District Health Board

Serious and Sentinel Events

2010/11

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**Codes used to classify events**

**1** Wrong patient, site or procedure

**2** Suicide of an inpatient

**3** Retained instruments or swabs

**4** Clinical management issue, plus sub-code(s):[[1]](#footnote-1)

**A** Diagnosis (including delayed and misdiagnosis)

**B** Treatment (including delayed and inadequate)

**C** Monitoring/observations (not performed and/or actioned)

**D** Procedure associated incident or complication

**E** Investigation (delayed, not ordered or actioned)

**F** Discharge and transfer

**G** Other

**5** Medication error

**6** Falls

**7** Blood transfusion reaction[[2]](#footnote-2)

**8** AWOL/missing patient

**9** Physical assault on patient

**10** Delays in transfer

**11** Other

**12** Hospital acquired infection

A **serious adverse event** is one that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function. A **sentinel adverse event** is life threatening or has led to an unanticipated death or major loss of function.

District Health Boards (DHBs) have classified the severity of the events either as Sentinel and Serious, or as Severity Assessment Code (SAC) 1 or 2; for the purpose of this report, these classifications are broadly comparable.

# Glossary

Anticoagulant Medicine used to prevent or slow normal clotting process, also known as ‘blood thinner’.

Ascites Fluid in the abdomen (peritoneum)

Bronchoscopy Endoscopy to view the lungs

CCU Coronary Care Unit

CT/CAT scan Computerised Tomography, Computerised Axial Tomography scan. ‘Contrast’ is sometimes given to the patient during a CT scan, a chemical that enhances the X-ray image.

CTG Cardiotocograph. Equipment that monitors fetal heart rate and the contractions of the mother’s uterus

CYFS Child Youth and Family Services

ECG Electrocardiogram, used to record function of heart

ED Emergency department

ENT Ear, nose and throat specialty

Epidural Injection or infusion into the spine, usually for anaesthesia, but also other drugs such as chemotherapy

Gastroscopy Procedure using a fibre-optic scope that views the stomach.

GCS Glasgow Coma Scale. An assessment of conscious level.

IM Intra-muscular, usually referring to an injection or infusion

ICU Intensive Care or Intensive Therapy unit

IV Intravenous, usually referring to an injection or infusion

MRI scan Magnetic Resonance Imaging scan

Pyrexia High body temperature

RMO Responsible medical officer. Generally, a doctor below the grade of consultant or senior medical officer (SMO)

SAC Severity Assessment Code, used to categorise severity of incidents

SMO Senior Medical Officer, also referred to as Consultant

WHO World Health Organization

# Northland District Health Board

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| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 5 | Patient misidentification resulted in wrong patient receiving medication. | Omission of patient identification checks during medication administration.  Staff workload management and re-allocation processes inadequate.  Handover processes did not provide relevant information clearly. | Revisit medication safety and administration of high-risk drugs for all Emergency Department (ED) staff. Review relevance to ED environment.  Review model of care.  Formalise handover – use SBARR (Situation, Background, Assessment, Recommendation, Response) tool.  Revise overload code plan to include staff workload management. | All undertaken. |
| Sentinel | 4 B&C | Unexpected birth at home. Unclear communication between ambulance officers and hospital staff, baby requiring unanticipated admission to intensive care unit. | Inadequate communication occurred between the health professionals involved in the care pathway; this had the potential to impact on the overall outcome.  Inadequate documentation. | SBARR – Situation, Background, Assessment, Recommendation, Response – (or equivalent) utilised to convey handover information.  Single set of clinical notes.  Consider opportunities for multiagency neonatal resuscitation education.  Adapt the ED ambulance call record to meet the need of the maternity services.  Reinforce the use of the emergency call system in hospital to seek any emergency assistance. | Handover is structured by using standard documentation on delivery suite.  Protocols are easy to access, both electronically and in hard copy.  Flow chart developed for use with the ambulance radio.  Monthly Basic Life Support updates including emergency call processes. |
| Sentinel | 5 | Patient given a 10-times overdose of two different types of insulin. | Distraction of staff, associated with ward rebuilding and refurbishment.  Staff elected not to use insulin pen for administration.  Insulin not stocked on ward.  Dose of insulin to be given written as ‘u’ instead of ‘units’; general acceptance of wrong abbreviation by doctors and nurses.  Doses prescribed as ‘1U’ and ‘2U’, and misread as ‘10’ and ‘20’ respectively.  Perceived high staff workload. | Review processes for safe use of insulin in ward; eg, using only insulin pens.  Educate nurses about correct use of abbreviations and no use of ‘u’ in any documentation.  Educate doctors on safe insulin prescribing as part of medical staff (RMO – responsible medical officer) education programme.  Develop systematic process for identifying and managing staff workload issues on real time basis. | Diabetes specialist nurses attended pharmacy and ward to do training.  Insulin pens which are able to give half units are now more freely available. Improved staff awareness of their utility and use monitored through auditing of medication charts.  Safe prescribing practices (eg, use of full word 'units') are covered in pharmacy teaching to doctors.  Safety alert sent out about necessity to prescribe using the word 'units' rather than using an abbreviation.  Care Capacity Management programme will assist in determining workload issues and better matching staff resources to demand. |
| Serious | 1 | Wrong type of orthopaedic implant inserted during surgery, requiring subsequent replacement (intramedullary rod). | Human error – misreading of labels despite use of correct double checking procedures.  Limited experience of staff may have contributed.  Labelling of implants similar for different types.  Different types of implants stored in close proximity. | Review storage and labelling of implants.  Identify if any other barrier for implant selection possible.  Ensure staff know how to access relevant resource information.  Use closed looped communication integrated into the double-checking process to add an auditory component as well as visual.  Review pre-operative checking process regarding availability of correct equipment. | Boxes of equipment relabelled.  Storage reviewed.  Staff awareness enhanced re hazards of reliance on checking.  Ongoing staff training. |

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# Waitemata District Health Board

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| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 4D | Blood cross-matched for mother (diagnosis of placental abruption) was given to baby in error. | Emergency situation at change of shift with multiple teams, resulting in inadequate checking process.  No adverse harm to baby. | Processes reviewed:   * requesting blood for a baby * emergency call in theatre * cord gas in resuscitation situation. | Recommendations/ corrective actions implemented. |
| Serious | 4D | Patient discharged with retained products (placenta) after birth. No ultrasound was conducted prior to discharge. | Patient had repeated bleeding with low haemoglobin level of 71.  Readmitted with persistent bleeding and plan for further surgery.  Experienced a cardiac arrest in operating theatre. Patient fully recovered. | Education around ordering ultrasound for retained products if there is repeated bleeding. | Completed. |
| Sentinel | 4A | Patient was discharged in early labour when cardiotocograph (CTG) was misread. | CTG was misread by independent midwife.  Midwife called and was told that no fetal movements noted since woman had gone home. (Discharge was 11.28am, readmission at 6pm.)  Reassessment and fetal death confirmed. | All CTGs to be reviewed by a clinical charge midwife (CCM) or a senior medical officer (SMO). |  |
| Sentinel | 5 | Medication administration error. Wrong medication administered. | Critically unwell on admission with major cardio-respiratory and other co-morbidities.  Nurse administered medications intended for another patient due to mix-up with prescription sheet.  The case has been referred to the Coroner (awaiting confirmed cause of death). | Approved medication administration procedures reinforced with nurses across the DHB. | Safe Medicines Steering Group monitors safety strategy initiatives, errors trends and significant incidents. |
| Sentinel | 5 | Medication administration error. Small dose was prescribed, but standard dose administered. | Prescription misread by the nurse administering medication.  Patient unwell with major cardio-respiratory and other co-morbidities. Due to very limited cardiovascular reserve this single dose was associated with circulatory failure, which was unresponsive to treatment.  The case has been referred to the Coroner (awaiting confirmed cause of death). | External expert review of investigation undertaken.  Review of practice for verbal communication of unusually small (or large) prescriptions to reduce the risk of misreading error.  Implement national medication chart with pre-printed decimal point.  Communication processes between clinical teams under review. | Recommendations being implemented.  Safe Medicines Steering Group monitors safety strategy initiatives, errors trends and significant incidents. |
| Serious | 5 | Medication prescription error. 1mg of **intravenous** Adrenaline prescribed and administered for patient having an anaphylactic (allergic response) event. | Adrenaline 0.5mg **intramuscular** injection should have been prescribed and administered.  Patient experienced significant rise in blood pressure. Transferred to intensive care unit (ICU). Cardiac impact noted.  Patient has had no long-term adverse effects. | Review of emergency protocols with doctor and nurses and competence update.  Review of 777 (emergency) call procedure with junior staff.  Training exercises using emergency algorithms for cardiac arrest and anaphylaxis scenarios. |  |
| Serious | 4B | Inappropriate procedure performed. | Abdominal ascites tap performed despite ultrasound stating no free fluid present.  Deteriorated overnight with increasing abdominal pain and hypotension from bowel wall haematoma. ICU admission.  Discharged after rehabilitation. | Review of rationale with doctor.  Reinforce communication with senior consultant. |  |
| Sentinel | 4A | Diagnosis error. It was believed patient had passed products of conception. Misoprostol given to complete miscarriage. | Patient presented with vaginal bleeding, and given Misoprostol to 'complete miscarriage'.  Ultrasound showed a live fetus with fetal bradycardia (slow pulse).  Patient given activated charcoal within 12 minutes of being given Misoprostol.  Later scan showed a non-viable pregnancy. | Policy written for ED staff over the use of Misoprostol.  Staff education undertaken. | Recommendations implemented. |
| Serious | 4C | Attempted suicide. | Cleared for discharge with family by Mental Health team.  Requested to go to the toilet, and found cyanosed and unconsciousness. Emergency action taken.  Difficulty monitoring mental health patients in previous department. | Risk assessment reviewed with staff.  Keys given so staff can readily access toilets in emergencies.  New department and procedures reduces risk. | New ED department opened in March 2011. |
| Serious | 4B | Delayed treatment. | Admitted with sepsis (infection) secondary to septic arthritis and necrotising fasciitis of left leg. Delayed referral by primary practitioner for ICU review. Deteriorated on ward.  Transferred to regional ICU post-op for cardio respiratory support secondary to multi-organ failure following four procedures (compartmental fasciectomies).  Plastic surgery was carried out at another hospital. The patient’s leg and all the muscles were saved. | ED pre-assessment prior to ward placement reviewed and staff educated about expectations. ED to use North Shore Early Warning Score (NEWS) prior to transfer from ED.  Reinforce expectation that antibiotics must be given on time as prescribed.  Strict compliance with NEWS policy.  Increased orthopaedic registrar involvement.  Improved communication. |  |
| Serious | 6 | Unwitnessed fall resulting in head injury (subdural haematoma) requiring surgery. | Patient was admitted for alcohol withdrawal (Section 9 of the ADA Act 1966). Diagnosis of sub-dural haematoma due to fall.  Patient required surgery to drain sub-dural haematoma. | No recommendations identified. |  |
| Serious | 6 | Unwitnessed fall resulting in cervical fracture (broken neck) requiring surgery for unstable cervical spine fracture/ dislocation. | In seclusion due to poor mental state.  A CT scan of the head and cervical spine identified neck fracture (unstable C4/C5 unifacet fracture dislocation). Taken to theatre for surgery (C4/C5 anterior cervical discectomy and fusion). Routine uncomplicated procedure.  Admitted to ICU post-procedure. | No recommendations identified. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Appropriate measures in place. | Quality Improvement Initiative is under way to implement evidence-based Falls Minimisation Programme.  The steering group meets monthly to monitor preventative measures put in place, review data and trends and impact of awareness programme on reduction in first time and multiple falls.  Falls Minimisation Programme is also linked to two other initiatives:   * Delirium Management Improvement, and * Medicine Reconciliation.   There is focus on sedation and medication issues.  Results of interventions showing gradual reduction in falls and falls with injury. |  |
| Serious | 6 | Inpatient fall resulting in broken rib and lacerations. | Assessed as high falls risk. All measures in place. Patient in rehabilitation, ready for discharge. Cleared to mobilise independently by the physiotherapist. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Appropriate measures in place. Difficulty with balance. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Appropriate measures in place. On 10-minute checks. Patient suffered from confusion. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Not preventable. All measures in place. Patient in rehabilitation, ready for discharge. Cleared to mobilise independently by the physiotherapist. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Delirium present, patient confused, agitated. Cot sides raised – not recommended.  Moved nearer nursing station. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Admitted following a collapse and postural hypertension, osteoporosis and previous fractured neck of femur (NOF). Mobilised independently against advice. |  |
| Serious | 6 | Inpatient fall resulting in fractured pelvis and haematoma. | Assessed as high falls risk. Change in patient condition. Falls risk assessment not repeated.  Change of room contributed to confusion. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Severe memory impairment. Low blood pressure from medication, low sodium, poor oral nutrition. |  |
| Serious | 6 | Inpatient fall resulting in fractured wrist. | Assessed as high falls risk. Did not wait for health assistant while showering. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Wearing thromboembolic deterrent (TED) stockings. Nocturnal confusion. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as a high falls risk. Delirium present. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Mobilised independently, against advice. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Transferring to bed with one assistant. Highly anxious. Slipped. |  |
| Serious | 6 | Inpatient fall resulting in fractured elbow. | Assessed as high falls risk. Mobilised with assistance. Memory impairment. Did not wait for health assistant outside toilet door. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip requiring surgery. | Assessed as high falls risk. Drowsy, fatigued and falling asleep during assessment. Fell out of bed. |  |

**Auckland District Health Board**

Auckland DHB advised subsequent to publication of the 2010/11 Serious and Sentinel Event Report that two cases initially reported to the Commission as SSEs had been reviewed, and were reclassified as not being serious or sentinel events.

