# Adverse Event Reporting Program Annual Report

**February 2010**

# Adverse Event Reporting Program Annual Report

**February 2010**

**Washington State Department of Health**

*Health*

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**Mary C. Selecky**
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# Preface

The Department of Health was created in 1989 to preserve and improve the public's health, monitor health care costs, and promote quality health care. We help oversee and plan the state's health care activities.

The department's mission is to protect and improve the health of people in Washington State. We identify significant factors that enhance or threaten health, develop policies and promising activities to address them, and assure that actions are taken and evaluated.

This report is the product of work by many interested groups and individuals. It reflects the agency's purpose and represents our initial work in the area of adverse events. It is my hope this report will assist legislature as it considers issues related patient safety.


Mary C. Selecky
Secretary of Health

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# Introduction

Adverse events are preventable medical errors that result in patient death or serious disability. In 2006 the Washington State Legislature required many health care providers to notify the Department of Health about cases that involve medical errors in 28 types of adverse events. (See appendix A) These providers include hospitals, psychiatric hospitals, child birth centers, Department of Corrections' medical facilities, and ambulatory surgery facilities. Each health care facility must then review the event and develop an action plan to help prevent reoccurrence.

The reporting law is meant to enhance accountability and transparency. By sharing adverse events and their causes, policymakers hope to foster a culture of learning and accelerate improvements that increase the safety of patients.

The department's Adverse Event Reporting Program receives adverse event notifications. Since 2006, 652 events have been reported from 60 hospitals and 53 percent of all health care facilities required to report. Each adverse event notification requires a "Root Cause Analysis." This is a system-based review of a medical error. The department finds out what happened, why it happened, and what the facility plans to prevent it from happening again.

The agency has seen important changes since reporting began. The law directed the department to evaluate the reports and provide consultation and training. Facilities look candidly at systems and care practices that put patients at risk. Facilities document changes in practices and procedures in their reviews and action plans.

The law also required the department to contract with an independent entity to create an Internet-based system to collect data. Vendor tasks included data analysis followed by recommendations for changes in health care practices, advisories about immediate changes needed, and an annual report to the governor and legislature. The first attempt to find a vendor failed. The bids we received to complete these tasks far exceeded the funding allocation. The second attempt was thwarted due to recent budget cuts. Some of the work of the program is on hold, such as the comprehensive data analysis. However, the work to improve systems has not stopped. This annual report shares the Department of Health's accomplishments and challenges so far.

# Program Activity

The adverse event reporting law, chapter 70.56 RCW, drives quality improvement in facilities as part of a broader statewide patient safety vision.  The strength of the system is the focus on learning, sharing information about root causes, and implementing best practices for prevention and increased awareness of adverse events.

The 2006 law requires health care facilities including hospitals, psychiatric hospitals, child birth centers, Department of Corrections' medical facilities, and ambulatory surgery centers to notify the department when an adverse event has occurred.  The agency's reporting system is based on a nationally accepted list of 28 types of mistakes (See appendix B).  The events are typically preventable and should never occur in a medical facility.

Across the country, 28 states now have adverse event reporting systems (See appendix C).  There is no single model and the programs vary greatly. Washington's system is unique, because it focuses on quality improvement rather than discipline.  That approach is based on the idea that there is more to be gained by reforming systems than punishing individuals.  The agency helps each facility understand what went wrong, determine the underlying causes, and develop a plan to prevent errors from occurring again.  The law allows public disclosure of adverse event notifications, but root cause analyses and action plans are considered confidential.

It's important to note that the adverse event program is separate from the health care facility regulatory programs.  There are no citations or sanctions in the adverse event reporting law.  However, health care facilities may be cited at the time of a licensing survey if:

- A possible adverse event is identified and the facility failed to follow the adverse event requirements, or
- A complaint received by the facility licensing program is an adverse event and the investigation findings support citations.

The agency's Adverse Event Reporting Program receives adverse event notifications.  Since 2006, 652 events have been reported by 60 hospitals.  Fifty three percent of all health care facilities who are required to report, have reported adverse events (See appendix B).  Also included is a document entitled the Adverse Event Table that displays the numbers of event types (See appendix D).

# Improving Patient Safety through Adverse Event Reporting

## *Notification of Adverse Events*

- Total of <u>652</u> events reported from June 2006 to September 2009
  - Pressure Ulcers - 342
  - Surgical Events - 192
  - Falls - 49
  - Medication Errors - 18
  - Other Adverse Event Types - 51
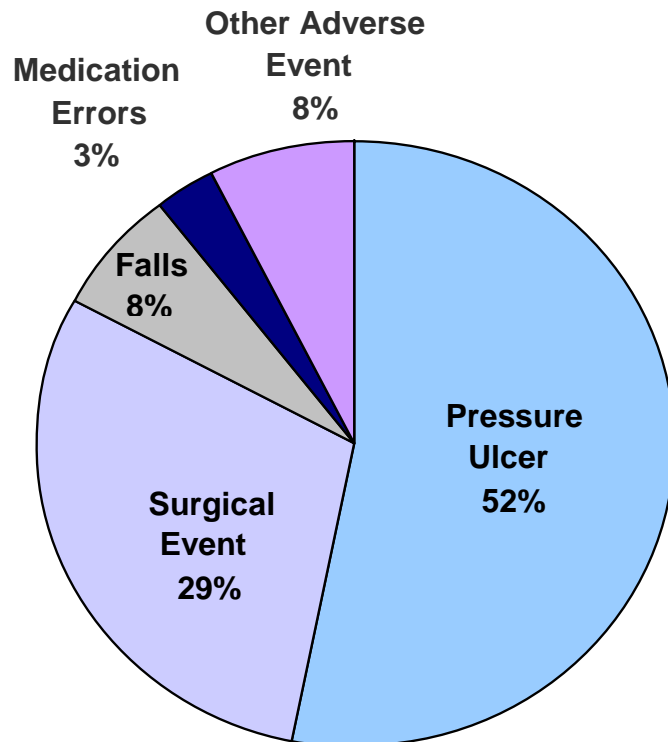


Pressure ulcers account for 52 percent of all events reported. The second largest category is surgical events, including retained foreign objects and procedures performed on the wrong body part. Death from falls is the third highest.

The Department of Health has seen important changes since reporting began. Facilities have looked candidly at systems and care practices that put patients at risk. Facilities document changes in practices and procedures in their reviews and action plans. Many facilities never experience another similar event which is evident in the Facility and Event Type Detail Report in Appendix D.

In 2009, for example, Harborview Medical Center received a *Qualis Health Award of Excellence in Healthcare Quality* for their work in reducing hospital acquired pressure ulcers (HAPU).  Between 2006 and 2008, Harborview reported 93 pressure ulcers to the agency's Adverse Event Reporting Program.  Because of these numbers, the medical center undertook a focused study (called a root cause analysis) of the risk factors of the specialty populations it serves. By targeting interventions (through an action plan), Harborview was able to reduce the overall rate of HAPU, increase detection of HAPU in early stages and eliminate stage 3 and 4 HAPU development for the 3 quarters in 2009.

These changes occur in large part through what are called root cause analyses.  Each adverse event notification requires a root cause analysis.  This is a system-based review of a medical error.  The department finds out what happened, why it happened, and what the facility plans to prevent it from happening again.

The Department of Health's patient safety adverse event officer leads this effort.  She provides feedback to facilities on the quality and completeness of the analysis and action plans.  Each facility receives a completed root cause analysis evaluation.  This document highlights what actions were complete or incomplete.  The patient safety adverse event officer provides on-site consultations to health care facilities to improve their root cause analysis methods.  These review and consultations give facilities the opportunity to discuss their unique challenges.  Consultations have been well received by the health care facility patient safety staff and administrators.

One area of success is the creation of a stakeholder group called the Patient Safety Adverse Event Advisory Committee.  The committee meets quarterly to review the program's plans and share ideas.  The department also participates in teleconferences, Washington State Hospital Association Safe Table Adverse Event Conferences, and conducts presentations for organizations.  In addition, the agency works with partners devoted to patient safety and adverse event issues.  These include the state hospital association, the Department of Social and Health Services and other department programs.

