
e-Appendix 3: Brief description of clinical details of adverse events occurring in 255 patients, by corresponding maximum degree of preventability*

Case Description of adverse event†

Virtually certain evidence of preventability

- 1 Acute on chronic renal failure caused by NSAIDs
- 2 Acute renal failure with hyperkalemia and intractable constipation with large-bowel obstruction ending in death. Lack of effect of enemas recorded in nurses' notes and results of bowel radiograph not acted upon
- 3 Admission because of severe anemia. The anemia had been documented in previous admission but not investigated fully, which resulted in delayed diagnosis of colorectal carcinoma
- 4 Delirium caused by benzodiazepines given to patient with hepatic encephalopathy
- 5 *Clostridium difficile* colitis following antibiotic therapy. Patient did not receive sufficient volume expansion, which led to acute renal failure and death
- 6 Cardiac valve replacement. Three days before discharge nurse noted wound was red, inflamed and painful, but no treatment or medical note. Nontherapeutic international normalized ratio (INR) on discharge. Readmitted at 2 weeks with a wound infection, echogenic mass on prosthetic valve and possible infective endocarditis
- 7 Chronic renal failure in patient taking sotalol and given increasing doses of digoxin, which led to increased QT interval, digoxin toxicity, heart block and worsening renal failure
- 8 Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
- 9 Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
- 10 Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and dementia
- 11 Delayed treatment of pseudomembranous colitis
- 12 Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical context of renal failure
- 13 Digoxin toxicity in patient with chronic renal failure possibly contributed to death
- 14 Drug-induced acute urinary retention and postrenal failure
- 15 Delirium and vomiting caused by electrolyte imbalance after chemotherapy
- 16 Excessive blood loss during extensive surgery resulted in anemia, which was not treated
- 17 Failure to follow protocol in management of acute ST-segment elevation myocardial infarction (MI). Patient readmitted after third MI 1 month after index admission
- 18 Multiple readmissions owing to failure to perform endoscopy or find source of gastrointestinal bleed before discharge
- 19 Transfer to intensive care unit (ICU) delayed because of failure to recognize and address the critical nature of the patient's illness. Respiratory failure led to death
- 20 Cirrhosis of the liver caused by hepatitis C transmission from transfusion
- 21 Inadequate investigation and post-discharge follow-up in patient with severe acute pancreatitis and probable pseudocyst
- 22 Recurrent infection and need for secondary surgery because of incomplete removal of nonfunctioning artificial urethral sphincter
- 23 Patient with malignant coronary artery disease referred for urgent cardiovascular surgery. Treatment delayed 3 months because of misplaced films at cardiovascular case conference
- 24 MI following delayed transfer of patient with unstable angina because referral hospital beds were unavailable
- 25 Misdiagnosis for over 1 year and resulting drug therapy without adequate monitoring led to delirium and multiple admissions because of falls
- 26 Missed diagnosis of anemia associated with recurrent gastrointestinal bleed. Appropriate blood work not done and patient inappropriately discharged
- 27 Normal blood pressure and no hypovolemia, while chest radiograph showed pulmonary edema. Patient given 2100 mL of normal saline intravenously over 48 hours; when saline stopped and furosemide given, confusion and dyspnea cleared
- 28 NSAIDs in context of chronic renal failure and coumadin with lack of proper monitoring resulted in digoxin toxicity and hypercoagulability
- 29 Ovaries removed during hysterectomy; consent indicated that patient understood they would be left

- 30 Overmedication in context of alcohol intoxication led to unresponsive patient with possible aspiration
- 31 Acute renal failure in response to prolonged treatment with diuretic in patient admitted with chronic renal failure
- 32 Hepatitis caused by lipid-lowering drugs in patient with chronic pancreatitis and familial hypercholesterolemia
- 33 Patient with metastatic cancer and known hypercalcemia readmitted for intravenous therapy for recurrent hypercalcemia. Serum calcium level not measured during previous admission
- 34 Perforation of bladder during routine gynecological surgery in patient with no adhesions
- 35 Hospital stay prolonged because equipment necessary for pacemaker insertion not available
- 36 Pulmonary embolus initially treated as pneumonia, with no diagnostic testing for possibility of pulmonary edema
- 37 Worsening of renal failure because of renal toxicity related to prescription of multiple medications
- 38 Both cardiac and respiratory disease misdiagnosed in seriously ill patient
- 39 Steroid-dependent patient not given steroids in hospital, which led to adrenal insufficiency

