



# DHB Summary of Serious and Sentinel Event Report 2008/09

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# Northland

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	11	N/C	Extreme weather associated with water entry caused outage of patient management systems.	Reliance on electronic systems. Knowledge deficits. Lack of contingency plans.	Re-positioning of computer switchboard. Attention to maintenance. Develop contingency plans.	Completed. Discussion by executive team. Business continuity plans under development.
Serious	4A	N/C	Patient failed to progress in labour in regional hospital. Subsequent transfer, emergency caesarean, baby died.	Relevant previous obstetric history which might have prompted earlier transfer not obtained. Equipment shortage and resuscitation processes to be addressed.	Regional midwives to be reminded of best practice re obtaining obstetric history. Foetal monitoring machine to be purchased for theatre.	Completed at education session by Maternity Nurse Manager. Now four machines throughout the service.
Sentinel	4A	N/C	Patient presented to emergency department x 3 over a six-year period. X-rays taken on each presentation identified pulmonary tuberculosis, not actioned until third presentation.	X-ray results filed without action.	New alert process on radiology reporting system.	System for ensuring clinicians alerted to radiological abnormalities in process.
Sentinel	4A	2	Mammogram identified potential carcinoma, referral never actioned. Diagnosis delayed until further presentation.	No process for handing on patients when clinician leaves.	Database of patients requiring annual mammograms. Radiology Department to proceed directly to biopsy if clinically indicated. Process of handover.	System in place December 2008. Commence by January 2010. To be completed by November 2009.
Serious	4B	2	Child received overdose of fluids.	Misread guideline, using adult instead of paediatric section to calculate fluid. Limited review of treatment on transfer from emergency department to paediatric ward.	Highlight paediatric section of guideline. Improve protocol access. Fully implement smart pump technology. Develop and trial precalculated weight-based infusion guidelines. Develop transfer protocols for paediatric patients. Revise paediatric fluid guidelines.	All implemented or underway.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	4D	1	Cardiac arrest during laparoscopic surgery.	No clear risk factors. Likely rare complication of gas entering circulation. All treatment appropriate.	Full complement of theatre staff even during low risk procedures.	None required.
Sentinel	3	1	Swab retained post surgery. Delayed recognition even though visible on x-rays.	Still under review.	Pending.	Pending.

# Waitemata

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	5	3	<p>It is likely that three of the 24 patients vaccinated with Hiberix® vaccine did not receive a dose of active vaccine – instead they may have received a dose of diluent only.</p> <p>All patients were receiving the vaccine post-splenectomy (Hiberix® immunises against Haemophilus influenzae type B).</p>	<p>The Hiberix® vaccine is packaged in lots of 10 with the diluent in prefilled syringes and the vials containing the active vaccine powder in a separate unmarked cardboard box contained within the main box.</p> <p>Several other vaccines come as a single prefilled syringe and it seems that on three occasions, the person dispensing the syringe did not realise there were two components, hence the diluent syringe was dispensed without the vaccine.</p> <p>Not possible to establish which three of the 24 patients did not receive vaccine, hence all potential patients advised.</p>	<p>Pharmacy awareness raised through education sessions.</p> <p>Switched to procuring the vaccine in single packs (diluent and vial contained in a single box).</p> <p>Large warning labels are placed on the vaccine boxes as they are receipted into the pharmacy.</p> <p>Letter sent to each of the 24 patients explaining the situation and offering free revaccination.</p> <p>Letter to company advising of potential problem (no response received).</p> <p>Notification given to the Pharmaceutical Society of New Zealand.</p> <p>E-mail sent to other hospitals via the hospital pharmacists e-mail group.</p>	<p>No further problems.</p> <p>Education sessions completed on all vaccines (others are now also packaged in this way).</p> <p>Supplier has not responded to letters or e-mails about this issue. Supplier (GSK) has since discontinued the single pack of vaccine so we have had to revert to using the 10 pack.</p>
Serious	2c	4	<p>Inadequate monitoring of three newborn babies resulting in urgent admission to SCBU.</p>	<p>Three newborn babies were identified as having low blood glucose and low temperature on the ward over a month period. Required admission to SCBU and prolonged care.</p> <p>Potential and impact of hypoglycaemia and hypothermia was not recognised in a timely manner. Delayed referral to SCBU paediatrician.</p>	<p>Policy and guidelines reviewed and used in staff education. Education programme for midwives to ensure awareness.</p> <p>Increased monitoring and overview by senior staff.</p>	<p>Training well established.</p> <p>No further events.</p>
Serious	9	3	<p>Assault of one patient on another in inpatient courtyard. Fall with fractured neck of femur requiring surgery.</p>	<p>Fall not witnessed. Patient found lying on the ground. Helped to bed but later found to be in shock.</p> <p>Leg noted to be shorter. Assessed as having fractured neck of femur.</p> <p>Appropriate action taken in transfer to acute hospital. Transferred to emergency department for surgery.</p>	<p>Signs and symptoms of fracture, appropriate emergency processes reviewed with staff.</p>	<p>Nil further required.</p>

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Serious	5	3	Medication error.	Prescribed and administered diuretic Frusemide IV 1000 mgs eight-hourly.	Audiometry tests done to check for side effects. Nil evident. Education session for medical and nursing staff on safe prescribing and appropriate dosage.	No further events of this type have occurred. No apparent ill effects for patient.
Serious	4b	3	Pulled out nasogastric. Not replaced in a timely manner. Nutrition care plan not reviewed.	Admitted after stroke. Pulled out nasogastric tube. Not replaced. Poor nutrition replacement as was nil per mouth for seven days. Rehabilitation delayed.	Requirement specified of key roles to review care plans of patients who are nil per mouth to ensure appropriate nutrition. Referral to stroke CNS and nutrition service reinforced.	Audit of nutrition screening has occurred at regular intervals through the year.
Sentinel	4b	2	Vitamin K not given after birth. Baby had seizure and developed intracranial bleeding.	Misunderstanding between independent midwife and mother about the importance of Vitamin K after birth. Vitamin K not given. Baby had seizure. Found to be irritable, unequal pupils and neurological signs 8–10 hours after birth. Coagulation deranged consistent with Vitamin K deficiency.	Requirement for increased formal documentation of discussion with mothers reinforced to ensure full informed consent in birth plan. Reinforced that where mother not clear about what to do, must be offered second opinion.	Baby has long-term health issues. Audit of documentation in birth plans. Case review with independent staff.
Serious	6	1	Fall resulting in fractured neck of femur and surgical repair.	On commode. Fell off while unattended. Post fall assessment noted fractured neck of femur. Transferred for surgery to repair fracture. Deceased three days later.	Prioritisation of post fall assessment reviewed with medical staff. Nurses reviewed procedures for monitoring patients on commodes.	Fall minimisation planning reinforced.
Serious	4b	3	Delayed treatment for high INR.	Admitted for treatment post haemodialysis as INR 10.9. Delayed assessment in emergency department. Developed minor complications. Delayed administration of plasma and delayed Prothrombinex administration.	Treatment to be given in haemodialysis unit. Increased supervision of treatment plans and prescriptions in emergency department. Staff advised to call nurse specialists if too busy.	

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Serious	5	3	Medication incident.	Patient prescribed 900 mgs of Amiodarone for 3D then 300 mg BD. 3D was interpreted as three days. Patient received 6 x 900 mgs over 48 hours. Very nauseated post angiogram. Found that non-standard abbreviation resulting in overdose of Amiodarone.	Accepted abbreviations reinforced. Appropriate dosage reviewed with staff and increased vigilance reinforced.	No long-term effects for patient.
Serious	6	3	Fall unwitnessed resulting in fractured neck of femur and surgery.	Found on floor in bathroom with walker nearby. Assessed as having fractured neck of femur and transferred for surgery. Rehabilitation prolonged. Resulted in relocation.	Procedures for monitoring dependent patients when self mobilising reinforced. Review of bathroom layout.	
Serious	4a	3	Inadequate documentation of patient admitted for elective procedure.	Patient admitted for elective procedure. Patient deteriorated with fatal post-op complications. At time of deterioration and medical registrar and ICU review, little information was found on the admission planner, or any subsequent evaluation (other than for knee surgery) despite being in hospital for five days.	Elective assessment procedures reviewed to ensure complete documentation. Reinforcement of requirement for daily review and documentation in clinical record.	Audited.
Serious	4f	2	Unwell patient not assessed prior to transfer and transit nurse not present.	Patient being transferred to the dialysis unit. Ambulance officer identified patient was vomiting and appeared to have decreased level of consciousness. Requested transit nurse. Not done. On arrival patient not breathing.	Transit policy reviewed with nurses to reinforce expectations. Reinforced with St John that they can refuse to take patients if not happy with condition and transit arrangements.	Increased staff training about transit care procedures and assessment skills. Review of staff transfer of care practices.
Serious	4c	3	Poor coordination of care resulting in prolonged recovery.	Inpatient with severe menorrhagia and related cardiac rhythm symptoms requiring 10 unit transfusion, hysteroscopy, surgery, intrauterine balloon tamponade. Poor co-ordination with clinical plan of care not clearly communicated to relevant team. Discharged prior to treatment and without prescription. On re-admission, delayed treatment commenced prior to surgery. Patient recovery delayed.	Review models of care – clear clinical team ownership. Review medical staff numbers and supervision. Review authority for discharge planning. Communicate with patient about plan of care and provide discharge documents.	Service continuing to review this situation to ensure systems issues are addressed.

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Serious	4c	3	Baby admitted to SCBU after birth as monitoring of woman in labour inadequate.	Monitoring of mother and baby was not adequate or according to policy. Baby severely compromised at birth and required resuscitation and admission to SCBU inadequate handover from Independent midwife to core midwife.	Handover procedures reviewed with all parties. Policy expectations reviewed with midwifery team. Routines reinforced.	Service continuing to review this incident to ensure systems issues are addressed.
Serious	4c	3	Baby admitted to SCBU after deterioration.	Baby delivered as caesarean section. Monitoring of baby temperature and respiratory rate overnight inadequate. Required urgent transfer to SCBU and treatment.	Policy expectations reviewed with team. Routines reinforced. Care plans updated and staff training increased.	Service continuing to review this incident to ensure systems issues are addressed.
Serious	4c	3	Patient deterioration and delayed assessment.	Early warning scoring inconsistent resulting in delayed assessment. Emergency call not made when the score indicated it should have, despite doctor in attendance. Patient required transferred to ICU after initial stabilisation and had prolonged recovery.	Staff knowledge and assessment skills using the early warning score reviewed. Reinforcement of emergency calls reviewed with staff.	Staff training increased in the service and assessment skills reviewed.
Serious	4d	3	Medication administration error.	Morphine elixir via an IV line instead of a gastric tube. Medication checking process to the bed side inadequate. Dedicated syringe for gastric tubes not used in administration process.	Best practice not followed. Increased supervision required. Equipment changed and staff trained to identify correct administration practice.	Case review undertaken and used in teaching. Equipment change actioned.
Sentinel	4d	2	Unexpected death following elective surgery.	Underwent an elective inguinal hernia repair. Discharged home the next day. At home collapsed and died. Autopsy identified complication after surgery.	Pre discharge assessment requirements reviewed with staff.	Service continuing to review this incident.
Serious	11	2	Prolonged infection outbreak.	Prolonged ESBL outbreak with colonisation of a number of patients. ESBL has contributed to infections which may have contributed to deaths of a few patients.	Extensive outbreak management plan has been in place. Reviewed by CDC. Intensive audit and staff education programme in place.	Services continuing to review this situation to ensure systems issues are addressed.