Each quarter the Department of Health produces adverse event notification reports (See appendix D).  These reports provide information about adverse event notifications and are sorted by facility, date, and type.  This information is requested by citizens, media, health care associations and organizations, insurers, Washington State Hospital Association, the Puget Sound Health Care Alliance, and Department of Social and Health Services Health and Recovery Services Administration.  These reports are currently available upon request, but will soon be available on an Internet site dedicated to adverse event reporting.

Non-reporting of adverse events is a national problem.  In Washington only 64 percent of hospitals have reported adverse events to the department.  Critical access hospitals account for 40 percent (38 of 94) of acute care hospitals.  The

department has only received adverse event notifications from 34 percent or 13 of these critical access hospitals. Many critical access hospitals care for only one to five acute care patients per day, which is a small part of what they do. Emergency room, lab/imaging, swing beds, and long-term care patients can far outnumber inpatients. Critical access hospitals function differently then acute care hospitals.

To investigate non-reporting, the Department of Health recently implemented a "Check-In Policy" that requires all facilities to respond to the department, whether they had an event or not. This is expected to improve reporting and also help the agency understand why the reporting rate is low. The department will be able to determine if all health care facilities know about the reporting requirement, and the findings will provide opportunities to work with facilities about the adverse event reporting requirements.

The department is also creating a new Adverse Event Reporting Program Web site to provide helpful information for reporting facilities and the public. Included on the Web site will be the quarterly adverse event notifications reports.

## Conclusions

Even in the face of budget reductions, the department's vision for the future includes:
- Creating an Internet-based system for event reporting
- Seeing all required health care facilities report adverse events and conduct root cause analyses
- Publishing what the department is learning about the causes of events and sharing the solutions with health care facilities.

Ultimately, and most importantly, the state Department of Health wants to see a reduction in adverse events.

# APPENDIX:  A

# Chapter 70.56
# Adverse Health Events and Incident Reporting

# Chapter 70.56 RCW

# Adverse health events and incident reporting system

## RCW Sections
70.56.010 Definitions.

70.56.020 Notification of adverse health events -- Notification and report required -- Rules.

70.56.030 Department of health -- Duties -- Rules.

70.56.040 Contract with independent entity -- Duties of independent entity -- Establishment of notification and reporting system -- Annual reports to governor, legislature.

70.56.050 Confidentiality of notifications and reports.

70.56.900 Findings -- Intent -- Part headings and subheadings not law -- Severability -- 2006 c 8.

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## 70.56.010
## Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.
    (1) "Adverse health event" or "adverse event" means the list of serious reportable events adopted by the national quality forum in 2002, in its consensus report on serious reportable events in health care. The department shall update the list, through adoption of rules, as subsequent changes are made by the national quality forum. The term does not include an incident.
    (2) "Ambulatory surgical facility" means a facility licensed under chapter 70.230 RCW.
    (3) "Childbirth center" means a facility licensed under chapter 18.46 RCW.

(4) "Correctional medical facility" means a part or unit of a correctional facility operated by the department of corrections under chapter 72.10 RCW that provides medical services for lengths of stay in excess of twenty-four hours to offenders.

(5) "Department" means the department of health.

(6) "Health care worker" means an employee, independent contractor, licensee, or other individual who is directly involved in the delivery of health services in a medical facility.

(7) "Hospital" means a facility licensed under chapter 70.41 RCW.

(8) "Incident" means an event, occurrence, or situation involving the clinical care of a patient in a medical facility that:

(a) Results in unanticipated injury to a patient that is not related to the natural course of the patient's illness or underlying condition and does not constitute an adverse event; or

(b) Could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. "Incident" does not include an adverse event.

(9) "Independent entity" means that entity that the department of health contracts with under RCW 70.56.040 to receive notifications and reports of adverse events and incidents, and carry out the activities specified in RCW 70.56.040.

(10) "Medical facility" means a childbirth center, hospital, psychiatric hospital, or correctional medical facility. An ambulatory surgical facility shall be considered a medical facility for purposes of this chapter upon the effective date of any requirement for state registration or licensure of ambulatory surgical facilities.

(11) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.
[2007 c 273 § 20; 2006 c 8 § 105.]

**Notes:**
**Effective date -- Implementation -- 2007 c 273:** See RCW 70.230.900 and 70.230.901.

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# 70.56.020
# Notification of adverse health events — Notification and report required — Rules.

(1) The legislature intends to establish an adverse health events and incident notification and reporting system that is designed to facilitate quality improvement in the health care system, improve patient safety, assist the public in making informed health care choices, and decrease medical errors in a nonpunitive manner. The notification and reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(2) When a medical facility confirms that an adverse event has occurred, it shall submit to the department of health:

(a) Notification of the event, with the date, type of adverse event, and any additional contextual information the facility chooses to provide, within forty-eight hours; and

(b) A report regarding the event within forty-five days. The notification and report shall be submitted to the department using the internet-based system established under RCW 70.56.040 (2) if the system is operational.

(c) A medical facility may amend the notification or report within sixty days of the submission.

(3) The notification and report shall be filed in a format specified by the department after consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1). The format shall identify the facility, but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

(4) As part of the report filed under subsection (2)(b) of this section,the medical facility must conduct a root cause analysis of the event, describe the corrective action plan that will be implemented consistent with the findings of the analysis, or provide an explanation of any reasons for not taking corrective action. The department shall adopt rules, in consultation with medical facilities and the independent entity if an independent entity has been contracted for under RCW 70.56.040(1), related to the form and content of the root cause analysis and corrective action plan. In developing the rules, consideration shall be given to existing standards for root cause analysis or corrective action plans adopted by the joint commission on

accreditation of health facilities and other national or governmental entities.

(5) If, in the course of investigating a complaint received from an employee of a medical facility, the department determines that the facility has not provided notification of an adverse event or undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to provide notification or to undertake an investigation of the event.

(6) The protections of RCW 43.70.075 apply to notifications of adverse events that are submitted in good faith by employees of medical facilities. [2009 c 495 § 12; 2008 c 136 § 1; 2006 c 8 § 106.]

**Notes:**
**Effective date -- 2009 c 495:** See note following RCW 43.20.050.

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## 70.56.030
## Department of Health — Duties — Rules.

(1) The department shall:

(a) Receive and investigate, where necessary, notifications and reports of adverse events, including root cause analyses and corrective action plans submitted as part of reports, and communicate to individual facilities the department's conclusions, if any, regarding an adverse event reported by a facility; and(b) Adopt rules as necessary to implement this chapter.

(2) The department may enforce the reporting requirements of RCW 70.56.020 using its existing enforcement authority provided in chapter 18.46 RCW for childbirth centers, chapter 70.41 RCW for hospitals, and chapter 71.12 RCW for psychiatric hospitals.
[2009 c 495 § 13; 2009 c 488 § 1; 2007 c 259 § 13; 2006 c 8 § 107.]

**Notes:**
**Reviser's note:** This section was amended by 2009 c 488 § 1 and by 2009 c 495 § 13, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025 (1).**Effective date -- 2009 c 495:** See note following RCW 43.20.050.

**Severability -- Subheadings not law--2007 c 259:** See notes following

## 70.56.040
## Contract with independent entity — Duties of independent entity — Establishment of notification and reporting system — Annual reports to governor, legislature.

(1) To the extent funds are appropriated specifically for this purpose, the department shall contract with a qualified, independent entity to receive notifications and reports of adverse events and incidents, and carry out the activities specified in this section. In establishing qualifications for, and choosing the independent entity, the department shall strongly consider the patient safety organization criteria included in the federal patient safety and quality improvement act of 2005, P.L. 109-41, and any regulations adopted to implement this chapter.