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| --- | --- | --- | --- | --- | --- |
| Serious | 4G | Child under current care of DHB Early Childhood team admitted with non-accidental injury. | Communication difficulties with Child, Youth and Family Services (CYFS); risk not escalated. | Multidisciplinary ‘at risk’ discharge planning and template.  Improve process for escalation if plan not followed.  Communication standards for CYFS. | Ongoing. |
| Serious | 1 | Patient was administered a platelet transfusion intended for a different patient. No harm, high-risk event. | Platelets sent to the wrong destination.  Checking process prior to administration was inadequate. | Staff education regarding patient identification standards.  Simplify documentation and move to electronic ordering of all blood and blood products.  Review blood bank layout and check process. | Ongoing.  Implementation commenced.  Complete. |
| Serious | 5 | Epidural infusion of local anaesthetic administered intravenously to a woman in labour.  No patient harm, high-risk event. | Although colour-coded, epidural and IV connections are inter-changeable.  Credentialing/training of staff inconsistent.  Double check of correct connection not required. | Assess potential for introducing counter-clockwise locking system.  Revise policy and training to require bedside double-checking of the infusion and connection. | In progress.  In progress. |
| Serious | 4B | Equipment deficiencies during two ward resuscitations:   * suction system * laryngoscope * manual ventilation bag.   Deaths of two patients involved were not directly caused by these equipment issues, but risk was increased. | Suction canister damaged when the bed moved up.  Use of plastic bag dust cover can dislodge suction.  Difficult re-assembly of suction unit.  Older laryngoscope style with risks of loss of locking pin, loose light bulb, and incompatible blades.  Checking and restocking of resuscitation trays and emergency trolley is inconsistent. | Revise suction canister height at the bed-space in all inpatient wards.  Plastic bags not permitted to cover suction canisters.  High quality laryngoscopes to be brought to ward resuscitations, rather than kept on ward trolleys.  Full revision of resuscitation tray, trolley and checking/re-stocking process. | In progress.  Implemented.  Implemented.  Revision complete; roll-out of new system in progress. |
| Sentinel | 4B | Remotely monitored patient sustained cardiac arrest. Probable delay in resuscitation; influence on fatal resuscitation outcome not clear. | Delay in advising ward; coronary care staff called unattended ward phone.  Ward staff unfamiliar with response systems.  Inadequate communication with family. | Change to calling co-ordinator cellphone rather than ward phone.  Standard messages/phrasing to be used when Code is called from Coronary Care Unit (CCU).  Review of bereavement processes and resources. | Implemented  Implemented  Organisation -wide programme in progress |
| Serious | 4C | Delay in emergency response for uterine perforation after termination of pregnancy. | Delayed recognition; poor communication; inadequate post-operative physiologic monitoring.  Unfamiliarity with emergency call systems due to historic independence of service. | Protocol for suspected or actual uterine perforation.  Standardised post-operative physiologic monitoring.  Staff education and training on emergency call systems. | Complete.  Implemented.  Complete. |
| Sentinel | 4A | Lack of co-ordination of care resulting in stillbirth of a baby with intrauterine growth retardation. | Ultrasound scan request form not sent.  Planned induction date by term was missed as full clinical notes not available.  Delay in caesarean section due to perceived need for cross-matched blood.  Delayed communication with on-call obstetrician. | Summary of specialist plan to go to independent midwives.  Electronic clinic record project.  ‘Rapid rounds’ and structured handover in Delivery Unit and Women’s Assessment.  System for early bookings for induction of labour in women with high-risk pregnancies.  Clarify obstetrician on-call/cover arrangements.  Guidelines for the management of women with positive antibodies who need urgent surgery. | Implemented  In progress.  Implemented.  Complete.  Complete. |
| Sentinel | 8 | Patient with steroid-induced psychosis absconded from general ward despite having a security watch and subsequently found drowned. | Lack of appreciation of risk due to poor handover.  Inadequate definition of role for staff providing security watches.  Limited options for smoking for psychiatric patients in physical health wards. | Revise standards for patient watch/security process, documentation, smoking provisions and training.  Explore alternative smoking options for patients for whom nicotine replacement is inappropriate. | Complete.  In progress. |
| Serious | 4A | Inappropriate discharge from ED –patient returned within 24 hours with infection (fulminant sepsis) and multiorgan failure. | Blood tests ordered but not taken or checked.  Abnormal physiological signs were not re-checked.  High workload. | Review abnormal physiology guidelines.  Remind staff to escalate if workload excessive. | Completed.  Completed. |
| Serious | 5 | Excessive sedative dose for an infant undergoing a radiology procedure, causing coma for 24 hours. | Poor communication between ward and radiology regarding use of sedation. | Paediatric sedation policy to be reviewed and updated.  Development of a checklist for the wards.  Handover guidelines between wards and Radiology staff. | Completed  In progress  In progress |
| Serious | 5 | Infant received 10 times overdose of intravenous fluids.  Required additional treatment but no long-term adverse effects. | Incorrect prescription not detected.  Chart does not highlight bolus volume size.  No limit for volume on infusion pump. | New design paediatric fluid prescription and administration chart.  Use of infusion pump ‘smart’ software. | In final stage of development.  Implemented. |
| Serious | 4D | Three-month delay in liver biopsy performed without review of appropriateness when patient unwell and at high risk.  Post-procedure major bleeding. | Overdue procedure not identified.  No clinical review prior to procedure.  No IV access constrained treatment when bleeding occurred. | Alert system in radiology information system (RIS) for overdue prioritisation requests.  Escalation process for review of elective procedures when patient condition has changed.  Standardise practice: all patients having intra-abdominal solid organ cutting needle biopsy to have IV access. | Not possible with current system.  Ongoing.  Implemented. |
| Sentinel | 4A | Delayed diagnosis of major pressure area of a patient under district nursing care in the community.  Subsequently died from severe infection. | Treatment was focused on the lower leg ulcers.  Complex patient, no multi-disciplinary co-ordination or long-term holistic care plan. | Revise district nursing supervision model.  Revision of assessment form to be more comprehensive including multi-disciplinary information.  Identification of all complex patients and assignment of primary nurse. | Implemented. |
| Serious | 4A | Missed diagnosis of ‘sentinel’ bleed prior to large brain (subarachnoid) haemorrhage three days later.  No long-term harm; high-risk event. | Headache was not usual for subarachnoid bleeding.  No other diagnostic tests performed. | Policy change: Emergency medicine specialist review required to confirm discharge without further investigation for atypical headache presentations. | Implemented. |
| Serious | 5 | Heparin infusion (anticoagulant) incorrectly increased to 80ml/hr during minor surgery, causing significant bleeding. | Confusion between multiple pumps.  Unfamiliarity with volumetric pumps. | Use of infusion pump ‘smart’ software. | Implemented. |
| Sentinel | 4A | 14 months for an urgent (<8 weeks) appointment in the eye clinic. Patient now legally blind. | Booked into incorrect clinic.  Administrative procedures for incorrect clinic attendance unclear.  Referral sent to wrong DHB twice. | Central Referrals Office to ‘colour code’ clinics as a means of clinic identification.  Written guideline for process for patients presenting to the wrong clinic.  Regional issue to be discussed with neighbouring DHBs. | Completed.  In progress.  In progress. |
| Unclear | 10 | Delay in transferring baby from referring DHB. Death possibly preventable by earlier transfer. | Inadequate communication and handover.  Infectious status conflict with clinical urgency. | Electronic register and tracking system for referrals.  Referrers advised of thresholds for escalation.  Review infection control guidelines. | In development.  In progress.  No change required. |
| Serious | 4D | Perforation of uterus during gynaecological surgery with bowel injury requiring further surgery (rectal resection, hysterectomy and temporary ileostomy). | Surgical technique used (Microwave endometrial ablation technique) caused full thickness uterine burn. | Scheduled for surgical audit. | Awaiting review. |
| Serious | 1 | Child flown from another DHB for an unnecessary CT scan under general anaesthesia. | Future booking for CT scan had not been cancelled after urgent surgery had been required, making the scan unnecessary. | Modification of booking system to require review and re-confirmation of future outpatient bookings after inpatient admissions. | Organisation-wide issue – under review. |
| Serious | 4D | Injury to upper lobe of lung during surgery (resection of lower lobe), eventually requiring complete removal of left lung. | Misinterpretation of intra-operative test  Reduced visualisation from minimally-invasive surgical approach | Surgical audit.  Re-confirmed the need for absolute certainty of anatomy prior to division of major structures. | Complete |
| Sentinel | 4B | Four-month delay in treatment for cancer as clinical staff unaware of unexpected findings on histology report. | Surgical audit form completed without histology available.  No system to ensure histology results are reviewed after patient discharge.  No mandatory escalation process for unreviewed histology reports.  Important unanticipated abnormal histology results not highlighted. | Reinforce standards with surgical registrars.  Mandatory electronic escalation system for unsigned reports.  Retrospective sign-off process for all unaccepted histology reports – automatic 2009 or earlier, manual 2010 onwards.  Reduce/eliminate paper reports.  Review reporting systems with pathology and information systems. | Completed.  In process with regional IT provider and individual services.  In process.  May incorporate into e-Lab development. |
| Sentinel | 4D | Aspiration of feed into lungs due to dislodgement of naso-gastric tube.  Patient died despite appropriate treatment. | Nasogastric feeding uncommon on this ward.  Partial tube removal by patient not identified. | Increase awareness in nursing staff around best practise with naso-gastric feeding.  Commencement of bedside handovers.  Naso-gastric Resource Nurse appointed. | Completed. |
| Serious | 6 | Fall causing fractured upper arm and intracranial (brain) bleeding. | Unobserved fall out of bed. Rails in place. | **ADHB Falls Prevention Programme**   1. Establish baseline data with consistent identification of falls with harm for 2010/11 – completed. 2. Develop new metric to track monthly performance – defined as falls with major harm per 1000 bed-days – trial monthly data now being reported. 3. ‘Gap analysis’ data collection tool to prioritise improvement strategies – in progress. 4. Develop costing model to assess cost-effectiveness of specific fall/harm prevention interventions – in progress. 5. Revise interventional programme on the basis of the above data – priority areas now under review. | |
| Serious | 6 | Fall causing fractured ribs and minor internal bleeding. | Fell returning from toilet. Severe underlying medical conditions. Death unrelated to injuries. |
| Serious | 6 | Fall causing fractured tooth. | Child fell in play area of Children’s Emergency Department. |
| Serious | 6 | Fall causing facial fracture and intracranial (brain) bleeding. | Unobserved fall from bed with rails while awaiting X-ray. |
| Serious | 6 | Fall causing fractured upper arm. | Unwitnessed fall when going to toilet. |
| Serious | 6 | Fall causing spinal fractures. | Confused patient left ward and fell outside hospital. |
| Serious | 6 | Fall causing fractured hip. | Confused. Fell while mobilising without assistance. |
| Serious | 6 | Fall causing scalp laceration. | Dementia. Fell while mobilising without assistance. |
| Serious | 6 | Fall causing fractured hip. | Fell while mobilising without assistance. |
| Serious | 6 | Fall causing fractured wrist. | Unobserved fall from low bed. |
| Serious | 6 | Fall causing fractured nose. | Unobserved fall while trying to get out of bed. Bed rails not in use. |
| Serious | 6 | Fall causing opening of surgical wound. | Fall while exercising in gym unsupervised. |
| Serious | 6 | Fall causing fractured wrist. | Fell while getting up to walker. Did not seek assistance. |
| Serious | 6 | Fall causing intracranial (brain) bleeding. | Tripped over mattress on the floor in mental health unit. |
| Serious | 6 | Fall causing intracranial (brain) bleeding. | Fell while attempting to get out of bed unaided. |
| Serious | 6 | Fall causing dislocated hip. | Previous hip replacement. Fell while attempting low seating position. |
| Serious | 6 | Fall causing facial laceration. | No known falls risk. Fell while returning to ward from outside hospital. |
| Serious | 6 | Fall causing scalp laceration. | Confused. Fell trying to get out of bed unassisted. |
| Serious | 6 | Fall causing fractured hip. | Fell while self-mobilising to commode. Death from underlying terminal disease. |
| Serious | 6 | Fall causing fractured upper arm. | High falls risk. Self-mobilised against instruction while staff were attending another patient. |
| Serious | 6 | Fall causing scalp laceration. | Fell while self-mobilising against instructions. |
| Serious | 6 | Fall causing facial laceration. | Unwitnessed fall in toilet. |
| Serious | 6 | Fall causing intracranial (brain) bleeding. | Fell while being assisted to toilet. |
| Serious | 6 | Fall causing fractured sacrum (lower spine). | High falls risk. Mobilised without assistance against instruction. |
| Serious | 6 | Fall causing fractured hip. | Dementia. Fell while mobilising without usual assistive aids. |
| Serious | 6 | Fall causing large scalp laceration. | Unwitnessed fall in toilet. |
| Serious | 6 | Fall causing fractured hip. | No known falls risk. New onset urinary incontinence. Slipped on wet floor. |
| Serious | 6 | Fall causing fractured hip. | Unsupervised fall when going to toilet. |
| Serious | 6 | Fall causing facial fractures. | No known falls risk. Unwitnessed fall. May have tripped on bedside table. |
| Serious | 6 | Fall causing fractured hip. | High falls risk. Mobilised without assistance against instruction. |
| Serious | 6 | Fall causing fractured ankle. | Fainted while being mobilised by physiotherapist. |
| Serious | 6 | Fall causing facial laceration. | Dementia. Mobilised without required assistance. |

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# Counties Manukau District Health Board