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Sentinel	4d	1	Unexpected death from complications of anticoagulation therapy.	Admitted for treatment of myocardial infarction with Clexane and Aspirin. Deteriorated and transferred to ICU. CT scan showed bleeding from inferior epigastric artery associated with large rectus sheath haematoma. Transferred to the vascular service. Deceased.	Administration practice of Clexane reviewed as appropriate. Case review used in staff teaching to increase awareness of recommended sites for administration in patient teaching.	Continuous education process.

## Auckland

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Serious	4a	2	Transferred from emergency department to ward in unstable state prior to specialist team review.	Delay in specialist registrar review. No medical review prior to transfer. Inadequate nursing handover. No long-term adverse outcome.	Escalation to consultant after one hour. Modify nurse handover.	Implemented.
Serious	4d	2	Excessive X-ray dose during cardiac investigation.	Default settings used rather than reduced dose for patient size. No immediate adverse effects.	Change to dose checking process. Use of "time out".	Implemented.
Sentinel	1	1	Scalp incision made on incorrect side.	Consent form had incorrect side noted. "Time out" process only partially used.	Improved documentation. Consistent use of marking operative side. Full implementation of "time out" check.	Currently under audit. Implemented. Completed.
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Sentinel	4d	1	Fatal blood loss due to disconnection of dialysis circuit.	No cause for disconnection found all procedures followed appropriately. Machines unable to detect early circuit leakage.	Ensure circuit lines are visible at all times. Advise other dialysis services of risk.	Patient compliance has limited implementation.
Serious	4b	2	Six-hour delay in surgery for bleeding, patient's condition deteriorated significantly.	Priority initially correct, but not revised as patient not reviewed while waiting. No long-term adverse outcome.	Escalation to specialist level if unable to review in an appropriate timeframe.	Implemented.
Serious	4a	2	Incorrect pathological diagnosis of type of tumour leading to inappropriate more toxic treatment at the time.	Tumour histology incorrectly reported five years ago. Patient suffered significant complications of treatment.	No change to current systems required.	Not applicable.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Inpatient fall causing fractured wrist.	Patient left in care of visiting family while staff were on break.	Update / expand falls prevention programme.	In progress.
Serious	4b	2	Non-fatal cardiac arrest due to bleeding during caesarean section in high-risk patient.	Inadequate planning of surgery and anaesthesia. Technical difficulties during procedure.	Multi-disciplinary planning group for high-risk cases. Specific credentialing for high-risk surgery. Review use of arterial balloons.	Implemented. Proposal under review. Process revised.
Serious	4b	2	Delay in receiving follow-up after cancer surgery. Late identification and treatment of tumour recurrence.	Post-op clinic appointment not sent due to communication failure.	Patient co-ordinator position required.	Nurse specialist appointed.
Sentinel	4a	1	Failure to act on significant drop in patient's haemoglobin. Patient died next day.	Rest home requested blood test using form with incorrect details. Results sent to hospital staff who were on leave. Laboratory did not contact rest home.	Test request form to have correct contact details. Requestor responsible for follow-up of results. Laboratory to review criteria for identification and communication of critical results.	Letter sent to rest home.  Issue raised with community laboratory.
Sentinel	2	1	Inpatient suicide in mental health unit.	Currently under review.	Currently under review.	Not applicable.
Serious	4d	2	Severe pressure ulceration requiring surgery.	High risk case in ICU. Cardiovascular instability limited frequency of patient turns. Early signs of injury not recognised.	Modify education regarding early risk assessment.  Revise approach to turns for unstable patients.	Implemented.
Serious	8	2	Client requiring escorted leave absconded from temporarily locked ward and attempted suicide.	Client left as staff member entered. Identity of patient and leave status was not known. Placement in open ward was appropriate.	Review monitoring and security systems for clients requiring leave supervision in open wards.	In progress.
Serious	4b	2	Bleeding from lung unable to be suctioned due to inadequate equipment.	Room not appropriately prepared for complexity of patient. Delay in resuscitation team arriving due to unfamiliar location.	Wider range of equipment with improved labelling. Increase nursing cover in evenings. Modify resus team teaching.	Implemented. Implemented. Implemented.
Serious	5	2	Incorrect dose (20x) of concentrated sodium added to IV	4 mmol/ml misunderstood as 4 mmol per 20 ml ampoule.	Labelling change.	In progress with manufacturer.

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			fluids. Patient developed critically high sodium level.	High concentration not emphasised on label. Staff unfamiliar with concentrated saline.	Revise IV fluid protocol. Staff education.	In progress.
Serious	6	2	Fall from radiology table during procedure causing lacerated scalp.	In stable position stable for 45 minutes, but then turned and fell, assuming procedure had ended. Larger table may have prevented fall. Death next day unrelated to this injury.	Higher risk cases to use largest available table. More clear instructions to patients.	Implemented.
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Serious	11	2	Major failure of clinical computer systems for four hours. Significant clinical risk.	Replacement of uninterruptable power supply damaged by power "spike" caused sequential failure of multiple systems. Inadequate knowledge of power supply requirements. Key servers had single power supplies.	Revised documentation to support maintenance operations. Higher level authorisation for equipment changes. Upgrade of all servers to fully separated dual power supply	Completed. Implemented. Mostly completed, some ongoing work.
Serious	4b	2	Delay in recognising and acting on severity of deterioration of patient with pneumonia.	Death probably not preventable, but intervention should have occurred some hours earlier. Delay in senior medical review.	Improved communication between medical staff. Review of medical high dependency services.	All staff involved aware of issues. Review in progress.
Serious	6	2	Inpatient fall causing fractured hip.	Not formally reviewed.	Update / expand falls prevention programme.	In progress.
Sentinel	4b	1	Fatal multi-organ failure triggered by bleeding from dental extraction. History of severe liver disease and blood product refusal not known to dental staff	Patient did not declare recent medical history. No recheck of severity of clotting abnormality. Health questionnaires do not ask about treatments unacceptable to patient.	Document all verbal checks of patient history. Revised surgical technique for patients with mild clotting abnormalities. Revise health questionnaire.	Implemented. Implemented. In progress.
Serious	4a	2	Missed lower leg fractures in patient with multiple injuries.	Secondary trauma examination incomplete due to severity of other injuries.	Feedback to medical staff.	Completed.

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Serious	4a	2	Chest x-ray report identifying incidental lung cancer not reviewed by treating clinicians.	Current manual system is unable to ensure that appropriate clinical signoff occurs. Previous similar cases.	New radiology ordering, reporting and sign-off process.	\$1 million software system currently being implemented.
Sentinel	4a	1	Undiagnosed leaking thoracic aorta leading to death in emergency department.	Triage 3 category appropriate. Hospital and emergency department full – patient in low acuity room with non-ED nurse. Delay in medical assessment due to high volume of cases. Preventability uncertain, but earlier assessment may have helped.	Reduce incidence of high ED occupancy by improving patient flow to inpatient beds.	National “six-hour rule” established. Expansion of inpatient bed capacity in progress.
Serious	4b	2	Treatment delay leading to eye injury.	Currently under review.	Currently under review.	
Serious	4b	2	Delay in spinal surgery leading to reduced mobility.	Currently under review.	Currently under review.	
Serious	4a	2	Delay in identifying stone in double urinary tract requiring repeat surgery.	Currently under review.	Currently under review.	

## Counties Manukau

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	1	1	Patient on heart monitor wrongly identified leading to delay in reviewing patient after alert by coronary care unit team. Emergency team called, but resuscitation unsuccessful and patient died.	Incorrect and absent patient name labels above beds. Failure to check wrist band. Lack of bedside handover process. Vital signs not checked when coronary care unit requested patient review.	Audit extent of incorrect use of patient name labels in medical wards. Introduce bedside handover as part of Handover Project. Draft guidelines to ensure ward staff have clear understanding of expectations when asked by coronary care unit to review a patient.	Audit completed. No ward achieved 100%. Trial of patient labels on beds rather than wall above bed being considered. The handover communication tool is currently being trialed on three wards for shift to shift, bedside handover and documentation. This includes checking of patient identification. Draft procedure written and consultation in progress.
Serious	3	2	Retained clip following surgery resulting in second procedure for removal.	Changeover of nursing staff during procedure. Count not completed before skin closure.	Introduction of Safer Surgery Checklist. Review count policy and procedures. Review and update theatre documentation sheets.	Safer Surgery Checklist project under way and reviewed with nursing staff and surgical governance group. Policy and procedures review completed. Theatre documentation sheets reviewed and update under way.
Sentinel	4A	1	Late presentation of patient to maternity services (phoned when in early labour) with unrecognised breech. Inadequate phone advice. Baby stillborn.	No standardised phone advice process in Assessment and Labour Birthing Unit. No documented process for self referral antenatal bookings. Lack of agreed clinical prioritisation process for antenatal booking referral.	Develop agreed process for managing unbooked women, with transparent clinical prioritisation criteria and agreed timeframes. Standardise the booking and grading process across the Women's Health Service.	In progress.

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Sentinel	4A	1	Elderly man admitted to local community hospital by general practitioner. Lack of recognition of physiological deterioration delayed admission to main hospital where patient died shortly after.	Failure to recognise acuity of patient's condition by medical and nursing staff. Vital signs not consistently carried out and no fluid balance chart kept.	Patient admitted to community to have minimum three sets of vital signs recorded in first 24 hours. Physiologically unstable patient protocol (adapted for community setting) to be followed for any patient assessed as unstable. Education for nursing staff to review accurate and timely recording and monitoring of vital signs and fluid balance.	Physiologically unstable patient protocol currently being reviewed for implementation in community hospitals. All registered staff in both community hospitals completed training in vital sign recording and monitoring to recognise clinical deterioration.
Serious	4A	2	Eye disease in premature baby not picked up at screening resulting in significantly impaired vision in one eye.	Service reliant on single ophthalmologist causing problems when covering leave. Limited peer review / audit.	Recall programme for all babies previously screened by doctor undertaken with assistance from Neonatal Unit Staff. New paediatric ophthalmologist being recruited and job description to specify clinical competencies in greater detail. Develop system for clinical audit of screening process.	All babies were recalled and re-examined. Recruitment underway and job description updated. National auditing completed.
Serious	4C	2	Serious tissue injury to baby's hand from intravenous (IV) line requiring surgery. Good recovery.	Fluid balance chart doesn't facilitate documentation of IV checks. Scoring tool not used to assess IV site. Splinting used in paediatric patients to secure the IV site hides development of complications.	Redesign current paediatric fluid balance chart. Incorporate scoring tools into new fluid balance chart. Develop standards for IV splinting and securing for paediatric patients.	New fluid balance chart implemented 01/07/2009. Scoring tools included in new fluid balance chart. Standards for IV securing and splinting in children developed and implemented.
Serious	4C	2	Serious tissue injury to baby's foot from intravenous (IV) line requiring surgery. Good recovery.	Process of wrapping did not allow for adequate visualisation of site. Process for administering fluids continuously also contributed.	Paediatric study day to up-skill nursing staff on management of IV sites. Develop standards for IV splinting and securing for paediatric patients. Fluid to be entered in hourly and not run continuously.	Paediatric study days have been attended by 50% of staff and programme in place for nurses to rotate through Paediatric Intensive Care Unit. Standards for IV securing and splinting in children developed and implemented. Fluids now entered in hourly as well as hourly documentation of IV site.

