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state		filing required	confi-dential	non-punitive	immunity garanteed	hospitals involved	corresponds to all state hospitals	cases/year	remarkable points
Colorado	CO	verbal: 1 business day, written: 5 working days	o			85	o	2000/2001	x
Connecticut	CT	hospitals: verbal: 24 hours, written: 3 days, CAP: 7 days; nursing homes: verbal: immediately, written: 3 days	x	x	x	about 40	o	145/first 3 months	x
Florida	FL	24 hours, within 15 days & annually by April 1. (depending on the report)	o	x		260	o	4541/2000	requires facilities to utilize Licensed Health Care Risk Managers
Georgia	GA	24 hours or next business day	o	o	x	159	o	mandatory reporting from March 2003	
Kansas	KS	by the end of that quarter		x	yes, for person reporting the incident	152 hospitals, 45 ambulatory surgical centers	o	436/2001	x
Maine	ME		o						
Massachusetts	MA	immidiatly:fire, suicide, serious criminal acts, strike, serious injury or harm to patient resulting from accident or unknown cause, written (1week):other serious incidents	x	x		68 acute care hospitals and 19 non-accute care hospitals	o	883/2000	x
Mississippi	MS	verbal: 24 h, written: 72 h	o	x	o	111	o	400/2002	x
Missouri	MO	within 5 months of the quarter of the year that the patient is discharged	o	x	o	all acute care hospitals & freestanding surgeryclinics, some state hospitals	x	total records: 5mill/year, injury related: 6-700000/year	state obtains emergency room records & patients name, soc. sec. number & address on all records, & E-codes related to injuries
New Jersey	NJ	verbal: immediately, written: 7 days, plan of correction: 10 business days after receipt of notice of violation	o, no names of individuals disclosed	x, but not against the individual	x, Dept.HSS fines/ sanctions:to:fac., individuals:to:Dept. of Law&Publ Safet	118	o	about 400	x
New York	NY	1 business day	o	mostly	state investigations might lead to sanctions/fines	252	o	25000 +	x

state		filing required	confi-dential	non-punitive	immunity garanteed	hospitals involved	corresponds to all state hospitals	cases/year	remarkable points
New York, from website	NY	24h after completion of report	o			all	o	n/a	n/a
North Carolina	NC	24h after completion of report	o	o	x	125	o	average 5	x
Pennsylvania	PA	24h	o	x		232 hospitals, 128 ASF, not incl.psychiatric hosp.	o	over 34000/2002	
Rhode Island	RI	24h to notify licensing agency, 72 hours to Department of Health if reportable incident	o	x	o	14	o	about 200	no additional funding
South Carolina	SC	written within 10 days	o		original reports destroyed after data input into database	102	o		
South Dakota	SD	event occurrence report: 48h, investigation report: 5 days, plan of correction: 15 days	o	o	o	all hospitals licensed by SD	x, exempt: Indian health hosp.(5) & VA hosp.(2)	about 1-none/1 month	x
Tennessee	TN	7	o	o,:but:punitive:if:corrective action:plan:not:mplemented	x	135	x, does not include Psychatric Hospitals	3500	Extranet based (facility can report electronically but not mandatory)
Utah	UT	senitel event reports: 72 h, but not later than 4 hours prior to convening a formal root cause analysis	o	o	o	53	o	34/first year	x
Washington	WA	immidiately	x	o	x	94	o	about 50	x
Wisconsin	WI	death: 30, hospitalization and ambulatory data: quaterly	o	o	o	147 hosp., 30 ambul.surgery, 72 med. exam. & coroners	o	2000: 51deaths, 11547hospitalizations, 4239amb. surgery visits	x
Wyoming	WY	verbal: immidiately, written: 5 days	o	o	unknown	all facilities and types	o	hundreds	x