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| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 1 | CT scan performed on patient in error. | Name label mistakenly attached to another patient’s CT request form. | Review process of storing patient identification labels and develop interventions to improve safety of system.  Investigate the potential for using electronic requests for procedures. | A Patient Identification Group has been established to review incidents involving misidentification of patients.  This group is currently working on better systems for storing and managing labels.  An electronic solution is not currently feasible, but is likely to be developed in the next 24 months. The group is investigating ways of modifying internal referral processes for procedures. |
| Serious | 1 | Gastroscopy procedure was completed on a patient when meant for another patient. The patient then required a second procedure to reinsert a stomach tube (nasojejeunal tube) resulting in a gastric perforation. | Name label mistakenly attached to another patient’s form due to:   * practice of storing patient identification labels for multiple patients in a single location * process of writing most referrals at the end of the ward round * absence of a clearly defined process, defined roles, use of ‘Time Out’ in establishing patient identity. | Review process of storing patient identification labels and develop interventions to improve safety of system.  Develop and implement a Gastroenterology Procedural Checklist.  Develop standard operating procedures for Gastroenterology Intervention Suite. | The Patient Identification Group is working on a better system for storing and managing labels.  A modified World Health Organization (WHO) Time Out procedures checklist has been implemented in Endoscopy.  An Endoscopy Quality Group has been established to develop standard operating procedures. |
| Serious | 1 | Patient was scheduled for a bronchoscopy. Patient consented for and received a gastroscopy in error. | Absence of a clearly defined process for checking and confirming patient identity and indications for the procedure with the patient prior to sedation.  No clearly defined processes for consenting patients who have English as a second language. | Implement the Time Out before procedure/sedation checklist.  Review of consenting process in the Endoscopy Unit for patients who have English as a second language. | By the end of July 2011, 1200+ staff had received education on formal identification of patients – this was done in conjunction with:   * updating policy and procedure * roll-out of a standardised method of face-to-face engagement with patients and their whānau * roll-out of the modified World Health Organization Time Out procedures checklist in Endoscopy. |
| Serious | 4A | Treatment delayed for a patient with severe chest pain resulting in the patient sustaining significant cardiac damage. | Because the blood test for heart damage (troponin) was negative, the severe pain was not recognised as being potentially cardiac in origin and care was not escalated.  Later electrocardiogram (ECG) signs of an anterior myocardial infarct (heart attack) were not initially recognised by nursing and medical staff.  The patient was discharged home following treatment. | Multidisciplinary governance group to be set up to manage issues relating to management of the ‘patient at risk’.  Ward staff to be up-skilled in management of acute coronary syndrome and the basic interpretation ECG changes.  Training session for house surgeons on anterior myocardial infarct and interpretation of ECGs. | A multidisciplinary ‘patient at risk’ governance group has been set up.  Education and training for nursing staff on the ward is ongoing.  A training session was given to house surgeons by a senior medical officer (SMO) and will be ongoing as part of the annual orientation programme for the new house surgeons intake. |
| Serious | 4B | Treatment delayed in a patient with a severe stroke who deteriorated and subsequently died. | Nursing staff did not recognise changes associated with deterioration in a patient with a severe stroke and did not document observations overnight. It is unlikely this would have changed the outcome for this patient.  Variations in staff understanding about when and how often neurological observations should be undertaken in the neurologically compromised patient, including triggers for action. | Education and training regarding patients who may have this pathology.  Institute regular formal competency assessments for all nursing staff within the stroke ward to ensure maintenance of clinical skills with regard to using the Glasgow Coma Scale (GCS) to assess neurological status. | Training package around assessing neurological status using the GCS has been developed. This includes an e-module to be completed prior to a face-to-face competency assessment.  This training will be implemented on the ward and also included in an organisation-wide orientation package. |
| Serious | 4B | After surgery, a patient was not discharged on a blood thinner (Enoxaparin) as planned, and was readmitted with a blood clot (pulmonary saddle embolism). No permanent harm. | There was no mechanism in place to ensure all discharge instructions are completed and/or checked off prior to the patients discharge.  Short-term Enoxaparin prescriptions are not included on the discharge medications prescription as it is customary practice to dispense from the patient’s ward. | Develop a standardised discharge checklist and pilot in Surgical Services with a view to possible roll-out across the organisation.  Review the organisational process of dispensing Enoxaparin and develop an organisation-wide flow chart. | A standardised discharge checklist was developed and piloted in Surgical Services. A working group is being developed to consider possible roll-out across the division and then the organisation.  A review of the organisational process for dispensing Enoxaparin was completed.  Flow charts and posters were developed and placed in all medication areas. The pharmacy website was updated with new information. |
| Sentinel | 4D | Patient received Warfarin (drug to prevent blood clotting) for a clot in the leg (deep vein thrombosis – DVT) during the first trimester of pregnancy, resulting in harm to the baby. | A pregnancy test was requested and checked, but because a positive pregnancy test result is not highlighted in any way it was misread and interpreted as negative.  The senior medical officer (SMO) prescribed Warfarin on the basis of a verbal report rather than checking the blood results.  No new encounter number was generated for the haematology visit. This meant the results were sent to the previous service and not reviewed. | Laboratory report form to be modified to highlight a positive pregnancy test.  The Haematology Service to develop a policy and procedure detailing who is responsible for sign-off of laboratory results. | Positive pregnancy test results are now reported in red. |
| Serious | 5 | Patient collapse following repeated exposure to skin disinfectant (Chlorhexidine), to which the patient had a known and documented allergy. | Alerts to allergy had not been put in place to prevent subsequent exposures.  Lack of awareness among staff that commonly used swabs contain Chlorhexidine. | Clinicians supported by clinical pharmacists to report all drug allergies to local and national databases.  Implement systems for effective documentation and management of drug allergies and drug adverse reactions in the organisation.  Raise awareness across the organisation about the widespread use of Chlorhexidine in the organisation and the potential for patient allergies. | Formation of an Allergy and Adverse Reaction Group to address allergy reporting issues across the organisation.  Clinical pharmacists are taking a more active role in allergy and adverse drug reaction reporting.  Promotional campaign on reporting and raising awareness of allergies including presentations to stakeholders is in progress, which will include a poster campaign.  Project to increase the functionality of the clinical information system to improve the reporting of allergies and adverse drug reactions is in progress. |
| Serious | 5 | Patient with known allergy was administered CT Contrast resulting in a severe skin adverse reaction requiring surgical intervention. | Despite this patient having known allergies to both an antibiotic (Vancomycin) and CT Contrast, there was no record of this in the patient information management system or in the national databases. | See above. | See above. |
| Serious | 5 | Patient with a known and documented allergy to a drug (Cyclizine) was administered that drug, resulting in a severe adverse reaction requiring an emergency callout. | Failure to report allergy alert on local and national databases. | See above. | See above. |
| Serious | 6 | Fall resulting in a fractured ankle. | Appropriate interventions to mitigate harm for high-risk patient not implemented. | A Falls Prevention Group was established under the ‘Zero Patient Harm’ programme.  All falls are investigated to identify contributing factors and are referred to this group to inform falls prevention strategies. | In the first phase of a comprehensive falls prevention programme, the organisation has implemented multiple strategies to mitigate harm from falls. These include:   * falls risk assessment to be completed for all patients within six hours of admission to the ward * risk assessment tool changed to a more comprehensive and internationally validated tool that identifies interventions for every level of risk * tailored interventions to be put in place for patients at risk of falling * alarm system using invisible beams on beds and chairs to be implemented in satellite aged care facilities and adult rehabilitation hospital wards for high-risk patients * non-slip socks * absorbent flooring options being investigated for some areas * watch criteria developed to ensure watches are in place where appropriate. |
| Serious | 6 | Fall resulting in a fractured hip. | Appropriate interventions to mitigate harm for high-risk patient not implemented. |
| Serious | 6 | Fall resulting in fractured cervical spine and lacerations to the face. | Was assessed as high risk but was for discharge that day.  Absorbent flooring may have mitigated harm that occurred from this fall. |
| Serious | 6 | Fall resulting in a fractured hip. | Item required by patient left out of reach. Patient fell out of bed trying to reach it. |
| Serious | 6 | Fall resulting in fractured ribs. | Patient not reassessed for falls risk after cognitive decline and was left unattended. |
| Serious | 6 | Fall resulting in facial fractures. | Walking frame required by patient left out of reach. Patient mobilised without frame and fell. |
| Serious | 6 | Fall resulting in a fractured left shoulder. | Not recognised that patient was medically unfit to mobilise. |
| Serious | 6 | Fall resulting in a fractured hip. | Walking frame required by patient left out of reach. Patient mobilised without frame and fell. |
| Serious | 6 | Fall resulting in fractured hip. | Falls risk assessment didn’t correctly classify patient as high risk which meant no interventions were put in place to mitigate risk of falling. |
| Serious | 6 | Fall resulting in fractured hip. | High-risk patient left unattended. |
| Serious | 6 | Fall resulting in fractured hip. | Falls risk assessment didn’t correctly classify patient as high risk which meant no interventions were put in place to mitigate risk of falling. |
| Serious | 6 | Fall resulting in fractured foot bones (metatarsal). | Falls risk assessment didn’t correctly classify patient as high risk which meant no interventions were put in place to mitigate risk of falling. |
| Serious | 6 | Fall resulting in facial skin tear requiring surgery. | Falls risk was not identified from either the falls risk assessment (not completed) or the clinical history (dementia and multiple falls). This meant no interventions were put in place to prevent further falls. |
| Serious | 6 | Fall resulting in fractured left distal femur (thigh bone). | No clear criteria in place for ordering a watch for a patient, which meant no ‘watch’ was put in place for patient with dementia. |
| Serious | 6 | Fall and subsequent death of a patient who was terminally ill. | Falls risk assessment didn’t correctly classify patient as high risk which meant no interventions were put in place to mitigate risk of falling. This meant a severely ill patient was allowed to mobilise independently and fell. It is likely the fall may have hastened the patient’s death. |
| Serious | 6 | Fall resulting in fractured arm (humerus). | Unclear whether high risk of falling was included in handover between wards when patient transferred.  The addition of the new medications for a patient with dementia may have contributed to the patient falling. |
| Serious | 6 | Fall resulting in a head injury causing a cerebral (brain) bleed. | The falls risk assessment didn’t correctly classify the patient as high risk which meant no interventions were put in place to mitigate risk of falling.  Patient was on blood thinners and required transfer to another hospital for surgical drainage. |
| Serious | 6 | Fall resulting in a fractured arm (humerus). | The falls risk assessment was not accurately scored and therefore appropriate interventions not put in place. |
| Serious | 6 | Fall resulting in fractured ribs. | Patient request for assistance to remove anti-embolic stockings was not acted on and patient slipped and fell. |
| Serious | 6 | Fall resulting in fractured arm (humerus). | Falls risk assessment incorrectly calculated and no review of risk after surgery. No interventions in place. |
| Serious | 6 | Fall resulting in fractured wrist. | No interventions put in place for a patient assessed as being at high risk of falling. |
| Serious | 6 | Fall in Radiology resulting in skull fracture. | No requirement for medical radiation technologists (MRTs) to assess patient’s risk of falls prior to radiology procedures.  No handover from Emergency Care (EC) to radiology regarding patient’s risk of falling. | Radiology to consider including triage questions to assess risk of falls prior to radiology procedures.  Training package to be developed and implemented for MRTs to reduce risk of falls.  Review falls risk identification procedures in Emergency Care. | As a second phase, the Falls Prevention working group is planning to address falls prevention in services such as radiology, renal dialysis, maternity and haematology.  Future work will include investigating special cases, such as outliers on different wards and staff ratios over winter. |
| Serious | 6 | Fall while undergoing an X-ray on the ward resulting in a head injury (subdural haemorrhage) and subsequent death. | Patient had been assessed and not identified as at high risk of falling. Fall resulted from a faint and was likely to have contributed to his death. Because of the patient’s additional conditions, and following consultation with his family, the decision was made to provide palliative care only, and the patient subsequently died in hospital. |
| Serious | 6 | Fall in Radiology resulting in a fractured thigh bone (femur). | Radiology unaware patient was at risk of falling. Patient fell while attempting to stand. |
| Sentinel | 11 | Patient on home haemodialysis inadvertently misconnected haemodialysis lines causing significant blood loss and death. | Although lines are colour coded and comply with required safety standards, the design of the haemodialysis machine allows incorrect connection of lines, putting patients at risk.  Comprehensive education and training in place for patients on home haemodialysis, but some revision of the education process and training materials required to suit patient population. | Alert to be sent by Clinical Head to all renal units in New Zealand advising them of the risk of inadvertent misconnection.  Discussion with the company involved requesting that connections be redesigned to prevent future occurrences.  Review education process and training materials with organisation education specialists. | Alert has been sent to all renal units within New Zealand and a Medsafe report submitted.  A letter was sent to the company requesting consideration of redesigning haemodialysis line connections.  Plans are in place to review education and training materials for patients. |

# Waikato District Health Board

[www.waikatodhb.health.nz/quality](http://www.waikatodhb.health.nz/quality)

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 4B | Delay in treatment due to transport problems transporting patient from regional hospital. | Consultant-to-consultant referrals from all provincial hospital when needing to activate a transport team.  There is no 24-hour seven-day a week onsite CT service.  There is currently no centrally co-ordinated transfer role for inter-hospital transfers.  There is no central air transport service, no contractual requirements re air service, no central co-ordination, no budget; plane/helicopter providers are responsible for their own maintenance.  This is a rare/complex clinical condition. There is no clear documented pathway within Waikato DHB of how patients with this condition in a non trauma situation are managed. | Discussion to occur at clinical directors’ forum regarding consultant-to-consultant referral as this in not a one-business-unit issue. When criteria agreed a memo to come out of Chief Medical Advisor (CMA) office to all provincial hospitals (not Waikato DHB rural facilities), advising of new requirement.  Undertake a retrospective audit of time of referral and time of actual scan for after-hours patients (after 4pm) (approx 50 cases over a three-month period).  Presentation of that data to Management Executive Committee and action plan to be developed to address any issues identified.  Implement the inter-hospital transfer project.  No action plan developed as this is a national issue.  This risk needs to be added to the organisation risk register/plan.  There needs to be a standard approach to how patients with this condition are managed. | Inter-hospital project in progress. |
| Serious | 4B | Delay in patient treatment due to lack of SMO oversight. Patient later died. | Failure by SMO to formally hand over care to another SMO (ie, consultant to consultant). | Clinical Director to write to SMOs outlining SMO responsibilities; ie, that the admitting SMO has primary responsibility for the patient and that if they are unable to meet their care obligation they must formally handover care to another SMO.  Clinical Director to ensure this issue is discussed at the surgical meeting and that responsibilities and handover of care are clarified to all SMOs.  The Clinical Director to ensure that all surgical registrars are advised that should they have concerns and the SMO is not available, they are to escalate to the Clinical Director or Clinical Unit Leader.  A copy of this documentation to be included in the Registrar service orientation documentation. |  |
| Serious | 4G | Delay in treatment due to transport problems transferring patient from regional hospital. Patient died in theatre. | Review under way.  Referred to Coroner. | Issues identified will be addressed through the Midland region inter hospital project currently in progress | Ongoing. |
| Serious | 4G | Delays in management of trauma patient’s care. Patient died 10 days later. | Review under way |  |  |
| Serious | 4A | Delay in diagnosis of cancer. | The patient had a cancer type that was rare and difficult to diagnose. Incidence is reported to be an incidence of 1-2 per million.  There were fragmented pieces of information: the operation note of 2007, histology of 2007 (reported in 2008), and the patient’s symptoms of 2009. These were not put together to get a complete clinical picture for the patient until November 2009.  The CT request form of Nov 2009 was lost due to a paper-based referral system with multiple entry points which caused a further three-month delay in diagnosis. | Share learnings of the review with medical staff.  A key person is needed to case manage a patient identified as a complex case.  Identify key roles within the service to undertake the case management function.  Short-term solution:  Purchase a dedicated printer or sorting printer for the inpatient CT and the outpatient CT machine so faxing is sorted to a separate area from printing.  Review the process for managing/processing referral forms received into the department. This includes:   * introducing electronic order entry * ability of teams to view wait times * how faxed referrals are received.   Discussion to take place at Community Laboratory Governance Forum re GPs receiving results electronically.  Undertake a review of current discharge checking processes within each area and advise any changes required. |  |
| Serious | 4D | During a check procedure involving a pacemaker, the device was turned off accidentally. Patient deteriorated and died. | Review under way.  Referred to Coroner. |  |  |
| Serious | 4G | Patient pulled out intravenous line, which led to death. | Critically ill, confused, patient bled to death because his femoral central venous line was pulled out. The patient had a history of pulling out lines and the patient required restraint.  Inadequate assessment of the risks for this patient was undertaken at the receiving ward, and inadequate documented plan of care for the management of the patient’s confusion, history of pulling lines and presence of a central venous line.  Death referred to Coroner who decided not to investigate further. | Review how critically unwell, elderly confused patients are managed in acute settings – this action included in the Delirium project.  Review handover and transfer process whereby patients transferred from areas with high nurse: patient ratio to areas with lower nurse: patient ratio.  Formalise the handover process between health professionals as part of the Hospital at Night project.  Random audit by two Nurse/Midwife Directorate members to critically analyse a set of patient records and provide feedback to the charge nurse where this is inadequate or incomplete. |  |
| Serious | 4B | Senior doctor responsible for patient was not informed of deteriorating patient condition. Patient died later in day. | The practice of not rostering specialist medical staff on the night duties resulted in consultant not being called to review patient. | Changes made to roster to ensure specialty medical staff are on call. | Completed. |
| Serious | 4B | Failure to diagnose/ recognise unstable patient. | Misinterpretation of patient’s clinical signs and symptoms led to patient being clinically managed as a stable rather than an unstable patient. | Document for management of trauma cases to be updated in required format.  Implementation plan to include education and ongoing education and orientation.  To re-assess ED medical staff number against expected norm for other equivalent EDs. |  |
| Serious | 10 | Delay in treatment due to transport problems transporting patient from regional hospital. Patient died. | Review under way. | [HQSC comment – subsequently advised by DHB after SSE report went to printing that case not an SSE] |  |
| Serious | 4G | Patient died on ward shortly after admission from ED. | Review under way. |  |  |
| Serious | 4A | Delay in diagnosis of cancer due to failure to follow up results. Patient has subsequently died. | Review under way. |  |  |
| Serious | 4D | Patient suffered complications during surgery and required further surgery. | Review under way. |  |  |
| Serious | 4B | Communication breakdown between services resulted in delayed treatment for patient. Patient has since had appropriate management and treatment. | Department staff unaware of the requirement to contact the requesting clinician if a significant change to a result or diagnosis is made.  Department staff currently have no process of recording these notifications/ conversations in the patient’s clinical record. | Department staff will contact requesting clinician directly to advise of significant change.  Develop a process for recording this communication in the clinical record.  Department to adjust format of report sent so that if further work is being done to confirm diagnosis this will be clearly documented in report. |  |
| Serious | 4B | Delays in referral and treatment of patient. Patient developed problems and required toe amputation. | Lack of clear processes in place to manage these high-risk patients. | Process to be developed for return of care of patients to Diabetes Podiatry service.  [Waikato DHB subsequently stated that, following further review, this case was not a serious event. However, this advice was received after the SSE report was completed, and this case is included in the data within the main report.] |  |
| Serious | 4B | Delay/failure to treat abnormality leading to patient developing cervical cancer. | The process for checking and ensuring patient’s details are correct was not carried out. | Share learning about this incident with all clinical and administrative staff, eg, at staff meeting.  Emphasise the practice of checking patient details and updating of patient label and information on clinical records during each visit to ensure information current and correct.  Mandatory use of electronic system for such details.  Check and refresh patient details during each visit to ensure information current and correct.  Audit of this compliance to take place. |  |
| Serious | 4B | Core midwife did not see that she had full responsibility for the patient in the absence of the Lead Maternity Carer (LMC). This led to a communication issue between core and independent midwife regarding fetal monitoring outcome.  Baby was born dead two days later. | Documentation of the outcome of the assessment, interpretation of the fetal monitoring and nature of the discussion with the LMC was not of the required standard.  Internal perinatal review revealed that fetal compromise occurred within last weeks of baby’s life. | Develop a package that clearly identifies the requirements when assessing an LMC’s patient. This will be given to each core midwife who will sign to identify they have read, understood and will comply.  Re-launch fetal monitoring protocol with staff.  Develop a telephone record to capture clinical data when requested to assess an independent midwife’s patient. |  |
| Serious | 4B | Delay in transferring mother with post-partum bleed from rural maternity unit to tertiary unit. Both mother and baby recovered well. | Independent midwife did not recognise the significance of the bleed and escalation process was delayed. | Introduce updated emergency flip chart, strategically placed.  Education for nursing staff on emergency management. |  |
| Serious | 4B | Delay in treatment of woman with breast cancer. | The major root cause of this incident is the database having a reporting failure. | Ongoing vigilance by screening staff members when checking reports to ensure there are no other anomalies with other invitational processes.  As a result of identifying these issues, the data manager has developed a new local Access failsafe report to prevent and mitigate the risk of similar incidents occurring/reoccurring in the future. | Completed. |
| Serious | 4G | Patient suffered complications as a result of treatment and required further surgery. | Patient was discharged to an area where staff were unfamiliar with equipment being used on patient. | Discharge process was reviewed and education provided to staff on how to use this equipment safely. | Completed. |
| Serious | 4G | Delay in recognition and management of patient who presented to ED with stroke. | Review in progress. |  |  |
| Serious | 6 | Patient fell and fractured hip. | Incomplete assessment since admission led to inadequate care planning and management of the specific needs of an elderly patient with physical limitations and co-morbidity in an unfamiliar environment of a hospital. | Share learning of this event with nursing and medical staff including implication of practice about management of confused patients.  Implement the falls management practices to area. |  |
| Serious | 6 | Patient fell and sustained a head injury. Patient died five days later from injury. | Incomplete assessment on admission led to inadequate care planning and management.  Referred to Coroner. | Share learning of this event with nursing and medical staff including implication of practice about management of the specific needs of a confused elderly patient with physical limitations and co-morbidity in an unfamiliar environment of a hospital.  Implement the falls management practices to area. |  |
| Serious | 6 | Patient fell and fractured hip. Patient’s condition deteriorated, and the patient died five weeks later. | Review under way. |  |  |
| Serious | 6 | Patient fell and fractured hip. Surgery required and patient deteriorated following surgery and died. | Patient mobilised independently without supervision. | Share learning of this event with nursing and medical staff including implication of practice about management of the specific needs of a confused elderly patient with physical limitations and co-morbidity in an unfamiliar environment of a hospital.  Implement the falls management practices to area | Ongoing  Completed |
| Serious | 6 | Patient fell whilst mobilising independently. Condition deteriorated and patient died | Patient while in a confused and disorientated state pushed a table aside, mobilised independently and fell. | As a result of this incident the following actions were taken:   * all tables fitted with brakes * ward continues to trial and evaluate different equipment resources to minimise falls, including current use of exit alarms and pressure mats/cushion. * falls project completed and new risk assessments and education in place for staff. | Completed.  Completed. |
| Serious | 6 | Patient fell and hit head. Condition deteriorated following fall and patient died | The patient was not sufficiently stable on feet, due to clinical condition | Falls project completed and new risk assessments and education in place for staff.  Audits completed to ensure compliance with falls assessment requirements. | Completed.  Completed. |
| Serious | 6 | Patient fell and fractured hip. Required surgery. Condition deteriorated after surgery, and patient died. | No root causes found. | Other learning needs identified:  Review staff knowledge of care planning process and timely/accurate completion of documentation – including the process of handover/completion of information between shifts. |  |
| Serious | 6 | Patient fell from bed and sustained a head injury and died. | All appropriate actions pre and post fall were taken. | Review supervision of compromised patients whilst in bed. |  |
| Serious | 6 | Patient fell and sustained fractured shoulder. Patient later died from unrelated events. | Patient fell whilst standing from commode. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and fractured ankle. | Patient was not compliant with medical treatment, due to other medical conditions. | Medical team to discuss with Mental Health team as to future management of patient in ways that will allow required medical management. | Completed. Agreed plans in place for ongoing care. |
| Serious | 6 | Patient fell and fractured hip requiring surgical repair. | Unpreventable fall. Review identified that all appropriate actions pre and post fall were taken. | No recommendations. |  |
| Serious | 6 | Patient fell mobilising and fractured shoulder. No surgical intervention required. | Inadequate care planning and management of specific needs of a confused elderly patient with physical limitations and other medical problems in an unfamiliar environment of a hospital. | Falls project completed and new risk assessments and education in place for staff. |  |
| Serious | 6 | Patient fell and fractured hip. Surgical repair required. | Patient with confusion mobilised and fell. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and required surgical repair of lacerations sustained in fall. | Patient with limited mobility mobilised and fell. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and sustained fractured hip. | Patient lost balance when closing the bathroom door. | Patients will be supervised with their mobility for the first 48 hours of admission regardless of level of independence. | Completed. |
| Serious | 6 | Patient fell and fractured wrist. | Patient fell earlier in day and no corrective actions taken to minimise, thus patient fell again later. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and fractured hip, which required surgical repair. | Patient assessed as requiring assistance mobilising walked alone and fell. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and sustained head injury (sub arachnoid haemorrhage). | Patient with fluctuating confusion and decreased mobility attempted to mobilise unaided. Patient was known to be high risk for falling and was on increased watch. | Patients who are able shall have meals in the dining room with one staff member present at all times.  Rapid nursing rounds are conducted Mon-Fri and identify that fall risk assessment is carried out per procedure. | Completed.  Completed. |
| Serious | 6 | Patient fell and fractured hip, requiring surgical repair. | Review in progress. |  |  |
| Serious | 6 | Patient fell resulting in her sustaining a fractured wrist. | Patient stood up from chair and fell. | Increased supervision for patient.  Use of lap belt identified as appropriate for this patient. | Completed.  Completed. |
| Serious | 6 | Patient fell and sustained fractured skull. | Patient with history of falls mobilised without supervision. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and sustained head injury. | Patient with history of falls mobilised without supervision. | Falls project completed and new risk assessments and education in place for staff | Completed |
| Serious | 6 | Patient fell and dislocated pelvis bone. | Patient mobilised independently without supervision. | Falls project completed and new risk assessments and education in place for staff. | Completed. |
| Serious | 6 | Patient fell and fractured shoulder. | Patient had medical condition that likely contributed to fall. | Introduction of escalation flow chart to expedite transfers to medical wards and consistency of information used to assess requirement for general hospital admission. | Completed. |
| Serious | 11 | Patient’s cardiac arrest not noticed as alarm did not activate in theatre. Patient died later in ICU from other causes. | Review concluded that no issue with alarms. Active resuscitation was initiated within seconds of arrest being noticed.  Referred to Coroner. | No root causes found. | Completed |
| Serious | 12 | Elective admission to hospital. Patient developed flu in hospital and died. | Review concluded no issues with care provided. | Consideration is given to extending the hospital flu vaccination programme to offer the flu vaccine to high-risk patient groups. | Completed. |
| Sentinel | 1 | Patient had procedure (PICC Line – peripherally inserted central catheter – inserted) that was meant for another patient. | The patient identity was not verified by two members of staff to ensure correct patient was transferred to radiology. | To develop a policy on patient identification. Policy to have implementation plan agreed as part of process.  To develop a patient verification handover process –this process to include patient not to be transferred until process is completed. Process to include phone verification checks.  To implement the WHO Surgical Safety Checklist for Radiology Interventions Only process. | Completed |
| Sentinel | 3 | Patient had retained swab following cardiac procedure. Required additional procedure to remove swab. | Patient’s procedure did not stop when incorrect count was notified to the team. | Review implementation process of the Waikato DHB policy: Surgical Count for Swabs, Sharps and Instruments.  Discussion to take place regarding implementing a ‘Time Out/Stop’ command when incomplete count is notified. If agreed, this action to be added to Surgical Count for Swabs Sharps and Instruments policy.  Implement the WHO Surgical Safety Checklist in department.  The operating surgeon should also verbally acknowledge they have heard the scrub practitioner [(Rationale 6)](http://www.gosh.nhs.uk/clinical_information/clinical_guidelines/cpg_guideline_00012/#rationals9310#rationals9310). |  |
| Sentinel | 1 | Surgical procedure performed on wrong patient due to two patients’ biopsy samples being mixed up, and incorrect diagnoses for both patients involved. | Ineffective quality control processes being in place/implemented and environmental issues led to biopsy tissue belonging to Patient B being placed in Patient A cassette during laboratory process.  This resulted in patient having surgical procedure meant for another patient. | Review laboratory process/work flow (in consultation with Waikato DHB process specialist).  Review the current quality monitoring and reporting systems within laboratory and implement any recommendations.  Initiate creation of a regional networking quality model (with a focus on learning/sharing of best practice) for this laboratory.  Revise/produce procedure documentation regarding independent double checks on biopsy specimens.  Review practice of processing like specimens (eg, breast) through laboratory.  Review options for technical and managerial leadership structures in this laboratory. |  |
| Serious | 4A | Two patients’ biopsy samples were mixed up resulting in incorrect diagnoses for both patients involved. | As above. | As above. |  |
| Serious | 11 | Patient assaulted a third person whilst being transported to hospital by family. | Review completed. | Scheduled for panel 2012. |  |
| Serious | 11 | Patient attempted self-harm and sustained minor injuries. | Observation levels were not clearly communicated or promptly enacted.  Service user was not sighted by morning staff at commencement of shift.  New RN not aware RNs can increase level of observation without medical officer approval if risk identified. | Clarity on observation procedure given to all ward staff and confirmation of responsibility for handover between shifts.  Handover procedure has been amended to including the requirement for staff to sight all service users immediately following handover.  All new nurses to have identified preceptors and training to be provided to increase number of available preceptors. Training continues through 2011 and preceptorship and available preceptors are monitored via the Clinical Nurse Director and Clinical Governance Forum. | Completed  March 2011  April 2011.  Ongoing. |
| Serious | 11 | Self-harm resulting in life-threatening injuries. | The immediate management and communication of identified escalating risk directly following assessment, was not adequate.. | Review the Levels of observation procedure to include: The communication and management plan process between staff, directly following assessment indicating increased risk. | Ongoing |