(2) If an independent entity is contracted for under subsection (1) of this section, the independent entity shall:

(a) In collaboration with the department of health, establish an internet-based system for medical facilities and the health care workers of a medical facility to submit notifications and reports of adverse events and incidents, which shall be accessible twenty-four hours a day, seven days a week. The system shall be a portal to report both adverse events and incidents, and notifications and reports of adverse events shall be immediately transmitted to the department. The system shall be a secure system that protects the confidentiality of personal health information and provider and facility specific information submitted in notifications and reports, including appropriate encryption and an accurate means of authenticating the identity of users of the system. When the system becomes operational, medical facilities shall submit all notifications and reports by means of the system;

(b) Collect, analyze, and evaluate data regarding notifications and reports of adverse events and incidents, including the identification of

performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of the state;

(c) Develop recommendations for changes in health care practices and procedures, which may be instituted for the purpose of reducing the number or severity of adverse events and incidents;

(d) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce adverse events or incidents;

(e) Issue recommendations to medical facilities on a facility-specific or on a statewide basis regarding changes, trends, and improvements in health care practices and procedures for the purpose of reducing the number and severity of adverse events or incidents. Prior to issuing recommendations, consideration shall be given to the following factors: Expectation of improved quality of care, implementation feasibility, other relevant implementation practices, and the cost impact to patients, payers, and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on a publicly accessible web site. The recommendations made to medical facilities under this section shall not be considered mandatory for licensure purposes unless they are adopted by the department as rules pursuant to chapter 34.05 RCW; and

(f) Monitor implementation of reporting systems addressing adverse events or their equivalent in other states and make recommendations to the governor and the legislature as necessary for modifications to this chapter to keep the system as nearly consistent as possible with similar systems in other states.

(3)(a) The independent entity shall report no later than January 1, 2008, and annually thereafter in any year that an independent entity is contracted for under subsection (1) of this section to the governor and the legislature on the activities under this chapter in the preceding year. The report shall include:

(i) The number of adverse events and incidents reported by medical facilities, in the aggregate, on a geographical basis, and

a summary of actions taken by facilities in response to the adverse events or incidents;

(ii) In the aggregate, the information derived from the data collected, including any recognized trends concerning patient safety;

(iii) Recommendations for statutory or regulatory changes that may help improve patient safety in the state; and

(iv) Information, presented in the aggregate, to inform and educate consumers and providers, on best practices and prevention tools that medical facilities are implementing to prevent adverse events as well as other patient safety initiatives medical facilities are undertaking to promote patient safety.

(b) The annual report shall be made available for public inspection and shall be posted on the department's and the independent entity's website.

(4) The independent entity shall conduct all activities under this section in a manner that preserves the confidentiality of facilities, documents, materials, or information made confidential by RCW 70.56.050.

(5) Medical facilities and health care workers may provide notification of incidents to the independent entity. The notification shall be filed in a format specified by the independent entity, after consultation with the department and medical facilities, and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180. The protections of RCW 43.70.075 apply to notifications of incidents that are submitted in good faith by employees of medical facilities.

**Notes:**

**Effective date -- 2009 c 495:** See note following RCW 43.20.050.

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## 70.56.050

## Confidentiality of notifications and reports.

(1)(a) When notification of an adverse event under RCW 70.56.020(2)(a) or of an incident under RCW 70.56.040(5), or a report regarding an adverse event under RCW 70.56.020(2)(b) is made by or through a coordinated quality improvement program under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee for the purpose of preparing a notification of an adverse event or incident or a report regarding an adverse event, the report itself, and the notification of an incident, shall be subject to the confidentiality protections of those laws and RCW 42.56.360(1)(c).

    (b) The notification of an adverse event under RCW 70.56.020(2)(a),shall be subject to public disclosure and not exempt from disclosure under chapter 42.56 RCW. Any public disclosure of an adverse event notification must include any contextual information the medical facility chose to provide under RCW 70.56.020(2)(a).

    (2)(a) When notification of an adverse event under RCW 70.56.020(2) (a) or of an incident under RCW 70.56.040(5), or a report regarding an adverse event under RCW 70.56.020(2)(b), made by a health care worker uses information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200 or a peer review committee under RCW 4.24.250, a notification of an incident, the report itself, and the information or documents used for the purpose of preparing notifications or the report, shall be subject to the confidentiality protections of those laws and RCW 42.56.360(1)(c).

    (b) The notification of an adverse event under RCW 70.56.020(2)(a) shall be subject to public disclosure and not exempt from  disclosure under chapter 42.56 RCW. Any public disclosure of an adverse event notification must include any contextual information the medical facility chose to provide under RCW 70.56.020(2)(a).

[2008 c 136 § 3; 2006 c 8 § 110.]

**70.56.900**

**Findings — Intent — Part headings and subheadings not law — Severability — 2006 c 8.**

See notes following RCW 5.64.010.

# APPENDIX:  B

# Adverse Event Definitions

**Adverse Event Definitions**
National Quality Forum Serious Reportable Events
Chapter 70.56 Adverse Health Events and Incident Reporting System

| | |
|---|---|
| *Surgical Events* | |
| 1. | Surgery performed on the wrong body part. |
| 2. | Surgery performed on the wrong patient. |
| 3. | Wrong surgical procedure performed on a patient. |
| 4. | Unintended retention of a foreign object in a patient after surgery or other procedure. |
| 5. | Intra-operative or immediately post-operative death in an ASA Class 1 patient. |
| *Products or Device Events* | |
| 6. | Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility. |
| 7. | Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. |
| 8. | Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility. |
| *Patient Protection Events* | |
| 9. | Infant discharged to wrong person. |
| 10. | Patient death or serious disability associated with patient elopement (disappearance). |
| 11. | Patient suicide, or attempted suicide, resulting in serious disability, while being cared for in a health care facility. |
| *Care Management Events* | |
| 12. | Patient death or serious disability associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration). |
| 13. | Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products. |
| 14. | Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the health care facility. |

| 15. | Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. |
|---|---|
| 16. | Patient death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinimia neonates. |
| 17. | Stage 3 or 4 pressure ulcer acquired after admission to a health care facility. |
| 18. | Patient death or serious disability due to spinal manipulative therapy. |
| 28. | Artificial insemination with the wrong donor sperm or egg. |
| **Environmental Events** | |
| 19. | Patient death or serious disability associated with electric shock or elective cardioversion while being cared for in a health care facility. |
| 20. | Any incident in which a line designed 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 from any source while being cared for in a health care facility. |
| 22. | Patient death or serious disability associated with a fall while being cared for in a health care facility. |
| 23. | Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility. |
| **Criminal Events** | |
| 24. | Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider. |
| 25. | Abduction of a patient of any age. |
| 26. | Sexual assault on a patient within or on the grounds of a health care facility. |
| 27. | Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a health care facility. |

# APPENDIX:  C

# Adverse Event Reporting Programs

# Adverse Event Reporting Programs

| State | Agency |
|---|---|
| California | California Department of Health |
| Colorado | Colorado Department of Health and Environment |
| Connecticut | Connecticut Department of Public Health |
| District of Columbia | District of Columbia Office of Health Regulation and Licensing Administration |
| Florida | Florida Agency for Healthcare Administration, Florida Center for Health Information and Policy Analysis, Risk Management and Patient Safety Program |
| Georgia | Georgia Department of Human Resources, Office of Regulatory Services, Healthcare Facilities Regulation |
| Illinois | Illinois Department of Health, Division of Patient Safety and Quality |
| Indiana | Indiana State Department of Health, Healthcare Quality and Regulatory Services Commission |
| Kansas | Kansas Department of Health and Environment, Bureau of Child Care and Health Facilities |
| Maine | Maine Division of Health and Human Services, Division of Licensing and Regulatory Services |
| Maryland | Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality |
| Massachusetts | Massachusetts Department of Health, Bureau of Healthcare Safety and Quality |
| Minnesota | Minnesota Department of Health |
| Nevada | Nevada State Health Division, Bureau of Health Statistics Planning, and Emergency Response |
| New Hampshire | New Hampshire Department of Health and Human Services, Division of Public Health Services |
| New Jersey | New Jersey Department of Health and Senior Services |
| New York | New York State Department of Health |
| Ohio | Ohio Department of Health, Center for Public Health Statistics and Informatics |
| Oregon | Oregon Department of Human Services, Office of Community Health and Health Planning |
| Pennsylvania | Pennsylvania Patient Safety Authority |
| Rhode Island | Rhode Island Department of Health, Office of Facilities Regulation |
| South Carolina | South Carolina Department of Health and Environmental Control, Division of Health Licensing |
| South Dakota | South Dakota Department of Health |
| Tennessee | Tennessee Department of Health, Bureau of Healthcare Licensure and Regulation, Division of Healthcare Facilities |
| Utah | Utah Department of Health |
| Vermont | Vermont Department of Health |
| Washington | Washington Department of Health, Office of Community Health Systems |
| Wyoming | Wyoming Department of Health, Preventive Health and Safety Division |