state		events reported	information included in report
Colorado	CO	see manual: 1. Unexplained deaths, 2. Brain injuries, 3. Spinal cord injuries, 4. Life-threatening complications of anesthesia, 5. Life threatening transfusion errors/reactions, 6. Severe burns, 7. Missing persons, 8.physical abuse, 9. verbal abuse, 10. sexual abuse, 11. neglect, 12. missappropiation of property, 13. deverted drugs and malfunction/misuse of equipement	see occurrence reporting report: facility's name, name, title and tel.no of reporting person, date of occurrence, type of occurrence, date reported to HFD, patients sex, ID# and age, significant medical history, and special data for all cases

state		events reported	information included in report
Connecticut	CT	death; adverse events resulting in patient harm; environmental events such as fires	hospitals: *verbal report*: facility name and address, sequential report number, contact person and tel no., date and time verbal report is being reported, patient's billing number, patient's ageand sex, date and time event occurred, date and time event first known, notification of the Medical Examiner's Office, brief summery of the event and patient's condition, class of adverse event (i.e., A, B, C). *written report*: facility's name address, type and license number, sequetial number, reporter's name, verbal report, patient information, date and time event first known, location of occurence, class of adverse event (A, B or C). *corrective action plan (CAP)*: (a CAP means a plan that implements strategies that reduce the risk of similuar events occuring in the future.) facility's name and address, sequential number, date of event, date CAP submitted, patient's billing number, class of adverse event (A,B, or C), time line for implementation, completed date of CAP, identification of staff member by title who has been designated the responsibility for monitoring the CAP, submitter's name and date of submission. **nursing homes**: *written reports*: date of report and date of event, licensed level of care and bed capacity of the facility, identificatior of the patiens through name, age, injury, distress or discomfort, dispositi date of admission, current diagnosis, physical and mental status prior to and after the event, location, nature and brief describtion of the event, name of physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, incl. findings and orders, name of any witnesses, any other information deemed relevent, signatures of person who prepared the report and the licensed administrator

state		events reported	information included in report
Florida	FL	24 hours reportable events: death, brain or spinal damage, surgery on the wrong patient, surgery at the wrong surgical site, or performing the wrong surgical procedure. Code 15 reportable events: all of the 24h events, plus: perfoming a surgical procedure that is medically unnecessary or unrelated to the patients diagnosis or medical condition, performing a surgical repair of damage resulting from a planned surgical procedure, or surgery to remove unplanned foreign objects remaining from surgical procedure. Annual reportable events: all of Code 15 events, plus: permanent disfigurement, fracture or dislocation of bones or joints, limitation of function that continue after discharge, events requiering specialized medical attention, surgical intervention, or transfer to a higher level of care	24 Hour Report: Outcome; Whether events represent a potential risk to other patients (if Yes-explanation); Name, address and phone number of reporting facility; Name and Title of person reporting; Name, address, Patient I.D., Age, & Sex of patient, Date of Admission, Admitting Diagnosis (and ICD-9 Code), and patient's Medicare and Medicaid status; Date, time and location of incident, Whether the medical examiner was notified, and whether an autopsy will be performed; and the Name of the Medical Examiner (when outcome is death);Narrative description of the incident; Signature, and Title of person preparing the report; Date report completed. [ICD-9: International Classification of Diseases, 9th revision], Code 15 Report: Whether a 24 Hour Report was competed, and Date submitted; Name, address and phone number of reporting facility; Name and Title of person reporting; Name, address, Patient I.D., Age, & Sex of patient, Date of Admission, Admitting Diagnosis (and ICD-9 Code), and patient's Medicare and Medicaid status; Date, time and location of incident, Whether the medical examiner was notified, and whet and the Name of the Medical Examiner (when outcome is death); Narrativ description of the incident; ICD-9 Code of procedure being performed at time of the incident; ICD-9 Code of the accident, event or circumstances causing the injury; ICD-9 Code of the resulting injury; List of any equipme used if directly involved in the injury; Outcome; List of personnel directly involved in the incident; List of personnel witnessing the incident; Analysi of the apparent cause of the incident; Description of corrective action(s) taken; signature, and Title of person preparing the report; Date report completed.