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# Bay of Plenty District Health Board

www.bopdhb.govt.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 3 | Four months after surgery, retained swab identified during X-ray. | Investigation difficult as staff recall of event poor.  Systems in place are sufficient.  Communication within teams to be enhanced. | Improve team culture – the productive operating theatre and team steps have been implemented in theatre. | Subject to ongoing monitoring. |
| Serious | 4D | Blood stream infection resulting from an IV line requiring long-term antibiotics and prolonged inpatient stay. | Reviewed by the infection control team. On earlier discharge when IV cannula removed it was noted to be red. Readmitted with severe sepsis. The findings were consistent with recent IV audit. | Issues identified will be addressed with the implementation of the audit recommendations. | Completed. |
| Sentinel | 4C | Failure to recognise and act on deteriorating condition resulting in death. | Lack of a standardised process of handover between departments contributed to a loss of continuity with plan of care.  Failure to repeat observations following abnormalities resulted in the MEWS (Modified Early Warning Score) not being adequately assessed or interpreted, causing a delay in response. | Standardised handover process is implemented in all clinical contexts.  Consideration should be given to how to ensure that it is understood that MEWS is the explicit trigger tool for clinical communication and escalation. | SBARR (model for effective information transfer) implemented. |
| Serious | 1 | Appendix removed subsequently found to be an ovary.  Error not noted until pathology results received. | Abnormal position of fallopian tube. Anatomy distorted by inflammatory process. | Ongoing education for surgeons to include identifying and confirming anatomy where anatomy is unusual. | Lessons learnt shared. |
| Serious | 9 | Unwitnessed assault on an inpatient by co patient. Sustained multiple injuries resulting in permanent disability. | Risk assessment and management plan appropriate. | Nil recommendations made. | Referred to Police. |
| Serious | 4D | IV drug leaked into tissue, requiring surgery. | IV cannula insertion difficult as patient having a fit. IV protocol including flushing line was followed and the line was deemed patent. As the patient was suffering a fit, the line was secured with a bandage, thus unable to observe.  Two hours later, the IV site was checked and leak was discovered. | Feedback to nursing staff on Phenytoin infusion (drug to treat fit) and selection of IV insertion site. | Completed. |
| Serious | 6 | Inpatient fall resulting in fractured shoulder. | Elderly patient who required assistance to mobilise got out of bed to go to bathroom, without calling for assistance. | BOPDHB Patient Safety Programme has three significant organisation-wide projects under way including Safe Mobilisation – reducing harm from inpatient falls.  Literature reviewed shows that no one strategy works.  Falls with harm for BOPDHB have been analysed and strategies to address the key causes of falls have been identified and the following plan is being implemented.  Medical ward identified as pilot site:   * HCA/RN (Health Care Assistant/Registered Nurse) rounding * ward tidies * bedside ‘flip chart’ developed – mobility tool * patient assessment (based of LITE assessment tool) assessment/ care plan tool developed.   Whole-of-organisation education day planned promoting ‘safe mobilisation’.  A review of ‘low, low’ beds was found to make a difference. Plan in place to increase access to these. | |
| Sentinel | 6 | Inpatient fall resulting in subsequent death. | Appropriate assessment made but still fell. The apparent cause of the fall was multi-factorial, and not necessarily attributed to a single cause. |
| Sentinel | 6 | Inpatient fall resulting in fractured hip and subsequent death. | The fall was not the root cause of the death.  No formal falls risk assessment undertaken. Reporting requirements not met. |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Unwitnessed fall. Patient assessed as requiring a walking frame to mobilise moved from a chair back to bed without it. |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Unwitnessed fall. Identified as high falls risk. Was able to mobilise with frame and assistance of one. |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Unwitnessed fall. Patient assessed as high falls risk, ‘desperate’ to go to the toilet got up without assistance.  Impression: collapse secondary to effects of night sedation. |
| Serious | 6 | Inpatient fall resulting in fractured pelvis (no surgery). | Elderly patient with dementia observed mobilising with walking frame ‘just fell’. |
| Serious | 6 | Inpatient fall resulting in fractured pelvis (no surgery). | Unwitnessed fall. Elderly patient assessed as requiring supervision with all mobility got up to go to the toilet without calling for assistance. |

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# Lakes District Health Board

www.lakesdhb.govt.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 6 | Patient fall resulting in fractured hip and surgery. | Falls Risk Assessment not completed on admission. History indicated falls risk. | Discussions with ward staff regarding Falls Risk Assessments being completed on admission.  DHB has implemented a Falls Committee which is preparing an annual plan and identifying a review process of falls strategies.  Feedback regarding falls strategies to be given to the governance groups of all services. | Bi-monthly Falls Committee Meetings.  DHB participating in National Working Party on Falls Prevention. DHB will implement national guidelines when agreed.  Units implementing their own local falls initiatives and undertaking regular falls audits. |
| Serious | 4B | Anticoagulants discontinued when they were clinically indicated.  Patient suffered a stroke on day of procedure requiring longer hospital stay and ongoing rehabilitation. | CHADS scoring (Clinical prediction tool for determining the risk of stroke) is not routinely undertaken as part of DHB guidelines as bridging therapy in the pre-operative care process. | DHB will review CHADS scoring guideline as it impacts across the service.  Surgical Services is currently reviewing the preoperative care documentation and this has highlighted the need for a more co-ordinated approach to management of anticoagulation. Surgical Services is developing a proposal for a colorectal nurse specialist position. Such a position will aim to provide a more comprehensive care programme for all patients and reduce the likelihood of such events in the future. | CHADS scoring is in the policy. Nurse-led specialists are in position for preoperative clinics. Colorectal nurse position is not yet funded. |
| Serious | 6 | Patient fall resulting in fracture of bone in face (maxillary sinus). | Clinical File Review completed.  Family meeting determined fall was a result of a health professional’s actions not a process failure. | No further action. |  |
| Serious | 5 | Morphine over-prescribed and administered for pleuritic (chest) pain.  Patient went into respiratory arrest and required intubation. A full recovery was made. | Poor prescribing practice. Prescribing according to protocol, however Lakes DHB did not have a morphine titrate protocol.  Not all nurses within the secondary service hospital had the expertise to provide narcotics on titrate protocol. | The Intensive Care Head of Department has issued a memorandum to all doctors around the appropriate prescription of morphine (doses in particular) for the general wards as opposed to the ICU setting.  Development of an organisation-wide protocol for intravenous opioids for acute pain, identifying the level of expertise required to administration it. This includes a flow chart for decision-making. |  |

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# Tairawhiti District Health Board

www.tdh.org.nz

Tairawhiti DHB has adopted the Severity Assessment Code (SAC) rating terminology in accordance with the draft national policy on reportable events. SAC1 and SAC2 events are broadly comparable, respectively, with ‘Sentinel’ and ‘Serious’ events.

The SSE report stated that Tairawhiti had six SSEs. Following review, one of these cases was the suicide of a community mental health and addiction services patient in the community, so should not have been included in the overall numbers.