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Serious	4C	2	Pressure area requiring surgery.	Complex patient with pre-existing conditions. Pressure area assessment not completed on admission or as pressure areas began to develop. Patient compliance issues relating to pressure area cares at times.	Implement pressure area risk assessment and cares according to organisational action plan.	Organisational pressure injury audit undertaken May 2009. Pressure injury prevention action plan led by Clinical Nurse Directors has been developed to implement cares to reduce pressure injuries sustained within the organisation by 10%.
Serious	4D	2	Drainage of chest fluid resulted in bleeding and cardiovascular compromise requiring resuscitation and transfer to ICU.	No formal training for registrars in therapeutic chest drainage. Patient at increased risk of bleeding. Use of spring loaded needle may have contributed to bleeding. Poor communication with nursing staff following procedure.	Add therapeutic chest draining to training programme. Case to be presented at mortality and morbidity meeting to highlight risks. Removal of spring loaded needles from ordering system. Clear plan for observation to be communicated to ward staff following procedures.	Completed.  Completed.  To be completed.
Sentinel	4F	1	Urgent readmission within two hours of discharge. Patient subsequently died.	Family concerns were not acted on upon discharge. Lack of clarity for family around care / treatment received.	All senior nurses reminded to include family members in discussions on discharge planning, to clarify questions from family in writing and to organise further meeting if requested by family. Review communication with all surgical teams. Trial having family present at ward rounds.	Discussed at senior nurse forum – completed. Discussed at surgical governance forum. Case to be presented at a governance meeting with recommendations for trial of families to be present at ward rounds.
Sentinel	4G	1	Cross infection in single unit between seven patients. Subsequent infection and sepsis in one patient resulting in death.	Process not in place to ensure all multiuse equipment routinely cleaned between patients. Hand hygiene education by Infection Control nurse had not been effective in preventing further cross infection.	Ensure personal protective equipment is implemented for multi-resistant patients. Review and modify cleaning process for all equipment that is multiuse to ensure it is appropriately cleaned. Raise 'hand hygiene' awareness.	Unit manager enforcing use of personal protective equipment where appropriate. Cleaning process review in progress. Hand hygiene coordinator appointed and hand hygiene project currently being implemented organisation wide.

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Serious	5	2	Incorrect administration of medication requiring antidote and transfer to Coronary Care Unit. Full recovery.	Correct protocol not accessed. Correct process not followed to administer controlled drug. Discrepancy between nursing and pharmacy protocols for administration of controlled drugs. Inaccurate documentation of dose given in notes.	Review process for accessing protocols and administering controlled drugs with nursing staff. Nursing and pharmacy to review and amend policies so they align. Documentation and communication re administration of medication to be incorporated into orientation training for new graduates.	Education about accessing protocols and administering controlled drugs completed January 2009. Pharmacy currently reviewing and modifying policies. In progress plus additional 'socialisation / orientation' one-day programme being run for new nursing staff with focus on expectations and communication.
Serious	5	Potential 1	Patient administered overdose of insulin to himself after receiving a poor prognosis by medical team. Appropriate countermeasures taken.	Delivery of poor prognosis to patient without support in place. Ward round made without nursing or allied health staff and no handover after round. Conversation with patient not documented clearly.	Develop training module for medical and nursing staff relating to 'sharing bad news', including providing patient support. End of life discussion and decisions to be clearly documented.	Advance Care Plan coordinator to be appointed for a one-year trial period. Responsibilities will include educating staff about sharing bad news, grief counselling, conducting family meetings and enacting advanced care planning directives.
Serious	5	2	10 x overdose of medication	Poor design of medication chart for writing dose. Poorly written prescription was not validated or challenged. Shortage of ward pharmacist. Automated medicines dispensing cabinet does not have safety software to alert re overdose.	Redesign medication chart to incorporate decimal point for documenting dose. Safe prescribing initiative. Develop business proposal to increase staff. Investigate software to enhance system to alert re overdose.	Medication chart redesigned to facilitate correct interpretation of dose. Safe prescribing initiative and business proposal underway. System enhanced but not yet tested or implemented.
Serious	5	2	Penicillin related medication given to patient with documented allergy to penicillin resulting in anaphylactic reaction requiring urgent treatment.	Failure to recognise medication was penicillin related.	Clinical pharmacist to review medications that contain penicillin with staff. Develop posters which lists commonly prescribed drugs containing penicillin. Clinical pharmacist to review good prescribing practices with doctors.	Medications reviewed. Posters developed and placed in all clinical areas.

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Serious	5	2	Patient received chemotherapy in two different DHBs resulting in side effects.	Medical staff at DHB 1 not able to readily access pertinent information about patients attending other DHB for treatment. This has been an ongoing issue.	Urgent meeting to be held between providers to facilitate access to DHB electronic records for senior doctors.	Meeting held. Agreed login to be given to senior doctors. Steps in place for regional document reviewer to cover all DHBs by mid-2010.
Serious	5	2	Due to unclear prescribing, incorrect dispensing and drug administration an elderly patient received an 8 x overdose of medication over prolonged period.	Unclear documentation on medication chart. Failure of pharmacy checking system to identify error.	Ambiguous doses on chart to be confirmed with ward pharmacist. New standard operating procedures developed describing how charts are to be annotated and validated by pharmacists so that doses are clear to all and not open to interpretation.	Ward pharmacists to check with prescriber where ambiguous dose identified. Chart annotation policy for ward pharmacists now in place.
Serious	6	2	Patient fall resulting in fractured humerus.	Repeat falls risk assessment not carried out after patient's condition changed.	All patients undergo risk assessment using standardised tool. Nursing to consider introducing hourly rounds in the ward to review patients. Falls prevention role to be implemented and supported in all ward / unit areas.	Operational Committee set up to develop a consistent organisation wide evidence based approach to falls prevention and management with a target of reducing falls by 10%. Nurse co-ordinator appointed to co-ordinate implementation of falls prevention strategy across organisation.
Serious	6	2	Patient fall resulting in fractured hip requiring surgery.	No low bed available at the time. Bathroom in room unavailable so patient required walking further to access. Lack of regular toilet rounds on ward.	As above. Develop contingency plan to ensure low beds available over weekend. Patient in isolation rooms to use commode chairs.	As above. Completed. Commode chairs now used for all patients in isolation rooms.
Serious	6	2	Fall resulting in fractured hip requiring surgery.	Isolation status given priority resulting in patient being moved to unfamiliar environment away from nursing station.	As above.	As above.
Sentinel	6	1	Patient fall resulting in head injury and subsequent death.	Staffing shortages meant person to watch patient constantly not available.	As above.	As above.
Serious	6	2	Patient fall resulting in fractured skull and subdural bleed (patient recovered).	High falls risk patient left unsupervised.	As above.	As above.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Patient fall resulting in fractured pelvis.	Patient's condition changed – became confused and unstable on feet. No falls risk assessment completed.	As above.	As above.
Serious	6	2	Patient fall resulting in fractured hip requiring surgery.	Review of new bathroom layout revealed issues, including placement of grab rails, lighting and floor surface. Investigation of this fall also highlighted that flooring in new building was exceptionally slippery. Cleaning services inappropriately applied six layers of sealant to the floors in new building making them slippery. Inadequate communication with cleaning services re management of new floor surfaces.	As above plus: Comprehensive risk assessment undertaken by Occupational Health and Safety and sealant to be removed. Review process for communicating with Cleaning Services re appropriate treatment for new flooring. Implement control measures to reduce and manage spillages. Investigate 'dry' cleaning methods to avoid wet floors. Review process of floor specification and selection in new buildings.	As above plus: Comprehensive risk assessment completed and sealant removed. Working group set up to consider development of a specification for new bathrooms and flooring based upon slip-resistance criteria and to establish process for communicating with cleaning staff re appropriate treatment to clean floors.
Serious	11	2	Patient injured when anaesthetist inject local anaesthetic into patient's eye, was bumped by someone in the adjacent cubicle. Procedure delayed, but later completed with no lasting harm to the patient.	Soft curtains between cubicles. High traffic area. Ward beds leave little room for staff in narrow cubicles.	Identify safe area for procedure to be performed with hard walls between cubicles.	Metal barrier (bar) placed between beds. Monitoring continues.
Serious	11	2	Theatre table extension gave way resulting in neck injury to patient. Patient readmitted for MRI and investigation of ongoing neck problems.	Staff lack of knowledge regarding fitting the extension and no identifying marks to match the catch and pipe. Extension table not checked before use and no safety mechanism to ensure the extension will not detach during use.	Bed to be assessed by engineering and appropriate modifications made to ensure safety of attachment. Future beds to have suitable x-ray attachments.	Bed assessed and modifications completed by engineering. Discussed in theatre meeting. Safer surgery checklist project under way.
Sentinel	MH 1	1	Suicide of a person subject to the Mental Health Act 1992.	Limited family understanding of risk and their role in managing risk. Information sharing regarding NGO involvement with client was inadequate.	Close liaison with families on what constitutes risk and how psychosis impacts on judgment, function and communication. Providers to have robust process in place and a standard process for information sharing.	Actions completed or under way. Coroners report sent.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	MH 3	1	Suspected suicide of an outpatient not subject to the Mental Health Act 1992 who is being actively managed by mental health services.	Unclear expectations re second opinion. Handover from crisis team to general team members was unclear about level of follow up required. Liaison with GP was delayed as there was no clarification about diagnosis.	Clear direction for second opinion to be drafted and circulated to ensure clarity of responsibilities including crisis team role to review and update risk assessment prior to hand over to general team. A letter is to be sent to the general practitioner with working diagnosis.	Actions complete. Coroners report completed.
Sentinel	MH 3	1	Suspected suicide of an outpatient not subject to the Mental Health Act 1992 who is being actively managed by mental health services.	Recent changes in risk unclear in the risk assessment. Information sharing between provider staff re changes in risk could improve. Information known to the family not made known to the clinical team due to lack of engagement with family members who were overseas during crisis period.	A new risk assessment and management plan to clearly reflect changes to risk. Process to be in place to ensure that all staff formally notify crisis staff of any deviation from agreed plan. Crisis staff to actively make contact with known primary caregivers and family members if a person is experiencing a significant period of crisis even if they are overseas.	Actions complete or under way.

