

SENATE FILE NO. SF0113

Medical safety event reporting.

Sponsored by: Senator(s) Massie and Representative(s)
Iekel and Osborn

A BILL

for

1 AN ACT relating to health care facilities; providing for
2 mandatory reporting of safety events by health care
3 facilities to the department of health as specified;
4 requiring an annual report of safety events by the
5 department of health; providing definitions; providing a
6 sunset date; providing an appropriation; and providing for
7 an effective date.

8

9 *Be It Enacted by the Legislature of the State of Wyoming:*

10

11 **Section 1.** W.S. 35-2-912 is created to read:

12

13 **35-2-912. Mandatory reporting of safety events.**

14

15 (a) For purposes of this section, "safety event"
16 means an unexpected occurrence involving death or serious

1 physical or psychological injury or the risk thereof,
2 including:

3

4 (i) Surgical events. Events reportable under
5 this paragraph are:

6

7 (A) Surgery performed on a wrong body part
8 that is not consistent with the documented informed consent
9 for that patient. Reportable events under this clause do
10 not include situations requiring prompt action that occur
11 in the course of surgery or situations whose urgency
12 precludes obtaining informed consent;

13

14 (B) Surgery performed on the wrong patient;

15

16 (C) The wrong surgical procedure performed
17 on a patient that is not consistent with the documented
18 informed consent for that patient. Reportable events under
19 this clause do not include situations requiring prompt
20 action that occur in the course of surgery or situations
21 whose urgency precludes obtaining informed consent;

22

23 (D) Retention of a foreign object in a
24 patient after surgery or other procedure, excluding objects

1 intentionally implanted as part of a planned intervention
2 and objects present prior to surgery that are intentionally
3 retained; and

4

5 (E) Death during or immediately after
6 surgery of a normal, healthy patient who has no organic,
7 physiologic, biochemical, or psychiatric disturbance and
8 for whom the pathologic processes for which the operation
9 is to be performed are localized and do not entail a
10 systemic disturbance.

11

12 (ii) Product or device events. Events
13 reportable under this paragraph are:

14

15 (A) Patient death or serious disability
16 associated with the use of contaminated drugs, devices or
17 biologics provided by the facility when the contamination
18 is the result of generally detectable contaminants in
19 drugs, devices or biologics regardless of the source of the
20 contamination or the product;

21

22 (B) Patient death or serious disability
23 associated with the use or function of a device in patient
24 care in which the device is used or functions other than as

1 intended. "Device" includes, but is not limited to,
2 catheters, drains, and other specialized tubes, infusion
3 pumps, and ventilators; and

4
5 (C) Patient death or serious disability
6 associated with intravascular air embolism that occurs
7 while being cared for in a facility, excluding deaths
8 associated with neurosurgical procedures known to present a
9 high risk of intravascular air embolism.

10

11 (iii) Patient protection events. Events
12 reportable under this paragraph are:

13

14 (A) An infant discharged to the wrong
15 person;

16

17 (B) Patient death or serious disability
18 associated with patient disappearance for more than four
19 (4) hours, excluding events involving adults who have
20 decision making capacity; and

21

22 (C) Patient suicide or attempted suicide
23 resulting in serious disability while being cared for in a
24 facility due to patient actions after admission to the

1 facility, excluding deaths resulting from self-inflicted
2 injuries that were the reason for admission to the
3 facility.

4

5 (iv) Care management events. Events reportable
6 under this paragraph are:

7

8 (A) Patient death or serious disability
9 associated with a medication error, including, but not
10 limited to, errors involving the wrong drug, the wrong
11 dose, the wrong patient, the wrong time, the wrong rate,
12 the wrong preparation, or the wrong route of
13 administration, excluding reasonable differences in
14 clinical judgment on drug selection and dose;

15

16 (B) Patient death or serious disability
17 associated with a hemolytic reaction due to the
18 administration of ABO-incompatible blood or blood products;

19

20 (C) Maternal death or serious disability
21 associated with labor or delivery in a low-risk pregnancy
22 while being cared for in a facility, including events that
23 occur within forty-two (42) days of post-delivery and

1 excluding deaths from pulmonary or amniotic fluid embolism,
2 acute fatty liver of pregnancy, or cardiomyopathy;

3

4 (D) Patient death or serious disability
5 directly related to hypoglycemia, the onset of which occurs
6 while the patient is being cared for in a facility;

7

8 (E) Death or serious disability, including
9 kernicterus, associated with failure to identify and treat
10 hyperbilirubinemia in neonates during the first twenty-
11 eight (28) days of life. "Hyperbilirubinemia" means
12 bilirubin levels greater than thirty (30) milligrams per
13 deciliter;

14

15 (F) Stage three (3) or four (4) pressure
16 ulcers acquired after admission to a facility, excluding
17 progression from stage two (2) to stage three (3) if stage
18 two (2) was recognized upon admission; and

19

20 (G) Patient death or serious disability due
21 to spinal manipulative therapy.

22

23 (v) Environmental events. Events reportable
24 under this paragraph are:

1

2 (A) Patient death or serious disability
3 associated with an electric shock while being cared for in
4 a facility, excluding events involving planned treatments
5 such as electric counter shock;

6

7 (B) Any incident in which a line designated
8 for oxygen or other gas to be delivered to a patient
9 contains the wrong gas or is contaminated by toxic
10 substances;

11

12 (C) Patient death or serious disability
13 associated with a burn incurred from any source while being
14 cared for in a facility;

15

16 (D) Patient death or serious injury
17 associated with a fall while being cared for in a facility;
18 and

19

20 (E) Patient death or serious disability
21 associated with the use or lack of restraints or bedrails
22 while being cared for in a facility.

