SB 1301 Takes Effect July 1, 2007:
Imposes Mandatory Reporting for "28 Never" Events

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In an effort to improve patient safety and increase incident reporting, California Senate Bill 1301 adds language to California Health & Safety Code §1279.1 that requires each hospital to report specified serious adverse events to the California Department of Health Services (DHS) within five days, or within 24 hours, if the event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors. **This law is effective 7/1/07**.

An adverse event is defined in the new law and generally includes the National Quality Forum (NQF) "Never 27 Events" plus a "catch-all" category of adverse events. CA DHS must then conduct an on-site investigation within 45 days of any adverse event report that indicates an ongoing threat of imminent danger of death or serious bodily harm. The law also sets deadlines for DHS to provide written information to the public about reports of substantiated adverse events and the outcomes of inspections and investigations (by Jan. 1, 2009) and must make this information available on its website (by January 1, 2015).

This is the list of reportable adverse events that are so serious they should never happen, plus #28 a Catch All for additional events:

1. Surgery on the wrong body part
2. Surgery on the wrong patient
3. Wrong surgical procedure performed on a patient
4. Object left in patient after surgery
5. Death of a patient, who had been generally healthy, during or immediately after surgery for a localized problem
6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
7. Patient death or serious disability associated with the misuse or malfunction of a device
8. Patient death or serious disability associated with intravascular air embolism
9. Infant discharged to the wrong person
10. Patient death or serious disability associated with patient disappearing for more than four hours
11. Patient suicide or attempted suicide resulting in serious disability
12. Patient death or serious disability associated with a medication error
13. Patient death or serious disability associated with transfusion of blood or blood products of the wrong type
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
15. Patient death or serious disability associated with the onset of hypoglycemia, a drop in blood sugar
16. Death or serious disability associated with failure to identify and treat hyperbilirubinemia, a blood abnormality, in newborns
17. Severe pressure ulcers acquired in the hospital
18. Patient death or serious disability due to spinal manipulative therapy
19. Patient death or serious disability associated with an electric shock
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
21. Patient death or serious disability associated with a burn incurred in the hospital
22. Patient death associated with a fall suffered in the hospital
23. Patient death or serious disability associated with the use of restraints or bedrails
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
25. Abduction of a patient
26. Sexual assault on a patient
27. Death or significant injury of a patient or staff member resulting from a physical assault in the hospital
28. A CATCH-ALL: Any adverse event or series of adverse events that causes the death or serious disability of a patient, personnel or visitor.

Time to educate the administration, physicians and staff on this new law before an event occurs! For further descriptions of these events and their consequences, go to http://www.leginfo.ca.gov, go to California law, then Health and Safety Code, enter section 1279.1.