Strong evidence of preventability

- 40 Abdominal surgery. Drain was intended but not available. Postoperative hematoma required 2 units of blood and another operation
- 41 Acute chronic renal failure secondary to drug therapy with subsequent MI, congestive heart failure and infections
- 42 Patient admitted because of delirium, which cleared after correction of hyponatremia and cessation of drug therapy. Lack of investigation of low hemoglobin concentration led to subsequent admission
- 43 Patient admitted because of gastrointestinal hemorrhage. Upper gastrointestinal endoscopy showed no source of bleeding; colonoscopy not performed. Patient readmitted several months later with recurrent gastrointestinal bleed and died
- 44 Patient admitted with diagnosis of pancreatic cancer and died later in palliative care. The diagnosis was not conclusively established
- 45 Antibiotics given for catheter-related urinary tract infection. No investigation for *C. difficile*, and patient discharged 12 days later with diarrhea
- 46 Delay of 3 days in diagnosing urinary tract infection
- 47 Acute delirium secondary to drugs or alcohol withdrawal after lung surgery. Pneumonia also developed postoperatively
- 48 Following diagnostic laparoscopy and endoscopic surgery, patient readmitted 3 times because of abdominal pain, diarrhea and vomiting. Diagnosis of intestinal occlusion missed
- 49 Acute respiratory acidosis secondary to high doses of intravenous morphine therapy following thoracotomy for repair of ventricle; hospital stay prolonged
- 50 Patient in emergency department day before admission and death; ultrasound at that time showed large abdominal aortic aneurysm, but diagnosis was renal colic. Patient sent home and admitted next day with ruptured abdominal aortic aneurysm
- 51 Inadequate monitoring of patient with hyponatremia and diuretic treatment on initial and then index admission
- 52 Inappropriate discharge home resulted in further fall-related injuries
- 53 Intraoperative complications during elective procedure led to extensive bleeding that necessitated extensive surgery and abscess drainage. Pseudoaneurysm developed as complication of arterial embolizations to stop bleeding, and abscess developed at site of embolization puncture
- 54 Intraoperative perforation of bowel required repair and resulted in prolonged hospital stay
- 55 Patient with known coronary artery disease admitted with gastrointestinal bleed and negative scope. No monitoring of hemoglobin concentration for 2 days. Hemoglobin had fallen by 60%, and patient had MI
- 56 Laceration of cervical vertebra (C2) during surgery
- 57 Misdiagnosis and then poor management of syncope secondary to aortic stenosis, with multiple falling episodes and inappropriate morphine use
- 58 Mismanagement of chronic constipation with inadequate and possibly incorrect medication use and inadequate instructions to patient
- 59 Mismanagement of diabetic patient with non-Q-wave MI, which resulted in congestive heart failure and death

- 60 Multiple admissions because of gastrointestinal bleed requiring transfusion, which delayed surgery in patient at high risk for cerebral infarct
- 61 Multiple complications pre- and postoperatively in cancer patient
- 62 Diagnosis of endocarditis missed on index admission, which resulted in prolonged hospital stay and readmission with same symptoms 2 weeks later, when correct diagnosis was made
- 63 Bradycardia and hypotension secondary to drug interaction/overmedication in patient with angina
- 64 Patient with atrial fibrillation not given therapeutic heparin, which resulted in cerebrovascular accident and death
- 65 Postcystoscopy urinary retention caused sepsis and consequent gout. Gout treated with NSAID and no cytoprotective agent; patient had gastrointestinal bleed
- 66 Inadequate management of postoperative complications (including biliary obstruction and neurological deficit) following exploratory laparotomy
- 67 Postoperative complications, including hematoma and wound infection, following knee surgery, and excessive coumadin with inadequate monitoring
- 68 Patient presented to emergency department with severe and suspicious headache and discharged home. Presented to index emergency department several days later with recurrent headache and found to have subarachnoid hemorrhage
- 69 Untreated hyperkalemia in context of acute renal insufficiency resulted in MI, cardiac arrest and death
- 70 Patient with urinary tract infection prescribed antibiotic therapy and discharged. Five days later culture showed drug-resistant bacteria, but therapy not modified. Patient readmitted later for urethral dilatation
- 71 Very-high-risk patient had postoperative acute MI and cardiorespiratory failure and died. Conservative treatment was an option