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 6 | Fall causing injury to eye and subsequent loss of vision in that eye. | Inconsistent communication processes for patients attending the Day of Rehabilitation Unit (DRU).  Clinical notes did not accompany patient to the DRU.  Out-dated falls policy and hence varying understanding of falls risk.  DRU nurse vacancy. | Revise the handover process between inpatient wards and the rehab unit and consider handover sheet.  Visual means of identifying patients at risk of falling in line with new Falls Policy.  Clinical notes to accompany patients to the rehab unit.  Implement revised Falls Policy.  Training regarding falls risk and prevention provided to all levels of staff who care for at risk patients, at orientation and updates thereafter. | Vacancy filled.  Falls policy reviewed and implemented, including:   * new falls risk form and identification stickers as an easy communication method to identify patients at risk of falling * handover between ward 9 and DRU standardised * clinical notes accompany patients attending DRU. |
| Serious | 4F | Injury sustained while patient awaiting admission to child/youth mental health unit. | No child/youth inpatient mental health facility available locally.  Challenges in caring for children suffering mental health problems between a safe environment and what is in the best interest of the child. | Develop and implement policy relating to transfer of patients to inpatient facility.  Improve communication between Child and Adolescent Mental Health Service (CAMHS), the paediatric ward and adult in-patient ward to better manage such situations.  Funding for better support in the community where inpatient care is not in the best interest of the patient.  Mental health staff to provide care to patients in their own home.  Written information given to family to support decision-making.  CAMHS implement a practice that addresses leave provisions for patients detained under the Mental Health Compulsory Assessment and Treatment Act. | Reviewed pathway for management of patients requiring transfer out of district. Work in progress. |
| Serious | 4A | Five-month wait for colonoscopy procedure, resulting in delayed treatment. | Information transfer from the Clinical Prioritisation Assessment Criteria (CPAC) tool to the surgical waiting list (an electronic system) require coding but each uses different codes and therefore requires interpretation to best fit the electronic system. This provides opportunity for misinterpretation of the priority of the patient. | Organisational discussion and consultation is required to identify and implement, with appropriate training to staff, a single standardised diagnostic/prioritisation tool for use throughout the organisation. Ministry of Health recommendations to be included in this process.  Ensure that the chosen tool is compatible with patient management system so that prioritisation codes are not open to interpretation.  Regular review of waiting list to ensure it is being managed effectively.  Computer generated standardised letters to be reviewed. Letter to include full details of who to contact if there is deterioration/change in condition, to encourage patient participation in the process.  The timeframe process for the procedure to be transparent and communicated to local communities. | Recent root cause analysis review RCA. Work streams to be progressed. |
| Sentinel | 4C | Neonatal death and maternal haemorrhage. | Chorioamnionitis with Group B strep infection after prolonged induction.  Intrapartum asphyxia.  Failure to correctly interpret CTG tracing and respond appropriately.  Overall deteriorating clinical situation was not appreciated. | Intrapartum Fever” guideline including” presumed chorioamnionitis” developed. Approved and released August 2011  **CTG training**   * Majority of staff completed K2 training * New staff to complete K2 training in 1st month * Plan to link regionally with RANZCOG training and aim to achieve all Midwives and O&G Consultants attending   Quality Meetings   * Weekly MDT Clinical Quality meetings to review CTG’s, discuss clinical cases and to encourage open communication between Midwives and O&G Consultants. |  |
| Serious | 5 | Patient collapsed during sedation. |  | RCA in progress.  Conscious sedation guidelines are under review. |  |

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# Taranaki District Health Board

www.tdhb.org.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 1 | Wrong patient anaesthetised (son rather than father, with same name). | Both father and son had exactly the same name and contact details.  Son was registered on the local Patient Management System with his National Health Index (NHI) number but the father was not.  Son had symptoms that correlated with his father’s surgical diagnosis.  Son had recently been returned to his mother’s care and displayed symptoms that led her to believe that her son was already on the wait list.  The surgical referral form did not contain the patient’s NHI number.  The identification of the signee on the consent form (ie, patient, parent or guardian) was not marked.  The procedure for adding a patient to the surgical waiting list was not followed. | Ensure that all referrals have the patient’s NHI number and date of birth clearly documented.  Ensure that when discussing consent with the patient, the consent form is completed, including the identification of the signee.  Ensure staff read all referrals thoroughly and not accept/enter any referrals that are not completed appropriately. Reminders given to staff.  Referral documents are to be reviewed at pre-admission and anaesthetic assessment appointments.  Discussion to occur between the contracted provider hospital and the DHB to identify where streamlining can occur. | All completed |
| Serious (cont’d) | 1 (cont’d) | Wrong patient anaesthetised (cont’d). | (cont’d) The son’s referral document was not available and not sighted at pre-admission clinic.  At the anaesthetic appointment, the consent/referral form was not viewed.  Staff member competent in the referral onto the surgical booking list process.  The surgical booking team had undergone significant changes including reorganisation of work allocation, staff turnover, increased workload and added pressure while recruitment occurred. |  |  |
| Serious | 4A | Delay in diagnosis and treatment for lung cancer that was visible on a chest X-ray taken in July 2008. | The discharge summary was not completed.  The Clinical Management of Test Results and Investigations procedure was not followed.  Failure to arrange follow-up specifically related to the chest X-ray result.  When admitted for the operation, the patient’s previous chest X-ray result was not noted.  The patient’s chest X-ray result and advice concerning follow-up was not communicated to the patient or noted in the patient’s discharge summary to the patient’s GP. | Sending copies of all X-ray results to the patient’s GP commenced in 2009.  Digital radiology commenced in 2009, allowing easier access to X-rays.  The Clinical Management of Test Results procedure has been reviewed and is now a policy. Responsibilities have been clearly communicated.  Explore options where information technology can assist clinical staff with results management to improve robustness.  Explore options for reviewing X-ray results that have not been ‘marked as read’ prior to 2009 and implement the best solution. | Completed.  Completed.  Completed.  In progress.  In progress. |
| Serious | 4B | Patient presented with back pain that was diagnosed 48 hours later as an epidural abscess. | Reviewing neurosurgeon to review the case notes and determine whether there are any actions to be taken to prevent delay in diagnosis. | Report pending.  [Commission comment: Advised by Taranaki DHB after report printed that this case, following review, was not considered a serious or sentinel event.] |  |
| Serious | 4B | Following the death of a patient from a stroke and pneumonia, the DHB was advised that the deceased patient’s dentures were found down the back of his throat. | ‘Difficulty in Swallowing’ form, care plan and assessment questionnaire not completed.  Upper dentures placed in the deceased’s mouth, but this was not documented in the patient property book.  Non-compliance with oral hygiene cares in relation to denture care.  Coroner investigation progressing. | Feedback to staff member and to all ward staff.  Audit/review of nursing documentation for all new admissions to commence.  Deliver brief education sessions for all ward staff around oral hygiene and care of the deceased with specific relevance to denture care.  Change the current ‘Difficulty in Swallowing’ form to enable additional details about denture information.  Change the current care plan to allow additional information relation to oral cares/denture management. | Completed.  Initiated and ongoing.  Completed.  Completed.  Completed. |

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# Whanganui District Health Board

www.wdhb.org.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 4A | Undiagnosed low haemoglobin (blood count) which resulted in the patient falling. Patient subsequently died. | As a result of a full blood count not being taken for two days, a significant drop in haemoglobin was not detected.  Patients in CCU are cared for by a different clinician each day which has the potential to lessen continuity of care. | Adjust the cardiac pathway to reflect that a full blood count is taken every day that a patient is on blood thinning medication.  Education for RMOs by Pharmacy staff as part of their orientation.  Consider increasing the continuity of care for those patient in CCU. | Audit cardiac pathway six-monthly.  Review RMO orientation checklists.  To be discussed by the Clinical Board. |
| Sentinel | 1 | Anaesthetic given for tooth extractions that had been performed two years previously. No ill effects for patient. | Several different conventions for documenting the teeth to be extracted.  Surgeons and therapists documented in different parts of the patient’s health record and did not read each other’s documentation.  Booking sheet completed by dental unit staff and not signed off by surgeon, as he lived out of town.  Dental X-ray unit was out of order, waiting for parts. Dental X-ray from 2008 was erroneously filed with the booking sheet. | All staff in the dental unit and Patient Scheduling are to use the recognised tooth numbering system when booking patients for extractions/repairs.  Dental surgeons will document their treatments and surgeries in the therapists’ section of the health record to ensure that all involved in the patient’s care are aware of what has already taken place.  All booking sheets for dental surgery are to be reviewed and signed off by the surgeon before being sent to Patient Scheduling.  The signed booking sheets must be accompanied by a complete dental X-ray when forwarded to Patient Scheduling. | Audit six-monthly to ensure correct numbering system is being utilised.  Audit six-monthly.  Audit six-monthly.  Audit six-monthly. |
| Serious | 5 | Patient found unconscious after administration of morning medications, which patient should not have been prescribed, and required transfer to CCU. Patient made a full recovery. | Patient admitted to the Day Unit. Medicine reconciliation did not occur before patient’s surgery. RMO prescribed medications from patient’s own medication card, however, the anti-hypertensive medications had been discontinued some time ago. | All medications should be checked and written on a medication chart prior to transfer to the ward from the day unit. If this cannot be completed, then medications may have to be withheld and the patient monitored until medicine reconciliation is completed.  Education regarding blood pressure and anti-hypertensive medications to be conducted. | Pharmacy staff to monitor.  Conducted. |
| Serious | 4B | Failure to make outpatient appointment resulting in a delay in treatment. | Electronic discharge summary stated outpatient appointment to be made in one week; however, this was not written in the ‘follow-up appointments to be made’ section, and was overlooked by administration staff.  An audit of discharge summaries showed inconsistency in recording follow-up appointments. | Tutorial for RMOs on the correct use of the follow-up section of the electronic discharge summary. | Ongoing. |
| Serious | 6 | Admitted to surgical ward, as a blistery rash had developed under a leg plaster. While mobilising in the ward, patient fell and fractured a hip, requiring surgery. | No evidence of written or verbal instructions given by clinic regarding plaster care and symptoms to look out for.  No falls risk care plan implemented on admission. | Written copy of patient care instructions must be given to patient prior to discharge. All verbal instructions given to patient must be listed in patient notes.  All staff on the surgical ward to have an understanding and awareness of the new Falls Injury Prevention Standard by 1 April 2011. | Template for instructions developed March 2011.  New falls risk assessment tool introduced and end of bed falls care plan implemented April 2011. |
| Sentinel | 4A | 15-month delay in diagnosing lung cancer. Palliative treatment undertaken and patient died several months later. | Chest X-ray taken prior to dental surgery showed a lung lesion.  Patient presented to ED with chest pain, lesion was larger and had spread (metastisised).  No copy of X-ray report sent to GP.  Previous chest X-rays not reviewed. | Patient’s GPs to be sent a copy of all X-ray reports generated from the dental unit.  Previous chest X-ray films/reports must be viewed when an abnormality is detected. | Completed.  Ongoing. |
| Serious | 5 | Medication given in incorrect order, resulting in patient experiencing temporary paralysis prior to procedure in theatre. Patient traumatised by the event. | Order of Theatre list was changed at short notice due to a hole in the instrument wrapping being detected. This resulted in the patient not being mentally prepared and it was thought there was no time to administer a pre-medication.  Anaesthetic medications drawn up and syringes were labelled; however, incorrect syringe used.  Patient known to be anxious on previous occasions and this was not adequately responded to by staff. | Develop a flow chart for premed options including timeframes and patient presentation.  Replace sterile tray shelving units to allow for better storage of sterile trays.  Consider protective devices for corners of instrument trays to prevent inadvertent piercing of sterile packing.  Introduce red-barrelled syringes for paralysing agents.  Research and implement anxiety rating scale to accurately identify patients’ anxiety.  Review Pre-operative Checklist. Include section for anxiety rating scale and notification of who the patient wishes information to be given to such as next of kin/support person. Benchmarking with other DHBs is recommended. | Completed.  Audit in six months for compliance.  Under way.  Implement and audit in six months for compliance. |
| Serious | 6 | Patient fell from beside bed, resulting in hip fracture. | Palliative care patient assessed as a very high falls risk. All appropriate falls risk minimisation measures instituted, including bell mat alarm. Alarm sounded, staff responded immediately but patient had already fallen.  There was a delay in informing the family of the event. | Patient was placed on constant supervision.  All staff made aware of the Whanganui DHB’s Open Disclosure policy and timely communication with families. | Completed. Centre for Patient Safety will monitor compliance with the Open Disclosure policy. |
| Serious | 4 A | Delay in responding to deteriorating patient post-operatively. Patient required further extensive bowel surgery and transfer to a tertiary facility Intensive Care Unit. | Junior medical staff did not escalate their concerns to senior medical staff.  Nursing staff did not follow the early warning score protocol and notify the Duty Nurse Manager about the patient’s condition.  Once the deterioration was recognised the patient’s vital signs were closely monitored; however, not all recordings were documented. | Tutorial held for junior medical staff to improve communication competency.  The surgical team have conducted in-service ‘recognition of the acute abdomen’.  Requirements of Health Records Policy and documentation standards reiterated to all staff. | Completed.  Completed.  Audit six-monthly. |

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# Hawke’s Bay District Health Board

www.hawkesbay.health.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Sentinel | 6 | Fall resulting in fractured hip. Patient died three days post fall. | Falls risk assessment completed and falls prevention strategies incorporated into care plan.  Staff member left patient unsupported for a short period of time. | In-service education to include falls minimisation. | Hospital falls project expanded scope of responsibility for falls minimisation to be district-wide. |
| Sentinel | 6 | Fall resulting in fractured hip and arm and head injury. Patient died 23 days post fall. | Falls risk assessment completed and falls prevention strategies incorporated into care plan.  Fall result of impulsive behaviour.  Aspiration pneumonia a contributing factor to death. | No recommendations. |  |
| Sentinel | 4A | Failure to identify maternal and fetal deterioration during labour.  Infant died several hours after birth. | Failure to recognise deteriorating condition.  Miscommunication between independent midwife and medical staff. | Fetal monitoring training for staff.  Review clinical responsibility between independent midwife and hospital team.  Review methods of communication with patients and between clinical staff.  Referred to the Coroner. | Education completed.  Policies and procedures reviewed, including communication methods.  Awaiting Coroner’s findings. |
| Serious | 4G | Delayed diagnosis due to failure to schedule appointment within required timeframe. | Patient waiting greater than expected time for colonoscopy.  Patient postponed for more urgent case. | Review management of endoscopy waiting list systems and processes. | Full clinical and administration review of waiting list completed.  Access criteria developed.  Resources reviewed.  Waiting times improved. |
| Serious | 4B | Delayed diagnosis and treatment due to failure to act on abnormal radiological findings. | Abnormal X-ray findings not followed up.  GP name not entered in radiology system until after report finalised. | Review guideline for routine pre-operative investigations.  Review sign-off process for abnormal radiology results.  Ensure GPs are always assigned in the radiology system so they receive a copy of the finalised report. | In progress. |
| Serious | 4A | Delayed diagnosis due to failure to schedule radiology procedure and delayed radiology reporting following the procedure. | Shortage of radiologist resource. Implementation of new electronic radiology system resulted in patient report delays. | Increase/recruit radiologist resource.  Develop and implement clinical indicators/flags for monitoring CT colonoscopy waiting times. | Additional radiologist employed.  Electronic radiology system implemented.  Reporting volumes are being monitored. |
| Serious | 4A | Procedure delay and reporting delay resulting in delayed diagnosis. |