# Waikato

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	5	1	Patient died as a result of an allergic reaction to medication.	Patient's allergy/adverse reaction status was not checked prior to medication administration.	Discussion to be taken to Medication Safety Forum and agree plan of action from there.	In progress.
Serious	11	1	Outpatient suicide after discharge from inpatient mental health facility.	No issues identified with care provided.	Nil.	N/A
Serious	11	1	Outpatient suicide after discharge from inpatient mental health facility.	Client was discharged from inpatient facility and not followed up by the key worker within the timeframe he was told would happen. Medical staff orientation did not include requirements of the key worker role.	To audit the time period clients discharged from inpatient facility to community mental health adult urban teams. To ensure that clients of team members who are on leave are allocated to another member of the team during the period of that leave. To develop a medical staff orientation process that includes requirements of the key worker role.	In progress.
Serious	11	1	Client committed suicide whilst on weekend leave from inpatient facility.	Non-compliance with treatment planning policy.	Community team staff to be informed of this learning arising from this event review.	In progress.
Serious	11	1	Inpatient suicide attempt that resulted in injury.	Handover did not include all relevant information including risk status. Risk management information is documented on a number of different forms including the clinical record but not in the MDT plan. Staff shortages led to reduced supervision of junior staff.	To revise and review handover process. To review staff workload and allocation processes. To review how the risk management is documented.	In progress.
Serious	11	1	Outpatient suicide six days after contact with service.	No findings.	Family advised of outcome from review.	In progress.
Serious	6	1	Patient fall resulting in an injury that required surgery to repair.	Patient's clinical condition contributed to the fall.	To undertake a DHB-wide project to identify best practice strategies to reduce patient harm from falls.	Implementation of falls project recommendations under way.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	1	Patient fall resulting in an injury that required surgery to repair.	Patient's clinical condition contributed to the fall.	To undertake a DHB-wide project to identify best practice strategies to reduce patient harm from falls.	Implementation of falls project recommendations under way.
Serious	4(b)	1	Patient had radiology investigation that was not followed up.	Failure to recognise and or action a significant incidental finding in this case an aortic abdominal aneurysm on an inpatient between May and June 2008.	The conclusion/impression section of radiology reports will firstly include the findings/ abnormalities in answer to the clinical question being asked and thereafter any other significant incidental findings should be listed.	In progress.
Serious	11	2	Patient injured by bed rail.	Patients underlying condition increased susceptibility of injury.	Ward to complete feasibility of assignment of padded bed rails to specific inpatient population. Include learnings from this event in the education schedule for the ward.	Completed.
Serious	6	2	Patient fall with resulting injury sustained.	Wet floor area caused patient to slip.	Non-slip lino to be replaced by end 2008 as part of property and infrastructure upgrade programme.	Completed.
Serious	6	2	Patient fall with resulting injury sustained.	Patient fell whilst attempting to turn television off. Patient left sitting in lazy boy chair for longer period than normal due to nurse workload.	Discussion to occur with staff on risks in use of televisions, and management of workloads. Controls to be documented for dealing with low staffing risks.	In progress.
<b>Serious</b>	6	2	Patient fall with resulting injury sustained	Incomplete risk assessment carried out and patients clinical condition contributed to the fall.	Ensure admissions are vetted for appropriateness and that a clear admission process is completed on admission. Sensor mats to be sourced.	In progress.
Serious	11	2	Patient hit leg on side of wheelchair. Required surgery to repair and ongoing plastic surgery treatment.	Review in progress.		
Serious	4b	2	Patient's condition deteriorating. Slow response from medical team to review.	Review in progress.		

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	11	2	Physical assault by patient whilst on leave from inpatient facility.	Ensure appropriate accommodation on discharge.	Ensure discharge planning process considers appropriate discharge accommodation.	In progress.
Serious	4b	2	Patient had x-ray of hand and there was a delay in taking action of the result. Had fractured hand.	Review in progress.		
Serious	6	2	Patient fall with resulting injury sustained.	Review in progress.		
Serious	11	2	Patient had neurosurgical drain removed in error. Patient had to return to theatre for re-insertion.	Drain very similar in colour to other drains in use, making it easy to remove incorrect drain.	Change drain type to coloured to reduce risk of similar event recurring.	In progress.
Serious	4a	2	Delayed diagnosis and assessment of patient due to self discharge and incomplete assessment by staff.	No follow-up provided – was to be discussed at mortality and morbidity meeting.		
Serious	4g	2	Communication issues between departments.	Review in progress.		
Serious	11	2	Wrong body uplifted from mortuary.	The funeral director did not check the identification of the body being uplifted. The procedures describing the process for persons uplifting bodies are not readily accessible at the point of transfer in the mortuary and have not been circulated to relevant parties such as funeral directors. This contributed to the confusion regarding who was responsible for identifying the body.	Review mortuary procedures relating to persons depositing or removing bodies plus DHB Care of deceased policy and procedure.  Draft mortuary procedures to be circulated to funeral directors for comment. Controlled copies of final procedures to be distributed to funeral directors.	In progress.
Serious	4g	2	Patient's discharge was unsafe from private hospital. Care was being provided under contracted service.	Review in progress.		
Serious	4f	2	Unwell patient transferred to another hospital without nurse escort.	Incomplete patient assessment carried out by team involved.	Audit clinical records to determine compliance with transfer requirements.	In progress.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	11	2	Child patient sustained an injury while attending clinic.	Item had wooden frame on end that fell on child. Children assist with clearing items as part of therapy.	Hazards clearly identified in area. Children supervised moving or carrying objects.	Completed.
Serious	4f	2	Deteriorating patient transferred from ICU to ward and then had to be readmitted to ICU.	Review in progress.		
Serious	4d	2	Patient injury occurred during nasotracheal intubation procedure.	Review completed and was unfortunate episode. Staff involved were very experienced.	Nil.	Family advised of findings and ongoing support provided to them.
Serious	4b	2	Deteriorating patient. Medical team did not respond in a timely manner to review patient.	Review in progress.		
Serious	4b	2	Patient diagnosed with invasive cancer on follow-up appointment.	Review in progress.		
Serious	4f	2	Patient transferred to another hospital in very unstable condition.	Staff did not recognise deteriorating patient condition. Communication between hospitals was not thorough or effective.	Escalation process in place. Include learnings from this event in staff education forums.	In progress – DHB wide project in place for deteriorating patient.
Serious	4c	2	Paediatric patient suffered injury due to tracheotomy tape placement.	Not thoroughly checking under the full length of the trachy tapes to include the back of the neck. Care plan documented that trachy dressing to be changed and cleaned every shift. General oedema limiting staff ability to easily view the neck.	Staff education particularly when a trachy is newly inserted. The care plan and all the trachy care instructions neglected to specifically highlight that the back of the neck or the whole neck needs to be checked underneath the tapes.	All actions completed.
Serious	11	2	In appropriate monitoring use of external ventricular drainage (EVD).	Inconsistent process for management of EVD and procedure was not clear for staff to follow.	Extensive education to ensure correct procedure is followed. CNM/educators to assist staff with all admission requiring EVD. Audit to be carried out on management of EVDs in ICU.	In progress.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4d	2	Patient harm following surgical procedure.	No root causes identified.	Clinical audits in place. Learnings from case discussed with colleagues.	In progress.
Serious	6	2	Patient fall with resulting injury sustained.	Patients clinical condition contributed to the fall.	Implement falls management risk strategies.	Implementation of falls project recommendations under way.
Serious	4f	2	Patient self harmed on discharge from unit.	Review in progress.		
Serious	6	1	Patient fall with resulting injury sustained. This was not diagnosed until patient was discharged from hospital. Patient readmitted for surgery.	Patients confused and tried to mobilise without calling for staff assistance. No falls risk assessment. No falls mitigation strategies documented or implemented. Neither the falls risk assessment nor the mitigation strategies were reassessed and revised after fall.	Staff members to sign that they have read and understood the Inpatient Falls Assessment and Management Protocol. Falls Protocol to be complied with as evidenced by compliance audit results. Audit to be conducted by Q&R Standards and Audit Facilitator. Hourly rounds to be implemented as part of nursing model. Falls risk management education to be provided to all staff.	Implementation of falls project recommendations under way.
Serious	6	1	Patient fell and sustained fractured hip and required surgical repair.	Patients confused and tried to mobilise without calling for staff assistance.	Falls protocol to be complied with as evidenced by compliance audit results.	Implementation of falls project recommendations under way.
Serious	6	1	Seven patient falls events.	Falls project completed November 2009.	Increase compliance with existing Waikato DHB falls risk minimisation strategies through audit, education and nursing rounds. Ongoing monitoring of falls and compliance with organisational requirements.	Implementation of falls project recommendations under way.
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		
Serious	4c	1	Patient was not monitored as per requirements.	RCA review in progress.		

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4a	1	Surgery delay for patient with severe finger injury.	Multiple missed opportunities, to recognise the severity of the patient's infected finger combined with theatre delays contributed to the patient's finger being severely infected preoperatively and the patient having decreased functional use of his left index finger post operatively.	Referral system be reviewed and improved to ensure more timely and formalised booking process.  Medical handover process to be developed.	In progress.
Serious	4a	1	CTG not recognised as abnormal – baby died two days later.	RCA review in progress.		
Serious	11	1	Client attempted suicide within the inpatient facility and died later from her injuries.	RCA review in progress.		
Serious	3	1	Retained needle following surgical procedure.	No root causes found. Other learnings identified.	Open disclosure education package to be developed and provided to clinical staff.	In progress.
Serious	11	1	Outpatient suicide one day after contact with service.	RCA review in progress.		
Serious	4a	1	Delay in diagnosis due to delay in accessing imaging result.	RCA review in progress.		
Serious	1	1	Wrong patient had investigative procedure.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of discharge from inpatient area.	RCA review in progress.		
Serious	4a	1	Patient died from sepsis. Had presented multiple times to hospital and was reviewed by numerous teams.	Multiple missed opportunities to recognise the patient's deterioration and missed opportunities for more senior and experienced staff to intervene and manage the patient's deterioration in a timely and effective way contributed to the patient's death from overwhelming sepsis.	The development and implementation of a new in-hospital rapid response system.  Development of an 'early recognition and management of sepsis' pathway for the emergency department.	In progress.
Serious	4g	1	Patient required surgical intervention following post cardiac catheterisation.	RCA review in progress.		

