes
- Hurricanes
- Wind and Storm damage

**Catastrophic Disasters:**
- Bioterrorism
- Bomb Threat
- Terrorism
EXAMPLES of EXTERNAL DISASTER

Include:

- External water main break caused flooding in the outpatient dialysis center requiring one patient to be sent to the main campus that evening for dialysis. An additional nine patients had to be rescheduled for dialysis treatments the next day.
- Power outage in the northeast temporarily affected the electrical system. Back up generator immediately restored power to most of the hospital. The A wing however, was on partial power for 20 minutes due to a malfunction of one of the two generators. During that period life support systems were manually maintained in that wing until full generator power was restored.
- Lightening strike caused a 4 hour interruption in facility telephone service. ED on diversion for one hour until appropriate back-up with cell phone and radio established.

Exclude:

- A fire began in the supply room trashcan and spread to a nearby shelving unit causing the ignition of sterile surgical packs. Patients in rooms adjacent to the supply room were moved to another wing due to heavy smoke (report as code 935).
- A septic pipe within the wall of A wing broke and cause spillage of toxic waste materials and gases. All patients from A wing were immediately transferred to other units (report as code 935).
- Monthly generator testing performed, electrical changeover resulted in 3 OR circuits to flip leaving partial power to the three OR rooms and no power to computers in OR for 15 minutes. Surgeries were delayed (report as code 935).
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<th>OCCURRENCE CODE 933</th>
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| Submit Short Form Only | Termination Of Any Services Vital To The Continued Safe Operation Of The Hospital 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. | • Exclude services maintained by back-up services; planned transitions with seamless continuation of services. (e.g., back up generator to maintain electric for brief period- no change in continuum of care/operations or harm to patient; back up O$_2$ supply that is immediately retrieved and no change in continuum of care/operations or harm to patient; laundry vendor changed with seamless continuation of service/operations).  
• Termination of services due to the direct result of a natural or catastrophic disaster outside the control of the hospital (code as 932).  
• Equipment failure directly related to defect or malfunction (code as 937 or 938).  
• Hospital fire or other internal disaster that disrupts service/operations or causes harm (code as 935). |
| Root Cause Analysis Not Required | Report Within 24 Hours Of Date Of Awareness. | NOTE:  
This code is specific to contract services such as oxygen, pharmacy, blood, laundry, and utility (e.g. electric, water, etc.). |
TERMINATION OF SERVICES EXAMPLES

Include:

- Telephone service went down throughout hospital due to a computer lock up. Cell phones were available but had to be delivered to the units. All areas were without phone service for approximately 15-20 minutes.
- During the scheduled cleaning of electrical switch gear, a contractor accidentally shut down an emergency power panel. Some computers and laboratory refrigerators were affected. Hospital maintenance staff responded immediately and restored power within 10 minutes.
- Following a routine generator check the telemetry monitoring units went off, although staff responded immediately and hit the reset buttons, one patient experienced a syncopal event, no cardiac monitoring strips were available.
- Maintenance staff turned off cold water to repair a leaking toilet, unaware that shut off valve-affected water supply to dialysis treatment room. Dialysis treatment was delayed for 30 minutes.
- Laundry vendor experienced staffing emergency, unable to deliver clean supplies on 2/2/04. Linens only changed if soiled, shortage of towels for morning showers. Patients were supplied with disposable washcloths, linen supply restored within 24 hours.

Exclude:

- Phone service to entire area went down when fiber optic phone company cable was severed during a lightening strike (code as 932).
- Excessive rain caused flooding of Hudson River onto parking area for outpatient surgical services. Surgeries had to be rescheduled (code as 932).
- Malfunction of heating system caused short and inability to control building temperature, blankets provided and patients transferred to main hospital for continued care, no harm to patients (code as 937).
- Water service down due to construction accident of new hospital wing, water service cut off to dialysis unit. Five patients had to be rescheduled for following day, two patients were sent to hospital for evening dialysis care (code as 935).
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<tr>
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<tbody>
<tr>
<td>934</td>
<td>Poisoning Occurring Within The Hospital (water, air, and food).</td>
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</tbody>
</table>

Submit Short Form Only
Root Cause Analysis Not Required
Report Within 24 Hours Of Date Of Awareness.

EXAMPLES

Include:
- Chemical glacial acetic acid was spilled in the pharmacy storage room releasing toxic fumes. Responding hazmat team contacted to mitigate the spill, all personnel in the basement were evacuated. Following neutralization of spill and resumption of ventilation, pharmacy personnel and other departments returned to work within two hours.
- One hour following lunch on the medical surgical floor, four patients complained of severe abdominal pain, nausea and vomiting. Culture sent to identify organism, positive for salmonella (all patients had egg foo young). Complete investigation included actions conducted by food services and risk management.
- Patient complained of burning sensation in throat after drinking lemonade following dinner. It was discovered that the patient had ingested 60 ml of a citrus scented room deodorizer left at the bedside. Poison control contacted and recommended 30 ml of oral Maalox and swish/spit 3 glasses of water. Recommendation followed, complaints of sore throat resolved within one hour.
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<tr>
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<tbody>
<tr>
<td>Submit Short Form Only</td>
<td>Hospital Fire or other internal disaster disrupting patient care or causing harm to patients or staff.</td>
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<tr>
<td>Root Cause Analysis Not Required</td>
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<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
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**NOTE:**

- This code should be used to identify fires or other internal disasters which result in alteration, cancellation or delay of any patient care services, or result in harm to patients or staff.
- A fire resulting in a patient death or serious injury should be reported under codes 915-918.
FIRE OR OTHER INTERNAL DISASTERS EXAMPLES

Includes:
- A flood occurred at an outpatient dialysis center due to an internal water main break. Several patients received only 2 hours of hemodialysis instead of 4 and returned the next day for full treatment. One patient required transfer to inpatient dialysis for evening treatment.
- A leak within the wall adjacent to inpatient wound treatment center caused instability of the wall and ceiling tiles below. Patients were removed from unsafe areas and alternate services were set up for outpatient treatment due to inability to provide services due to repairs.
- A fire occurred on the west wing of the sixth floor, fire doors and sprinkler systems worked appropriately. Delay in colonoscopies due to transfer of patients to OR.
- During a flash fire in the OR, the patient sustained a second degree burn to the left arm and abdomen (code as 701 and 935).

