Adverse Event Reporting Program Annual Report

February 2010

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For more information or
Additional copies of this report contact:

Office of the Secretary
101 Israel Road SE
Post Office Box 47890
Tumwater, Washington 98504-7890

Phone: 360-236-4030
Fax: 360-586-7424

Mary C. Selecky
Secretary of Health

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:

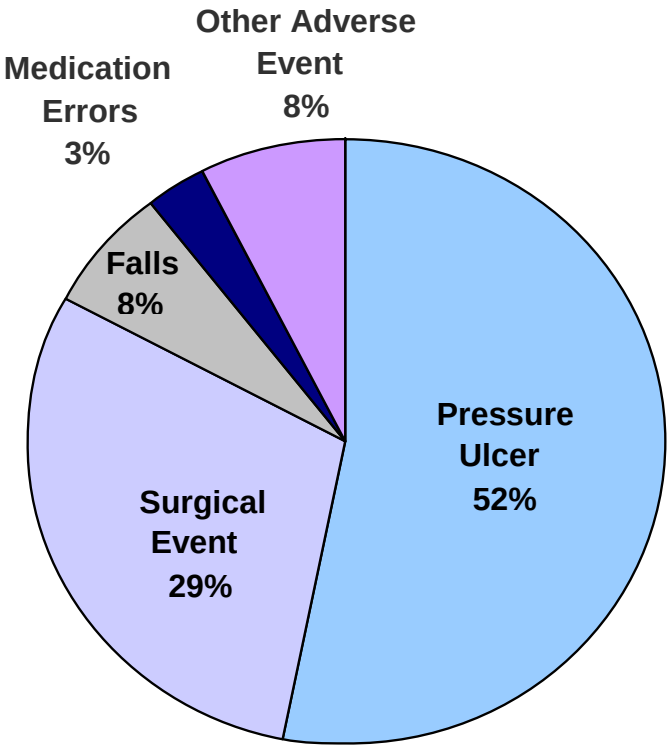
- A possible adverse event is identified and the facility failed to follow the adverse event requirements, or
- A complaint received by the facility licensing program is an adverse event and the investigation findings support citations.

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 652 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.

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.

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.

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

RCW 41.05.033.

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.

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

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*

Washington State Department of 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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Washington State Department of 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
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

Adverse Health Events
Report: Facility by Quarter

		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
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	Clallum															**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

Adverse Health Events
Report: Facility by Quarter

		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

Washington State Department of Health

Adverse Health Events

Report: Facility and Event type detail; 2004-2009

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

Washington State Department of Health

Adverse Health Events

Report: Facility and Event type detail; 2004-2009

Facility No.	Facility	County	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	TOTAL Events
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**

Washington State Department of Health

Adverse Health Events

Report: Facility and Event type detail; 2004-2009

Facility No.	Facility	County	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	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																													

Washington State Department of Health

Adverse Health Events

Report: Facility and Event type detail; 2004-2009

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.

This is confidential and protected quality improvement information per RCW 4.24.250 and 70.41.200. Please protect this information and share it only with those who are directly involved in the Quality Improvement process.