state		events reported	information included in report
Florida, continued	FL		Annual Report: Name, address and phone number of reporting facility; Name, address and phone number of reporting facility Owner; e-mail address for contact with facility; Total number of reportable incidents causing injury to patients; Total number of surgical incidents causing injury to patients; ICD-9 surgical procedure code, ICD-9 event ("E" Code) Code, ICD-9 Resulting injury Code, Involved personnel identifier and facility relationship for each surgical injury; Total number of diagnostic incidents causing injury to patients; ICD-9 diagnostic or treatment procedure code, ICD-9 event ("E" Code) Code, ICD-9 Resulting injury Code, Involved personnel identifier and facility relationship for each diagnostic injury; Total number of other actions causing injury to patients; ICD-9 event ("E" Code) Code, ICD-9 Resulting injury Code, Involved personnel identifier and facility relationship for each other action resulting in injury; Total number of New Malpractice Claims; Total number of Pending Malpractice Claims; Total number of Closed Malpractice Claims; Claim number, personnel identifier,

state		events reported	information included in report
Georgia	GA	Section 0708 – Patient Incidents Requiring Report: No later than 90 days after the effective date of these rules, the hospital's duly constituted peer review committee(s) shall report to the Department, as required below, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred. Any unanticipated patient death not related to the natural course of the patient's illness or underlying condition; Any rape which occurs in a hospital; Any surgery on the wrong patient or the wrong body part of the patient; Section 0709: Effective three months after the Department provides written notification to all hospitals but not later than three years from the effective date of these rules, the hospital must begin reporting any of the following incidents: Any patient injury which is unrelated to the patient's illness or underlying condition and results in a permanent loss of limb or function; Second or third degree burns involving twenty percent or more of the body surface of an adult patient or fifteen percent or more of the body surface of a child which burns were acquired by the patient in the hospital; Serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment; Discharge of an infant to the wrong family; Any time an inpatient, or a patient under observation status, cannot be located, where there are circumstances that place the health, safety, or we of the patient or others at risk and the patient has been mis for more than eight hours; and Any assault on a patient, whi results in an injury that requires treatment.	Section 0710 – The hospital's peer review committee(s) shall make the self–report of the incident within twenty–four hours or by the next regular business day from when the hospital has reasonable cause to believe an incident has occurred. The self–report shall be received by the Department in confidence and shall include at least: The name of the hospital; The date of the incident and the date the hospital became aware that a reportable incident may have occurred; The medical record number of any affected patients(s); The type of reportable incident suspected, with a brief description of the incident; and Any immediate corrective or preventative action taken by the hospital to ensure against the replication of the incident prior to the completion of the hospital's investigation.

state		events reported	information included in report
Kansas	KS	Any incident that the standard of care was not met and there was injury or probability of injury and any incident that is below that standard of practice for professionals.	Number of incidents reported to the risk management program at each individual facility, the standard of care given each report and individual, the type of incident. Corrective action for any incident that meets one of the reportable definitions and any corrective action for processes that the facility has taken to improve care in the facility.

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state		events reported	information included in report
Maine	ME		

state		events reported	information included in report
Massachusetts	MA	fire, suicide, serious criminal acts, pending or actual strikes, serious physical injury resulting from accident or unkown cause, and other serious incidents that seriously affect the health and safety of patients. 'Serious injury' is defined as injuries that are life threatening, result in death, or require a patient to undergo significant additional diagnostic or treatment measures.	facility name, name title and phone number of reporting individual, incident date and time, patient information: name, age, sex, date admitted, ambulatory status, activities of daily living status and cognitive level, type of incident, safety precaitions taken prior to the incident, activity of the patient at the time of the incident, and location where incident occured, any equipment of safety devices in use, brief description of corrective action in plan, wether family and physician were notified, physician's name, name and title of the individual in charge of the facility at the time of the incident, name and titles of witnesses