# APPENDIX:  D

# Adverse Health Event Reports

- *Adverse Events Table – Aggregate Report*
- *Facility by Quarter*
- *Facility and Event Type Detail*
- *Contextual Information*

# Health

**Adverse Health Events**
**Serious Reportable Events 2006 - 2009**

| Adverse Event Type | Q2 2006 | Q3 2006 | Q4 2006 | Q1 2007 | Q2 2007 | Q3 2007 | Q4 2007 | Q1 2008 | Q2 2008 | Q3 2008 | Q4 2008 | Q1 2009 | Q2 2009 | Q3 2009 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Surgical Events** | | | | | | | | | | | | | | | |
| Wrong site | 1 | 4 | 5 | 3 | 8 | 2 | 1 | 6 | 4 | 5 | 3 | 2 | 7 | 3 | 54 |
| Wrong patient | | | | 1 | | | | | 1 | 1 | | | | 1 | 4 |
| Wrong surgical procedure | 3 | | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 21 |
| Retained foreign object | 2 | 6 | 7 | 7 | 9 | 11 | 6 | 8 | 11 | 15 | 9 | 6 | 9 | 4 | 110 |
| Post-operative death | | | | 1 | | 1 | | | | | 1 | | | | 3 |
| **Products or Device Events** | | | | | | | | | | | | | | | |
| Contaminated drugs, devices, biologics | | | | | | | | | | | | | | | 0 |
| Device function or use | | 1 | 2 | | | | 1 | 1 | | | | 1 | | | 6 |
| Intravascular air embolism | | | | | | | | | | 2 | | 1 | | | 3 |
| **Patient Protection Events** | | | | | | | | | | | | | | | |
| Infant discharged to the wrong person | | | | | | | | | | | | | | | 0 |
| Patient elopement (disappearance) | | | | | | | | | | | | | | 1 | 1 |
| Patient suicide or attempted suicide | | | | 1 | | | | | 3 | 3 | | | 1 | | 8 |
| **Care Management Events** | | | | | | | | | | | | | | | |
| Medication error | 1 | 2 | 3 | | | 1 | | | 2 | 4 | 2 | 1 | 2 | | 18 |
| Wrong blood product | | | | | | | | | | 1 | | | | | 1 |
| Maternal death | | | | | 2 | | | | | 2 | 1 | | | | 5 |
| Hypoglycemia | | | | | | | | | | | | | | | 0 |
| Hyperbilirubinemia | | | | | | | | | | | | | | | 0 |
| Pressure ulcers | 3 | 17 | 27 | 22 | 34 | 38 | 31 | 24 | 36 | 22 | 14 | 20 | 27 | 27 | 342 |
| Spinal manipulative therapy | | | | | | | | | | | | | | | 0 |

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*Adverse Events Table - Aggregate Report*
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*Washington State Department of*
**Health**

| Adverse Event Type | Q2 2006 | Q3 2006 | Q4 2006 | Q1 2007 | Q2 2007 | Q3 2007 | Q4 2007 | Q1 2008 | Q2 2008 | Q3 2008 | Q4 2008 | Q1 2009 | Q2 2009 | Q3 2009 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wrong sperm or egg | | | | | | | | | | | | | | | 0 |
| *Environmental Events* | | | | | | | | | | | | | | | |
| Electric shock | | | | | | | | | | | | | | | 0 |
| Wrong gas | | | | | | | | | | | | | 1 | | 1 |
| Burn | | | | | | | | | | | | | | | 0 |
| Fall resulting in death | 1 | 2 | 2 | 3 | 3 | 5 | 1 | 1 | 3 | 5 | 4 | 3 | 7 | 9 | 49 |
| Restraints | | | | | | | | | 1 | 1 | 2 | | | 1 | 5 |
| *Criminal Events* | | | | | | | | | | | | | | | |
| Impersonation | | | | | | | | | | | | | 1 | | 1 |
| Patient Abduction | 1 | | | | | | | | | | | | 1 | | 2 |
| Sexual assault | 1 | 3 | 1 | 1 | | 1 | | | 2 | | 1 | | 1 | 2 | 13 |
| Physical assault | | 1 | | | | | | | | 1 | 1 | 1 | | 1 | 5 |
| **Quarterly Total (all events)** | 13 | 36 | 48 | 41 | 58 | 61 | 41 | 49 | 66 | 57 | 37 | 39 | 55 | 51 | 652 |

*Prepared and updated by Phi V. Ly, Office of Community Health Systems, Research, Analysis, and Data Section, 11-3-2009.*