# MidCentral District Health Board

www.midcentraldhb.govt.nz

| **Serious or sentinel** | **Event code\*** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 4A | Fall resulting in fractured ankle prior to admission. Diagnosis delayed by four weeks. | Fracture occurred prior to admission during cardiac arrest when patient fell at home. Was missed by staff for four weeks until patient began mobilising. X-ray immediately ordered and fracture noted. | Colour, warmth and movement, and sensation assessments to be completed early where potential bony injuries identified. | Completed. |
| Sentinel | 4C | Patient found dead during morning round. | No causal factors were identified in this incident. Regular overnight checking was completed, however more in-depth inspections are required. | Review the observation policy and procedure for the detail of the inspection process that is required overnight. | Completed. |
| Serious | 4D | A haemodialysis machine was not disinfected prior to connection to patient. No identified harm to patient. | The process flow for the management of dirty to clean machines was not clear and was impacted by inadequate storage space. | Strengthen standards for process and flow of cleaning haemodialysis machines.  Identify additional storage space to have clean and dirty machines separated. | Completed. |
| Serious | 5 | Incorrect dose of Methadone administered. | 10 times correct dose of Methadone given (ie, 50ml instead of 5ml) as a result of the unfamiliarity with medication. Intensive monitoring of patient was required. | Review and strengthen medication checking process in specialist units when staff are unfamiliar with medication.  Explore options for obtaining lower strength medication (ie, 1mg/ml). | Completed. |
| Serious | 3 | Part of a surgical instrument left in abdomen following surgery. Subsequently the patient was returned to theatre for removal of the retained instrument part. | An additional instrument was brought into theatre during the surgery and was not added to the count. | Revise and strengthen process to ensure all instruments used in surgery are included on count lists. | Completed. |
| Serious | 5 | A 14-month old child was administered too much intravenous fluid during a procedure under general anaesthetic, resulting in increased inpatient stay. | Fragmented communication and handover re child’s hydration status.  No agreed interdepartmental process related to perioperative fluid management in acute paediatric patients. | Strengthen clinical handover process with a primary focus on the documented information, from Child Health to Anaesthetics. | Completed. |
| Serious | 5 | Chemotherapy intravenous medication administered to the wrong patient, resulting in increased inpatient stay. | The process for preparing, storing and checking of chemotherapy medication was not followed and did not provide clarity around this process. | Chemotherapy protocols to be standardised.  Develop process to track chemotherapy medication delivery and administration. | Completed. |
| Serious | 5 | One unit of fresh frozen plasma given in error. | Existing protocols for checking of blood components prior to administration were not followed. | Audit compliance with protocols.  Ensure all staff complete mandatory update on blood component administration protocols. | Completed. |
| Sentinel | 2 | Suspected suicide while on day leave from inpatient unit. | There was incomplete risk assessment documentation leading to gaps in knowledge regarding the patient’s risk levels. There was also lack of clarity regarding leave processes for voluntary patients. | Leave form to be adjusted to include a process for voluntary patients.  Assessment of mental status to be documented on leave form. | Completed. |
| Serious | 3 | Gauze swab missing from count at end of procedure. Patient examined and swab not found. Abdomen closed and X-ray performed. Swab identified in abdomen therefore patient required further surgery to remove swab. | Portable X-ray machine not available in theatre before patient’s abdomen was closed. Taken to X-ray after surgical closure and swab identified. | No recommendations made. | Completed. |
| Serious | 6 | Inpatient fall resulting in scalp laceration and fracture of hip. | Patient fell while walking from toilet to hand basin. Staff not present when fall occurred. Falls risk assessment was completed on admission. | The following generic recommendations apply to all falls:   * review organisation-wide falls reduction programme * implement evidence-based best practice initiatives to reduce falls. | The Falls Action Group has been strengthened and a detailed plan developed to ensure that the target of Falls Injury Reduction in the 2011/12 Annual Plan is met. Whilst there are components of both risk assessment and falls prevention strategies in place they are not well co-ordinated. Both national and international evidence will be used to strengthen falls prevention. |
| Serious | 6 | Fall resulting in fractured wrist. | Patient mobilising independently. Had a shower and reached for towel and lost balance. Fell to the ground and used wrist to break fall. Falls risk assessment completed on admission and was not assessed as a risk. All appropriate steps taken. |
| Serious | 6 | Fall whilst an inpatient resulting in skin tears and fractured hip. | Fall occurred when patient was getting out of bed and used chair to assist with standing. Chair moved and patient fell to the ground. Unwitnessed fall. Patient had been assessed as a falls risk and was confused. |
| Serious | 6 | Fall resulting in fracture of hip and increased hospital stay. | Patient assisted to toilet. When patient turned to sit on toilet, leg gave way and patient fell to the ground twisting leg. Patient was on assisted walking and toileting. |
| Serious | 6 | Patient fall resulting in fractured hip.  Event not observed. | Unable to accurately define when fracture took place or how the event occurred. |
| Serious | 6 | Patient fall resulting in fractured hip. | Patient had been independently mobilising with low frame. Assessed as nil falls risk prior. Patient fell whilst moving from frame to toilet seat. |
| Serious | 6 | Patient fall resulting in fractured wrist. | Patient had gone for a short walk and was found outside the ward by the lift. Fall was unwitnessed. Patient not able to state how they fell. |
| Serious | 6 | Patient fall resulting in fractured left arm. | Patient fell when getting up from toilet. Had a history of falls. Staff member with patient at the time of fall but was unable to completely stop injury occurring. All appropriate actions taken. |
| Serious | 6 | Patient fall resulting in fractured left arm. | Patient was transferring back to bed. Transfer was unsteady which resulted in patient landing on arm on bed. |
| Serious | 6 | Patient fall resulting in fractured right arm. | No identified risk of falls. Fell on the way to toilet after hitting water cooler. At time of fall patient was wearing slippers that may have contributed. All appropriate actions had been taken prior to fall. |
| Serious | 6 | Patient fall resulting in fractured hip. | Patient was attempting to mobilise out of bed to go to toilet. Was wearing socks at the time and slipped beside bed falling to the floor. | Patients to be advised to wear non-slip footwear.  Also as above. |
| Serious | 6 | Patient fall resulting in fractured hip. | Patient had a previous stroke with limited mobility. Escorted to toilet and given privacy. Whilst nurse out of room, patient attempted to stand up resulting in fall. | Revise the approach to management of privacy for patients at risk of falling.  Also as above. |

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# Wairarapa District Health Board

www.wairarapa.dhb.org.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 6 | Patient fall resulting in a fractured hip requiring surgery. | Patient was assessed as being at risk of falling and precautions had been taken. | Reviewed as part of the Falls Management Group, and also by reportable event group. No actions identified which could have mitigated the fall. | Closed. |
| Serious | 6 | Patient fall resulting in a fractured rib. | Patient was assessed as being at risk of falling and had been visited by the nurse and checked 10 minutes before the fall. | Reviewed as part of the Falls Management Group, and also by Reportable Events Group. Patient was in a single room for infection prevention management; ideally would have been more observable in a four-bed bay. Infection prevention team looking at more effective observation methods for patients under standard precaution management in single rooms. |  |

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# Hutt Valley District Health Board

www.huttvalleydhb.org.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 12 | Patient death in hospital following hospital-acquired infection (rotavirus). | Number of issues identified relating to clinical management and physical environment. | Replace floor coverings in ward.  Review environmental cleaning practice.  Ongoing education for staff regarding hand hygiene, appropriate use of personal protective equipment, recognition of sick child and role of infection prevention and control team.  Review instruction sheets for making up concentrated feeds.  Review use of short stay observation chart. | Appropriate changes recommended have been implemented in ward. |
| Sentinel | 4G | Patient death in hospital following admission for suspected overdose. | External review highlighted a number of systems and process issues related to the communication and co-ordination of care through primary and secondary services and whilst in hospital that may have contributed to the patient’s death. | 20 recommendations from the review are in an action plan including:   * implementation of a case management/key worker model of care to ensure that patient care is co-ordinated between services * improve communication and inter-service relationships, including inter-ward and inter-DHB transfers * improve integration of mental health records and medical records * implement an organisation-wide morbidity and mortality review process. |  |
| Sentinel | 6 | Patient fall. Subsequently found to have fracture. Patient died following surgery to repair fracture. | Patient admitted with significant co-morbidities and poor prognosis. Assessed as moderate falls risk on admission. During admission falls risk increased and 15-30 minute check protocol implemented. Patient had surgical repair of fracture on day after fall. Surgery successfully completed, but patient condition deteriorated post operation; died three days after the fall occurred. | Fall ‘hot-spots’ mapping under way as part of hospital-wide Falls Prevention Project.  All falls documentation and effectiveness of same under review.  Falls incidence and prevention standing agenda item at ward meetings. | Falls Prevention Project ongoing and added to organisation wide key performance indicators. Progress monitored on a quarterly basis by Patient Safety Leadership Group. |
| Serious | 6 | Patient fall resulting in fracture. | Patient fell whilst independently transferring from chair to bed. | Review completed. Chair sensor pad trialled with patient – this worked well following event and trial will be extended for other patients. | Falls prevention project ongoing and added to organisation-wide key performance indicators. Progress monitored on a quarterly basis by Patient Safety Leadership Group. |

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# Capital & Coast District Health Board

www.ccdhb.org.nz

From 1 July 2009, Capital and Coast DHB stopped using the terminology ‘serious’ and ‘sentinel’ and adopted Severity Assessment Code (SAC) rating terminology in accordance with the draft national policy on reportable events. SAC1 and SAC2 events are broadly comparable, respectively, with “Sentinel” and “Serious” events.

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 11 | Patient self-harm. Police involved in response. | The review concluded that appropriate actions and decisions were made in respect of the management of the patient. | The review did not make any recommendations. | Not applicable. Closed. |
| Serious | 4B | Child seen twice on same day at hospital clinic. Transferred to hospital emergency department on second presentation. Patient died in Intensive Care Unit later that day. Meningococcal septicaemia. | Review found that care provided by the hospital clinic was appropriate. Review identified a delay in the administration of antibiotics due to the transfer time from the clinic to the emergency department. | Review recommended the hospital clinic protocol be amended to specify that antibiotics be given in the clinic to any patient suspected to be suffering from meningococcal septicaemia. Review also recommended that the DHB apologise to the family for the delay in administration of antibiotics. | Referred to Coroner at time of event. Coroner decision not to open an inquiry. Coroner reconsidering need for inquiry at request of family.  The Paediatric Service and hospital clinic have revised the protocol for antibiotic administration. Report and apology provided to family. |
| Serious | 4B | Significant deterioration of existing pressure area during hospital admission. | Review found that while overall care was appropriate and the pressure area was at high risk of deterioration, some aspects of communication of wound care assessment and management were not consistent and not escalated when indicated. | Review recommended an education plan to develop staff further on pressure area management and wound expertise, the development of a process for management of complex wounds and strengthening of communication between inpatient areas and community nurses. | The education plan and the process for management of complex wounds were developed and implemented and communication processes between inpatient and community nurses strengthened. Closed. |
| Sentinel | 11 | Apparent intentional removal of vascular catheter by patient. Despite emergency response the patient died. | Review found that the action by the patient could not have been predicted and that staff had acted appropriately when the incident occurred. | Review did not make any recommendations | Referred to Coroner at time of event. Coroner decision not to open an inquiry. |
| Serious | 4B | Patient admitted due to a complication one day after having had insertion of a tube into the stomach (Percutaneous Endoscopic Gastrostomy tube – PEG). The tube was removed four days later (delayed removal). The patient died later that day. | Review found that while a delay had occurred in removing the PEG, the patient’s care was appropriate and there were no significant clinical concerns about the PEG remaining in place until the equipment was available. The review team did not consider that the delay contributed to the outcome.  Review identified that the delay occurred because the type of PEG tube had not previously been used in the department and specialist equipment for removal was not immediately accessible. | Review recommended that a formal process for the introduction of new equipment to the service be developed and implemented and that a check be completed to ensure all necessary equipment is stocked. | A process has been developed and implemented for the introduction of new equipment to the service. A patient education brochure has been developed at the request of the patient’s family and is available.  Closed. |
| Serious | 4B | Patient presented with bronchial carcinoma. It was identified that a chest X-ray taken two years previous showed an opacity and recommended further investigation. | Review identified that the radiology report was communicated to the patient’s GP and that a clearer process for direct communication of such results should be developed as there was a lack of clarity as to who was following up the result. | Review recommended informing the primary provider of the event and outcome of DHB review, ensuring the patient had been informed, and development of a more robust system for communication and follow-up of reports. | The primary provider was informed and subsequently confirmed that the patient had been informed. Work is in progress to strengthen the system for communication and follow up of reports of unexpected findings on chest x-ray. |
| Serious | 4C | Patient deterioration. Concern that there was a delay in transfer to the Intensive Care Unit. Patient died. | Review found patient’s treatment was in keeping with clinical guidelines, although in hindsight earlier transfer to Intensive Care should have been undertaken. | Review endorsed the DHB’s existing implementation of an Early Warning Score Chart and mandatory Medical Emergency Team call system for predetermined parameters.  Review also recommended that the service agree the most appropriate pathway for the care of complex patients experiencing deterioration; and to consider whether the Patient at Risk team should have the ability to directly request the opinion of an Intensive Care doctor where they are concerned regarding patient management. | Referred to Coroner at time of event.  The Early Warning Score Chart and the mandatory Medical Emergency Team call system have been implemented. The service has agreed the pathway for the care of complex patients. The Patient at Risk team are able to contact the ICU registrar or consultant at any time if concerned about a patient’s condition. |
| Serious | 4B & 5 | Unexpected patient death following anticoagulant treatment for suspected heart attack (non-STEMI myocardial infarction). | Review found that the main factor that contributed to the patient’s death was the decision to treat the patient for a non-STEMI myocardial infarction (heart attack) on the basis of Troponin T test results. Review also noted that double the intended dose of anticoagulant was prescribed and given as a first dose due to human error, and that an algorithm included in guidance related to a new high sensitivity Troponin T test may contribute to the risk of such an event. | Review recommended development of organisation wide guidelines for the diagnosis and treatment of non-STEMI myocardial infarction (heart attack) and that the guidelines be developed and agreed between the emergency, cardiology and internal medicine services. | It was identified that the death had not been referred to the Coroner at the time. Coroner subsequently notified.  Development of the guideline is under way. |
| Sentinel | 11 | Patient death in community. Patient had been admitted that day for suspected deep vein thrombosis (DVT – clot). The patient had been allowed short-term leave to return for ultrasound scan. Patient died a few hours after taking leave. | Review found that the patient’s assessment was fully completed and the appropriate treatment pathway was commenced prior to the leave. The decision to allow the leave was based on established practice of treating such patients on an outpatient basis. The review team consider this patient received appropriate care and did not identify any deviation from usual practise. The review team concluded that the DVT pathway is appropriate and supported by current research-based practice and no modifications were required. | The review made no recommendations. | Police referred to Coroner at time of event (as death occurred in community). |
| Serious | 4F | Patient required Medical Emergency Team call upon arrival in ward after transferring from the Emergency Department. | Review in progress. |  |  |
| Serious | 4B | Patient admitted within 24 hours of procedure (angiogram). Patient deterioration and death. Concerns regarding co-ordination and level of care. | Review in progress. |  |  |
| Serious | 4C | Stillbirth following induction at 39 weeks gestation. | Review identified that the cardiotocograph (CTG – baby’s heart tracing) reading was not reassuring and indicated the need to review and change the plan of care. Review did not conclude that the adverse outcome could have been averted and noted that the opportunity for intervention may have been missed. | Review recommended review of service education and practice related to cardiotocograph interpretation. | The report was provided to the family and a subsequent meeting held to discuss the report.  Regional approach to training in progress and planned roll-out of cardiotocograph/Fetal Surveillance Education Training Passport for relevant staff at CCDHB in place. |
| Serious | 4C | Patient developed paraplegia resulting from epidural haematoma during epidural infusion therapy. | Review identified a five-day delay in identification of the patient’s loss of lower limb sensation and implementation of appropriate treatment, during which time the patient developed permanent paralysis. During this period changes were initially attributed to the epidural infusion. | Review recommended an apology be made to the family, the epidural policy be amended, staff education to learn from the event and review of existing documentation to specify action required when any unusual or persistent sensory or motor deficit is present. | The report was provided to the family and a subsequent meeting held to discuss the report.  The Ward Advanced Analgesia Observation Chart and ICU Observation charts have been modified. Policy and staff education actions are in progress. |
| Serious | 5 | Prolonged fetal bradycardia (low fetal heart rate) due to a bolus dose of syntocinon during labour that resulted in the woman requiring an emergency caesarean. | The review team identified that the mother received a bolus of syntocinon due to a human error in the set-up of the syntocinon infusion through a pump. | Review recommended and practice change related to syntocinon administration. | The report was provided to the family. Syntocinon Infusion Policy updated including specific process for checking and pump set up. Staff refresher education re Management of Healthcare Incidents/ Open Communication Policies completed. |
| Sentinel | 6 | Patient fall while medical and nursing staff present during ward round. Patient subsequently deteriorated, transferred to ICU (diagnosis of extradural haematoma). Patient died. | Review in progress. |  |  |
| Serious | 11 | Failure of messaging from laboratory information system to hospital clinic meant that laboratory results were intermittently received by the clinic for nearly two months in 2010. | The messaging failure was not initially recognised due to intermittent nature.  Once identified and fixed there was a lack of end-to-end testing which meant that the resend of the results was not complete and this was not identified for several months.  All results were then reviewed and re-sent to general practitioners. A small number of patients needed to be advised and followed up. | Review recommended the learning from this event be shared with neighbouring DHB, primary and secondary services to review the way their results are sent out, and to endorse the need for a system for the sign-off of results that ideally includes a process to identify outstanding results. Review also recommended continuation of end-to-end audits, further enhancements to message monitoring, and a system for regular analysis of similar incidents to identify potential trends/systemic issues. | Learning has been shared with neighbouring DHB, primary and secondary services. The need for a system for sign-off of results has been included in current Information Technology System project for electronic results. Audits are being implemented. |

