

Seattle Children's Adverse Health Events Occurring During a Six Year Period (2004-2010)

Keeping our patients safe is central to everything we do at Seattle Children's Hospital.

Health care adverse events are defined as episodes of care in which a patient is harmed, or is at risk for harm, based on medical treatment, rather than on their underlying disease. Adverse events may or may not be associated with a medical error. Our goal is to eliminate all adverse health events and medical errors. However, to reach this goal we need accurate data about the number of adverse events we have each year. To that end, we have implemented a culture of safety which encourages staff to report errors. This open communication allows us to accept accountability for errors, identify what went wrong and implement new safety measures to prevent them from happening again. We also support staff in reporting "close calls" – situations where an error was detected before it reached a patient – so that we can learn from those, as well. We also listen to our patients and their families and involve them in the design and implementation of safety improvements.

Every day we move closer to our goal of zero errors while our staff remains focused on keeping our patients safe.

Below are descriptions of seventeen events that have occurred at Children's over the last six years (2004 – 2010). These categories all fall under the Washington State Department of Health's definition of *Serious Reportable Events in Health Care*.

Wrong Site Procedure (1)

This incident involved a therapeutic injection to the incorrect leg for a patient's musculoskeletal problem. This necessitated a second injection on the correct side.

Retained Foreign Object (1)

In the process of placing a large intravenous line, the guide-wire was inadvertently left in the patient at the end of the procedure. The guide-wire was removed without problem several hours later.

Device Function or Use (1)

A feeding tube perforated the intestinal wall of a patient with complex congenital heart issues; leading to the death of the patient.

Medication Error (1)

We prescribed and dispensed a high-dose fentanyl patch for outpatient post-operative pain control to a teenager with special needs who could not tolerate pills or liquid medicines. The patient died at home on the night of surgery, from an inadvertent narcotics overdose.

Pressure Ulcers (8)

Eight patients developed Stage 3 or 4 pressure ulcers over the last five years. These ulcers occurred in critically ill patients who could not be easily repositioned to relieve pressure points on their skin, and in other critically ill children around the site of life-saving medical devices. We have made

several changes in the way that we provide care in an attempt to prevent further pressure ulcers at Children's.

Fall Resulting in Death or Disability (1)

An infant with a chronic medical condition fell from his crib when the rail released from the "up" position as the child pulled to a standing position. The patient recovered fully.

Patient Abduction (1)

An infant with a chronic health condition was abducted from the hospital by their mother. The patient was readmitted to the hospital a few days later, received treatment and was released.

Sexual Assault (2)

A teen patient was allegedly assaulted by the parent-assigned caregiver who was responsible for staying with the patient overnight. Hospital staff reported the incident to the appropriate authorities.

A teen patient was allegedly assaulted by another patient while staying in the Inpatient Psychiatric Unit. Hospital staff reported the incident to the appropriate authorities and implemented additional safety procedures.

Physical Assault (1)

A teen patient was allegedly assaulted by another teen patient. Hospital staff reported the incident to the appropriate authorities.