Preventability more than likely (> 50% likelihood)

- 72 Acute pulmonary edema in patient with chronic renal failure given intravenous fluids for dehydration
- 73 Patient admitted because of cellulitis of foot; -blocker therapy discontinued, and patient had non-Q-wave MI
- 74 Patient admitted for management of burn secondary to radiation therapy for cancer
- 75 Patient admitted because of dyspnea due to pneumonia; hypokalemia developed in response to diuretic therapy with inadequate monitoring
- 76 Blood transfusion administered too quickly, which resulted in congestive heart failure and death
- 77 Cellulitis of right side of face following excision of skin lesion. Subsequent paranoia and psychosis treated with multiple drugs. Delirium workup incomplete. Evidence of untreated urinary tract infection
- 78 Chronic painful condition managed with intravenous morphine therapy up to 10 hours before discharge. Patient discharged with no pain medication; readmitted for pain control 24 hours later
- 79 Critically low hemoglobin value not communicated to physician for patient admitted because of weakness and abdominal pain. Patient did not receive transfusion and died suddenly
- 80 Cerebrovascular accident following cardioversion for atrial fibrillation. Anticoagulation was considered but rejected as being inappropriate
- 81 Delayed treatment of peptic ulcer in patient with history of untreated *Helicobacter pylori* infection and gastrointestinal bleed; patient subsequently readmitted because of anemia
- 82 Severe back pain and headache after epidural anesthetic, possibly due to dural tear. Also postoperative wound infection
- 83 Patient discharged early after coronary artery bypass grafting (CABG). Readmitted because of missed pneumonia
- 84 Failure of consultants to follow-up postoperative patient who went into congestive heart failure
- 85 Deep vein thrombosis and delay of surgery because of failure to provide adequate anticoagulation in cardiac patient
- 86 First syncope episode misdiagnosed, and treatment not appropriate in clinical context of congestive heart failure, low electrolyte levels and new-onset diabetes
- 87 Hematoma after neck surgery owing to ligature slipping off vein. Return to operating room and tracheotomy required
- 88 High-risk patient with advanced dementia and weakness underwent uneventful surgery for

- repair of hip fracture that resulted from a potentially avoidable witnessed fall
- 89 Marked postoperative worsening of renal function owing to poor drug and intravenous fluid management
 - 90 Misdiagnosed renal cell carcinoma treated as pyelonephritis
 - 91 Mismanagement of diabetic patient postoperatively resulted in hypoglycemic episode that required intravenous glucose because of unresponsiveness
 - 92 Missed order for necessary drug after upper gastrointestinal bleed
 - 93 Multiple comorbidities. After surgery patient had several days of severe dyspnea recorded by nurse before pulmonary embolus finally diagnosed
 - 94 Multiple postoperative complications, including deep vein thrombosis, ileus, severe carpal tunnel syndrome secondary to surgical positioning, and readmission for treatment of abscess
 - 95 Patient overmedicated with benzodiazapine and had seizure after drug suddenly stopped
 - 96 Palliative care patient had delirium secondary to drug therapy for pain and nausea. Admitted to hospital and stabilized at reduced dosages
 - 97 Acute on chronic renal failure following coronary angiography owing to inadequate workup. Patient responded well to treatment
 - 98 Patient waited over 1 year for elective surgery. After anesthetic induction, review of radiograph indicated significant progression of disease, and patient was rescheduled for different procedure
 - 99 Morphine prescribed without bowel routine; confusion and constipation developed
 - 100 Poor communication with patient regarding medications, and inadequate follow-up to assess for infection. Digoxin toxicity secondary to renal failure led to heart block and death
 - 101 Postoperative atelectasis due to aspiration
 - 102 Postoperative pelvic abscess secondary to leak at anastomosis site required readmission for drainage
 - 103 Recurrent deep vein thrombosis and pulmonary embolus secondary to discontinuation of warfarin
 - 104 Shock secondary to alcohol withdrawal and infection. Patient restrained and sedated, and oral feeding led to aspiration pneumonia. Poor communication between staff and inadequate observation
 - 105 Patient unable to undergo surgery to repair abdominal aortic aneurysm because of cardiac and renal comorbidities. Aneurysm rupture caused death
 - 106 Upper gastrointestinal bleed following treatment of headaches with ASA-containing drug