Washington State Department of *Health*

| | County | Q2 2006 | Q3 2006 | Q4 2006 | Q1 2007 | Q2 2007 | Q3 2007 | Q4 2007 | Q1 2008 | Q2 2008 | Q3 2008 | Q4 2008 | Q1 2009 | Q2 2009 | Q3 2009 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| \multicolumn{17}{l}{*Acute Care Hospital - 56 Facilities and Critical Access Hospital - 38 Facilities*} |||||||||||||||||
| 183 | Auburn Regional Medical Center | King | | | | 1 | | | | | 4 | | | | 1 | 1 | **7** |
| 197 | Capital Medical Center, Olympia | Thurston | | | | | | | | | | | | | | | **0** |
| 158 | Cascade Medical Center, Leavenworth | Chelan | | | | | | | | | | | | | | | **0** |
| 106 | Cascade Valley Hospital, Arlington | Snohomish | | | | | | | | | | | | | | | **0** |
| 168 | Central Washington Hospital, Wenatchee | Chelan | | | | | | 4 | | | | 2 | 1 | | | | **7** |
| 45 | Columbia Basin Hospital, Ephrata | Grant | | | | | | | | | | | | | | | **0** |
| 150 | Coulee Community Hospital | Grant | | | 1 | | 1 | | | | | | | 1 | | | **3** |
| 141 | Dayton General Hospital, Dayton | Columbia | | | | | | | | | | | | | | | **0** |
| 37 | Deaconess Medical Center, Spokane | Spokane | | 2 | 2 | 3 | 1 | 1 | | 2 | | 1 | | | | 7 | **19** |
| 111 | East Adams Rural Hospital, Ritzville | Adams | | | | | | | | | | | | | | | **0** |
| 35 | Enumclaw Regional Hospital | King | | | | | | | | | | | | | | | **0** |
| 164 | Evergreen Healthcare | King | | 1 | | | | | 1 | 1 | | | | | 1 | | **4** |
| 167 | Ferry County Memorial Hospital | Ferry | | | | | | | | | | 1 | | | | | **1** |
| 54 | Forks Community Hospital | Clallam | | | | | | | | | | | | | | | **0** |
| 209 | Franciscan HS, St. Anthony Hospital, Gig Harbor | Pierce | | | | | | | | | | | | | | | **0** |
| 132 | Franciscan HS, St. Clare Hospital, Tacoma | Pierce | | 1 | 1 | | | | | | | | 1 | | | | **3** |
| 201 | Franciscan HS, St. Francis Community Hospital | King | | | | | | | | | | | | | | | **0** |
| 32 | Franciscan HS, St. Joseph Medical Center, Tacoma | Pierce | | 2 | | | 1 | | | | | 3 | | 1 | 6 | 1 | **14** |
| 82 | Garfield County Public Hospital District, Pomeroy | Garfield | | | | | | | | | | | | | | | **0** |
| 81 | Good Samaritan Hospital, Puyallup | Pierce | | 1 | | 2 | | 1 | | 1 | 1 | 1 | | | 3 | 2 | **12** |
| 63 | Grays Harbor Community Hospital, Aberdeen | Grays Harbor | | | | | | | | | | | 1 | | | | **1** |
| 20 | Group Health Cooperative/Central Hospital | King | | | | | 1 | | | | 1 | | | | | | **2** |
| 29 | Harborview Medical Center | King | 3 | 11 | 17 | 7 | 11 | 11 | 16 | 2 | 27 | 4 | 3 | 1 | 5 | 3 | **121** |
| 142 | Harrison Medical Center, Bremerton | Kitsap | | | | | 1 | | | 2 | 1 | 3 | 1 | 1 | 1 | 2 | **12** |
| 126 | Highline Medical Center | King | | | | | | | | 1 | | | 2 | 1 | | | **4** |
| 134 | Island Hospital | Skagit | | | | | | | | | | 1 | | | | | **1** |
| 85 | Jefferson Healthcare | Jefferson | | | | | | 1 | | | | | | | | | **1** |
| 161 | Kadlec Medical Center, Richland | Benton | | | | | | | | | | | | 1 | 4 | | **5** |
| 39 | Kennewick General Hospital | Benton | | | | 1 | | | | | | | | 1 | | | **2** |
| 148 | Kindred Hospital Seattle | King | | 1 | | | 1 | 1 | | 2 | | | 0 | | | | **5** |
| 140 | Kittitas Valley Community Hospital, Ellensburg | Kittitas | | | | | | | | | | | | | | | **0** |
| 8 | Klickitat Valley Health, Goldendale | Klickitat | | | | | | | | | | | | | | | **0** |
| 165 | Lake Chelan Community Hospital | Chelan | | | | | 1 | | | | | | | | | | **1** |
| 208 | Legacy Salmon Creek Hospital, Vancouver | Clark | | | | | 1 | 3 | | 1 | | | | | | | **5** |
| 137 | Lincoln Hospital, Davenport | Lincoln | | | | | | | | | | | | | | | **0** |
| 22 | Lourdes Medical Center, Pasco | Franklin | | | | | | | | 1 | | | | | | | **1** |
| 186 | Mark Reed Health Care District, McCleary | Grays Harbor | | | | | | | | | | | | | | | **0** |
| 175 | Mary Bridge Children's Hospital and Health Center, Tacoma | Pierce | | | | | | | | | | | | | | | **0** |
| 152 | Mason General Hospital, Shelton | Mason | | | | | | | | | | 1 | | | | | **1** |
| 147 | Mid-Valley Hospital, Omak | Okanogan | | | | | | | | | 2 | | | | 1 | | **3** |
| 173 | Morton General Hospital, Morton | Lewis | | | | | | | | | | | | | | | **0** |
| 176 | Multicare, Tacoma General Hospital | Pierce | | | 2 | | 2 | 1 | | | 2 | 1 | | 1 | | 7 | **16** |
| 21 | Newport Community Hospital | Pend Oreille | | | | | | | | | | | | | | | **0** |
| 107 | North Valley Hospital, Tonasket | Okanogan | | | | | | | | | | | 1 | | | | **1** |
| 130 | Northwest Hospital and Medical Center, Seattle | King | | | | | 1 | | | | | 2 | | | | | **3** |
| 79 | Ocean Beach Hospital, Ilwaco | Pacific | | | | | | | | | | | | | | | **0** |
| 80 | Odessa Memorial Healthcare Center | Lincoln | | | | | | | | | | | | | | | **0** |
| 23 | Okanogan Douglas District Hospital, Brewster | Okanogan | | | | | | | | | | | | | | | **0** |
| 38 | Olympic Medical Center, Port Angeles | Clallam | | | | | | | | | | | | | | | **0** |
| 125 | Othello Community Hospital | Adams | | | | | | | | | | | | | | | **0** |
| 131 | Overlake Hospital Medical Center, Bellevue | King | 1 | 2 | 1 | 2 | 1 | 1 | | 1 | | | 1 | 3 | 3 | | **16** |
| 145 | Peacehealth St. Joseph Hospital, Bellingham | Whatcom | 1 | | 1 | | 1 | | 1 | 4 | 1 | 1 | 4 | 3 | 7 | 5 | **29** |
| 26 | PeaceHealth, St. John Medical Center, Longview | Cowlitz | | | | 2 | | | | 1 | | | 1 | | | | **4** |
| 46 | Prosser Memorial Hospital | Benton | | | | | 1 | | | | 1 | | 1 | | | | **3** |
| 191 | Providence Centralia Hospital | Lewis | | | 1 | 1 | | | | | 1 | 1 | | | | | **4** |
| 139 | Providence Holy Family Hospital, Spokane | Spokane | | | 2 | | | | | | 2 | 1 | 1 | | | 1 | **7** |
| 193 | Providence Mount Carmel Hospital, Colville | Stevens | | | 1 | | | 1 | | | | | | | | | **2** |
| 84 | Providence Regional Medical Center, Everett | Snohomish | 3 | 2 | | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 1 | 2 | | **19** |
| 162 | Providence Sacred Heart Medical Center, Spokane | Spokane | 1 | | 1 | 2 | 1 | | | 2 | | 4 | 3 | | | | **14** |
| 194 | Providence St. Joseph's Hospital, Chewelah | Stevens | | | | | | | | | | | | | | | **0** |
| 50 | Providence St. Mary Medical Center, Walla Walla | Walla Walla | | | 2 | | 2 | 2 | 1 | | | 1 | | | | | **8** |
| 159 | Providence St. Peter Hospital, Olympia | Thurston | | | 1 | 2 | 2 | 6 | 3 | | 2 | | 2 | 1 | 1 | 2 | **22** |
| 172 | Pullman Regional Hospital | Whitman | | | | | | | | 1 | | | | | | | **1** |
| 129 | Quincy Valley Medical Center | Grant | | | | | | | | | | | | | | | **0** |
| 202 | Regional Hospital for Respiratory & Complex Care | King | | | | | 1 | | | | | | | | | | **1** |
| 78 | Samaritan Healthcare, Moses Lake | Grant | | | | | | 1 | 1 | | | 1 | | 1 | | | **4** |
| 204 | Seattle Cancer Care Alliance Hospital | King | | | | | | | | | | | | | | | **0** |
| 14 | Seattle Children's Hospital & Regional Medical Center | King | 1 | 3 | 1 | | | 1 | | 1 | | 1 | 1 | 4 | | 1 | **14** |
| 42 | Shriners Hospital for Children, Spokane | Spokane | | | | | | | | | | | | | | | **0** |
| 207 | Skagit Valley Hospital, Mt. Vernon | Skagit | | | 1 | 1 | | | 1 | 1 | 2 | 2 | | 1 | | | **9** |

