TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Regulatory Licensing Unit
Health Facility Licensing Group

Annual Occurrence and Best Practice Reports for period ending June 30, 2005

Best Practice Reports were submitted to the department for the reporting year July 1, 2004, through June 30, 2005. Some Best Practice Reports were submitted on a voluntary basis, as the hospitals had no reportable events for the year. Some best practices submitted were implemented to address patient safety issues specific to the reporting facility and are not necessarily applicable to all facilities of the same licensure type.

The volume of information available to the public regarding patient safety is increasing steadily. This information evolves continually as the public, health care organizations, and health care professions work toward a common goal of increasing patient safety. Since many of the best practices reported by the facilities were adopted from nationally recognized guidelines, the department has elected to publish a list of links to evidence-based patient safety resources rather than the individual hospital best practice reports which varied in format, substance and breadth.

The department suggests licensed health care facilities review the information available regarding patient safety, evaluate their respective facilities on an ongoing basis, and implement patient safety strategies that best fit their unique environments.

Click here for links to Patient Safety information. Each licensed facility should consider the appropriateness of these recommendations for possible implementation. Please send comments or recommendations regarding this list to jane.guerrero@dshs.state.tx.us.

ANNUAL OCCURRENCE REPORT July 1, 2004-June 30, 2005

	GENERAL AND SPECIAL HOSPITALS	GENERAL AND SPECIAL HOSPITALS	GENERAL AND SPECIAL HOSPITALS	GENERAL AND SPECIAL HOSPITALS	AMBULATORY SURGICAL CENTERS	PSYCHIATRIC HOSPITALS & CSU'S
TOTAL NUMBER OF FACILITIES	204	96	81	104	274	28
Occurrence Description	*Beds (under 50)*	*Beds (50-99)*	*Beds (100-199)*	*Beds (200 plus)*		
A medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient	1	4	3	17	1	0
A perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams	2	1	5	11		
The suicide of a patient in a setting in which the patient received care 24 hours a day	0	0	0	1	0	2
The abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant	0	0	0	0		
The sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility	0	1	2	7	0	2
A hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities	1	0	1	1	0	0
A surgical procedure on the wrong patient or on the wrong body part of the patient	2	5	8	31	13	
A foreign object accidentally left in a patient during a procedure	3	2	13	53	2	
A patient death or serious disability associated with the use or function of a device designed for a patient that is used or functions other than as intended	0	0	0	9	1	0