Preventability not quite likely (< 50% likelihood)

- 107 Patient admitted because of pneumonia and experienced acute hypotension from drugs. Intubated. Acute tubular necrosis developed with residual renal dysfunction
- 108 Cardiac ischemia and renal insufficiency resulted in death because of severe anemia in patient refusing transfusion
- 109 Diagnosis of ischemic colitis later found to be perforation of small bowel at autopsy
- 110 Drug-induced diarrhea, NSAID-induced gastrointestinal bleed and resuscitation despite do-not-resuscitate order
- 111 Acute renal failure induced by contrast medium following angiography in elderly patient
- 112 Syndrome of inappropriate antidiuretic hormone (SIADH) developed in patient with low sodium level and prescribed diuretics with no routine monitoring
- 113 Missed diagnosis of MI postoperatively with inadequate investigation of patient's deterioration
- 114 Postoperative hemorrhage requiring 4 units of blood and reoperation for drainage of hematoma
- 115 Surgery for hip fracture with postoperative foot drop
- 116 Treatment of acute on chronic renal failure resulted in pulmonary edema and subsequent readmission to hospital
- 117 Unsuccessful and improper reduction of fractured humerus in emergency department and subsequent radial nerve dysfunction
- 118 Urinary retention after transurethral resection of the prostate required readmission, during which no urine culture was ordered

Slight to modest evidence of preventability

- 119 Renal failure and hepatic failure developed after shunt placement in patient with alcoholic cirrhosis of the liver

- 120 Patient admitted because of nausea, vomiting, diarrhea and mucocutaneous ulcerations secondary to chemotherapy
- 121 Pneumonia and septicemia developed in CABG patient and required prolonged postoperative intubation
- 122 Coumadin stopped before revision surgery in patient with history of deep vein thrombosis. Second deep vein thrombosis developed following surgery
- 123 Cerebrovascular accident following admission for transient ischemic attacks. Heparin was considered but deemed inappropriate
- 124 Delirium and dehydration following total hip replacement in elderly man
- 125 Drug interactions, no laboratory monitoring and sudden death
- 126 Emergency cardiac surgery after perforation of coronary artery during placement of angioplasty stent. Return later to operating room for athrombectomy, during which severe anoxic encephalopathy occurred
- 127 Postoperative enterocutaneous fistula requiring surgical revision. Septicemia secondary to subclavian intravenous catheter
- 128 Excessive bleed requiring return to operating room and transfusion
- 129 Hip fracture from fall following benzodiazepine administration for sedation
- 130 Following cardiac surgery patient experienced sepsis, pneumonia, urinary tract infection and acute tubular necrosis possibly due to vancomycin
- 131 Hydrocephalus, intraventricular bleed and delirium caused by removal of infected ventriculoperitoneal shunt
- 132 Leg swelling in immobilized patient given steroids and no anticoagulant; patient admitted with diagnosis of deep vein thrombosis
- 133 Inappropriate choice of antiarrhythmia medication for elderly patient
- 134 Readmission for antibiotic therapy because of urinary tract infection immediately following CABG in patient with known large prostate
- 135 Lung atelectasis after insertion of chest tube for hydropneumothorax
- 136 Bleeding after attempt to place biliary drainage tube in patient receiving heparin
- 137 Gastrointestinal bleed in patient treated with NSAID. Scope showed healing gastric ulcer, and biopsies negative for *H. pylori* and malignant disease. Reason for NSAID unclear
- 138 Delirium, likely drug induced, developed in patient with severe chronic obstructive pulmonary disease taking steroids and sedatives
- 139 Polyp successfully removed during second colonoscopy performed during laparotomy. Laparotomy could possibly have been avoided if colonoscopy had been repeated immediately before surgery
- 140 New severe weakness of quadriceps noted after hip arthroplasty
- 141 Postoperative dyspnea with no diagnosis. Subsequent large deep vein thrombosis and pulmonary embolus
- 142 Postoperative cystitis
- 143 Postoperative fluid management led to heart failure and acute respiratory distress syndrome
- 144 Hospital stay prolonged because of excessive postoperative bleeding after planned day surgery
- 145 Readmission because of inguinal pain after cardiac catheterization; additional surgery required after ultrasound confirmation of false aneurysm and hematoma
- 146 Respiratory arrest during radiological procedure in patient with multiple comorbidities
- 147 Seriously ill patient underwent emergency surgery. About 2 weeks later patient had sudden episode of shortness of breath with rapid deterioration and died. Pulmonary embolus suspected
- 148 Upper gastrointestinal bleed likely secondary to coumadin and NSAID use
- 149 Vertebral compression fracture in patient treated with oral steroid therapy for severe asthma

