Washington State Department of Health

Adverse Event Contextual Information Form (Optional)

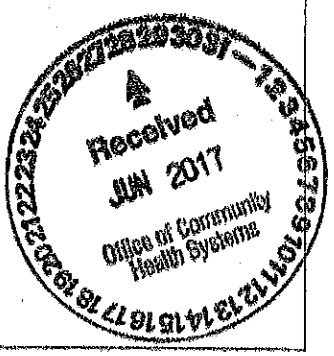
State law requires facilities to confirm adverse events with the Department of Health when they occur. (RCW 70.56.020) The facility must notify the department within 48 hours of confirming an event. Notification includes date, type of adverse event, and facility contact information. Facilities may also 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:	Northwest Hospital
Facility Contact:	Kristen Krebs
Facility web site:	nwhospital.org
Date of Event Confirmation:	June 16, 2017
Facility capacity: (e.g., # of beds, rooms, procedures per year)	281 licensed beds
Other Facility Information:	
Event Information:	4F event relates to a patient with an admit BMI of 16.55 with flu, pneumonia, ARDS that necessitated RotoProne therapy as a life sustaining measure. She developed unstageable pressure injuries on her forehead and cheekbones related to the RotoProne bed use. This very ill patient survived her hospitalization.



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Facility Name:	Whitman Hospital & Medical Center
Facility Contact:	Heather Reathaford
Facility web site:	https://www.whitmanhospital.org/
Date of Event Confirmation:	06/14/2017
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25 beds
Other Facility Information:	
Event Information:	Possible device malfunction. During cataract extraction with intraocular lens implant, the lens injector did not function as normal. Surgeon's operative notes indicates, "The lens was in its preloaded cartridge, where entry into the eye was started and the lens was advanced forward. However, the threads on the lens injector never engaged and resulted in a lens that came into the eye quickly. I did a thorough inspection of the capsular bag, and there did not appear to be a rear or rent in the capsule even though it likely did stretch the capsule during entry." On 6/14/17, Whitman Hospital was notified by surgeon's office that patient's lens appears to have moved and patient will be taken back into surgery in Spokane for lens removal. 6/14/17 Whitman Hospital notified device manufacturer, Abbott, and filed FDA MedWatch voluntary report form 3500.

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Facility Name:	Lincoln Hospital
Facility Contact:	Brandi Maleho RN DNS
Facility web site:	
Date of Event Confirmation:	3/16/17
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25
Other Facility Information:	CAH
Event Information:	On 3/16/17 at 1835 patient AW was found by staff RN on the floor of her room in front of her sink. she was found sitting on her buttocks with weight on her right buttock. she sustained a skin tear to her right elbow. patient was A/O x3 and had not complaints of immediate pain. patient was assisted back to bed. neuro checks ordered and done q2 hours with increased frequency of visual checks. patient had a fall alarm that became detached so staff was not alerted to patient movement prior to the fall. patient was in a room closest to the nurses station for visualization. patient had a call light in reach, bed in low position, and foot wore on. the patient was confused during the day of the fall and had an individual sitter with her until 4pm. staff attempted to get another sitter to stay with the patient but no one was available. when family contacted about a sitter not being available they stated non of them were available either. on 3/19/17 in the early am when staff were interacting with the patient she complained of pain in her right hip. the staff informed the provider and orders obtained for xray. xray confirmed fracture of the proximal right femur. provider notified family of findings.

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Facility Name:	Northwest Hospital
Facility Contact:	Kristen Krebs
Facility web site:	nwhospital.org
Date of Event Confirmation:	January 21, 2017
Facility capacity: (e.g., # of beds, rooms, procedures per year)	281 beds
Other Facility Information:	
Event Information:	Information to accompany report of 'serious injury associated with a medication error' - the patient in question presented to the ED with N/V/D following a hospital stay and the inadvertant taking of multiple antibiotics. It is the opinion of Northwest Hospital that if the patient required IVF to manage her symptoms of N/V/D related to her medications that this should be reported conservatively as an error.

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- Fax to: Adverse Events (360) 236-2255

Facility Name:	Columbia Basin Hospital
Facility Contact:	Heidi Cline, RN, BNS
Facility web site:	www.columbiabasinhospital.org
Date of Event Confirmation:	1/4/17
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25 bed Critical Access Hospital
Other Facility Information:	
Event Information:	A complaint was placed to DOH. Marietta Smith come to the facility on visit and visit and did an investigation.

Date of Incident: 12/27/16

At 1335 an 89 year old female patient was found deceased in her room sitting in her wheelchair, incontinent of urine, sliding down in chair. A front clipping gait belt was secured around her waist as she had fallen out of her wheelchair on two other incidents over past few weeks. Patient had been a resident of this facility for past 12 years with Parkinson's diagnosis. She had a gradual decline in mobility this past year with further decline noted over the last 4 months with falls on 1/14/16, 8/2/16, 8/28/16, 9/27/16, 10/2/16, 11/13/16, 11/28/16, 12/16/16, and 12/20/16.

Patient also had dental surgery on 12/8/16 in which she was scheduled to have 2 teeth removed and wound up having more extensive surgery removing 6 teeth resulting in excessive bleeding and needing to be hospitalized overnight for observation in Yakima where dental surgery took place.

After this procedure patient's condition continued to decline and she was no longer able to ambulate or transfer self. A chair and bed alarm was placed as patient continued to be very independent and would not consistently call for help. She had 2 more subsequent falls after this procedure in which she fell out of her wheelchair. She stated she started moving and got going too fast with arm and leg tremors and could not stop herself. Both times she fell out of chair due to this she was incontinent of urine. After second fall patient was in agreeance to have some type of seatbelt for her wheelchair to keep her from falling out. She stated she was very scared and afraid of falling out of chair again. She agreed to have a front clipping gait belt placed until a wheelchair seatbelt could get ordered in. She stated she had been using gait belt when staff walking with her for some time and was able to take them off. Her daughter was also called after second fall out of wheel chair and was also in agreeance to use the front clipping gait belt as a seatbelt to keep her from falling out of chair again.

There were no forms filled out documenting patient's ability to demonstrate opening and removing gait belt or signed permission by patient, just verbal documentation of her and her daughter's agreeance. As she progressively got worse the last few days of her life she needed assistance to brush her teeth and to feed herself as the tremors increased and she had difficulties controlling movement and mobility. There was no reassessment of patient to indicate she still was capable of removing gait belt.

ED MD was called to patient room at time of incident/death to assess patient for any signs of trauma related to use of gait belt as seatbelt. His assessment indicated that he saw no signs of trauma. Call was placed to coroner and reviewed with him as well. He indicated this was not a coroner case and to release the body to mortuary. Family was contacted and body was released to mortuary of choice.

A complaint was placed to DOH and Marietta Smith RN came to facility on 1/10/17 and 1/11/17 and did investigation. Her findings were that there was an adverse event due to the lack of documentation of patient's ability to unclip gait belt at time of incident and will submit a report back to Columbia Basin Hospital within 10 days and will need a plan of correction back to her within 10 days of receiving report.

Heidi Cline RN DNS