



**SUMMARY OF THE
ILLINOIS ADVERSE HEALTH CARE EVENT REPORTING LAW OF 2005
Updated August, 2008**

As part of the Hospital Assessment Act of 2005, Illinois passed a mandatory adverse event reporting law requiring hospitals and ambulatory surgical treatment centers to report to the Illinois Department of Public Health (IDPH) information on 24 serious adverse events based on a list adopted by the National Quality Forum in 2002. The stated purpose of the law is to “establish an adverse health care event reporting system designed to facilitate quality improvement through communication and collaboration...not to be used to punish errors”. This law is designed to facilitate error identification and reduction through root cause analysis and the adoption of corrective action plans in response to such errors. It is called the [Illinois Adverse Health Care Events Reporting Law of 2005](#) and its provisions are described below.

When does this reporting system take effect?

Although the Illinois law was to be fully operational by January 2008, state funding issues contributed to a delay in appointing the mandated advisory committee and adopting regulations. Under the law, both requirements must be completed prior to a six month reporting pilot. The statewide advisory committee was appointed in April, 2008 and rules are anticipated to be published as first notice for public comment in the Illinois Register in fall 2008.

What events must be reported?

Any of the following events must be reported to IDPH within 30 days of discovering the event:

1. **Surgical events.** Such events include:
 - surgery performed on a wrong body part
 - surgery performed on the wrong patient
 - the wrong surgical procedure performed on a patient
 - retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted or retained; and
 - death during or immediately after surgery of a normal, health patient.

2. **Product or device events.** Such events include:
 - patient death or serious disability associated with the use of contaminated drugs, devices, where the contamination is generally detectable

- patient death or serious disability associated with the use or function of a device in patient care, such as catheters, drains, and other specialized tubes, infusion pumps, and ventilators in which the device is used or functions other than as intended; and
 - patient death or serious disability associated with intravascular air embolism that occurs while being care for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
3. **Patient protection events.** Such events include:
- an infant discharged to the wrong person
 - patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and
 - patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.
4. **Care management events.** Such events include:
- patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose
 - patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
 - maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy; and
 - patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility for a condition unrelated to hypoglycemia.
5. **Environmental events.** Such events include:
- patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock
 - 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
 - patient death or serious disability associated with a burn incurred from any source while being cared for in a facility
 - patient death associated with a fall while being cared for in a facility; and

- patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

6. **Physical security events.** Such events include:

- any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- abduction of a patient of any age
- sexual assault on a patient within or on the grounds of a facility; and
- death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

What must be reported?

The report shall be filed in a format that will be specified by the Director and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved.

What else must hospitals do?

Following the occurrence of an adverse health care event, the facility must conduct a root cause analysis of the event. Following the analysis, the facility must: (1) implement a corrective action plan to address the findings of the analysis or (2) report to the Director any reasons for not taking corrective action. If the root cause analysis and the implementation of a corrective action plan are complete at the time an event must be reported, the findings of the analysis and the corrective action plan must be included in the report of the event. The findings of the root cause analysis and a copy of the corrective action plan must otherwise be filed with the Director within 90 days of submission of the initial report of the event.

What will the IDPH do with this information?

The IDPH must do the following with the reported information:

- analyze adverse event reports, corrective action plans, and findings of the root cause analyses to determine patterns of systemic failure in the health care system and successful methods to correct these failures;
- communicate to individual facilities its conclusions, if any, regarding an adverse event report by the facility;
- communicate with relevant health care facilities any recommendations for correction action resulting from the analysis of submissions from facilities; and
- publish an annual report:
 - i. describing, by institution, adverse events reported;
 - ii. summarizes, in aggregate, corrective actions plans implemented by health care facilities; and
 - iii. making recommendations for modifications of state health care operations

Will the reported information be available to the public?

Other than the published annual report, the events reports, findings of root cause analyses, and corrective action plans filed by a facility under this Act and records created or obtained by the IDPH shall not be available to the public and shall not be discoverable or admissible in any civil, criminal or administrative proceeding against a facility or health care professional. Moreover, hospitals must have 30 days to make corrections and to add helpful explanatory comments about publicly available information before its publication.

How is this law enforced?

Non-compliance with the reporting provisions of this law shall constitute a violation of the Hospital Licensing Act, which may lead to a suspension of the hospital's license.