Virtually no evidence of preventability

- 150 Abdominal pain and fever following elective surgical procedure. Patient readmitted for antibiotic treatment
- 151 Acute complications following angioplasty with stent resulted in repeat angiography (x2), repeat angioplasty (x1) and prolonged hospital stay
- 152 Acute hypothyroidism after radiation therapy for head and neck carcinoma in patient with normal thyroid-stimulating hormone level preoperatively
- 153 Acute MI following prostate surgery

- 154 Patient admitted because of neutropenia and infection following chemotherapy; given treatment with multiple antibiotics. Discharged 2 days later. Continuation of symptoms resulted in readmission
- 155 Patient admitted because of gastrointestinal bleed; died of hypovolemia and prerenal volume depletion and septic shock owing to pneumonia, acute respiratory distress syndrome, staphylococcal septicemia, *C. difficile* infection
- 156 Adverse effects of chemotherapy resulted in veno-occlusive disease, cor pulmonale and death
- 157 Atrial fibrillation, transient congestive heart failure and pleural effusion developed after cardiac surgery; all treated without sequelae
- 158 Acute cholecystitis developed after surgery. Guide wire traversed gall bladder wall during attempted percutaneous cholecystectomy
- 159 Allergic reaction after third dose of penicillin prescribed for dental abscess
- 160 Cerebral hemorrhage following anticoagulation for atrial fibrillation. INR within therapeutic range
- 161 Bladder dystonia due to prolonged catheterization in post-hysterectomy patient
- 162 *C. difficile* diarrhea following admission for hemoptysis
- 163 *C. difficile* infection following antibiotic therapy
- 164 Cellulitis and fasciitis of abdominal wall following abdominal surgery for unsuccessful fistula closure
- 165 Cellulitis following bone biopsy; intravenous antibiotic therapy required
- 166 Chronic pain and infection following surgical repair where tissue noted to be poor and closure difficult
- 167 Chronic postoperative wound infection; readmission and debridement required
- 168 Complex case with respiratory distress following CABG; repeated intubations and eventual tracheotomy required
- 169 Cerebrovascular accident, confusion and antibiotic-related diarrhea following surgery
- 170 Hematoma following cardiac catheterization; infection following surgical drainage
- 171 Postoperative hospital stay prolonged because of *Pseudomonas* infection of prosthetic hip
- 172 Transient hypotension and angina following surgery
- 173 Partial tear of sigmoid colon during laparoscopic gynecological surgery; open procedure required in context of significant adhesions
- 174 Deep vein thrombosis, pulmonary embolus and acute renal failure following arthroscopic surgery for septic knee; dialysis required
- 175 Pancreatitis and pseudocyst following endoscopic retrograde cholangiopancreatography for sphincterotomy and dilation
- 176 Fever after discharge following surgery; readmission because of pelvic abscess
- 177 Probable episode of pseudomembranous colitis and delirium following bowel surgery. Result of test for *C. difficile* toxin not in chart
- 178 Sternal infection, dehiscence and mediastinal abscess following CABG. Return to operating room for partial resection of sternum, evacuation of mediastinal abscess and reconstruction. Readmission 3 weeks later because of new wound infection; treatment with antibiotics
- 179 Small-bowel obstruction following repair of abdominal aortic aneurysm; death from aspiration pneumonia
- 180 Anastomotic leak following surgery and subsequent pelvic abscess. Multiple admissions because of recurrent pelvic pain and fever
- 181 Following vaginal hysterectomy, laparoscopic treatment of adhesions and second laparoscopic surgery to remove ovaries for pain control
- 182 Hematoma following pacemaker insertion and restarting of anticoagulant therapy
- 183 Hospital-acquired infection after manipulation of bladder tumour
- 184 Hypotension and non-Q-wave MI after laparoscopic surgery
- 185 Hypotension during colonoscopy in patient receiving versed and fentanyl
- 186 Iatrogenic heart block possibly due to calcium-channel blocker
- 187 Iatrogenic pneumothorax with prolonged air leak after bullectomy. Hospital stay prolonged, and readmission required
- 188 Infection in patient with agranulocytosis following chemotherapy
- 189 Inguinal hematoma and false aneurysm following femoral artery cardiac catheterization
- 190 Bleeding during facial surgery led to postoperative facial swelling, breathing difficulty and secondary surgery

