Washington State Department of Health

# Adverse Event Contextual Information Form (Optional)

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- Mail to: DOH Adverse Events, PO Box 47853, Olympia, WA, 98504-7853, or
- Fax to: Adverse Events (360) 236-2830

| | |
|---|---|
| **Facility Name:** | Columbia Basin Hospital |
| **Facility Contact:** | Vicki Polhamus RN, DNS |
| **Facility web site:** | columbiabasinhospital.org |
| **Date of Event Confirmation:** | 1/3/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 |
| **Other Facility Information:** | CAH |
| **Event Information:** | Patient to ED with mental health complaints of hearing voices and not taking his medications. Patient medically cleared and Grant Mental Health MHP here to evaluate patient. MHP picked up patient's prescriptions prior to coming to see him. MHP administered the morning dose of Clozapine from the prescription bottles that she brought in. The MHP left the hospital, leaving the prescription bottles in the room with the patient. Patient next found on floor of room, unarousable. Clozapine 200mg bottle missing 4 pills. Unknown as to whether patient intended to harm self. Pt with GCS of 7, to CT,and then transferred by helicopter to Holy Family Hospital. |

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| | |
|---|---|
| **Facility Name:** | Central Washington Hospital |
| **Facility Contact:** | Sarah Harris |
| **Facility web site:** | |
| **Date of Event Confirmation:** | 1/26/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | |
| **Other Facility information:** | |
| **Event Information:** | The patient was malnourished at admission and had areas of breakdown present upon admit. The patient was instructed to utilize the bedpan intermittently due to increased risk of skin breakdown. The patient had frequent loose stools and did not want to comply with this request. The patient had improvement in his breakdown that was present prior to his admission, but after sitting on the bedpan for an extended period of time the patient developed redness. Additional education was provided to the patient and wound care was notified. Unfortunately in this case had the patient been more compliant with the requests and education regarding extended periods of time of bedpan use, this may have been avoided. |

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| | |
|---|---|
| **Facility Name:** | Snoqualmie Valley Hospital |
| **Facility Contact:** | Rachel Weber BSN, RN, Director of Nursing |
| **Facility web site:** | snoqualmiehospital.org |
| **Date of Event Confirmation:** | January 29, 2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 beds per Med-Surg unit. Critical Access Hospital with a Swing Bed Program, We have approximately 700 patient days per month. |
| **Other Facility information:** | |
| **Event Information:** | Patient was admitted on December 26th. As required per policy a two nurse skin assessment was performed. Documentation stated the patient had skin at risk and RN implemented protocol to float heels. She is 92 years old and her co-morbidities include Diabetes II, elderly, thin and poorly nourished. The patient is post-hip surgery and is in our Swing Bed program for rehab.<br><br>The patient experiences pain in her hip area with legs elevated when floating heels. She frequently removed this measure. On 1/1 she began to have pain in her bilateral heels which were also assessed by the RN to now be red. The feet were again elevated, instructing the patient and family of the need to do this measure. By morning of 1/2 her heels were noted to have bilateral DTPI.<br><br>A certified wound nurse was immediately consulted and implemented soft protective boots. Wound care and increased monitoring was put into place. This patient was having numerous rehab visits where it is was discovered that placing her shoes on her feet during transfer to a wheelchair may have been contributing to her skin pressure ulcers.<br><br>Nurses do head to toe patient assessments twice a day per our policy. It was noted that the skin assessments were not as complete as they should be.<br><br>An RCA was conducted with debriefing, root causes identified and multiple solutions were offered up and are being implemented.<br><br>On 1/23 one heel had the blister open, this was staged at 2. By 1/29 the second heel was determined to be unstageable due to some eschar in the wound. Thus, this self report is being implemented. |

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| | |
|---|---|
| **Facility Name:** | Clearview Eye and Laser |
| **Facility Contact:** | Shelby Milne |
| **Facility web site:** | Clearview Seattle.com |
| **Date of Event Confirmation:** | 2/8/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 2 OR., 4 beds, approx. 2,000 cases/yr. |
| **Other Facility Information:** | |
| **Event Information:** | Yag Laser procedure started on wrong eye. Procedure had already been performed on eye seven months prior. Surgeon charted correct second eye during surgery post-op appointment, but selected the wrong eye on EMR, which started the computer pathway to pre-op the wrong second eye. Procedure aborted after 2 Laser shots (60 shots used commonly). No injury reported to patient. Patient and family notified by Surgeon immediately. |

