Adverse Event Contextual Information Form (Optional)

State law requires facilities to confirm adverse events with the Department of Health when they occur. (RCW 70.56.020) The facility must notify the department within 48 hours of confirming an event. Notification includes date, type of adverse event, and facility contact information. Facilities may also include contextual information regarding the reported event by completing and submitting this form. This form is optional and not required as part of the reporting requirements.

Public disclosure requests of an adverse event will include any contextual information the medical facility chose to provide. (RCW 70.56.020(2)(a))

Complete the following information and return by:

- Email to: AdverseEventReporting@doh.wa.gov, or
- Mail to: DOH Adverse Events, PO Box 47853, Olympia, WA, 98504-7853, or
- Fax to: Adverse Events (360) 236-2830

Facility Name:	Grays Harbor Community Hospital
Facility Contact:	Jamy Jurin
Facility web site:	http://www.ghchwa.org/
Date of Event Confirmation:	April 19, 2013
Facility capacity: (e.g., # of beds, rooms, procedures per year)	140 licensed beds
Other Facility information:	
Event Information:	Patient noted on 04.15.2013 to have a small open area to her coccyx, photo documentation done and patient was placed on a baribed and moved from room 320 to 302 so staff could use the ceiling lift to help reposition in the patient easier. On 04.17.2013 the wound was noted to be larger in size and an allevyn foam dressing was placed. On 4.18.2013 an order for a would consult was obtained and the patient was placed ona airbed.

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(Optional)

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Facility Name:	The Olympia Surgery Center
Facility Contact:	Chris Ballew RN, BSN
Facility web site:	olyortho.com
Date of Event Confirmation:	06/17/13
Facility capacity: (e.g., # of beds, rooms, procedures per year)	4 OR's
Other Facility information:	Orthopedics / Pain Management
Event Information:	Patient was scheduled for a (Rt) Cervical ESI. Patient pmeds c significant disease c a Comp Term plan to treat both sides. Physiatrist and the pt prep to confirm procedure and permit. The patient was taken to the OR by the room RN and P positioning and Time Out the procedure was completed. It was noted by the staff in room that the procedure was done on the left side. The physiatrist discussed the occurrence c the patient immediately. Patient was cared for and discharged from PACU per P&P. Postop call completed the next day c patient doing well c recovery. Pt. concerned about left vs Right and physiatrist informed.

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Facility Name:	Providence Regional Medical Center Everett
Facility Contact:	Paula Bradlee
Facility web site:	www.providence.org/everett
Date of Event Confirmation:	06/14/13
Facility capacity: (e.g., # of beds, rooms, procedures per year)	468
Other Facility information:	
Event Information:	Event Type 1a Wrong surgery / invasive procedure site reported 06/14/13: Further event clarification that this was a needle placed in the spine via incorrect level but medication injected into correct space.

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Facility Name:	Salmon Creek Plastic Surgery
Facility Contact:	Virginia Huang, M.D. / 360-430-2776
Facility web site:	www.salmoncreekps.com VHuang@salmoncreekps.com
Date of Event Confirmation:	5/2/13
Facility capacity: (e.g., # of beds, rooms, procedures per year)	
Other Facility information:	
Event Information:	35 year old healthy female underwent bilateral breast augmentation at Salmon Creek Plastic Surgery on 5/2/13. She was discharged to home shortly after the procedure. She apparently suffered a PEA (pulseless electrical activity) cardiac arrest at home and was admitted urgently to Legacy Salmon Creek Hospital. It was strongly suspected that she had suffered from Marcaine (Bupivacaine) toxicity. One of the pain pump containers was noted to be nearly empty indicating that she had gotten a high dose of marcaine. She was extubated & went on to have an uneventful recovery & was discharged from the hospital on 5/7/13

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Facility Name:	Puyallup Endoscopy(Center Western WA Endoscopy Center)
Facility Contact:	Dana Murphy
Facility web site:	dmurphy@digestivehlth.com
Date of Event Confirmation:	9/19/2013
Facility capacity: (e.g., # of beds, rooms, procedures per year)	Approximately 8000 procedures per year.
Other Facility information:	
Event Information:	Patient presented to the Puyallup Endoscopy Center on 9/5/2013 for an upper endoscopy. Pat had EGD (esophogastroduodenoscopy) with dilation for history of dysphagia. Found moderate Schatzki ring (dilated), hiatal hernia, with normal stomach. Patient tolerated procedure well and discharged home after meeting discharge criteria. On 9/6/2013 staff were making the post procedure follow up phone call and was informed by family that the patient had a cardiac arrest and was in asystole when paramedics responded to her home. She was transferred to Good Samaratin Hospital and later passed away. Final diagnosis per hospital death summary: cardiac arrest, multi-system organ failure, anoxic encephalopathy, history of COPD/asthma with morbid obesity. Chest x-ray indicated pneumonia or pulmonary edeme. No evidence of perforation on CT scan.

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Facility Name:	United General Hospital
Facility Contact:	Bertha Barlund
Facility web site:	United general. org
Date of Event Confirmation:	11/20/13
Facility capacity: (e.g., # of beds, rooms, procedures per year)	Critical Access Hospital
Other Facility information:	
Event Information:	Patient had a Serious injury associated with the fall out of bed.

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Facility Name:	Pacific Rim Outpatient Surgery Center
Facility Contact:	Joel Schmitt, RN
Facility web site:	
Date of Event Confirmation:	11/21/13
Facility capacity: (e.g., # of beds, rooms, procedures per year)	5 operating rooms, 1 procedure room
Other Facility information:	
Event Information:	Event occurred on 9/30/13. The final operative report was received on 10/10/13. It was decided that a peer review would be conducted using a surgeon outside of the community. An orthopedic surgeon in Skagit County was contracted to provide this service. After review by outside surgeon a final meeting was set up for 11/20/2013 that included the director of nursing (myself), the facilities medical director and the orthopedic surgeon who commited the error. During the course of the meeting the case was discussed along with the opinion of the outside review. The root cause analysis was reviewed along with the action plan and the changes to the policy titled "time-out: verification and documentation of the surgical patient and procedure." this was agreed upon by all parities. During the operative case the surgeon performed three different procedures on the same patient. The surgeon felt that the time-out prior to the start of the procedure was done correctly. When the surgeon was ready to perform the trigger release he approached the surgical site from the opposite side that he usually operates from. He made the incision in the location of the surgical marking. Due to the fact that the surgeon sat on the opposite side he identified the incorrect A-1 pulley. After releasing the pulley the surgeon recognized that he had in fact released the wrong pulley. The surgeon increased the length of the incision approximately 2mm. the correct pulley was then released. The incision was closed. The patient was informed of the error. The changes that have been made to the policy are based on the World Health Organizations Surgical safety checklist along with information from AORN. The changes include a separate time-out for each procedure that occurs on the same patient. Staff training for this new policy has begun and final Board of Managers approval for this policy will be obtained at the next board meeting occuring in the

Washington State Department of Health

Adverse Event Contextual Information Form (Optional)

	first week of December.