- 191 Large hematoma following surgery required readmission for drainage
- 192 Hospital stay of liver transplant recipient prolonged because of significant intraoperative bleeding secondary to medications
- 193 Mismanagement of upper gastrointestinal bleed in patient with significant anemia and congestive heart failure
- 194 NSAID may have contributed to subarachnoid hemorrhage in patient taking coumadin with therapeutic INR
- 195 Patient taking coumadin for prosthetic valve had hemorrhage from fall. Coumadin maintained because of valve thrombus; re-bleed necessitated return to operating room for repeat evacuation of hematoma
- 196 Open reduction of fracture with inadequate attention to comorbidities in patient who had postoperative chest pain and congestive heart failure
- 197 Pancytopenia following chemotherapy
- 198 Antibiotic-induced colitis in patient admitted for treatment of severe rash
- 199 Atrial fibrillation and congestive heart failure 2 days following CABG with endarterectomy; reintubation required
- 200 Large pleural effusion following CABG; hospital stay prolonged
- 201 Prolonged ileus in patient receiving narcotics after surgery; relieved after acute pain service modified pain routine
- 202 Death from brain-stem stroke following surgery for ruptured cerebral aneurysm
- 203 Severe epigastric pain from presumed bleed following outpatient percutaneous liver biopsy; hospital admission required
- 204 Sepsis due to chemotherapy-induced neutropenia and foot drop possibly related to chemotherapy in patient with acute myeloid leukemia
- 205 Postoperative oxygen therapy and hospital admission following day surgery of patient with chronic obstructive pulmonary disease
- 206 Increased confusion and agitation following hip surgery in patient with dementia; hospital stay prolonged, with no return to baseline by discharge
- 207 Acute MI following inguinal hernia repair under local anesthesia in patient with severe cardiac disease
- 208 Pneumococcal sepsis and death following splenectomy for thrombocytopenia
- 209 Pneumothorax following transthoracic lung biopsy
- 210 Ventricular fibrillation and bleeding through sternotomy following aortic valve replacement
- 211 Psychotic behaviour on meperidine following appendectomy; hospital stay prolonged 2 days
- 212 Postoperative ileus secondary to small-bowel adhesions and overmedication
- 213 Postoperative bleeding after laparoscopic cholecystectomy; readmission required for drainage
- 214 Postoperative bleeding following CABG; repeat surgeries required and hospital stay prolonged
- 215 Postoperative cellulitis at saphenous vein site following CABG
- 216 Postoperative electrolyte anomalies and MI and congestive heart failure leading to death
- 217 Postoperative hypoxemic respiratory failure and admission to ICU because of undiagnosed large thoracic aortic aneurysm
- 218 Postoperative infection necessitating readmission and management with intravenous antibiotics
- 219 Postoperative nausea and vomiting due to paralytic ileus, which resolved with conservative treatment
- 220 Postoperative obstruction of gastroenterostomy and development of abscess requiring revision. Iatrogenic injury to duodenum during surgery; patient transferred to tertiary care hospital for reoperation
- 221 Postoperative pain requiring unplanned readmission
- 222 Drug-induced delirium and hallucinations following surgery; hospital stay prolonged by 1 day
- 223 Postoperative wound infection
- 224 Postoperative wound infection. Suicidal ideation expressed to physician not investigated before discharge
- 225 Postoperative wound seroma and infection necessitating hospital admission
- 226 Postoperative MI following surgery for fractured hip
- 227 Prolonged postoperative wound infection
- 228 Pulmonary embolism following orthopedic surgery
- 229 Pulmonary embolus following cystoscopy for hematuria