Washington State Department of Health

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| | |
|---|---|
| **Facility Name:** | PacMed ASC |
| **Facility Contact:** | Marisa Liepman 206-505-1219 |
| **Facility web site:** | pacmed.org |
| **Date of Event Confirmation:** | 2/28/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 3 rooms, est. 7000 procedures. |
| **Other Facility information:** | GI and Pain procedures conducted in this facility |
| **Event Information:** | The patient was scheduled in the EMR for a Right Medial Branch Block and a Left Medial Branch Block was done. The consent was written for a Right MBB initially and the RN crossed off "right" and changed it to the "left" MBB day of the procedure per MD request. This patient had previously had the left MBB. |

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| | |
|---|---|
| **Facility Name:** | Booker Rest Home |
| **Facility Contact:** | Janet Ihle |
| **Facility web site:** | www.cchd-wa.org |
| **Date of Event Confirmation:** | 3/25/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 35 |
| **Other Facility Information:** | |
| **Event Information:** | RE: Fall on 3/25/18 resulting in fractured fractured humerous<br>Initial Adverse Event Notification and completed RCA for Fall with Injury identified the only injury as fractured humorous. Recent, unrelated symptoms indicated the need for Abdominal CT, performed on 5/18/18 in which the findings included the observation of "healing bilateral and inferior pubic rami and pubic bone fractures. Healing sacral ala vertical fracture." In further speaking with the radiologist, he was able to estimate that these fractures were likely sustained during a time frame consistent with the same incident in which her elbow was fractured. We have also determined that there has been no additional incident in or out of our facility since the date of the reported fall on 3/25. |

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| | |
|---|---|
| **Facility Name:** | Kaiser Permanente Central Hospital |
| **Facility Contact:** | Patient Safety Officer - Karen Birmingham, PharmD |
| **Facility web site:** | https://wa.kaiserpermanente.org/ |
| **Date of Event Confirmation:** | 4/2/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | |
| **Other Facility Information:** | |
| **Event Information:** | This event was reported to Kaiser Permanente Patient Safety on 10/30/17 and is related to a surgical repair of a clavicle fracture, during which a medial plate was accidentally attached to the sternum. At that time, the event was not considered to meet the criteria for wrong site surgery, but was still determined to be a serious safety event. A root cause analysis was conducted. On 4/2/18, a follow up meeting with the RCA team was held to discuss corrective actions and the issue of wrong site surgery was reconsidered. After reviewing the case again, the RCA team determined that the event should be considered a surgery performed on the wrong site. |

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| | |
|---|---|
| **Facility Name:** | First Hill Surgery Center |
| **Facility Contact:** | Carmen Slater |
| **Facility web site:** | www.firsthillsurgerycenter.com |
| **Date of Event Confirmation:** | 5/14/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 12 OR , 36 Pre Post beds, approximately 7000 per year |
| **Other Facility Information:** | ASC |
| **Event Information:** | Provider reported that after discharge to home, patient reported that "something" came out of her vagina. Patient had Laparoscopy on 5/8/2018. Provider determined while speaking with patient that item was the tip of vaginal instrument used during procedure. Director of Nursing was notified on 5/14/2018.<br><br>Interim Action: The Cohen uterine manipulator tip will be confirmed as present prior to entering the patient and again on completion of the procedure - staff have been educated to this process change which will be in effect until RCA has been completed and the formal action plan has been instituted. |

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| | |
|---|---|
| **Facility Name:** | Cascade Valley Hopsital |
| **Facility Contact:** | Mary-Katherine Waters |
| **Facility web site:** | http://www.cascadevalley.org/ |
| **Date of Event Confirmation:** | Confirmed June 21, 2018. Event occurred on 4/23/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | Skagit Regional Health, the umbrella name for Skagit Valley Hospital, Cascade Valley Hospital and Skagit Regional Clinics, is a health care leader in Northwest Washington, providing advanced, quality and comprehensive services to the people of our communities.<br><br>Cascade Valley Hospital is a 48-bed acute care facility in Arlington, Washington with a free-standing surgery center and wound care center. Cascade Valley Hospital provides acute, critical care, general surgery, a level IV Emergency Department, and Family Birthing Center, plus a wide array of outpatient and diagnostic imaging services. |
| **Other Facility Information:** | N/A |