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4g	1	Patient died during pacemaker surgery.	RCA review in progress.		
Serious	11	1	Patient sustained ruptured uterus during surgery.	RCA review in progress.		
Serious	4b	1	Staff did not recognise patient's deteriorating condition.	Patient's deteriorating condition was not escalated in a timely manner.	Develop process for ED staff to escalate deteriorating patient information.	In progress.
Serious	4g	1	Patient was transferred from ICU to ward. His condition deteriorated shortly after admission to ward and there was a communication issue within the team. Patient died.	RCA review in progress.		
Serious	8	1	Client was admitted under Mental Health Act went missing and was returned to inpatient area.	RCA review in progress.		
Serious	11	1	Outpatient suicide within four days of last contact with service.	RCA review in progress.		
Sentinel	2	1	Client committed suicide within hours of admission to inpatient facility.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		
Serious	1	1	Patient had HRCT scan in error.	RCA review in progress.		
Sentinel	1	1	Wrong body part removed in error.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		

## Bay of Plenty

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
	4B and 4C	1	Baby with slow heart rate delivered and transferred to tertiary hospital and died.	<p>An inability to communicate with patient due to language barriers.</p> <p>A failure of the private LMC to appreciate the severity of the baby's condition led to a delay in the decision to transfer to secondary care.</p>	<p>Encourage private LMCs involved in the care of pregnant woman who speak little or no English to have at least one antenatal appointment with an interpreter present.</p> <p>Booking process reviewed and process implemented to identify if a woman's first language is not English.</p> <p>Review processes for handover of care to ensure responsibility for care is clearly identified and understood at all times.</p> <p>RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines permanently available in delivery suite staff</p>	<p>In progress.</p> <p>Currently subject to coroner's inquiry.</p>
	4A	1	Failure to recognise deteriorating condition.	<p>A lack of knowledge and skills in management of actual complications of post thyroidectomy surgery.</p> <p>Seriousness of patient's condition was not recognised.</p> <p>Delays in assessment and treatment by an appropriately experienced person.</p> <p>Staff were not familiar with a parameter driven process of escalation.</p>	<p>Develop a specific complications prone protocol/care map for management of thyroidectomy patients.</p> <p>Operation notes are to be comprehensive and include possible complications and action to be taken should they arise.</p> <p>Post-thyroidectomy to be managed in high dependency environment.</p> <p>MEWS is to be fully implemented and evaluated.</p> <p>Communication processes must ensure doctors are contactable at all times when they are rostered.</p> <p>Review emergency pager systems and processes to ensure there is district wide alignment of paging systems.</p> <p>Junior doctors who are part of an emergency response team are to complete a competency based resuscitation programme.</p> <p>Orientation of new house officers is to include sessions in theatre for the purpose of performing intubation.</p>	<p>In progress.</p> <p>External review sought.</p> <p>Subject to HDC Investigation.</p>

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
	11	2	Mental health inpatient jumped from the ward roof sustaining head injuries.	No major system failures contributed to this event.	Review of protocol: inpatient leave planning and staff education. Review the mental health service specific policy: levels of observation and staff education to include leave requirements. Staff education to ensure relapse prevention plans for all consumers are initiated on admission that include warning signs of relapse and services/ actions to avoid relapse be completed before leave is taken and/or discharge.	Ongoing.
	4B	2	Patient referral for removal of simple skin lesion delayed: required extensive surgery and ongoing treatment.	Delays in internal transfer process between teams.	Review referral process for facial skin lesions.	In progress.
	8 and 11	2	Despite efforts to stop patient they ran from hospital and jumped off a bridge. Sustained multiple injuries.	There was a lack of communication between the mental health and ward staff as to the level of observation required.	Ensure all information documented by the mental health team is consistent and available to general hospitals in instances where current mental health intervention is being given. Review and formalise the processes, for assigning and prioritising levels of observation. Review practices related to patients who present following a self harm attempt are medically cleared and remain in hospital as they are too sedated for a mental status examination to be completed.	Subject to HDC Investigation.

## Lakes

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	High falls risk patient was not supervised by appropriately qualified staff in the shower resulting in a fall and dislocation of hip requiring surgical intervention.	Historical contract with non-clinical staff to assist male patients showering had been terminated in all other wards apart from this ward.	Showering assistance contract with non-clinical staff terminated.	No further incidents.
Sentinel	4B	1	Identified as a placental abruption however inadequate monitoring of complicated labouring mother and delay in transfer of care resulting in compromised baby.	Baby electronic monitoring (CTG) not adequate. Transfer of care not implemented in a timely manner.	Obstetrician conducted review of case to identify time of compromising. Independent review of midwifery care. Baby electronic monitoring (CTG) training for midwives. Review policies/processes to identify transfer criteria.	CTG audit scheduled within next six months and six-monthly thereafter. CTG and documentation education under development. Transfer guideline implemented.
Serious	6	2	Cognitively compromised high falls risk patient inadequately monitored resulting in fall and fractured hip.	High falls risk patient did not have a care plan completed therefore patient need for increased monitoring not identified.	Staff education on falls policy and process and on identification of patients in need of close monitoring. Audit of compliance to be conducted on six-monthly basis.	Regular review of trended falls data by newly established Falls Committee to support improvement opportunities.

# Tairawhiti

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
	4B	1	Unexpected deterioration and death following acute hernia repair operation.	Cause of deterioration difficult to determine. Multiple co morbidities added to the complexity of patients condition. Initial response reassuring however further deterioration and non-response to interventions.	<p>Both surgeon and anaesthetist to be called for deteriorating patients.</p> <p>A structured communication tool to be used to improve effective communication of patients condition.</p> <p>Patients admitted unexpectedly to ICU following surgery need a thorough handover process should happen including clear treatment plan (with target parameters, etc) written in the notes as well as all treatments and fluids properly charted. In most cases, a direct hand over by the doctor(s) to the ICU nurse should occur.</p> <p>Develop a range of standardised blood tests that should be taken shortly after admission in order to have some baseline indication and in some case to detect early the need for some therapeutic adjustments.</p> <p>Patients with co morbidities to be scheduled early in the day.</p>	Coroner's report pending. Recommendations implemented.
	4A	1	Preterm labour, intrauterine death from concealed placental abruption.	Concealed abruption with no obvious signs until infant in severe distress.	<p>Review of midwifery staffing levels.</p> <p>Increased focus on reducing smoking in pregnancy and increased use of nicotine replacement therapy.</p> <p>Improvements required in quality of documentation including medication prescriptions.</p> <p>Review synchronisation of clocks in unit.</p> <p>Improvements in education relating to inhibition of pre-term labour, CTG interpretation, and placental abruption.</p> <p>Improve inter and intra-professional collegial relations.</p> <p>Develop guidance on access of critical incident debriefing for staff.</p>	Review completed. Most recommendations implemented.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
4A		1	Diminished foetal movements. Delivered by emergency C section. Baby in poor condition transferred to tertiary care and subsequently died. Post Mortem findings suggest intrauterine event resulting in infants compromise.	Unclear urgency for C section resulting from presentation and monitoring. Infant resuscitation equipment needing upgrade.	<p>Improve categorisation of emergency C sections to include definitions and expected timeframes.</p> <p>Improve education for foetal health monitoring and CTG interpretation.</p> <p>Review procedures for transport of women to theatre including required equipment.</p> <p>Review requirements for notification to paediatricians when suspected foetal compromise.</p> <p>Increase neonatal resuscitation education including for anaesthetist.</p> <p>Purchase infant resuscitation equipment for theatre.</p>	<p>Coroner's hearing pending.</p> <p>Recommendations in progress.</p>
	4C	1	Lack of monitoring Intrauterine death.	Late identification of foetal distress resulting from inconsistent monitoring practices during labour.	<p>Implement a comprehensive CTG system that includes training, resources, documentation tools and related policies and procedures.</p> <p>Develop an assessment and audit system for monitoring of foetal heart rates.</p>	<p>RCA completed.</p> <p>Implementation under way.</p>
	1		Wrong side prosthesis inserted during elective surgery resulting in further surgery.	Timeout procedure did not include prosthesis couple with staff unfamiliar with the prosthetics the wrong side was used. Replacement was not necessary and patient has gained full range of function.	<p>Timeout guidelines improved to include equipment check.</p> <p>Improve labelling and storage of prosthetics.</p> <p>Improve cross-skilling of staff to reduce reliance on individuals.</p>	<p>RCA completed.</p> <p>Recommendations implemented.</p>

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
				Variable practice regarding the use of foetal monitoring during labour resulting in delay in recognition of foetal distress.	<p>Develop and implement risk assessment tool for intrapartum risks to be carried out on admission to the unit.</p> <p>Include risk information in handover sheets and identify on the whiteboard.</p> <p>Review workforce issues staff in primary and secondary care to improve workplace culture.</p> <p>A structured communication tool be used to improve effective communication of patients condition between professionals.</p> <p>Develop formal procedure for obtaining second opinion to review CTG trace.</p> <p>Implement education package for the appropriate documentation and assessment of CTG tracings.</p> <p>Establish minimum requirements training as a with annual recertification.</p> <p>Develop an additional clause for the Section 88 schedule 3 which reminds LMCs of their obligations under the HPCA Act to work within scope of practice and to take regular breaks to minimise risk of fatigue.</p> <p>Ensure LMCs have arrangements with a backup LMC for provision of periods of planned and unplanned leave that enable 24/7 cover.</p> <p>Standardise CTG monitors to reduce margin of error in setting alarm parameters.</p> <p>Set alarm default to the normal limits of a reassuring trace.</p> <p>Educate staff on the use of alarms.</p> <p>Prevent mute of FHR and alarms.</p>	<p>Referred to coroner.</p> <p>RCA completed – recommendations being implemented.</p>

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
				Referral to acute assessment team resulted in appointment arrangements for the following day, however suicide completed overnight.	Review of triage procedures and education to clarify expected response according to assessed triage. Review risk assessment processes and documentation tools. Improve PATT participation in supervision. Review and clarify various roles of community team. Review community clients' care plans and assessments. Ongoing evaluation of processes and systems needs to be implemented.	Referred to coroner. RCA completed – implementation of recommendations under way.

# Taranaki

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Patient fall resulting in a fractured hip.	Falls risk assessment, completed prior to event, did not indicate a high risk. Patient tried to get back into bed as had been doing this independently without assistance.	Encourage patient to seek assistance or supervision if feels unsafe.	Completed.
Serious	9	SAC 2	Inpatient assaulted co-patient resulting in two fractures to the right leg. Surgical repair was required.	Review staff presence in the intensive psychiatric care unit, including supervision of patients in the courtyard. Not all staff were up to date with calming and restraint training. Not all staff were carrying a duress alarm. Delay in contacting the responsible clinician. Emergency response delay.	CCTV cameras to be installed. Minimum of one staff member to be present within the intensive psychiatric care unit at any given time. Assessments are to be completed, based on patient acuity, to determine requirement of supervision in the courtyard. All staff to be trained in calming and restraint. All staff are to carry a duress alarm in the intensive psychiatric care unit at all times. Compliance be audited. Processes re contacting responsible clinician to be communicated at staff meetings. New protocol and process to be introduced for emergency response and site map pre-set into ambulance location.	In progress. Completed and ongoing. Completed and ongoing. Completed and ongoing. Completed and ongoing. Completed. Completed.

