

Serious Reportable Events  
 Reports to the Washington State Department of Health  
 6/2/2006-7/13/07

Summary of Events received from Critical Access Hospitals (CAHs) & Non-Critical  
 Access Hospitals

<b>Adverse Health Events</b>	<b>Non-CAHs</b>	<b>CAHs</b>	<b>All Hospitals</b>
<b>SURGICAL EVENTS</b>			
Surgery - wrong body part	18	2	20
Surgery - wrong patient	1	0	1
Wrong surgical procedure	7	1	8
Retention of foreign object post surgery/procedure	33	0	33
Post-operative death in ASA Class 1 patient	1	0	1
<b>PRODUCT OR DEVICE EVENTS</b>			
Patient death, serious disability from use or function of a device	3	0	3
<b>PATIENT PROTECTION EVENTS</b>			
Patient suicide or attempted suicide resulting in serious disability	1	0	1
<b>CARE MANAGEMENT EVENTS</b>			
Patient death, serious disability from medication error	4	2	6
Maternal death, serious disability (low risk pregnancy)	3	0	3
Stage 3/4 pressure ulcers	84	1	85
<b>ENVIRONMENTAL EVENTS</b>			
Patient death – fall	8	1	9
<b>CRIMINAL EVENTS</b>			
Abduction of a patient of any age	1	0	1
Sexual assault on a patient	7	1	8
Death, significant injury of patient or staff from physical assault	1	0	1
<b>Total (All Events)</b>	<b>172</b>	<b>8</b>	<b>180</b>

**Source:** Department of Health, Patient Safety Adverse Event Program, Prepared by Zeynep Shorter, PhD

Adverse events most often frequently reported were care management events, with surgical events coming in second. There were events in all six broad categories. When specific adverse events are examined separately, the most common are stage 3 or 4 pressure ulcers (85), retention of foreign object post surgery/procedure (33), and surgery-wrong body part (20). The pattern is the same for CAHs as for non-CAHs, except that no events were reported by the CAHs in two of the broad groups: product or device events, and patient protection events. There are too few adverse events overall reported by the CAHs (8) to draw inferences about the pattern separately for those hospitals. Furthermore, there is no information about the completeness of reporting by all hospitals.