Washington State Department of Health

# Adverse Event Contextual Information Form
## (Optional)

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|---|---|
| Event Information: | On 4/23/2018, patient had a surgical laparoscopy with partial colectomy and anastomosis. During the process of intracorporeal suturing, on of the suture needles could not be accounted for. Fluoroscopy of the abdominal cavity did not reveal the location of the needle. This was then followed by a flat plate abdominal x-ray of the abdomen with a suture needle on the abdomen as reference. There was no evidence of a retained needle within the abdominal cavity according to radiology.<br><br>On 4/26/2018 the physican performed CT scan there was no evidence of a leak, but in the process of performing the CT scan the needle that had been lost at time of surgery whose location could not be confirmed by fluoroscopy or flat plate the abdomen was noted to be a posteriorly behind the spleen high in the left upper quadrant. This information was conveyed to the patient and family. On 6/21/2018 clinical leadership confirmed there was an unintended retention of a foreign object in the patient after surgery.<br><br>System of communication did not reveal that an object was left in the body. Upon confirmation of the unintended retention of a foreign object with clinical leadership on 6/21/2018 Quality was directed to report immediately to the DOH. RCA has already been scheduled to be conducted. |

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| | |
|---|---|
| **Facility Name:** | Southwest Washington Regional Surgery Center |
| **Facility Contact:** | Nancy Molahan |
| **Facility web site:** | www.swrsc.com |
| **Date of Event Confirmation:** | June 21, 2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 8 Operating rooms. Approx 10,000 cases a year. |
| **Other Facility Information:** | |
| **Event Information:** | Non-surgical procedure. |

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|---|---|
| **Facility Name:** | Garfield County Hospital District |
| **Facility Contact:** | Jayd Keever RN DNS |
| **Facility web site:** | |
| **Date of Event Confirmation:** | 7-3-18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 beds |
| **Other Facility Information:** | NA |
| **Event Information:** | patient was being pushed in w/c to her bed to be transfered - care plan was being followed - patient leaned forward and fell out of w/c, hitting her head. was taken to ER and transfered to a higher level of care for diagnostic testing. Results include, multiple bruising, skin tears, fracture of C1:C2, Large hematoma on forehead that is open. Full root cause analysis is being done and will be submitted within the date range. |

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|---|---|
| **Facility Name:** | Eye Associates Surgery Center |
| **Facility Contact:** | 360.755.3840 Wendy Siapco, Administrator wendys@eyesurgery.co |
| **Facility web site:** | www.neoscade.com (link: Surgery Center) |
| **Date of Event Confirmation:** | July 11, 2018 at post-op appointment |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 2 operating rooms, ~2000 procedures annually |
| **Other Facility Information:** | |
| **Event Information:** | |

Patient was scheduled for a YAG Capsulotomy OS for June 25, 2018. The patient received an SLT, OD instead. This was discovered during postop clinic visit on July 11, 2018. The patient was advised that she received an SLT rather than the intended YAG capsulotomy. The patient was not harmed and there was no adverse outcome. The unintended procedure was not billed to Medicare (or billed and refunded) and the patient is now scheduled for the originally intended and necessary YAG Capsulotomy procedure with appropriate consent/orders.

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| | |
|---|---|
| **Facility Name:** | Monroe Correctional Complex |
| **Facility Contact:** | 206-484-8228 |
| **Facility web site:** | |
| **Date of Event Confirmation:** | 7/16/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 2800 |
| **Other Facility Information:** | Correctional Institution |
| **Event Information:** | Patient [redacted] had essentially normal labwork done on 7/6/18. He developed shortness of breath for approximately 4 days, and was seen at our facility's sick call. He got a CXR on 7/9/18 which was normal. He then developed a swollen lymph node on the right side of his neck, and did not appear to be improving with antibiotics. We sent him to Evergreen Monroe for an urgent CT neck on 7/12/18 which showed multiple enlarged lymph nodes with no necrosis and suspicious for lymphoma. He was returned to the Infirmary at MCC for close monitoring, where he was noted to have an elevated temp of approximately 102F, which did not wax and wane over the ensuing evening despite antibiotic treatment. He was also noted to have a rash on his hands. Overnight when his temperature did not decline, it was decided to send him to Evergreen Monroe ER on 7/13/18.<br><br>At Evergreen Monroe, a lymph node biopsy was initially planned, however he was found to be severely thrombocytopenic, and declined again after transfusion. He was then sent to Providence Everett in the evening on 7/13/18, with the biopsy planned for the morning on 7/16/18. Before he could be taken for biopsy, he went into cardiac arrest and could not be resuscitated.<br><br>A complete review of events at Monroe Correctional Complex is in progress, however preliminary review did not identify any delays or omissions in care or communication. |