# Whanganui

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4A	2	Eighteen-month delay in responding to an abnormal chest X-ray, resulting in the need for extensive treatment.	Inconsistent application of “red flag” alert process in radiology. No process, at the time, for communicating the results to the patient’s GP. Delays in both reporting the X-ray and reviewing the X-ray.	“Red flag” alert process reiterated to all radiologists and audited by the team leader. All radiology reports ordered by District Health Board consultants are now copied to the patient’s GP. Joint venture with Pacific Radiology has provided additional resource and minimised delays.	Further audit of “red flag” alert process in six months.
Serious	11	2	Patient collapsed and died during second stage of labour.	Postmortem indicated cause of death was an amniotic fluid embolus. In the initial resuscitation process, there was confusion regarding who was leading the emergency team.  The patient had no intravenous cannula to enable access for medication. The defibrillator in the unit did not have a screen or printout facility to enable staff to visualise heart rhythm. The resuscitation recording sheet was not used.	Improved training in resuscitation throughout the District Health Board, including regular simulation training for the cardiac arrest team members. Review the composition of the cardiac arrest team. Review resuscitation trolleys to ensure they are standardised. Protocol to be developed to ensure patients receiving intravenous analgesia are cannulated before the first dose is administered.  Resuscitation policy and procedures to be reviewed and all staff to be educated on the application of same.	Ongoing.  Developed.  Immediately upgraded.  Under way.
Serious	4A	1	Child diagnosed with viral infection in emergency department, discharged home. Presented again the next morning with meningococcal septicaemia and died.	Disease process was the single cause of the child’s death.  The review team did identify a number of clinical practice and systems issues which could be improved.	Eleven recommendations made, relating to reception, administration and triage processes for emergency department and the medical clinic. Introduce liaison meetings and shared education opportunities between the two providers. Review paediatric observation charts and parental advice sheets. Strengthen the available support to meet the emotional needs of family following a bereavement. Training for senior clinicians in the “open disclosure” process.	Under consideration.  Ongoing.  Under way.  Starlight bereavement packages purchased. Ongoing.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	8 and 2	2	Attempted suicide of mental health inpatient. Sustained major injuries. Patient survived.	High acuity and occupancy in the unit.  Unit layout hinders staff in adequately observing clients.	Contingency plan to be developed to ensure occupancy remains below 85%. Introduce an acuity measurement tool. Fully utilise regional services.  Review the observation policy and ensure all new staff are fully orientated. Referred to facilities for environmental modifications.	Developed.  Under way. Regional model of care being developed as part of a wider review of Mental Health Services.  Under way.  Feasible plans to be considered.
Serious	2	1	Suicide of a community mental health patient.	No deficits in care. Regular risk assessments documented. Patient aware of relapse and recovery plan.	Nil recommendation from internal review.	
Serious	11	2	Patient collapsed, emergency caesarean performed, mother and baby died.	Postmortem indicates cause of death as an amniotic fluid embolus.	Nine recommendations made, a number of which relate to documentation legibility and clarity. Consideration be given to the development of a perimortem caesarean section guideline and placement of a caesarean section tray in the maternity department.	Under way.  Under way.
Serious	3	1	Suicide of a community mental health patient.	No deficits in care. Regular risk assessments documented. Patient aware of relapse and recovery plan.	Nil recommendation from internal review.	

# Hawke's Bay

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4A and 11	1	Unexpected death post discharge.	<p>Postmortem findings: thoraco-abdominal dissection with cardiac tamponade.</p> <p>Inadequate documentation (no treatment times, patient contact times, assessment times, differential diagnoses and disposition).</p> <p>No protected teaching time for ED nurses and RMOs.</p> <p>Management plan did not include review by senior consultant prior to discharging patient in pain without a diagnosis.</p>	<p>All clinicians to utilise national documentation standards and DHB Records Policy.</p> <p>Adhere to protected teaching time for ED nurses and RMOs.</p> <p>Management plan to include comprehensive work-up/ discussion or review with senior consultants prior to discharging patients in pain without a diagnosis.</p>	<p>Ongoing.</p> <p>Ongoing.</p> <p>Ongoing.</p>
Serious	11	1	Sudden infant death, unsuccessful resuscitation due to placental bleed.	<p>Precipitous delivery. Cardiac arrest three hours post delivery. Feto-maternal bleed.</p> <p>Referred to Coroner's Office.</p> <p>Postmortem finding: hypoxia.</p>	No recommendations.	Coronial investigation under way.
Major	4A	2	Outpatient delayed follow up of radiological examination – undiagnosed cancer.	<p>Radiology system did not reflect the current general practitioner for the patient.</p> <p>Unable to confirm receipt of radiology report by general practitioner.</p> <p>No copy of radiology report forwarded to general practitioner on second presentation.</p> <p>No follow up of radiology result by DHB.</p>	<p>Training for staff re: data integrity.</p> <p>Review interface between patient management system and radiology system.</p> <p>“Copy to” field in radiology system to be mandatory.</p> <p>Review responsibility of ordering physician.</p>	<p>Completed and ongoing.</p> <p>In progress.</p> <p>In progress.</p> <p>In progress.</p>
Major	11	2	Suicide of a mental health outpatient.	<p>Referred to Coroner's Office.</p> <p>Excellent documentation by key worker.</p>	Standardise triage process throughout Mental Health and Addiction Service. Document prioritisation in health record.	Review process underway to ensure consistent approach.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
				Triage at 'each point of entry' inconsistent. Inconsistent use of new forms.	When new versions of forms / documentation are developed, earlier versions to be withdrawn from circulation.	Completed.
Major	11	2	Self-harm while on leave from inpatient service.	Intent for self harm under-estimated. Risk not fully canvassed.	Length of leave granted should reflect individual's needs with emphasis on shorter periods in the first instance.  Review individual risks and discuss with relatives prior to leave. Ensure discussion is documented.	Ongoing.  Implemented.

## MidCentral

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
	4B	2	Patient not receiving tertiary intervention in an appropriate timeframe. Patient outcome: stroke with significant hemiparesis.	Failure of referral mechanisms to tertiary hospital. Referral not followed up on when patient not reviewed within a reasonable timeframe. DHB found in breach of its obligations under the Health and Disability Code.	Implementation of a system to ensure inter-DHB referrals are received and actioned.	A system was implemented to ensure inter-DHB referrals are tracked and actioned.
	4B	2	A woman was transferred to secondary facility with complications following a normal delivery. Patient outcome: emergency surgery and admission to ICU	Inability to replace fluid loss in transit and lack of clarity as to receiving service at secondary hospital in the acute situation.	All relevant teams and Ambulance service agree to appropriate communication and transfer arrangements for women being transferred from a primary maternity unit to the secondary services with extreme complications.	Recommendations are currently being implemented.
	11	2	Young person was admitted to inpatient unit and sustained injury. Patient outcome: fracture of the humerus.	Injury occurred during the restraint procedure where both the co-ordination and the technique used were contributing factors to the injury. It appeared that the restraint procedures used by the two organisations differed and the roles and responsibilities of the employees of the two organisations need clarifying.	Calming and restraint should be undertaken by trained health staff only. When a young person requires admission immediate referral to tertiary provider should be actioned. Admission to an adult secondary health unit should be for the shortest time necessary.	Improved communication between secondary and tertiary health providers for timely and efficient transfer of young people. Staff appropriately trained.
	4B	SAC1	Shoulder dystocia. Patient outcome: neonatal death.	Baby transferred to tertiary hospital and subsequently died. Possible deficiencies in foetal monitoring.	RCA commenced.	RCA commenced
	4A	SAC 1	Patient discharged without full investigations. Patient outcome: unexpected death following accident.	Patient presented via ambulance as a result of a car accident. Upon arrival patient was assessed and was discharged home. Patient died five days later. A subsequent post mortem found that patient died as a direct result of injuries that were received in the motor vehicle accident.	SMO lead patient handover. Three definitive shift start times to assist with handover.	Improvements and changes to shift handover embedded. Improved number of senior medical staff in post.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
	6G	SAC2	Fall whilst an inpatient. Patient outcome: displacement of existing fractured tibia/fibula.	Patient on bed rest and aware of the requirement for bed rest. Leaned to locker and fell out of bed. Patient assessed and found to have displaced the previous relocation of tibia/fibia. Taken back to theatre for another relocation.	To ensure those patients on bed rest have equipment placed within a safe reaching distance, and have access to their call bell.	Reminders to nursing staff and care assistants.
	6C	SAC2	Fall whilst an inpatient. Patient outcome: fractured left tibia.	Patient admitted after stroke. Increased confusion and history of Alzheimer's. On falls prevention programme as assessed as at risk of falls. Patient room was away from nursing station. Identified as requiring level 2 observation (15 minute) but not completed at every interval. Patient placed on toileting plan (every two hours) but also not completed at required times.	Consistent documentation to be completed by all staff when patients on falls/observation programmes. Ongoing assessment and evaluation of risk factors around the patients falls risks. Assessment and evaluation of urinary elimination with toileting plan if applicable implemented. Use of Invisabeam monitoring in lieu of having an environment where patients can be continuously observed by staff.	In progress.
	6G	2	Fall whilst an inpatient. Patient outcome: fractured left neck of femur.	Patient with dementia, confused and disorientated. Plan in place to discharge. Hip protectors in place as constant observation was discontinued as per discharge plan. Patient mobilising with frame and assistance from staff.	Gradual discontinuation of specialising of dementia patients rather than an immediate stop to allow for ongoing assessment of needs of patients.	In progress.

# Wairarapa

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	N/C	Inpatient fall sustaining a # ulna.	Patient was documented as falls risk and precautions identified. On one-to-one observations in place.	No recommendations which would have prevented this incident as process had been followed however it was reviewed as part of the Falls Management Group.	Closed.
Serious	6	N/C	Inpatient fall sustaining a #NOF.	Patient stated he was using elbow crutches incorrectly, did not realise until the crutch slipped.	No recommendations which would have prevented this incident as process had been followed however it was reviewed as part of the Falls Management Group.	Closed.

# Hutt Valley

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	4B	1	Patient with disability underwent abdominal feeding tube insertion procedure. Bowel perforated during the surgical insertion procedure. This complication not diagnosed immediately, and patient subsequently died from infection.	An internal and external review undertaken. A wide ranging set of recommendations were made as a result of the review process. NB: Patient died in May 2008 so this should have been reported in the previous serious/sentinel report to 30 June 2008.	Most of the recommendations relate to improvements required in the assessment and planning of care for people with disabilities, especially when in the acute care setting. A comprehensive action plan based on the recommendations of the external reviewers is in place and under regular review. The summary report and actions were shared with the Health and Disability Commissioners, the Ministry of Health, the media and all District Health Boards.	Progress against the action plan is monitored quarterly: eg, May 2009, August 2009, November 2009, and February 2010.
Sentinel	4B	1	Patient with disability died following complications after abdominal surgery.	There were delays in the patient being assessed by a surgical registrar in the emergency department, inadequate nursing care and failure to take account of the patient's disability needs. The health and Disability Commissioner found Hutt Valley DHB in breach of Right 4 of the Code of Health and Disability Services Consumers Rights, stating that the patient did not receive an appropriate standard of care. NB: The patient died in March 2008 so this should have been reported in the previous serious/sentinel report to 30/06/08.	Improvements required in the way assessment and care planning meets the needs of disabled persons in the acute setting (linked to the above case). Improvements in the electronic record functions in the emergency department. Review of the surgical registrar role in relation to time taken to see patients in the emergency department. Review of training provided to nursing staff for male catheterisation. Ensure emergency department records accompany patient's admitted to inpatient wards. Review of the informed consent policy regarding patients not competent to give informed consent.	All recommendations are currently being worked on with progress reported quarterly as part of the case listed above. Work also continues on meeting the target for waiting times in the emergency department. A project to manage the flow of acute patients who require surgery has been completed, achieving improved co-ordination and decreased waiting times for such patients.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4D	2	Patient undergoing contrast tomography (CT) scan developed swelling and subsequent scarring when the contrast medium used for the scan infiltrated into arm tissue. The contrast was being delivered via a tube in the patient's arm which became displaced at some stage during the procedure.	An internal review highlighted that additional information was needed on the consent form signed by patients for CT scan, and that it was difficult for patients to alert staff if they needed assistance immediately. The Health and Disability Commissioner is currently reviewing our response to the complaint lodged by the patient.	The consent form for CT scanning now includes an explanation of risks. A bell has been installed in the CT scanner to enable patients to call for assistance during a scan. Patient has received plastic surgery for the scarring on their arm, and is under ongoing review by hand and scar therapists.	We await the outcome of the Health and Disability Commissioner review.
Serious	4D	2	Patient had tube inserted to assist with feeding into the bloodstream. Four days after insertion the patient experienced pain and shortness of breath. Chest X-ray showed tube had perforated into chest causing infection.	Tube placement tip confirmed by x-ray as being just within correct placement. Chest x-ray taken four days later to check placement due to patient complaint of pain. Patient transferred to ICU as they developed respiratory complications. Fluid collections drained via a chest drain, and patient made a good recovery.	IV policy states: a) that the tip position should always be verified by a radiographer prior to use in a clinical areas b) that nursing staff should undertake checking procedures to ensure placement is correct c) if in doubt, a chest X-ray should be performed prior to continuing or recommencing fluid infusion.	No further action required.
Serious	6	2	Inpatient fall resulting in broken wrist.	Patient had been assessed for falls risk on admission, and had been graded as at moderate risk and appropriate precautions for that level of risk were implemented.	Patient's falls risk assessment upgraded from moderate to high. Patient placed in close observation cubicle, and medical and nursing care plan documented.	
Serious	6	2	Inpatient fall resulting in fractured hip, requiring surgery.	Patient assessed on admission and not considered to be at risk of falling as normally independent. The patient had been undergoing preparation for surgery, and this may have contributed to the fall.	No recommendations.	