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state		events reported	information included in report
Mississippi	MS	immediate joepardy, actual harm and no actual harm	complainant's name, address and relationship to victim, facility's name and address, patient's name, gender, age and insurrance, suspect's naem, date and time of incident, witness' or person's familiar with the incident name and address, allegations, nature of incident

state		events reported	information included in report
Missouri	MO	all patients admitted or seen in the emergency room are reported regardless of the reason for going to the hospital	

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state		events reported	information included in report
New Jersey	NJ	events include, but are not limited, to 1. an unscheduled interruption for 3 or more hours of physical plant and/or clinical services essentiel to the health and safety of patients and employee; 2. Aal fires, disasters or accidents which result in serious injury or death of patients or employees, or in evacuation of patients out of the facility; 3. all alleged or suspected crimes which endanger the life or safety of patients or employees, which are also reportable to the police department, and which result in an immediate on-site investigation by the police	facility's name and address, date of event, date reported to DHSS, name, title and tel. of person reporting the event, patient 's name and medical record number, type of incident, date of admission, admission diagnosis, details of event, patient activity orders, assessment, treatment/intervention, follow-up/comments, signature, date of report

state		events reported	information included in report
New York	NY	*Medical Errors*: occurred that resulted in 1. permanent patient harm and 2. near-death event and 3. a patient death; -*Aspiration*: pneumonitis/pneumonia in a nontubated patient related to the conscious sedation; -*Intravascular Catheder*: 1. Necrosis or infection requiring repair incision and drainage, regardless of the location of the repair; 2. volume overload leading o pulmonary edema, 3. Pneumothorax, regardless of the size or treatment; -*Empolic and Related Disorder*: 1. new, acute pulmonary embolism, confirmed, or suspected and treated, 2. new documented DVT; -*Laparoscopic*: all unplanned conversions to an open procedure because of an injury and/or bleeding during laparoscopic procedure; -*Perioperative/Periprocedural Related*: 1. any new central neurological deficit, 2. any new peripheral neurological deficit, 3. cardiac arrest with successful resuscitation, 4. AMI (acute myocardial infarction) unrelated to a cardiac procedure, 5. death occuring after procedure; -*Burns*: 1. 2nd and/or 3rd degree burns, 2. falls resulting in x-ray proven fractures, subdural or epidural hematoma, cerebral contusion, traumati subarachnoid hemorrhage, and/or internal trauma; -*Procedure related*: 1. injury requiring repair, removal of an or other procedural intervention, 2. hemorrhage or hematom requiring drainage, evacuation or other procedural interventi 3. anastomatic leakage requiring repair, 4. wound dehiscence requiring repair, 5. displacement, migration or breakage of an implant, device, graft, or drain, whether repair ed, intentionall left in place or removed, 6. thrombosed distal bypass graft requiring repair,	

state		events reported	information included in report
New York continued	NY	7. post-op surgical wound infection following clean or clean/contaminated case requiring drainage during the hospital stay or INPATIENT hospital admission within 30 days, 8. any unplanned operation or reoperation (RTOR) related to the primary procedure, regardless of the setting of primary procedure, 9. post partum hysterectomy, 10. inverted uterus, 11. ruptured uterus, 12. circumcision requiring repair; -*Root Cause Analysis Required*: wrong patient, wrong site – surgical procedure, 2. incorrect procedure or treatment – invasive, 3. unintentionally retained foreign body due to inaccurate surgical count or break in procedural technique, 4. any unexpected adverse occurrence not directly related to the natural course of the patient's illness and/or underlying condition resulting in: 1. death (e.g. grain eath), 2. cardiac and/or respiratory arrest requiring BLS/ACLS intervention, 3. loss of limb or organ, 4. impairment of limb, 5. loss or impairment of bodily functions, 6. errors of OMISSION/DELAY resulting in death or serious injury RELATED to the patient's underlying condi injury, 8. suicides and attempted suicides related to an inpat hospitalization, 9. elopement from hospital resulting in death serious injury, 10. malfunction of equipment during treatment or diagnosis or a defective product which resulted in death o serious injury, 11. infant abduction, 12. infant discharged to v family, 13. rape by another patient or staff; -*submit short fo (root cause analysis not required)*: 1. serious occurrence wa DOH notification, 2. patients transferred to the hospital from diagnostic and treatment center, 3. misadministration of radi material, 4. strike by hospital staff,	