Washington State Department of Health

| | Facility | County | Q2 2006 | Q3 2006 | Q4 2006 | Q1 2007 | Q2 2007 | Q3 2007 | Q4 2007 | Q1 2008 | Q2 2008 | Q3 2008 | Q4 2008 | Q1 2009 | Q2 2009 | Q3 2009 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 96 | Skyline Hospital, White Salmon | Klickitat | | | | | | | | | | | | | | | **0** |
| 195 | Snoqualmie Valley Hospital | King | | | | | | | | | | | | | | | **0** |
| 170 | Southwest Washington Medical Center, Vancouver | Clark | | | 3 | 2 | | | 2 | 1 | 2 | 2 | 1 | 1 | 3 | | **17** |
| 157 | St. Luke's Rehabilitation Institute, Spokane | Spokane | | | 1 | | | | | | | | | | | | **1** |
| 138 | Stevens Hospital, Edmonds | Snohomish | | | | | 2 | 1 | | | | | | | | 1 | **4** |
| 198 | Sunnyside Community Hospital | Yakima | | 1 | | | | | | | | | 1 | | 1 | | **3** |
| 01-B | Swedish Medical Center, Ballard | King | | | | | 1 | | | | 1 | | | | | | **2** |
| 03 | Swedish Medical Center, Cherry Hill | King | | 1 | | | 6 | | | | 1 | | | | | | **8** |
| 01 | Swedish Medical Center, First Hill | King | 1 | 1 | 1 | | 7 | 1 | 5 | 6 | 4 | 2 | 4 | | | 3 | **35** |
| 199 | Toppenish Community Hospital | Yakima | | | | | | | | | | | | | | | **0** |
| 108 | Tri-State Memorial Hospital, Clarkston | Asotin | | | | | | | | | | | | | | | **0** |
| 206 | United General Hospital, Sedro-Woolley | Skagit | | | 1 | | | | | | | | 1 | | | | **2** |
| 128 | University of Washington Medical Center, Seattle | King | | 3 | 3 | 10 | 5 | 15 | 7 | 12 | 5 | 15 | 4 | 8 | 9 | 9 | **105** |
| 104 | Valley General Hospital, Monroe | Snohomish | | | | | 1 | | | 1 | 1 | | | 1 | | 1 | **5** |
| 180 | Valley Hospital and Medical Center, Spokane | Spokane | | | 1 | | | | | | | | | | | | **1** |
| 155 | Valley Medical Center, Renton | King | 1 | 3 | 2 | | | 3 | 1 | | | | 1 | 2 | 2 | 1 | **16** |
| 10 | Virginia Mason Medical Center, Seattle | King | | | | 1 | 5 | 4 | 1 | 2 | 2 | 4 | 1 | 2 | 1 | 4 | **27** |
| 43 | Walla Walla General Hospital | Walla Walla | | | | | | | | | | | | | | | **0** |
| 205 | Wenatchee Valley Hospital | Chelan | | | | | | | | | | | | | | | **0** |
| 156 | Whidbey General Hospital, Coupeville | Island | 1 | | | | | | | | | | | 1 | 1 | | **3** |
| 153 | Whitman Hospital and Medical Center, Colfax | Whitman | | | | | | | | | | | | | | | **0** |
| 56 | Willapa Harbor Hospital, South Bend | Pacific | | | | | | | | | | | | | | | **0** |
| 102 | Yakima Regional Medical & Cardiac Center | Yakima | | | | | | | | | | | | | | | **0** |
| 58 | Yakima Valley Memorial Hospital | Yakima | | | | 1 | 2 | | 2 | | 1 | | 1 | | 2 | | **9** |
| | | | 13 | 36 | 48 | 41 | 58 | 61 | 41 | 49 | 66 | 57 | 37 | 39 | 53 | 51 | **650** |
| *Psychiatric Hospital - 3 Facilities* | | | | | | | | | | | | | | | | | |
| 904 | Fairfax Hospital | King | | | | | | | | | | | | | 1 | | **1** |
| 15 | Lourdes Medical Center - Psych | Benton | | | | | | | | | | | | | | | |
| 19 | Navos West Seattle Psychiatric | King | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 1 | | **1** |
| *Birthing Centers - 11 Facilities* | | | | | | | | | | | | | | | | | |
| 26-BC | Bellingham Birth Center Inc | Whatcom | | | | | | | | | | | | | | | |
| 23-BC | Birthing Inn | Pierce | | | | | | | | | | | | | | | |
| 25-BC | Birthright LLC | Spokane | | | | | | | | | | | | | | | |
| 24-BC | Cascade Midwives & Birth Center | Snohomish | | | | | | | | | | | | | | | |
| 22-BC | Eastside Birth Center, PS | King | | | | | | | | | | | | | | | |
| 13-BC | Greenbank Women's Clinic & Birth Center | Island | | | | | | | | | | | | | | | |
| 15-BC | Lakeside Birth Center | Pierce | | | | | | | | | | | | | | | |
| 16-BC | Puget Sound Midwives & Birth Center | King | | | | | | | | | | | | | | | |
| 5-BC | Seattle Home Maternity Service | King | | | | | | | | | | | | | | | |
| 10-BC | Seattle Naturopathy Acupuncture & Birth Center | King | | | | | | | | | | | | | | | |
| 17-BC | Wenatchee Midwife Services & Child Birth Center | Chelan | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | **0** |
| *Dept. of Corrections Medical Facility - 7 Facilities* | | | | | | | | | | | | | | | | | |
| 2885-DOC | Ahtanum View Corrections Center | Yakima | | | | | | | | | | | | | 1 | | **1** |
| 3484-DOC | Airway Heights Corrections Center | Spokane | | | | | | | | | | | | | | | |
| 205-DOC | Monroe Correctional Complex | Snohomish | | | | | | | | | | | | | | | |
| 8877-DOC | Stafford Creek Corrections Center | Grays Harbor | | | | | | | | | | | | | | | |
| 4414-DOC | Washington Corrections Center | Mason | | | | | | | | | | | | | | | |
| 4417-DOC | Washington Corrections Center for Women | Pierce | | | | | | | | | | | | | | | |
| 204-DOC | Washington State Penitentiary | Walla Walla | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 1 | | **1** |
| | | **Totals** | 13 | 36 | 48 | 41 | 58 | 61 | 41 | 49 | 66 | 57 | 37 | 39 | 55 | 51 | **652** |

*Prepared by Phi V. Ly on 11-3-2009; Office of Community Health Systems; Research, Analysis, and Data Section*

# Adverse Health Events

**Report: Facility and Event type detail; 2004-2009**

Washington State Department of Health

Event type legend (Event Number):
1 = Wrong site; 2 = Wrong patient; 3 = Wrong surgical procedure; 4 = Retained foreign object; 5 = Post-operative death; 6 = Contaminated drugs, devices, biologics; 7 = Device function or use; 8 = Intravascular air embolism; 9 = Infant discharged to the wrong person; 10 = Patient elopement (disappearance); 11 = Patient suicide or attempted suicide; 12 = Medication error; 13 = Wrong blood product; 14 = Maternal death; 15 = Hypoglycemia; 16 = Hyperbilirubinemia; 17 = Pressure ulcers; 18 = Spinal manipulative therapy; 28 = Wrong sperm or egg; 19 = Electric shock; 20 = Wrong gas; 21 = Burn; 22 = Fall resulting in death; 23 = Restraints; 24 = Impersonation; 25 = Patient Abduction; 26 = Sexual assault; 27 = Physical assault