- 230 Rapid atrial fibrillation with hypoxemia following hip arthroplasty despite prophylaxis
- 231 Readmission because of knee effusion and pain secondary to ruptured suture from patella tendon repair
- 232 Readmission because of neutropenia and fever following chemotherapy
- 233 Readmission because of pneumonia following surgery
- 234 Recurrent abdominal pain following laparoscopic cholecystectomy
- 235 Recurrent falls possibly related to medications. Received "extra" dose of furosemide because of crackles and chest radiographic findings in emergency department following fall. Discharged home. Severe hypotension and loss of consciousness in response to nitroglycerin the following day. Admitted for 48 hours without sequelae
- 236 Recurrent intermittent bleeding following septorhinoplasty. No specific cause of bleeding found on reoperation
- 237 Significant hyperkalemia secondary to renal failure following treatment of congestive heart failure with angiotensin-converting-enzyme inhibitors in the context of diabetes and essential hypertension
- 238 Reoperation for fractured humerus due to migration of the pins and dislocation of head of humerus
- 239 Repositioning of ventricular electrode of implanted cardiac defibrillator
- 240 Long postoperative course of fever and elevated leukocyte counts following resection of colovaginal fistula; resolved once anastomotic leak found and repaired by colostomy
- 241 Replacement of defective battery required 1 day following pacemaker insertion
- 242 Sepsis and death due to chemotherapy-induced neutropenia in liver transplant patient with post-transplant lymphoproliferative disorder
- 243 Septic shock from untreated injury after a fall that led to aggressive cellulitis
- 244 Significant hemorrhage following dilatation and curettage for uterine fibroid. Patient had prior history of bleeding. Total abdominal hysterectomy and many transfusions ultimately required
- 245 Stroke following CABG
- 246 Syncope episode after prostate biopsy
- 247 Unavoidable trauma to vagus nerve during upper lobe resection for adenocarcinoma because of proximity of tumour
- 248 Unrecognized transient bacteremia following outpatient procedure; admission required for symptom management
- 249 Urinary retention and infection following surgery; repeat bladder catheterizations and antibiotic treatment required
- 250 Urinary tract infection and sepsis 1 day after cystoscopy and retrograde pyelography
- 251 Urinary tract infection treated with sulfamethoxazole-trimethoprim, to which organism was not sensitive. Hospital admission for 6 days because of severe systemic sulfa allergy. Symptoms resolved and urine culture negative
- 252 Urosepsis in patient with chronic urinary catheter for retention
- 253 Worsening of chronic renal failure in patient given diuretic
- 254 Wound infection following sigmoidectomy for diverticulitis
- 255 Wound infection with persistent draining sinus requiring excision 10 weeks after surgery

*Physician reviewers were asked to judge the evidence of preventability of adverse events using a 6-point scale, where 1 = virtually no evidence of preventability and 6 = virtually certain evidence of preventability (see Box 1).

†Adverse events were defined as events resulting in death, disability at discharge or prolonged hospital stay.