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|---|---|
| **Facility Name:** | Lincoln Hospital |
| **Facility Contact:** | Brandi Maioho RN DNS |
| **Facility web site:** | |
| **Date of Event Confirmation:** | July 23 2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 CAH |
| **Other Facility Information:** | NA |
| **Event Information:** | On July 21 2018 Patient J.B removed her tabs fall alarm, stood up from her recliner and prcoceded to ambulate herself to the sink. Nurse observed patient standing in room and wittnessed the patient sit down onto the floor. Initial assessment/finding by provider and nurse showed no complaints from patient or physical sufferings. The following day July 22nd the patient started to complain of back pain. The on call provider was notified by the nurse; patient was examined, and x-rays ordered. The reading of the x-rays states patient has "T11 and T12 compression fractures, possibly acute", and "L2 compression fracture age undetermined". When assessed the patient states has had a long history of back pain and osteoporosis.<br><br>Patient History: Admitted for hyponatremis, seizres related to hyponatremia, altered level of consciousness due to profound hyponatremia and post seizures. Patient previous records reviewed for comparison x-rays; none available.<br><br>Due to fall screening on admission showing high fall risk patient was close to the nurses station, and had facility fall risk interventions in plac. Patient had just been rounded on by staff; and declined any needs. Patient was eating a meal at the time, has call light in reach, fall prevention socks on, and Tabs alarm system attached to hospital gown. Patient had also been evaluated for high fall risk needs by physical therapy and occupational therapy. |

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| | |
|---|---|
| **Facility Name:** | Central Washington Hospital |
| **Facility Contact:** | Sarah Harris |
| **Facility web site:** | |
| **Date of Event Confirmation:** | 8/8/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | |
| **Other Facility Information:** | |
| **Event Information:** | Patient was know to have self destructive behaviors. The patient was closely monitored, although she was frequently caught "playing" with her IV tubing and insertion site. The patient at one point pulled a separate catheter out on her own when she became upset with a provider. This IV catheter was inspected and found to have no defects and was fully in tact. The broken IV catheter, when inspected, appeared to have been pulled apart from the IV catheter. It had been flattened to the point that there was no way it could have been in that state prior to insertion. |

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| | |
|---|---|
| **Facility Name:** | Columbia Basin Hospital |
| **Facility Contact:** | Vicki Polhamus |
| **Facility web site:** | Columbiabasinhospital.org |
| **Date of Event Confirmation:** | 8/28/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 |
| **Other Facility Information:** | 5 Emergency Department beds |
| **Event Information:** | Patient on gurney in ED room . Lab in to draw blood and did not put the side rail back up on gurney. Pt fell off gurney hitting her head. Pt stated she was having a bad dream and rolled off the gurney. Pt to CT with results showing a small subarachnoid bleed. No change in GCS. Pts blood ETOH level was 416. Patient transferred to Central Washington Hospital. |

Washington State Department of Health

# Adverse Event Contextual Information Form (Optional)

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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:** | Monroe Correctional Complex |
| **Facility Contact:** | Julia A. Barnett, MD |
| **Facility web site:** | n/a |
| **Date of Event Confirmation:** | 9/12/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 2800 |
| **Other Facility Information:** | Mental Health Residential Treatment unit |
| **Event Information:** | On Wednesday, September 12, 2018 at 0429 hours at the Monroe Correctional Complex (MCC) Special Offender Unit (SOU) D-Unit Officer [redacted] was conducting a tier check when he observed blood coming out of [redacted] onto the tier. Officer [redacted] quickly responded to the cell and observed the single cell occupant offender [redacted] leaning against the wall covered in blood. An emergency radio call was made and the Quick Response Strike Team supervised by [redacted] and Registered Nurse [redacted] responded to the incident site. QRST entered the cell at 0431 hours, Cardiopulmonary resuscitation (CPR) initiated at 0432 hours and 911 advanced life support was requested at that time. Washington State Reformatory Unit (WSRU) [redacted] briefed and prepared and armed chase car consisting of [redacted] for SOU use. At 0446 hours Monroe Fire Department Emergency Medical Services was escorted to the incident site. [redacted] reported that the offender slit his throat and that lifesaving efforts were continuing. At 0449 hours, Monroe EMS pronounced the offender deceased, [redacted] instructed to initiate a crime scene. Monroe Police Department Officer [redacted] on site at the facility. Local Facility Duty Officer [redacted] was briefed at 0509 hours and responded to the facility. Appropriate additional notifications and checklist initiated. Monroe Police Department Officer [redacted] provide case number [redacted] Snohomish County Corner estimated time of arrival 0730 hours. Monroe Police Officer [redacted] on site process the incident at 0530 hours. At 0630 hours, Officer [redacted] released the crime scene and departed the facility. |