NB: There are four further events that were still under investigation and not reported in the previous year.

Date	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
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Date	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
June 2009	4E	2	<p>Endoscopy service cluster of patients with delayed diagnostic procedures.</p> <p>A group of patients referred for endoscopy have been booked for procedures outside national guidelines for waiting times.</p>	<p>Internal reviews underway on individual cases and causes for this cluster as a whole.</p> <p>Three patients identified to date with cancer diagnosis:</p> <p>a) Patient A: Following initial triage, the patient was to be seen within three months but was seen after 6½ months. Diagnosed with cancer, currently undergoing treatment.</p> <p>b) Patient B: Following initial triage, the patient was seen 26 days outside guidelines. Diagnosed with cancer, and commenced palliative treatment. Deceased.</p> <p>c) Patient C: Following initial triage the patient was to be seen within three months but was actually seen nine months later. Diagnosed with cancer, currently undergoing treatment.</p>	<p>Discrepancy found on Ministry of Health website with two sets of national guidelines for triage times. MoH notified of discrepancy.</p> <p>Hutt Valley DHB has now developed and implemented its own set of guidelines for triaging of patients.</p> <p>Extensive review of endoscopy waiting list identified patients outside of wait times recommended by new guidelines. Additional capacity to provide procedures to patients found to be outside guidelines was commissioned by adding extra sessions within HVDHB endoscopy unit, contracting colonoscopy procedures to an external provider, and recruiting 0.5 FTE additional endoscopy specialist.</p> <p>All three patients have been directly contacted and an apology offered for the delay in being seen.</p> <p>For Patient C an external review was undertaken and the results shared with the patient.</p>	<p>Backlog reducing steadily.</p> <p>Monitoring of compliance with national guidelines ongoing.</p> <p>Backlog on track to be fully cleared by 20 December 2009.</p>
April 2009	4D	2	<p>Patient underwent chest drain insertion to relieve the fluid on the chest and shortness of breath. As the chest drain was inserted to drain the fluid, it pierced the patient's heart.</p> <p>The patient was transferred to another District Health Board for successful removal of drain.</p> <p>Patient made full recovery.</p>	<p>Enlarged heart size made the fluid look larger than it was.</p> <p>X-ray was taken two weeks prior and no other imaging undertaken.</p> <p>Exact location of drain not obvious from documentation.</p> <p>Patient and next of kin fully communicated with during and following procedure.</p>	<p>Clinical review completed.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• That a recent chest x-ray is undertaken prior to the procedure and is viewed prior to and during the procedure.</li> <li>• That advice is sought from the respiratory physician if clinically indicated.</li> <li>• That the informed consent process is clearly documented in the clinical record.</li> <li>• Attendance at teaching and training sessions for medical staff be recorded.</li> </ul>	<p>All recommendations communicated to medical staff as part of ongoing education following clinical review.</p>

Date	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
November 2008	4B	2	Patient admitted with inflammation on leg. Patient developed a pressure sore from being immobile and required surgery.	Classified by ACC as a serious treatment injury. Clinical review complete. Areas of concern raised: Ability of junior nursing staff to assess skin and general condition of complex patients on admission, and in the event of their health status changing. Skin assessment tool did not reflect other complications. Contact has been made with family to acknowledge and apologise for the quality of care issues highlighted.	Recommendations: <ul style="list-style-type: none"> <li>• Junior nurses to be upskilled in patient assessment process. Visual skin assessment to be included in patient notes.</li> <li>• Action plan and timeframe for completion to be completed.</li> <li>• Service to develop guidelines with support from Pacific and Maori Health Units, and Disability Advisor for use when family/caregivers wish to be involved with care.</li> </ul>	Action plan for service in place and all recommendations being progressed.
August 2008	5	1	Patient admitted to emergency department with a hip fracture. The patient was treated and discharged home, and prescribed a non-steroidal inflammatory medication for pain. The patient represented, with a bleeding stomach ulcer and subsequently died.	Patient was treated for the initial bleeding stomach ulcer, but developed further bleeding and later died.	The emergency department has implemented a policy ensuring the safe prescribing of non-steroidal inflammatory medications to elderly patients.	Policy in place and education of clinical staff in the emergency department on the policy has occurred through the clinical head of department.

## Capital & Coast

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	11	1	Possible anaphylactic reaction to antibiotic. Patient deceased.	The review team found that clinical management was appropriate but that the system for medication alerts did not provide a clear, current and accessible history of medication sensitivities.	Review recommended: <ul style="list-style-type: none"> <li>improving the system for medication alerts</li> <li>feedback of learning from this event to staff.</li> </ul>	Action plan in progress.
Serious	4C	2	Patient with peripheral central line developed clot in arm	The review team found issues across the multidisciplinary team relating to peripheral central line management.	Review recommended: <ul style="list-style-type: none"> <li>staff education re post insertion care and management</li> <li>improved information</li> <li>reinstate steering group to provide oversight, audit, monitor and respond to issues ongoing.</li> </ul>	Action plan in progress.
Serious	4A and B	2	A patient had treatment of a more extensive nature than would usually have been offered had it been known that the patient had metastatic disease at the time that treatment options were being considered.	The review team found that a report was not reviewed by the medical team until six months later. This was due to incomplete records and communication of information.	Review recommended: <ul style="list-style-type: none"> <li>notification to all SMOs regarding the event</li> <li>offering the patient an apology and explanation with the outcome of the review</li> <li>update of the risk register and mitigations to reflect the outcome of this event.</li> </ul>	Action plan in progress.
Serious	4D	NC	Patient admitted for a fractured arm and vascular injury – went onto develop nerve injury and associated foot drop during admission.	The review team found that the foot drop and nerve problems most likely resulted during care provided and subsequent to original injury.	Review recommended: <ul style="list-style-type: none"> <li>response to complaint and apology</li> <li>type of anaesthesia remain a clinical decision</li> <li>risks that arise when assumptions are made and included in clinical documentation be communicated to staff</li> <li>feedback regarding expected documentation standard.</li> </ul>	Action plan complete and closed. Follow-up audit of documentation is planned.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4G	NC	After a patient was anaesthetised it was identified that consent for the procedure had not been gained. The patient was woken and the procedure rescheduled.	The review team found the anaesthetic consent was mistaken for procedural consent when pre-procedure checks were completed.	Review recommended: <ul style="list-style-type: none"> <li>review of service practice for gaining consent to support compliance with informed consent policy</li> <li>redesign of service pre procedure check lists</li> <li>provide findings to team revising informed consent policy and teams involved</li> <li>review orientation.</li> </ul>	Action plan complete and closed. Follow-up audit planned.
Sentinel	4C	1	A patient admitted with chest pain went onto develop a life threatening cardiac rhythm. The patient's cardiac monitor did not alarm which delayed a medical response. Resuscitation unsuccessful.	Review found that immediate medical response did not follow the advent of a life threatening arrhythmia because the cardiac monitor did not alarm. The root cause for the alarms not activating appeared to be because the audible alarms on the cardiac monitor were turned off. The patient's family were not contacted when the patient was admitted.	Review recommended: <ul style="list-style-type: none"> <li>the planned purchase and installation of the new cardiac monitoring system be completed</li> <li>staff orientation be reviewed</li> <li>all patients admitted to the service be asked if they would like their family informed.</li> </ul>	Action plan almost complete including replacement of cardiac monitors – one recommendation still in progress.
Serious	6	NC	Outpatient fell in car park and sustained fracture.	Review found that severe wind gusts blew the patient over and injury resulted.	Review did not make specific recommendations.	NA
Serious	6	NC	Inpatient fall with fracture	Review found the patient had been identified as a high falls risk. Falls prevention strategies were in place. Some documentation incomplete.	Review recommended: <ul style="list-style-type: none"> <li>improved documentation of falls risk assessments</li> <li>compliance audit.</li> </ul>	Action plan complete and closed. Ongoing monitoring of falls in place.
Serious	6	2	Inpatient fall with fracture. Patient deceased a few hours later.	Under review – draft report in development.		
Serious	6	2	Inpatient fall with fracture.	Review found that this fall occurred without warning; relevant falls risk management was in place including direct supervision when mobilising and that this was an unfortunate event rather than an event that arose as a result of a deficiency in systems or processes of care.	Review did not make specific recommendations that would have prevented this fall from occurring.	Action plan complete and closed. Ongoing monitoring of falls in place.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	11		Patient died at home 24 hours after being discharged.	Review found communication between service providers was fragmented and that the practice of planning discharge on Fridays created risk in this specific situation due to significant change in service provision process required for weekend cover.	Review recommended: <ul style="list-style-type: none"> <li>improved internal and external interagency communication</li> <li>amended discharge planning where relevant.</li> </ul>	Action plan almost complete – one recommendation in progress.
Serious	5		Medication error resulting in cardiac arrest. Patient resuscitated, required admission to ICU, returned to ward and later discharged.	The review found of primary importance was the practice of storing a potentially dangerous medication next to a commonly used relatively innocuous medication. Omission of double checking, bedside checking and human factors contributed. Review also noted an issue with look alike medications – the plastic ampoules looked similar and the differences in visual presentation are not a significant barrier to mis-identifying the medication being selected.	Review recommended: <ul style="list-style-type: none"> <li>urgent review of the storage of and access to the medication across all clinical areas</li> <li>review of medication cupboards in the service</li> <li>separation and clear identification of dangerous medications</li> <li>review of hospital wide intravenous (IV) certification processes and education to ensure risks of the medication are highlighted to all clinical staff.</li> </ul>	Action plan is in progress: <ul style="list-style-type: none"> <li>quality improvement group convened to implement actions from the review</li> <li>findings circulated to other DHBs, Pharmac and QIC Safe Use of Medicines Group</li> <li>newsletter to all clinical staff.</li> </ul>
Serious	5		Medication error, resulting in reaction and tinnitus later reported.	Review found that this error occurred because a 'medication added' label was not attached to the syringe containing the antibiotic. There was also a delay between the preparation and administration.	Review recommended: <ul style="list-style-type: none"> <li>requirement for 'medication added' label fastened securely to syringe. Use of second medication added label required when titrating (rate/dose adjustment)</li> <li>inform family when administering medications</li> <li>staff education.</li> </ul>	Action plan almost complete – one recommendation in progress.
Serious	4a		Missed diagnosis – permanent harm resulted.	Review found that clinical examination findings were not compatible with the diagnosis, and that it was likely that a change had occurred in the clinical presentation subsequently.	Review recommended: <ul style="list-style-type: none"> <li>apology to the patient and provision of the report</li> <li>risk of error continue to be emphasised in training to staff.</li> </ul>	Action plan complete and closed.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	4b	1	Investigations ordered post operatively were delayed, patient deteriorated resulting in cardiac arrest. Resuscitated. Patient required ICU admission, returned to ward and later discharged.	Review in progress – report in final draft.		
Serious	4b	NC	Unexpected breech delivery. Infant deceased.	Review identified that the birth position and clinical findings made it difficult to determine if resuscitation would have been effective. There were aspects of the resuscitation response that could be improved to increase efficiency.	Review recommended: <ul style="list-style-type: none"> <li>• amendment of summoning emergency assistance policy</li> <li>• increased practice emergency scenarios involving both services.</li> </ul>	Action plan in progress. Three actions to complete.
Serious	11	NC	Suicide of client in community-based respite care.	Review was not able to determine what triggered the client suicide, that staff involved were thorough and considered all information at all stages and that the plan developed was done so in conjunction with relevant staff, the client and family.	Review recommended: <ul style="list-style-type: none"> <li>• review of ligature risks at crisis respite</li> <li>• improved documentation</li> <li>• enhanced orientation</li> <li>• staff education regarding findings.</li> </ul>	Action plan in progress.
Serious	11	2	Suicide of client in community.	Review in progress – report in final draft.		
Serious	11	2	Client self-harm in community setting requiring hospital care.	The review team found that the client received good care, treatment and risk management and no systemic error was detected.	The review team made no recommendations.	
Serious	11	2	Client self-harm in community setting requiring hospital care.	The review team found that the client received good care, treatment and risk management and no systemic error was detected.	The review team made no recommendations.	
Serious	11	2	Suspected suicide of community patient.	Review in progress – report in final draft.		