state		events reported	information included in report
New York continued	NY	5. external disaster outside of the control of the hospital which effects facility operation, 6. 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 condition, rodent or pest control, laundry services, food or contract services, 7. poisoning occurring within the hospital, 8. hospital fire disrupting patient care or causing harm to patients or staff, 9. malfunction of equipment during treatment or diagnosis or a defective product which has a potential for adversely affecting patient or hospital personnel or a resulting in a retained foreign body.	

state		events reported	information included in report
New York, from website	NY	see copy: 1. Patient's death or impairment of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards; 2. Fires in hospitals which disrupt the provision of patient care services or cause harm to patients or staff; 3. equipment malfunction during treatment or diagnosis of patient which did or could have adversely affected a patient or hospital personnel; 4. poisoning occurring within the hospital; 5 strikes by hospital staff; 6. disasters or other emergency situations externel to the hospital environment which affect hospital operations and 7. termination of any service 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 tel., electric, gas, fuel, water, heat, air condition, rodent or pest control, laundry services, food and contract services.	see copy: 1. Explanation of the circumstances surrounding the incident, 2. Updated assessment of the effect of the incident on the partient(s), 3. Summary of current patient status including follow-up care provided and post-incident diagnosis, 4. chronology of steps taken to investigate the incident that identifies the date(s) and person(s) or committee(s) involved in each review activity, 5. indification of all findings and conclusions associated with the review of the accident, 6. summaries of any commity findings and recommendations associated with the review of the accident and 7. summary of all actions taken to correct identified problems, to prevent recurrence of the incident and/or to improve overall patient care and to comply with other requirements of this Part.

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state		events reported	information included in report
North Carolina	NC	any patient death that occurs while the patient is restrained or in seclusion	detailed events describing the incident. In addition, the hospital investigative report

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state		events reported	information included in report
Pennsylvania	PA	reportable events include, but are not limited to: 1. Deaths due to injuries, suicide or unusual circumstances, 2. Deaths due to malnutrition, dehydration or sepsis, 3. Deaths or serieous injuries due to a medical error, 4. Elopements, 5. Transfer to a hospital as a result of injuries or accidents, 6. complaints of patient abuse, wether or not confirmed by the facility, 7. rape, 8. surgery performed on the wrong patient or an the wrong body part, 9. hemolytic transfusion reaction, 10. infant abduction or infant discharged to the wrong family, 11. signifant disruption of services due to disaster as fire, storm, flood, or other occurrence. 12. notification of termination of any services vital to the continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange telephone service. 13. unlicenced pratice of a regulated profession, 14. receipt of a strike notice, 15. activation of internal or external emergency response plan, 16. other not listed above	reporting facility, patient's ID, day, date and time of event, event type, factual description of event, description of Follow-up Actions, submitter's name and title

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state		events reported	information included in report
Rhode Island	RI	*1.41. 'reportable events'* means: a) fire or internal desaster in the facility whoch disrupt the provision of patient care services or causes harm to patients or personnel, b) poisoning involving patient(s) of the facility, c) infection outbreak as may be defined by and in accordance with reference 21, d) kidnapping, e) elopement from inpatient psychiatric units and elopement by minors which are impatients, elopement of psychatric patients from outpatient or emergency departments who are reasonable thought to be in danger to themselves or to others, f) strike, official strike notices, or other personnel actions that may disrupt services, j) disaster or other emergency situations external to the hospital environment which adversely affects facility operations, and h) unscheduled termination of any health care services or utilities viatl to the continued safe operation of the facility or the health and safety of its patients and personnel.	there is no reporting form mandated by State – reports must include all required information