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|---|---|
| **Facility Name:** | Lincoln Hospital Dist. #3 Davenport Washington |
| **Facility Contact:** | Brandi Maioho RN DNS maiohob@lhd3.org 509-725-2979 Ex 1230 |
| **Facility web site:** | |
| **Date of Event Confirmation:** | October 1 2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 CAH |
| **Other Facility information:** | 8 of 25 Beds are Extended Care Swing Bed |
| **Event Information:** | On 9/30/2018 at 0451 92 YOF extended bed patient RM had an accidental un-witnessed fall in her private bathroom, landing on the left side of her body. RM used the call light in the bathroom to inform staff she needed assistance, when staff responded they found her on the floor. Lincoln Hospital uses the John's Hopkins fall assessment tool and intervention; RM was assessed and determined a high fall risk patient on admission and with each shift assessment. Patient RM refuses many of the advised fall risk interventions; including alarms or warning devices despite her inconsistency usage of her call light. Following the fall RM was assessed by RN and Provider; diagnostic finding confirm a left lateral malleolus fracture. Provider provided fracture care, and family was notified. RCA to follow per adverse reporting guideline |

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| | |
|---|---|
| **Facility Name:** | Cascade Valley Hospital |
| **Facility Contact:** | Mary-Katherine Waters |
| **Facility web site:** | http://www.cascadevalley.org/ |
| **Date of Event Confirmation:** | Leadership and Quality confirmed the event on 10/9/18. The event occurred on 10/7/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | Cascade Valley Hospital is a 48-bed acute care facility in Arlington, Washington with a free-standing surgery center and wound care center. Cascade Valley Hospital provides acute, critical care, general surgery, a level IV Emergency Department, and Family Birthing Center, plus a wide array of outpatient and diagnostic imaging services. |
| **Other Facility information:** | N/A |

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# Adverse Event Contextual Information Form
## (Optional)

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| Event Information: | On the evening on 10/7/18 patient sustained fall in room. The RN did not witness the event, patient stated she had lost balance while ambulating to bathroom with IV pole. MD came and conducted evaluation and treated laceration patient's left led. 8 stitches total put on left leg and cover with gauze and wrapped in kerlix. Patient was put on high fall risk, bed alarm on at all times. Confirmation of the event with full impact to patient occurred on the evening of 10/9/18. Quality pulled all information and reviewed records on 10/10/18 and is reporting immediately to DOH. RCA is in-process of being scheduled. |

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|---|---|
| **Facility Name:** | Cascade Valley Hospital |
| **Facility Contact:** | Mary-Katherine Waters |
| **Facility web site:** | http://www.cascadevalley.org/ |
| **Date of Event Confirmation:** | Confirmed on 10-12-2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | Cascade Valley Hospital is a 48-bed acute care facility in Arlington, Washington with a free-standing surgery center and wound care center. Cascade Valley Hospital provides acute, critical care, general surgery, a level IV Emergency Department, and Family Birthing Center, plus a wide array of outpatient and diagnostic imaging services. |
| **Other Facility information:** | N/A |
| **Event Information:** | Patient arrived via ambulance to the ED on 10/5/18. This is a comfort care patient who arrived septic from a nursing facility. There was reported redness and swelling on her left thigh and reportedly had been treated prior for an infection on her left thigh recently. On the day of admission, redness noted to coccyx, but skin intact. Patient was transferred to Acute Care. Patient was noted on 10/6/18 to have a blister and bruised areas on front side of left thigh and when repositioning her left buttocks and back of her left thigh was red and barely blanchable. This area progressed to an open wound the following day. On 10/8/18 patient determined to have progression of the red area on the coccyx, a stage 2 pressure ulcer. RCA will be conducted and interviews are underway. |