**Acute Care Hospitals - 56 facilities AND Critical Access Hospitals - 38 facilities**

| Facility No. | Facility | County | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 28 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | TOTAL Events |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 183 | Auburn Regional Medical Center | King | | | 1 | 1 | | | | | | | 1 | | | | | | | | | | | | 4 | | | | | | **7** |
| 197 | Capital Medical Center, Olympia | Thurston | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 158 | Cascade Medical Center, Leavenworth | Chelan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 106 | Cascade Valley Hospital, Arlington | Snohomish | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 168 | Central Washington Hospital, Wenatchee | Chelan | 1 | | | 4 | | | | | | | | | | | | | 1 | | | | | | | | | | | | **6** |
| 45 | Columbia Basin Hospital, Ephrata | Grant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 150 | Coulee Community Hospital | Grant | 1 | | | 1 | | | | | | | | | | | | | 1 | | | | | | | | | | | | **3** |
| 141 | Dayton General Hospital, Dayton | Columbia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 37 | Deaconess Medical Center, Spokane | Spokane | | | | 2 | | | | | | | | | | | | | 17 | | | | | | | | | | | | **19** |
| 111 | East Adams Rural Hospital, Ritzville | Adams | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 35 | Enumclaw Regional Hospital | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 164 | Evergreen Healthcare | King | 1 | | | 1 | | | | | | | | | | | | | 1 | | | | | | 1 | | | | | | **4** |
| 167 | Ferry County Memorial Hospital | Ferry | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | **1** |
| 54 | Forks Community Hospital | Clallum | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 209 | Franciscan HS, St. Anthony Hospital, Gig Harbor | Pierce | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 132 | Franciscan HS, St. Clare Hospital, Tacoma | Pierce | 1 | | | | | | | 1 | | | | | | | | | 1 | | | | | | | | | | | | **3** |
| 201 | Franciscan HS, St. Francis Community Hospital | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | Franciscan HS, St. Joseph Medical Center, Tacoma | Pierce | | | | 4 | | | | | | | | | | | | | 6 | | | | | 1 | 3 | | | | | | **14** |
| 82 | Garfield County Public Hospital District, Pomeroy | Garfield | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 81 | Good Samaritan Hospital, Puyallup | Pierce | 1 | 1 | | 1 | 1 | | | | | | | | | | 1 | | 4 | | | | | | 2 | | | | 1 | | **12** |
| 63 | Grays Harbor Community Hospital, Aberdeen | Grays Harbor | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | **1** |
| 20 | Group Health Cooperative/Central Hospital | King | 1 | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | **2** |
| 29 | Harborview Medical Center | King | 2 | 1 | 1 | 6 | | | | 2 | | | 2 | 1 | | | | | 100 | | | | | | 4 | | 1 | | 1 | | **121** |
| 142 | Harrison Medical Center, Bremerton | Kitsap | 1 | | 1 | 4 | | | | | | | | | | | | | | | | | | | 1 | | 1 | 1 | 3 | | **12** |
| 126 | Highline Medical Center | King | 1 | | | 1 | | | | | | | | | | | | | 2 | | | | | | | | | 0 | | | **4** |
| 134 | Island Hospital | Skagit | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | **1** |
| 85 | Jefferson Healthcare | Jefferson | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | | | **1** |
| 161 | Kadlec Medical Center, Richland | Benton | 1 | | | | | | | | | | | | | | | | 4 | | | | | | | | | | | | **5** |
| 39 | Kennewick General Hospital | Benton | | | | 1 | | | | | | | | | | | | | | | | | | | 1 | | | | | | **2** |
| 148 | Kindred Hospital Seattle | King | | | | | | | | | | | | | | | | | 2 | | | | | | 2 | | | 0 | | 1 | **5** |

# Adverse Health Events
### Report: Facility and Event type detail; 2004-2009

| Facility No. | Facility | County | Wrong site | Wrong patient | Wrong surgical procedure | Retained foreign object | Post-operative death | Contaminated drugs, devices, biologics | Device function or use | Intravascular air embolism | Infant discharged to the wrong person | Patient elopement (disappearance) | Patient suicide or attempted suicide | Medication error | Wrong blood product | Maternal death | Hypoglycemia | Hyperbilirubinemia | Pressure ulcers | Spinal manipulative therapy | Wrong sperm or egg | Electric shock | Wrong gas | Burn | Fall resulting in death | Restraints | Impersonation | Patient Abduction | Sexual assault | Physical assault | TOTAL Events |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Event Number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 28 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | |
| 140 | Kittitas Valley Community Hospital, Ellensburg | Kittitas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | Klickitat Valley Health, Goldendale | Klickitat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 165 | Lake Chelan Community Hospital | Chelan | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | 1 |
| 208 | Legacy Salmon Creek Hospital, Vancouver | Clark | 1 | | | 3 | | | | | | | | | | | | | 1 | | | | | | | | | | | | 5 |
| 137 | Lincoln Hospital, Davenport | Lincoln | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | Lourdes Medical Center, Pasco | Franklin | | | | | | | | | | | 1 | | | | | | | | | | | | | | | | | | 1 |
| 186 | Mark Reed Health Care District, McCleary | Grays Harbor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 175 | Mary Bridge Children's Hospital and Health Center, Tacoma | Pierce | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 152 | Mason General Hospital, Shelton | Mason | | | | | | | | | | | | 1 | | | | | | | | | | | | | | | | | 1 |
| 147 | Mid-Valley Hospital, Omak | Okanogan | | | | | | | | | | | | 2 | | | | | 1 | | | | | | | | | | | | 3 |
| 173 | Morton General Hospital, Morton | Lewis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 176 | Multicare, Tacoma General Hospital | Pierce | 1 | | | 7 | | | | | | | | 1 | | | | | 7 | | | | | | | | | | | | 16 |
| 21 | Newport Community Hospital | Pend Oreille | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 107 | North Valley Hospital, Tonasket | Okanogan | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | 1 |
| 130 | Northwest Hospital and Medical Center, Seattle | King | 2 | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | | 3 |
| 79 | Ocean Beach Hospital, Ilwaco | Pacific | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 80 | Odessa Memorial Healthcare Center | Lincoln | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23 | Okanogan Douglas District Hospital, Brewster | Okanogan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 38 | Olympic Medical Center, Port Angeles | Clallam | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 125 | Othello Community Hospital | Adams | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 131 | Overlake Hospital Medical Center, Bellevue | King | 2 | | 2 | 4 | | | | | | | | | | | | | 6 | | | | | | | | | | | 3 | | 17 |
| 145 | Peacehealth St. Joseph Hospital, Bellingham | Whatcom | 4 | | 2 | 4 | | | | | | | | | | | | | 15 | | | | | | | | | 4 | | | | 29 |
| 26 | PeaceHealth, St. John Medical Center, Longview | Cowlitz | 1 | | | 1 | | | | | | | 1 | | | | | | 1 | | | | | | | | | | | | 4 |
| 46 | Prosser Memorial Hospital | Benton | 1 | | | 1 | | | | | | | | | | | 1 | | | | | | | | | | | | | | 3 |
| 191 | Providence Centralia Hospital | Lewis | | | | 2 | | | | | | | | | | | | | 2 | | | | | | | | | | | | 4 |
| 139 | Providence Holy Family Hospital, Spokane | Spokane | 2 | | 1 | 1 | | | | | | | | | | | | | 2 | | | | | | | | | | | 1 | 7 |
| 193 | Providence Mount Carmel Hospital, Colville | Stevens | | | | 1 | | | | | | | | | | | | | | | | | | | | | | | | 1 | 2 |
| 84 | Providence Regional Medical Center Everett | Snohomish | 1 | | 5 | 7 | | | | | | | | | | | | | 2 | | | | | | | | | 1 | 1 | 1 | 18 |
| 162 | Providence Sacred Heart Medical Center, Spokane | Spokane | 5 | | | 8 | | | | | | | 1 | | | | | | 1 | | | | | | | | | | | | 15 |
| 194 | Providence St. Joseph's Hospital, Chewelah | Stevens | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 50 | Providence St. Mary Medical Center, Walla Walla | Walla Walla | 2 | | | 2 | | | | 1 | | | | | | | | | 2 | | | | | | | | | 1 | | | 8 |