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# Nelson Marlborough District Health Board

www.nmdhb.govt.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 4B | A 42-week gestation infant developed breathing difficulties during transfer to the postnatal ward. | Avoidable upper airway obstruction. | Review the discharge and transfer process between the recovery area and postnatal ward.  Ensure that orderlies are utilised for transporting the patient during transfer enabling the escorting midwife to care as required in line with NMDHB policy for internal transfer of patients.  Review of postpartum care following operative delivery to afford continuity of midwifery care to mothers and infants.  District-wide policy review to provide guidance for midwives regarding appropriate supervision of mother and infant whilst breastfeeding during transfer, especially if mother affected by sedative medication.  Review the appropriateness of the number and placement of resuscitaires and consider the need for permanent placement in theatre/recovery area. |  |
| Serious | 6 | Patient sustained bilateral wrist fractures as a result of a fall on an inpatient unit. The patient died several days later of an unrelated cause. | The patient’s fall was an unforeseeable incident. Appropriate assessment and intervention occurred specific to the patient’s mobility needs. | Nil. |  |
| Serious | 6 | Patient sustained a fractured hip as a consequence of a fall whilst a medical inpatient. | The falls assessment tool used by the NMDHB tended to result in underscoring and thus false negatives with regard to the identification of patients at increased risk of falls. This patient was incorrectly considered to be a low as opposed to medium falls risk and therefore appropriate risk reduction strategies were not put in place. | The NMDHB falls prevention project team is undertaking a review of the current falls prevention programme which includes consideration of the use of alternative validated risk assessment tools.  In the interim: amendments to be made to the current falls risk assessment to correct errors noted in the impaired mobility and altered cognitive state items.  Memo sent to all heads of department to draw attention to the errors, with support from nurse educators to reinforce this message. |  |
| Sentinel | 4G | A patient experienced a cardio-respiratory arrest five days following admission for an acute ENT (ear, nose and throat) condition. The patient died eight days later following the withdrawal of active treatment. | The patient had showed initial signs of clinical improvement following institution of medical treatment. However, it transpired the patient had an abscess that also required surgical drainage. A CT scan would have helped establish this diagnosis and change the course of treatment but was not performed due to a coexisting medical contra-indication. Transfer to ENT specialist care was considered but not undertaken due to the initial improvement in the patient’s condition. | Formalisation of the referral process of acute ENT patients between hospitals. |  |
| Serious | 6 | A patient fell and sustained a fractured hip following admission to the Day Stay Unit, prior to a surgical procedure. | There was no documentation pertaining to overall clinical assessment of the patient, including the risk of falls and management at the Day Stay Unit prior to the planned procedure. | Review falls risk assessment processes at NMDHB Day Stay Units.  Education to Day Stay Unit nursing staff on completion of nursing assessment and care plans.  Audit of nursing documentation and care plans three months following the above education. |  |
| Serious | 6 | A patient sustained a fractured hip in a fall on the surgical ward four days following an elective right total hip replacement. | The falls risk assessments undertaken at pre-admission clinic and on the day of admission placed the patient at the lower end of the scoring range for medium risk.  Further, the falls risk was not formally reassessed at any stage to reflect changes in the patient’s condition which further increased the falls risk and indicated the need for a revision of the care plan. | Memo circulated to nursing staff re updating falls risk assessment in nursing care plan as clinically indicated and to put in place appropriate steps to reduce the risk of falls and/or consequent injury. |  |
| Serious | 6 | A patient fell and sustained a fractured hip one week following admission. The patient died 11 days later from a pre-existing and unrelated cause. | The patient was incorrectly assessed as being a medium as opposed to high falls risk at the time of admission, due to a scoring error on the current falls risk assessment (as noted in a previous case). The falls risk was not formally reassessed at any stage of the admission despite the emergence of a number of subsequent clinical factors that further increased the falls risk. | New falls prevention programme to be implemented. This will include identification of falls prevention champion and education to nursing staff in all ward areas.  Re-circulate memo to all heads of department to draw attention to the error in current falls assessment, with support from nurse educators to reinforce this message.  Memo circulated to nursing staff re updating falls risk assessment in nursing care plan as clinically indicated and to put in place appropriate steps to reduce the risk of falls and/or consequent injury.  Delivery of delirium teaching package to ward nursing staff including NMDHB confusion and delirium guidelines. |  |
| Serious | 6 | A patient fell and sustained a fractured hip nine days following surgery for a fractured right neck of femur sustained in an earlier fall at home. | The patient was identified a high falls risk on admission and appropriate measures taken to manage this risk. Nonetheless the patient sustained a fractured neck of femur in an unwitnessed fall. | Nil. |  |

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# West Coast District Health Board

www.westcoastdhb.org.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Sentinel | 4B | Death of a baby following emergency caesarean section. | Review underway. | Report awaited. |  |
| Serious | 4B | Mother transferred to Christchurch by ambulance following birth was suffering from eclampsia on arrival. | Report completed. The patient had been medically cleared for ambulance transfer without escort.  While it appears that a clear process for assessment and transfer occurred in this instance, there are no written guidelines regarding transfer of mothers post delivery, nor guidance around when a midwife escort is appropriate. | A comprehensive handover be provided to appropriate CDHB staff for all maternity related transfers.  To support the process for mothers post delivery, a guideline be developed based upon the current document ‘Guidelines for transfer of Maternity Care, Secondary – Tertiary’, this to include guidance as to when a midwife escort is appropriate. |  |
| Sentinel | 4G | Death of a baby (twin) following emergency caesarean section. | Review completed.  Causal findings around   * the need for a more comprehensive programme of adjustment and orientation for Obstetric Specialists to the rural environment, * the need for a local guideline for the management of twins to assist staff when unexpected events occur,   the absence of multidisciplinary training in Greymouth to facilitate communication between disciplines in complex clinical situations -  may have resulted in staff not effectively sharing their knowledge of local procedures, not questioning decision making nor suggesting the use of additional procedures/equipment. | * The induction process for new medical staff is reviewed and adjusted to ensure there is suitable orientation to the facilities, support services and to the likely impact of these on clinical practice * Ensure best evidence guidelines specific to the WCDHB are developed, disseminated and available within the unit on;   + - electronic fetal monitoring  - including mention that  where continuous fetal monitoring is indicated but unable to be obtained, Fetal Scalp Electrode (FSE) should be used     - the management of twin labour and delivery – including delivery in theatre for all twins * A course specifically to improve management of obstetric emergencies is run at the WCDHB as a way of improving multidisciplinary teamwork between Obstetricians, Midwives, Anaesthetists, Duty Nurse and Midwife Managers etc   That consideration is giving to transferring women with multiple pregnancies to a tertiary centre at an appropriate gestational age. |  |
| Sentinel | 6 | Inpatient fall sustaining a broken hip. The patient later died. | Review completed. A family member who was visiting the patient raised the bed rails and  left  the bedside without notifying ward staff enabling the patient unobserved to climb out of bed, fall to the floor and fracture his neck of femur.  While known high falls risk, no formal assessment of same documented in file. | Clear guidelines are to be developed to assist staff discuss and clarify the involvement of family when visiting, and the need to notify staff of departure.  Falls risk assessments must be carried out for all patients on admission and where appropriate during the course of the admission. |  |
| Sentinel | 11 | Patient with known epilepsy was found dead while awaiting discharge. | Review completed – not a clinical incident.  Died of natural causes.  **[Information provided after publication of SSE report, so this incident is included in the overall data.]** |  |  |

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# Canterbury District Health Board

www.cdhb.govt.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Sentinel | 4B | Patient diagnosed with a stroke. Clot-dissolving therapy was administered and the patient later suffered a brain haemorrhage and died. | Information relating to the recent administration of drugs that also affect blood clotting was not available at the time the decision was made to administer the clot-dissolving therapy. | Information on the recent use of drugs which affect blood clotting must be included on forms and protocols used to assess the risk against benefits of clot dissolving therapy in individual patients.  Amend the discharge summary to include a section for documenting specific drugs that affect blood clotting that are administered to inpatients. | Completed. |
| Serious | 4B | Patient received a higher than intended dose of radiotherapy treatment | Separate prescriptions for the dose of radiation were written for each side of the limb. This resulted in the exit doses of radiation not being taken into account, leading to a higher than intended dose being delivered to the skin. | All treatments to the same or adjacent sites are to be prescribed on the same prescription form. | Action under way. |
| Serious | 4B | Planned antibiotic treatment to be given in labour was not administered. Baby developed septicaemia and became unwell. | Root Cause Analysis under way. | Report awaited. |  |
| Sentinel | 4B | Baby unwell at delivery, transferred to NICU and later died. | Root Cause Analysis under way. | Report awaited. |  |
| Sentinel | 4D | A planned removal of the gall bladder was complicated by a bowel perforation. The patient died unexpectedly 11 days later. | Root cause analysis review completed. | Report in draft. |  |
| Serious | 4D | Patient’s wound drains were removed prematurely, requiring a return to the operating theatre to have the drains reinserted under general anaesthetic. | Patient was cared for in another surgical specialty ward post-operatively where staff were less familiar with the post-operative care of breast surgery patients.  Instructions with regards to drain removal were misunderstood. | Continue review of surgical bed requirements and ensure the issues surrounding this event be made known to the group reviewing surgical bed requirements. | Action under way. |
| Serious | 5 | Concentrated potassium was administered as a bolus without resultant harm. | Incorrect administration of concentrated potassium. | No concentrated potassium will be held in any clinical area. | Action under way. |
| Serious | 8 | Mental health inpatient absconded from care. Potential for serious harm. | No preventable causal factors identified. | No recommendations. |  |
| Serious | 11 | A severe (stage 4) pressure injury developed during in-patient episode. | Timing issues/delays occurred in the reporting of the pressure injury and ordering and provision of pressure-relieving equipment. | All staff to complete revision of pressure area assessment and prevention, including the use of pressure-relieving equipment. | Actions under way |
| Serious | 11 | A severe (stage 4) pressure injury developed during inpatient episode. | Timing issues/delays occurred in the reporting of the pressure injury and ordering and provision of pressure-relieving equipment. | All staff to complete revision of pressure area assessment and prevention, including the use of pressure relieving equipment. |  |
| Serious | 4D | A baby unwell at delivery later died. | Despite many advances there remain significant limitations with respect to the usefulness of ultrasound to predict actual or imminent fetal compromise in late pregnancy. This meant that the degree of antenatal compromise in this pregnancy was not recognised.  There was inadequate senior medical officer (SMO) supervision of care. No one SMO took responsibility for making a plan of management and communicating the history and that plan to the team on Birthing Suite.  There was no systematic obstetric SMO involvement in the induction process. More senior obstetric opinion may have increased the awareness of risk and the priority for rapid delivery once events unfolded.  The current classification system for caesarean section does not provide a sufficiently clear indication either of urgency or of clinical indication. As a result, neonatal staff and some staff in Birthing Suite and Birthing Suite Theatre were not certain of the urgency regarding delivery nor the reason for that urgency. This may have increased the interval from decision to delivery and may have compromised staffing at baby’s resuscitation. | All women who are admitted to the maternity ward for observation in the antenatal period should be reviewed by an obstetric SMO on a regular basis, ideally at least twice per week.  The SMO must oversee care and formulate a coherent management plan and where appropriate communicate this to colleagues.  In all cases where there are suspected maternal or fetal risk factors the decision for induction of labour should be reviewed by an obstetric SMO.  The current maternity unit ‘Induction of Labour’ guideline will require review and amendment to reflect this recommendation.  SMOs should be involved at all steps of the induction process where such additional risk factors are identified and a logical plan for induction should be made by the obstetric SMO.  A classification system for caesarean section which leaves no room for misinterpretation of urgency is required.  The classification system will indicate the need for a member of the neonatal team experienced in advanced resuscitation.  On introduction of this change, appropriate staff education should take place.  Development of a guide for new neonatal RMOs on requesting anaesthetic support.  Improved processes for neonatal resuscitation training. | Actions under way. |
| Serious | 6 | Inpatient fall sustaining a broken hip. | The Clinical Board is providing a leadership role to progress work in falls prevention and management with the vision of having zero harm from falls. All SAC 1 & 2 falls are subject to a root cause analysis (RCA) review, the learnings from which contribute to the overall Clinical Board-led falls initiative. Key activities and initiatives in this area include:   * a fall event notification sticker implemented across the hospitals to make falls more visible in the clinical record and reinforce the heightened ‘falls risk’ of individual patients to staff * patient safety crosses and ward location maps used to display information regarding the number of falls in an area. These tools help to heighten awareness of the impact of falls * Patient Safety Walk Rounds have commenced. These provide an opportunity for front-line staff to have conversations with Clinical Board members about their concerns, successes and ideas for improvement regarding patent safety * an intranet page providing information for staff on the Clinical Board-led patient falls initiative * the Canterbury Clinical Network Transitional Leadership Board (TLB) has approved funding over the next two years for community-based falls prevention programme delivery. This forms a component of a wider health system initiative; ‘Moving Towards Zero Harm – a whole-of-system approach to falls prevention’ being championed by the CDHB Clinical Board. The funding provided by the TLB will be utilised for the provision of the Otago Exercise Programme (OEP) and Stay on Your Feet programme. Funding models and delivery currently being considered. | | |
| Serious | 6 | Inpatient fall sustaining a broken toe. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a broken arm. |
| Serious | 6 | Inpatient fall sustaining a broken arm. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a broken clavicle (collar bone). |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a dislocated hip. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fall sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell sustaining a severe skin tear. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken wrist. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Sentinel | 6 | Inpatient fell, sustaining a head injury. Patient’s condition deteriorated and they died three days later. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a head injury (small volume subarachnoid haemorrhage). |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a laceration requiring stitches. |
| Serious | 6 | Inpatient fell, sustaining a broken arm. |
| Serious | 6 | Inpatient fell, sustaining a laceration requiring stitches. |
| Serious | 6 | Inpatient fell, sustaining broken hip. |
| Serious | 6 | Inpatient fell, with worsening of an existing brain haemorrhage. Deterioration continued and patient died five days later. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken hip. |
| Serious | 6 | Inpatient fell, sustaining broken hip. |
| Serious | 6 | Inpatient fell, sustaining a broken elbow. |

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# South Canterbury District Health Board

www.scdhb.health.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Serious | 5 | Patient prescribed incorrect medications resulting in a significant deterioration in patient’s physical condition. The patient made a full recovery. | Correct medication reconciliation process was not followed. | Standardisation of process and confirmation requirements for medication reconciliation with community and hospital pharmacists established. | Action plan developed and monitored. All action points progressing with planned roll-out of medicines reconciliation across all inpatient services in 2011. |
| Serious | 6 | Resident fall in hospital level dementia unit, resulting in fractured hip. | Independently mobile resident sustained a fractured hip. Fracture surgically repaired. | Falls Prevention and Management Audit was completed in the third quarter 2010/11 following the introduction of the Falls Prevention and Management Programme on 20 September 2010.  Overall there was a high level of compliance with completing the falls action plan once a patient had been identified as a falls risk.  A Falls Champions Group has been established. This Group are currently working to identify key messages to feed back to staff to highlight risk of falls.  A pamphlet for patients/family/whanau to explain the programme is being developed. | |
| Serious | 6 | Patient fall with no obvious injury until two days later when swelling and X-ray revealed a fractured leg (tibial plateau). | Falls risk assessment completed and fall prevention plan in place. |
| Serious | 6 | Patient fall resulting in serious wound to leg. | Falls risk assessment completed on admission and falls prevention plan in place, including requirement for supervision when mobilising.  Patient attempted to mobilise independently. |
| Serious | 6 | Patient fall resulting in fractured ribs, pelvis and sacrum. | Falls risk assessment completed indicating a high falls risk. Falls prevention plan in place – including use of a sensor mat.  Sensor mat not plugged in when fall occurred. |
| Serious | 6 | Patient found on floor and subsequent review of X-ray showed multiple broken ribs. | Falls risk assessment not completed on admission. |
| Serious | 6 | Resident fell, sustaining a fractured hip. | Falls risk assessment completed, indicating high risk of falls and fall prevention plan in place.  Resident mobilised without walking frame and fell.  Fracture surgically repaired. |
| Serious | 6 | Resident fell, sustaining a fractured hip. | Falls risk assessment completed indicating high risk of falls and fall prevention plan in place.  Resident mobilised without walking frame and fell.  Fracture surgically repaired. |
| Serious | 6 | Patient fell from bed. No obvious head injury noted on examination. Two hours later patient found to be unresponsive and subsequently died. Referred to Coroner. | Falls risk assessment completed on admission and falls prevention plan in place; however, management guidelines relating to monitoring patients following a fall were not followed resulting in a failure to detect the deteriorating patient. |
| Serious | 6 | Patient fell, sustaining a fractured arm. | Falls risk assessment completed on admission and falls prevention plan in place. |