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|---|---|
| **Facility Name:** | Garfield County Hosptial District |
| **Facility Contact:** | Jayd Keener, RN DNS |
| **Facility web site:** | www.pomeroymd.com |
| **Date of Event Confirmation:** | 10/13/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 25 |
| **Other Facility information:** | Critical Accsess Hospital with swing bed program |
| **Event Information:** | On the morning of Saturday 10/13/18 a patient who resides at the facility in the permenent swing unit reported to two NAC's that a red head man had pushed him down in bed on his chest and would not let him get up. The staff immidiatly got the nurse on duty who went and did further investigation and he told the same account with adding more details. A physical exam was done and no visable injuries were noted however the patient was sore on his chest. DNS was contacted and investigation was started. The Trauma Cordinator went to the building and talked with the patient who stated the same account and added "he picked me up from behind".<br><br>Employee was identified and was contacted and placed on administrative paid leave pending the investigation. Patient's POA was contacted, another nurse head to toe was performed with bruising noted to his wrists (however patient had a lab draw with in the last week in these areas), patient was taken to the ED where a provider did a physical exam and the local law enforcment was contacted. APS was notified via on line and this notification.<br><br>Safety plan was put into place-employee is not allowed to be on the in patient side of the hosptial until further notice, alert charting was initiated for psycosocial affects, monitoring for physical changes, two person female personal cares implimented.<br><br>Investigation will continue and root cause will be done. |

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| | |
|---|---|
| **Facility Name:** | Cascade Valley Hospital |
| **Facility Contact:** | Mary-Katherine Waters |
| **Facility web site:** | http://www.cascadevalley.org/ |
| **Date of Event Confirmation:** | 10/16/2018 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | Cascade Valley Hospital is a 48-bed acute care facility in Arlington, Washington with a free-standing surgery center and wound care center. Cascade Valley Hospital provides acute, critical care, general surgery, a level IV Emergency Department, and Family Birthing Center, plus a wide array of outpatient and diagnostic imaging services. |
| **Other Facility Information:** | N/A |
| **Event Information:** | On 9/13 patient arrived at our Wound Care Center. Upon the MA walking patient back to the patient room the patient fell and hit their head on the door frame. There was no items in the path of the patient. Staff quickly turn around and physician and RN assisted. Upon examination the right elbow wound debrided. Had right scalp wound, clinical team cleaned the wound, closed with sutures, and sterile dressing was applied over the wound. RCA in-process. |

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| | |
|---|---|
| **Facility Name:** | Samaritan Healthcare |
| **Facility Contact:** | Kurtis Kuykendall, Director of Process and Quality Improvement<br>(509) 793-9709 |
| **Facility web site:** | https://www.samaritanhealthcare.com/ |
| **Date of Event Confirmation:** | 11/30/18 |
| **Facility capacity:** (e.g., # of beds, rooms, procedures per year) | 50 |
| **Other Facility Information:** | Samaritan Healthcare is a multifaceted healthcare organization located in Moses Lake, Washington and organized as Grant County Public Hospital District No. 1. We service a population of over 120,000 people. Samaritan Healthcare includes a 50-bed hospital and multi-specialty clinic along with a full array of other health services. Samaritan's outpatient clinic provides Family Medicine, Obstetrics-Gynecology, Pediatrics, Orthopedics, Podiatry, and Urgent Care. Samaritan also provides a number of outpatient services such as Physical Therapy, Cardiac Rehabilitation, and Ambulatory and Outpatient Surgery. In 2016, Samaritan saw 19,847 patients in the Emergency Department; admitted 3,912 patients; performed 5,166 surgeries; and delivered 1,006 babies. |

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# Adverse Event Contextual Information Form (Optional)

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|---|---|
| Event information: | Patient presented to Emergency Department with dizziness, weakness and was "favoring his right side". Patient reported a previous fall at his home earlier that day. No diagnostic imaging was done upon arrival to the Emergency Department.<br><br>Patient was admitted for concerns about a possible stroke. Upon arrival to the floor the patient was predictable, appropriate, alert and oriented. Patient had a Physical Therapy session and afterward, was assisted back to bed. Nursing staff instructed patient to call for help if he needed to get up for any reason. Patient was given call light and a bed alarm was placed.<br><br>Fifteen minutes after the patient was placed in bed, the bed alarm sounded. Nursing responded at the sound of alarm and patient was found on the floor. Diagnostic imaging was completed for right hip pain and initial x-ray was negative. Two days later after persistent pain, a C.T. was performed and it indicated a femoral neck fracture. |