23

1 (vi) Criminal events. Events reportable under
2 this paragraph are:

3

4 (A) Any instance of care ordered by or
5 provided by someone impersonating a physician, nurse,
6 pharmacist, or other licensed health care provider;

7

8 (B) Abduction of a patient of any age;

9

10 (C) Sexual assault on a patient within or
11 on the grounds of a facility; and

12

13 (D) Death or significant injury of a
14 patient or staff member resulting from a physical assault
15 that occurs within or on the grounds of a facility.

16

17 (b) Each licensed health care facility located within
18 this state shall designate a patient safety officer and
19 shall provide the department with the officer's name and
20 contact information. Through the patient safety officer,
21 each facility shall report to the department the occurrence
22 of any safety event occurring after June 30, 2005 and
23 described in subsection (a) of this section in the
24 following manner:

1

2 (i) A person who is employed by a health care
3 facility shall, within twenty-four (24) hours after
4 becoming aware of a safety event at the health care
5 facility, notify the patient safety officer of the facility
6 of the safety event. The patient safety officer shall,
7 within fifteen (15) days after receiving notification,
8 report the safety event;

9

10 (ii) If the patient safety officer of a health
11 care facility personally discovers or becomes aware, in the
12 absence of notification by another employee, of a safety
13 event at the health care facility, the patient safety
14 officer shall, within fifteen (15) days after discovering
15 or becoming aware of the safety event, report the safety
16 event.

17

18 (c) Safety event reports shall be filed in a format
19 specified by the department and shall identify the facility
20 but shall not include any identifying information for any of
21 the health care professionals, facility employees or
22 patients involved. The department may consult with experts
23 and organizations familiar with patient safety when
24 developing the format for reporting and in further defining

1 events in order to be consistent with industry standards.
2 The department may design the reporting system so that a
3 facility may file by electronic means the reports required
4 under this section. The department shall encourage a
5 facility to use the electronic filing option when that
6 option is feasible for the facility.

7

8 (d) In fulfilling the reporting requirements specified
9 under this section, the department shall use, when
10 practical, information already being generated by the health
11 care facility as a result of the reporting requirements of
12 other health care programs.

13

14 (e) Any notice, report, document and any other
15 information compiled or disseminated pursuant to the
16 provisions of this section is confidential, is not
17 discoverable or admissible in evidence in any
18 administrative or legal proceeding conducted in this state
19 and is not a public record.

20

21 (f) The department shall collect and maintain reports
22 received pursuant to this section and shall have the
23 authority to adopt rules and regulations to implement
24 reporting procedures and standards required by this

1 section. On or before December 31 of each year beginning
2 in 2006, the department shall prepare and publish a report
3 and analysis of all reported safety events for the previous
4 year, including a trend analysis and recommendations for
5 systemic improvements that are likely to enhance patient
6 safety and health care. The department may convene a panel
7 of health care experts to review the data and compile the
8 report. The report shall be made available to the public
9 and copies forwarded to the governor, the health care
10 commission and the joint labor, health and social services
11 interim committee. In its annual report and any other
12 public document, the department shall ensure that all
13 referenced information is aggregated so as not to reveal
14 the identity of any specific person or health care
15 facility.

16

17 (g) Any act authorized or required by this section
18 shall be subject to the confidentiality, immunity and
19 whistle blowing provisions of W.S. 35-2-910(a) and (b).

20

21 (h) Nothing in this section shall be construed to
22 limit or reduce any other reporting requirements for health
23 care facilities under any state or federal law, or limit or

1 reduce the department's authority over health care
2 facilities under any state or federal law.

3

4 (j) This section is repealed effective June 30, 2010.

5

6 **Section 2.** W.S. 35-2-609(b) by creating a new
7 paragraph (v) and 35-2-901(a)(xxiv) are amended to read:

8

9 **35-2-609. Disclosure without patient's authorization.**

10

11 (b) A hospital may disclose health care information
12 about a patient without the patient's authorization if the
13 disclosure is:

14

15 (v) Pursuant to W.S. 35-2-912.

16

17 **35-2-901. Definitions; applicability of provisions.**

18

19 (a) As used in this act:

20

21 (xxiv) "This act" means W.S. 35-2-901 through
22 ~~35-2-910~~ 35-2-912.

23

1 **Section 3.** There is appropriated from the general
2 fund to the department of health thirty-four thousand
3 dollars (\$34,000.00) and there is authorized one (1) full-
4 time position to the department of health for the period
5 beginning July 1, 2005 and ending June 30, 2006 to
6 implement the purposes of this act. The department of
7 health shall include these funds and this position in its
8 standard budget request for the 2007-2008 biennium. There
9 is appropriated a one (1) time appropriation of one hundred
10 thousand dollars (\$100,000.00) from the budget reserve
11 account to the department of health to retain a consultant
12 to develop the electronic reporting capability specified in
13 this act.

14

15 **Section 4.** This act is effective immediately upon
16 completion of all acts necessary for a bill to become law
17 as provided by Article 4, Section 8 of the Wyoming
18 Constitution.

19

20

(END)