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# Southern District Health Board

www.southerndhb.govt.nz

| **Serious or sentinel** | **Event code** | **Description of event** | **Review findings** | **Recommendations/actions** | **Follow-up** |
| --- | --- | --- | --- | --- | --- |
| Sentinel | 2 | Voluntary patient committed suicide while on overnight leave. | No clear single point of contact for the patient’s family and rostering of nursing staff means the primary nurse is only intermittently available.  The long-term high risk of suicide for this patient was not documented. Only short-term clinical risk was regularly noted.  Although the patient’s firearms were removed from his possession he was able to use his firearms licence to purchase a new gun. | A single contact point for family with a member of staff likely to be consistently available.  Review of the current risk documentation practices.  Discussion take place between Southern DHB mental health services and the NZ Police about the removal of firearms licences during significant episodes of depression and the pathway to reinstatement of firearms licences when full recovery has occurred. | Risk Management Working Group formed to review the service approach to risk assessment and management of clinical risk.  A draft revised treatment plan for inpatient areas is currently under consultation, part of which aims to improve the recording and follow-up of clinical risk observations and regularly changing leave status. |
| Serious | 6 | Inpatient fall resulting in laceration to inner forearm. | Falls prevention strategies were appropriate and supervision during activity was of a high standard. | All reasonable steps had been taken to keep the patient safe while permitting return to maximum independence. | Staff are now more aware of the hazard and will consider the potential risk when assisting or supervising patients’ mobility in areas where linen trolleys are located. |
| Sentinel | 2 | Inpatient suicide. | Investigation under way. |  |  |
| Sentinel | 3 | Retained central line guide wire following a complex central line insertion, requiring removal in radiology. | This was a complex insertion which required two central line packs to be used, resulting in the first wire accidentally being left in place.  The standard technique for inserting central lines is the ‘Seldinger’ technique which is a well-established procedure in clinical practice used to introduce catheters, probes, electrodes, etc. into vessels. | As the task is unable to be changed, the intensive care unit has educated all the staff who might be involved in any central venous line insertion to maintain vigilance to ensure that the wire is removed – particularly if two or more kits are used. |  |
| Serious | 3 | Retained surgical swab following a pacemaker insertion. Swab found during another surgical procedure. | No policy in place within the setting by which the attending doctor is required to advise the scrub nurse/circulating nurse that an open wound is/has been ‘packed’ with a gauze swab.  No policy within the setting enabling and requiring an instrument, sharps and/or a swab count to be undertaken when an open wound procedure is undertaken.  The gauze swabs used in the cardiology laboratory are not radio-opaque and therefore cannot be identified upon ultrasound or X-ray imaging.  The potential for a retained product producing an inflammatory response does not have a mechanism for investigatory escalation. | Requirement that all medical officers undertaking pacemaker implantation (or any other procedure involving an open wound) to advise the scrub nurse/circulating nurse of an intention, or the act of, placing a gauze swab (or any other temporary item) within the wound pocket.  Implement the Main Operating Theatre Surgical Count Policy in this area.  All swab material to contain a radio opaque marker.  When a surgical wound site demonstrates signs of infection, and/or inflammation, and/or oedema, multi-view X-rays of the site are performed for the purpose of excluding the possibility of retained equipment. | Cardiology Dept now has radio opaque gauze and all standard gauze has been removed.  Swabs (and all other equipment used) are counted and documented as per the surgical count policy.  Patient X-rayed during procedure which would highlight any remaining gauze. |
| Sentinel | 4B | Delay in resuscitation procedure that may or may not have contributed to patient death. | The basic adult collapse algorithm was followed correctly up to the point of early connection to a defibrillator.  Night staff to have further CPR training on working with smaller teams.  No formal handover practice outside of supervised handovers for medical staff.  One RN had to supervise another agitated patient on the ward which prevented other tasks from being completed.  Resuscitation team were not aware of their roles in the arrest leading to no one taking charge.  Difficulty obtaining telemetry reading from the patient. | Consider staff working a high proportion of night shifts be required to undertake CPR certification at level 5 or 6.  Review of handover practises outside of supervised handovers.  Review of the patient watch requirements.  Formal orientation to the role for resuscitation team members.  Telemetry request log is redesigned and the existing telemetry documents are reviewed. | Resuscitation Committee continue to audit the arrest team on a quarterly basis to monitor for further development opportunities. |
| Sentinel | 4A | Misdiagnosis resulting in patient developing clinical complication (osmotic myelinolysis) requiring intensive treatment and rehabilitation. | Infusion and subsequent correction of low sodium level (hyponatremia) resulted in osmotic myelinolysis.  Low sodium result was not initially recognised.  Meals low in sodium were not provided as requested. | All patients presenting with severe low sodium (less than 115) are admitted to ICU for controlled management.  Review pro forma for hand writing of blood test results. | A hospital-wide patient safety alert has been distributed for learning purposes.  Implementation of a new Food Management System which aims to improve meal provision to patients with specific dietary requirements. |
| Serious | 6 | Inpatient fall resulting in a fractured hip. | The falls prevention plan was developed and followed to best care for the patient.  Consideration was given to the residential context the patient was being discharged to and hence the falls alarm was discontinued just prior to the fall.  Protective hip pads, although not able to prevent the risk of falls, could minimise the risk of fractures resulting from falls. | The use of falls alarms should be continued as long as a high risk of falls exists and their use can be justified.  Consideration should be given to the purchase of hip protector pads to decrease the likelihood of a fall resulting in a hip fracture. |  |
| Serious | 4B | Management of mother in labour in the community requiring urgent treatment. | Investigation under way. |  |  |
| Sentinel | 11 | Inpatient death subsequent to taking Methadone obtained illegally. | Possibility that the patient obtained Methadone for recreational use while on approved ward leave.  Patient did not present with early warning signs of Methadone toxicity, therefore patient was only observed every 30 minutes overnight according to protocol. | Mental health staff to have education from the community alcohol and drug service about the high risks associated with recreational methadone use.  The Co-existing Problems Working Group will consider the inclusion of methadone toxicity as a subject in the development of the upcoming education.  A fact sheet on methadone toxicity be developed for patients identified as current or potential illicit methadone users. | Co-Existing Problems Working Group is meeting regularly and attention is being given to the development of a broad skill set among MH staff which will include addiction issues. |
| Serious | 6 | Inpatient fall resulting in fractured ankle requiring surgery. | The falls prevention programme is currently under development for mental health units.  Consideration of falls risk and the physical environment were not included in the patient’s care plan. | Implementation of falls prevention programme in mental health units. | A preliminary falls prevention education session has been provided to staff. |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Patient was assessed thoroughly and did not meet the criteria for provision of a falls alarm.  No evidence of medical instability or change in medication regime that could have contributed to this patient being a falls risk.  A contributing factor may have been long-standing back pain which may have affected patient’s balance and fall protection responses. | No corrective actions could be identified as patient, who felt confident to do so, mobilised independently against recommendations from staff. | Falls Prevention Programme Audits continue to ensure the assessment documents are capturing those at-risk patients appropriately. |
| Sentinel | 11 | Patient death in the community resulting from non-invasive ventilation machine ceasing to function during power failure. | The patient’s emergency plan had been established in line with current national and Australian practice.  Both the oxygen concentrator and ventilator were functional with working alarm systems.  No consistent provision of an uninterrupted power supply provided for non-invasive ventilation equipment supplied for home use. | Purchase of back-up battery power stations to supplement current non-invasive ventilation machines. | Three power stations have now been purchased for use. |
| Serious | 6 | Inpatient fall resulting in fractured knee. | Falls prevention risk planning was not completed prior to the patients fall; however, the physiotherapist had assessed the patient as being safe to independently mobilise | Documentation standards and expectations to be reinforced to staff via the charge nurse managers and educators on falls prevention and care planning. | Ongoing audit of the falls prevention programme to ensure it is being utilised correctly. |
| Serious | 5 | Intravenous cross contamination of a medicine (Fentanyl) between two patients. | The Fentanyl syringe was not discarded at the end of the duty and was subsequently used on another patient.  The Intravenous Medication Policy was not correctly followed. | Education sessions held for all staff to reinforce the principals of the IV policy and to provide instruction on correct discarding of controlled medications.  Controlled medication cupboard checks will be undertaken to ensure any leftover medications are discarded according to policy at the end of each shift. | The education session focused on ensuring practice change was occurring and to provide a question/answer session for staff queries and options on how to work within the scope of the policy. |
| Sentinel | 11 | Inpatient death. | Awaiting findings from the coroner as it appears this death may have been due to natural causes. |  |  |
| Serious | 6 | Inpatient fall resulting in a fractured leg (femur) requiring surgery. Patient subsequently died. | The patient was treated as high risk according to the falls prevention protocol and the fall was multi-factorial.  It does not appear that the fall contributed to the patient’s death. | All available preventative measures were in place therefore there are no recommendations. |  |
| Serious | 8 | Patient absconded and an alleged assault occurred. | Investigation under way. |  |  |
| Sentinel | 4F | Delayed access to emergency treatment in remote site prior to urgent transfer resulting in patient death. | Investigation under way. |  |  |
| Serious | 3 | Retained surgical instrument (clamp) following gastric bypass surgery requiring subsequent surgical removal. | Investigation under way. |  |  |
| Sentinel | 4A | Misdiagnosis resulting in patient discharge and subsequent death due to rupture of major abdominal artery (aorta). | The patient’s presenting complaint was of back pain. Misdiagnosis and discharge occurred despite thorough examination.  Delay in radiology reporting which may have identified the condition.  Current back pain proforma does not include rupture of abdominal aorta as part of the diagnosis as it is a rare cause. | A process to enable consultant involvement in decision making regarding discharge from the Emergency Department (ED).  Establish a process to ensure timely review of X-ray findings for ED patients.  Consider adding rupture of abdominal artery to the current proforma with guidance on potential for misdiagnosis. |  |
| Serious | 4C | Unrecognised patient deterioration due to inadequate monitoring. | Patient was subject to decreased respiratory drive possibly due to sedatives given and it is possible there was a primary aspiration event which compromised the patient’s ventilation.  The respiratory depression was treated and the patient recovered.  Patient-controlled analgesia protocol not followed. | The patient’s ongoing pain management plan was deactivated by the Hospital Pain Team.  A ward audit to be completed of all observation charts and medication charts to identify compliance with PCA protocol.  Review of the management and communication of patients under both long-standing and acute medical teams. |  |
| Serious | 9 | Inpatient assaulted by another inpatient requiring emergency treatment. | Patient who assaulted was appropriately treated and protection of others was managed by limited access to the ward with tight controls to ensure others’ safety, however this patient’s level of aggression was unpredictable. | The patient, as much as is practical, be managed in the community setting where there is less contact with other vulnerable patients. |  |
| Serious | 4C | Unrecognised patient deterioration due to inadequate monitoring. | Investigation under way. |  |  |
| Serious | 5 | Medication error involving a higher dose of opioid being administered, resulting in patient being treated in the high dependency unit. | Incorrect dose of opioid prescribed which resulted in the administration of five times patient’s normal dose.  Patient charted 37**mL** instead of 37**mg**.  Correct opioid dose not reconciled with patients usual prescriber. | Immediate Hospital Safety Alert disseminated to always prescribe liquids in milligrams because of the different strengths available.  Use of this medicine requiring medicine reconciliation be part of prescribing policy and included in orientation for all medical staff.  Nursing staff are to administer liquid medications only if prescribed in milligrams. | Pharmacy currently reviewing medication policy. |
| Sentinel | 4D | Cardiac arrest of ventilator-dependant patient during MRI scan. | Equipment became disconnected during transfer.  The incident was well managed with a successful outcome. | Anaesthetic Specialist, Registrar and Technician education regarding the equipment utilised in this and other environments in Radiology.  Continuing ongoing advanced life support education be undertaken by all Anaesthesia and ICU staff. | At least once yearly educational visits as part of departmental teaching to maintain familiarisation with this environment. |
| Serious | 6 | Inpatient fall resulting in fracture of pelvis. | Investigation under way. |  |  |
| Serious | 6 | Inpatient fall resulting in fractured knee. | Investigation under way. |  |  |
| Sentinel | 4F | Death of a child with complex underlying health conditions, which may or may not have been prevented by earlier admission to the Intensive Care Unit. | Baseline oxygen saturations when patient was well were not available for reference.  Resuscitation status was not clearly documented.  Paediatric Early Warning Scoring System (PEWS) not currently in use, but is under development for use in South Island DHBs. | Children with chronic cardio-respiratory conditions should have baseline oxygen saturations recorded at intervals when well.  Children with complex life-threatening medical problems presenting with acute illness should have their resuscitation status reviewed in discussion with family/whanau and clearly documented.  PEWS trial to take place on the children’s ward. |  |
| Sentinel | 4D | Inadvertent misplacement of a nasogastric tube resulting in patient death. | Investigation under way. | In the interim an organisational risk alert has been circulated to inform staff of the potential risks of this procedure. |  |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Investigation under way. |  |  |
| Sentinel | 4C | Delay in monitoring and response to the coagulation status of the patient may have contributed to bleed in brain (subarachnoid haemorrhage) and patient death. | Root cause analysis being undertaken. | Recommendations not finalised at time of reporting. | In progress. |
| Serious | 4A | Delayed radiological diagnosis resulting in paralysis. | Diagnostic error highlighted where spinal lesion missed on CT scan undertaken. Not identified until subsequent MRI taken to diagnose back pain and leg weakness.  Full disclosure and apology to patient and family. ACC treatment injury completed. | Departmental audits undertaken. | Completed. |
| Serious | 4E | Delay in receiving radiological diagnosis leading to disease progression of bladder cancer. | Referral prioritised incorrectly as non-urgent.  Examination completed 10 months post referral. | Review of Medical Imaging referral process completed.  Recommendations for improvement currently being implemented.  Wait list managed back within guidelines of six to seven weeks. | Completed. |
| Serious | 4E | Delay in diagnosis of cancer. | Root cause analysis undertaken finding issues with the handling of abnormal scan results. | Review medical staff orientation, Explore system to flag all abnormal results. | In progress. |
| Serious | 6 | Inpatient fall resulting in fractured hip. | Patient mobilising with distant supervision following clinical assessment in preparation for discharge, and fell. | Falls programme introduced. | Completed. |
| Serious | 8 | Patient expected to be assessed absconded while awaiting Mental Health Act assessment. | Miscommunication between Police and Duly Authorised Officer resulting in delay of assessment until the following day. | Review and update with Police to ensure that assessment happens in the most appropriate setting. Patient subsequently assessed with no adverse outcomes. | Completed. |
| Serious | 4C | Patient developed severe pressure sore. | Risk not adequately assessed and documented to facilitate optimal treatment.  Poor communication between community and hospital in a compromised patient resulting in severe pressure injuries following a surgical procedure and subsequent short hospital stay.  Underlying development of pressure sores in the community due to 28 days sitting and sleeping in chair with feet on foot rest. Theatre/recovery time added significantly to the pressure injury on heals – blister noted day two post-discharge. | Review risk assessment and monitoring.  Review communication between clinical teams.  Formation of Pressure Injury and Prevention Team (PIPI) has been actioned. | In progress. |
| Serious | 4A | Administration of medication resulting in termination of a potentially viable pregnancy. | Treatment commenced based on patients presenting symptoms and diagnostic information available at the time leading to misdiagnosis of an ectopic pregnancy. | Future decisions will follow new clinical protocol. | Completed. |

1. Some incidents involved more than one event category. [↑](#footnote-ref-1)
2. No blood transfusion reaction events were reported in 2010/11 as serious or sentinel (SAC1 or 2) events. [↑](#footnote-ref-2)