Exclude
- During the scheduled cleaning of electrical switch-gear, a contractor accidentally shut down an emergency power panel. Some computers and laboratory refrigerators were affected. Hospital maintenance staff responded immediately and restored power within 10 minutes (code as 933).
- Following routine generator check the telemetry monitoring units went off, although staff responded immediately and hit the reset buttons, one patient experienced a syncopal event, no cardiac monitoring strips were available (code as 933).
- Small trash fire extinguished with no harm to individuals or facility.
OCCURRENCE CODE 937

INCLUDES

- Malfunction of Equipment during treatment or diagnosis or a defective product which has a Potential For Adversely Affecting Patient Or Hospital Personnel or results in a retained foreign body.
- Please include:
  - equipment/device name
  - manufacturer
  - model #
  - serial #

EXCLUDES

NOTE:
The intent of this code is to capture the fact that a defect or malfunction has occurred and has potential for harm.

EXAMPLES OF EQUIPMENT MALFUNCTION WITH THE POTENTIAL FOR HARM

Include:
- Patient had an ureteroscopy to retrieve a renal calculus. During ureteroscopy with laser lithotripsy and basket retrieval, the basket broke and a piece was left behind because it couldn’t be passed through the swollen ureter.
- During varicose vein stripping and ligation procedure, stripping head broke off. An additional incision was made to retrieve stripping head. All product pieces retrieved, company notified.
- During laparoscopic right thoracoscopy the Endo GIA stapler malfunctioned. The staple was reloaded but continued to malfunction. The procedure was converted to an open thoracotomy and the planned right upper lobe wedge resection was accomplished.

Exclude:
- Malfunction of ventilator resulted in anoxic event despite ACLS resuscitation (code as 938).
- During abdominal resection for colon cancer the stapler malfunctioned and several staples were released at once. Surgical removal of excess staples completed, one week later the patient complained of unusual abdominal pain. A flat plate of the abdomen was ordered and revealed several retained staples. Patient was taken back to the OR for removal (code as 913).
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<tbody>
<tr>
<td>Submit Short Form Only</td>
<td>Infant Abduction.</td>
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<tr>
<td>Root Cause Analysis Not Required</td>
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<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
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</table>

**EXAMPLES**

**Include:**
- Newborn abducted from room while mother asleep. Appropriate code called, security responded and police notified. Newborn found in hospital attire at Burger King restaurant, returned to hospital by police.

**Exclude:**
- A toddler was brought to the ED for fever and cough; the child was diagnosed with pneumonia and transferred to the pediatric unit. Parents removed patient from unit and took patient home without consulting medical staff (code as 901).
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<th>OCCURRENCE CODE</th>
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<tbody>
<tr>
<td>962</td>
<td>Infant Discharged To Wrong Family.</td>
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**EXAMPLES**

**Include:**
- Male newborn discharged to wrong mother. Error caught during second male newborn discharge, just before first mother assisted into car to go home.
<table>
<thead>
<tr>
<th>OCCURRENCE CODE 963</th>
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<tr>
<td>Submit Short Form Only</td>
<td>Rape Of A Patient. (Includes alleged rape with clinical confirmation).</td>
<td></td>
</tr>
<tr>
<td>Root Cause Analysis Not Required</td>
<td></td>
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<tr>
<td>Report Within 24 Hours Of Date Of Awareness.</td>
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</tbody>
</table>

**EXAMPLES OF RAPE OF A PATIENT**

**Include:**
- On 2/2/03 a scream was noted from a female patient’s room, staff responded immediately and found a male patient engaged in apparent intercourse with the patient. Rape exam performed per policy, results of exam positive, appropriate interventions followed. Male patient transferred to another unit.
- At 9:30 PM a female patient with history of schizophrenia alleged that a male staff member forced her to have intercourse between 8-9PM. Rape exam performed and confirmed allegation. Police called and staff member taken into custody.

**Exclude:**
- Patient admitted for schizoactive disorder reported that she was forced to have both oral and vaginal intercourse by a male patient. Rape exam complete and negative, patient retracted statement.
<table>
<thead>
<tr>
<th>OCCURRENCE CODE 901</th>
<th>INCLUDES</th>
<th>EXCLUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit Short Form Only Root Cause Analysis May Be Required</td>
<td>Serious occurrence warranting DOH notification, (not covered by codes 911-963).</td>
<td></td>
</tr>
</tbody>
</table>

EXAMPLES OF SERIOUS OCCURRENCE WARRANTING DOH NOTIFICATION

Include:
- Patient retrieves used needle from receptacle and needle stick results.
- Kidney intended for transplant erroneously discarded and retrieved from trash still in sterile wrap. Transplant continued as still within window of opportunity for surgery.
- During delivery, mother kicked obstetrician causing her to be pushed away, instruments scattered, baby expelled to floor and has no injury requiring reporting in the 915-918 codes.
- Plates implanted in hip found not to have run a full sterilization cycle in the autoclave. IV antibiotics as patient monitored.
- Inappropriate delegation of surgeon’s authority by allowing a RN to perform surgery (muscle biopsy).
- Allegation of sexually inappropriate contact, patient complains that employee brushed up against her chest during a physical examination.