# Adverse Health Events
### Report: Facility and Event type detail; 2004-2009

Washington State Department of Health

| Facility No. | Facility | County | 1 Wrong site | 2 Wrong patient | 3 Wrong surgical procedure | 4 Retained foreign object | 5 Post-operative death | 6 Contaminated drugs, devices, biologics | 7 Device function or use | 8 Intravascular air embolism | 9 Infant discharged to the wrong person | 10 Patient elopement (disappearance) | 11 Patient suicide or attempted suicide | 12 Medication error | 13 Wrong blood product | 14 Maternal death | 15 Hypoglycemia | 16 Hyperbilirubinemia | 17 Pressure ulcers | 18 Spinal manipulative therapy | 28 Wrong sperm or egg | 19 Electric shock | 20 Wrong gas | 21 Burn | 22 Fall resulting in death | 23 Restraints | 24 Impersonation | 25 Patient Abduction | 26 Sexual assault | 27 Physical assault | TOTAL Events |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 159 | Providence St. Peter Hospital, Olympia | Thurston | 1 | | | | | | | | | | | | | | | | 19 | | | | | | 1 | | | | | 1 | 22 |
| 172 | Pullman Regional Hospital | Whitman | | | | | | | | | | | | 1 | | | | | | | | | | | | | | | | | 1 |
| 129 | Quincy Valley Medical Center | Grant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 202 | Regional Hospital for Respiratory & Complex Care | King | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | 1 |
| 78 | Samaritan Healthcare, Moses Lake | Grant | | | | 1 | 1 | | | | | | | 1 | | | | | | | | | | | | | | | | 1 | 4 |
| 204 | Seattle Cancer Care Alliance Hospital | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | Seattle Children's Hospital & Regional Medical Center | King | | | | 1 | | | | 1 | | | | 1 | | | | | 7 | | | | | | 1 | | | 1 | 1 | 1 | 14 |
| 42 | Shriners Hospital for Children, Spokane | Spokane | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 207 | Skagit Valley Hospital, Mt. Vernon | Skagit | 1 | | | 2 | | | | | | | | | | 1 | | | 3 | | | | | | 2 | | | | | | 9 |
| 96 | Skyline Hospital, White Salmon | Klickitat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 195 | Snoqualmie Valley Hospital | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 170 | Southwest Washington Medical Center, Vancouver | Clark | 2 | 1 | | 5 | | | | | | | | | | | | | 9 | | | | | | | | | | | | 17 |
| 157 | St. Luke's Rehabilitation Institute, Spokane | Spokane | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | 1 |
| 138 | Stevens Hospital, Edmonds | Snohomish | | | | 3 | | | | | | | | | | | | | | | | | | | 1 | | | | | | 4 |
| 198 | Sunnyside Community Hospital | Yakima | | | | | | | | 1 | | | | 1 | | | | | | | | | | | 1 | | | | | | 3 |
| 01-B | Swedish Medical Center, Ballard | King | | | | 1 | | | | | | | | | | | | | 1 | | | | | | | | | | | | 2 |
| 03 | Swedish Medical Center, Cherry Hill | King | 1 | | | 1 | | | | | | | | 1 | | | | | 5 | | | | | | | | | | | | 8 |
| 01 | Swedish Medical Center, First Hill | King | 3 | | | 4 | | | | | | | | 1 | | 2 | | | 21 | | | | | | 3 | | | | | 1 | 35 |
| 199 | Toppenish Community Hospital | Yakima | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 108 | Tri-State Memorial Hospital, Clarkston | Asotin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 206 | United General Hospital, Sedro-Woolley | Skagit | | | | | | | | | | | | 1 | | | | | | | | | | | 1 | | | | | | 2 |
| 128 | University of Washington Medical Center, Seattle | King | 4 | 1 | 3 | 14 | | 2 | | | | | | 4 | | | | | 75 | | | | | | 2 | | | | | | 105 |
| 104 | Valley General Hospital, Monroe | Snohomish | 1 | | 1 | | | | | | | | | | | | | | | | | | | | 1 | 2 | | | | | 5 |
| 180 | Valley Hospital and Medical Center, Spokane | Spokane | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | 1 |
| 155 | Valley Medical Center, Renton | King | 1 | | 1 | 2 | | | | | | 1 | 1 | 1 | | | | | 8 | | | | | | 1 | | | | | | 16 |
| 10 | Virginia Mason Medical Center, Seattle | King | 5 | | 1 | 4 | | | | 1 | | | | | | | | | 12 | | | | | | 3 | | | | | 1 | 27 |
| 43 | Walla Walla General Hospital | Walla Walla | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 205 | Wenatchee Valley Hospital | Chelan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 156 | Whidbey General Hospital, Coupeville | Island | | | | | 1 | | | | | | | | | | | | | | | | | | 2 | | | | | | 3 |
| 153 | Whitman Hospital and Medical Center, Colfax | Whitman | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 56 | Willapa Harbor Hospital, South Bend | Pacific | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

# Adverse Health Events
Report: Facility and Event type detail; 2004-2009

Washington State Department of Health

| Facility No. | Facility | County | 1 Wrong site | 2 Wrong patient | 3 Wrong surgical procedure | 4 Retained foreign object | 5 Post-operative death | 6 Contaminated drugs, devices, biologics | 7 Device function or use | 8 Intravascular air embolism | 9 Infant discharged to the wrong person | 10 Patient elopement (disappearance) | 11 Patient suicide or attempted suicide | 12 Medication error | 13 Wrong blood product | 14 Maternal death | 15 Hypoglycemia | 16 Hyperbilirubinemia | 17 Pressure ulcers | 18 Spinal manipulative therapy | 28 Wrong sperm or egg | 19 Electric shock | 20 Wrong gas | 21 Burn | 22 Fall resulting in death | 23 Restraints | 24 Impersonation | 25 Patient Abduction | 26 Sexual assault | 27 Physical assault | TOTAL Events |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 102 | Yakima Regional Medical & Cardiac Center | Yakima | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58 | Yakima Valley Memorial Hospital | Yakima | 1 | | 1 | 3 | | | | | | | 1 | | | | | | | | | | | | 3 | | | | | | 9 |
| **Birthing Centers - 11 facilities** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26-BC | Bellingham Birth Center Inc | Whatcom | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23-BC | Birthing Inn | Pierce | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25-BC | Birthright LLC | Spokane | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24-BC | Cascade Midwives & Birth Center | Snohomish | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22-BC | Eastside Birth Center, PS | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13-BC | Greenbank Women's Clinic & Birth Center | Island | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15-BC | Lakeside Birth Center | Pierce | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16-BC | Puget Sound Midwives & Birth Center | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5-BC | Seattle Home Maternity Service | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10-BC | Seattle Naturopathy Acupuncture & Birth Center | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17-BC | Wenatchee Midwife Services & Child Birth Center | Chelan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Department of Corrections Medical Facilities - 7 facilities** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2885-DOC | Ahtanum View Corrections Center | Yakima | | | | | | | | | | | | | | | | | 1 | | | | | | | | | | | | 1 |
| 3484-DOC | Airway Heights Corrections Center | Spokane | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 205-DOC | Monroe Correctional Complex | Snohomish | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8877-DOC | Stafford Creek Corrections Center | Grays Harbor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4414-DOC | Washington Corrections Center | Mason | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4417-DOC | Washington Corrections Center for Women | Pierce | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 204-DOC | Washington State Penitentiary | Walla Walla | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Psychiatric Hospitals - 3 facilities** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 904 | Fairfax Hospital | King | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | 1 |
| 15 | Lourdes Medical Center - Psych | Benton | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | Navos West Seattle Psychiatric | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | **Totals** | 54 | 4 | 22 | 109 | 3 | 0 | 6 | 3 | 0 | 1 | 8 | 17 | 1 | 4 | 0 | 0 | 344 | 0 | 0 | 0 | 1 | 0 | 49 | 5 | 1 | 2 | 13 | 5 | **652** |

*Prepared and updated by Phi V. Ly, Office of Community Health Systems, Research, Analysis, and Data Section, 11-3-2009.*

# CONTEXTUAL INFORMATION ABOUT AN ADVERSE EVENT NOTIFICATION FORM

RCW 70.56.020 states that a when a medical facility confirms that an adverse event has occurred, it shall submit to the Washington State Department of Health: Notification of the event, with the date, type of adverse event, and any contextual information the facility chooses to provide, within forty-eight hours.

Any public disclosure of an adverse event notification must include any contextual information the medical facility chose to provide under RCW 70.56.020(2) (a)

*Completing this form is optional.* This form may accompany the Adverse Event Notification Form and may be used to provide contextual information. This form may be faxed to the Department of Health (360-236-2901) or mailed to DOH Adverse Events, PO Box 47852, Olympia, WA 98504.

Facility Name: Seattle Children's Hospital
Date of Event Confirmation: 07/10/2008
Adverse Event: 27, Significant injury of a patient resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility.

Facility contact name and phone number: Jennifer Seymour, Director, Public Relations, 206-987-5207

Facility website: http://www.seattlechildrens.org/

Facility Capacity (beds, birthing rooms, units, stations) 250 beds

Total number of annual facility patient days, visits, other: FY07 - 67,900 patient days, 177,000 ambulatory visits, 33,800 emergency visits

Total number of annual procedures performed (indicate type): FY07 - 10,800 surgical, cardiac, nephrology and solid organ transplant

Additional information: This incident involved a patient-on-patient assault. We undertook a full root cause analysis and developed an extensive action plan to address the causes of this event. The action steps include improved plans for assessing the potential for aggression and development of intervention plans to deal with escalation and aggressive behavior.