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	11	2	Self-harm by community patient.	The review found that some documentation was lacking and that this made it difficult to clearly understand the plan of care while the client was an inpatient, that the timing of discharge and level of care in the community was not what the family had expected.	Recommendations related to use of client pathway documentation as per policy and completion of documentation of multi disciplinary reviews.	Action plan in progress.

## Nelson / Marlborough

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	1	2	Wrong site surgery.	A back operation was done at the wrong level requiring a second operation. Fusion L4/L5 instead of L5/S1. Contributing to this error was poor image quality. Patient recovered well after a second procedure.	Orthopaedic surgeons should agree on a guideline of using the old intensifier. SMOs should be reminded that concerns about equipment quality and availability need to be formally documented to district managers.	Guidelines agreed. SMOs reminded.
Serious	4c	2	A patient had a respiratory arrest while waiting for a procedure in theatre.	Patient was given morphine in ED and transferred to theatre where he was left alone in the anaesthetic room. When the nurse entered the room, she noticed the patient deeply cyanosed. He was resuscitated and recovered well.	The policy on transferring patients should be completed. A policy should be developed to guide the care of patients while in operating theatre suites. This should include the principle that a patient is never to be left alone.	Policy completed. Policy developed.
Serious	4c and 8	2	Attempted suicide of mental health inpatient	The client was on 10-minute observations but escaped from the mental health unit. He went to another part of the hospital and jumped from the sixth floor in a suicide attempt.	Care of this client was appropriate.	
Sentinel	4a and 4c	1	A patient with multiple myeloma, was admitted with hip pain. The diagnosis of septic shock was not made and the patient died.	The patient was admitted with hip pain as well as a low blood pressure. The low blood pressure was not treated and the diagnosis of septic shock was not made. He was known to have multiple myeloma. Staff did not read the pink card which the patient's wife showed them. This card clearly states that the patient may need immediate antibiotic therapy. Doctors were not alerted by the use of the early warning score.	SMOs involved should apologise and review their practice of caring for patients in shock and patients with neutropenia.  Staff should be reminded of the importance of taking note of information provided by patients and their families including written information.  The nursing staff involved should review their practice regarding the use of the early warning scoring system.	Apologies made and practice reviewed.  Staff reminded.  EWS implementation reviewed.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4b	2	The patient had a detached retina which was not treated in a timely manner.	The current referral arrangements from ED to the ophthalmology service are inadequate. The GP did not refer the patient with appropriate urgency. Given the delay in treatment, the patient suffered some loss of vision.	Review ED referral arrangements.	Referral arrangements reviewed.  Apology done and practice reviewed.
Sentinel	4a	1	A patient died in hospital due to a delay in diagnosis and treatment.	A CT abdomen was delayed and a sub-phrenic abscess, due to ruptured gallbladder, was only discovered some days after admission. There was a misunderstanding between the consultant and house surgeon as well as difficulties in communication between surgical consultants and between the surgical and medical teams and the family.	A process for clear, effective, written handover between consultants, especially at weekends should be developed.	Process agreed.

## West Coast

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	11	N/c	Sterile cannulated drill guide found to be contaminated prior to use on patient.	Drill guide had not been processed correctly.	Steps implemented to improve checking system.	Completed.
Serious	10	N/c	Delay in care provided to patient; transfer of trauma patient requiring tertiary level ICU delayed due to combination of weather, secondary tertiary hospital unable to read electronic radiology report so unable to accept patient (although this was eventually sorted out), and retrieval team undertaking another transfer.	Rare combination of events as both South Island tertiary hospitals unacceptable to accept transfers due to weather.	Need to investigate compatibility issues regarding electronic reports between all tertiary hospitals that are potential recipients of patients from West Coast.	Ongoing.

# Canterbury

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	2, 8	1	Inpatient suicide of mental health inpatient.	Patient left the ward unobserved.	Improve security at external doors.	Action completed.
Sentinel	2, 8	1	Suicide of an inpatient whilst absent without leave.	Risk status not updated following a change in the level of arousal of the patient. Observations undertaken but not documented.	Mental state and risk assessment must be repeated as soon as a change in the level of arousal of patient is noted. Reinforcement of documentation requirements as stated in the "observation including specialling" policy.	Recommendations underway
Serious	4A	2	Patient seen in ED, reviewed by multiple services and discharged. Patient represented the following day, admitted and required surgical management.	In hindsight the patient would have benefited from admission at first presentation. Difficulty in making initial diagnosis illustrated by cross referral across multiple services. No consistent rule regarding involvement of specialist when decision to not admit a patient under a particular service.	Registrar may not decline an admission without prior consultation with their specialist on call.	Actions completed.
Sentinel	4 A, B, C	1	Patient with increasing confusion managed on ward with sedation and observation. Found in cardiac arrest. Admitted to ICU. Patient died.	Lack of awareness of plan of care for patients with acute delirium. Use of early warning score tool and triggers for referral to ICU outreach team. Role of the intensive care outreach team.	Education and care pathways required regarding acute delirium. Incorporate the EWS in calls to the Clinical Team Co-ordinator to act as a prompt to further identify the deteriorating patient. Continuing education on the role of the ICU outreach the team required.	Actions underway
Sentinel	4B	1	Suicide of a mental health outpatient in the emergency department.	Lack of integration between psychiatric emergency services (PES) and emergency department (ED).	Establishment of a multidisciplinary review group from PES and ED to improve integration between the two services. Introduce a triage system based on the MoH ED Mental Health Triage Guidelines. Establishment of a 24-hour psychiatric ED liaison position based in ED. Introduce structures to enable increased levels of observation in ED. Review policies and procedures on the transfer of identified patients to ED.	All recommendations have been implemented.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	4B	1	Cellphone failure resulted in delay in obtaining specialist support necessitating emergency procedure to be commenced by registrar inexperience in this procedure. Patient survived procedure but died at a later time.	Procedures for obtaining alternative specialist support required. Failure of cellphone without alternative back options available.	Procedures for obtaining alternative specialist support to be developed.	Action completed.
Serious	4D	2	Neonatal death of an extremely premature baby following insertion of an endotracheal tube (ETT).	Dislodgement of ETT tube not recognised clinically or radiologically. The prematurity of the baby's skin caused difficulties in adequately securing the ETT in place. The difficulty of detecting this complication radiologically in small neonates resulted in the dislodgement not being noted. The baby's admission occurred "after hours". This resulted in a delay of regular Radiology review of the chest X-ray until the following morning.	Movements of the baby's head should be minimised to prevent the chance of ETT movement. That the X-rays in this case and any others of malpositioned ETT are maintained in a de-identified form to be utilised for teaching purposes. The introduction of a double check protocol for ETT placement. A review of current policy with regards to the frequency and method of checking an ETT placement where there is difficulty in securing the ETT.	These recommendations are currently being implemented.
Sentinel	4G	1	Recently discharged mental health outpatient found dead from suicide.	No causal factors identified.	No recommendations.	Nil
Sentinel	4G	1	Suicide of mental health outpatient.	RCA under way.	Report awaited.	
Sentinel	4F	1	Unexpected death of patient following discharge from ICU who had received reversal of narcotic.	Possibility that the patient became re-narcotised on the ward. Potential benefit from longer period of observation in ICU.	Patient to remain in ICU and monitored for four hours post-narcotic reversal.	Actions completed.
Sentinel	4C	1	Unexpected patient death 18 hours following surgical procedure.	Progressive respiratory failure not able to be detected by routine practice and monitoring.	Patient following this surgical procedure to be admitted to high dependency unit post-operatively. Pre-operative respiratory function tests to be undertaken for patients undergoing this surgical procedure.	Actions under way.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	10	1	Unexpected neonatal death.	Various factors led to delayed referral to obstetric team resulting in an inability to undertake timely intervention.	Promote birthing suite clinical co-ordinators as experts in secondary and tertiary level midwifery care of labouring women in order to be a resource for core staff as well as LMC. Introduction of regular birthing suite education forums.	All recommendations have been implemented.
Serious	11	2	Mental health inpatient threatened staff with a heavy object and caused wilful damage to property.	Review under way.	Report awaited.	
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.	Falls continue to be an area of concern.	A Clinical Board sponsored working party has been formed to support the falls prevention and minimisation strategies underway with the vision of having zero harm from falls.	Actions under way.
Serious	6	2	Inpatient fall sustaining a fractured skull and associated head injury.	Where specific causal factors have been identified these have been actioned.		
Serious	6	2	Inpatient with known risk of falls, fell sustaining a fractured hip.			
Serious	6	2	Inpatient with known risk of falls, fell sustaining a fractured neck of femur.			
Serious	6	2	Inpatient with known risk of falls fell sustaining a pelvic fracture. Patient died two weeks later from medical causes.			
Serious	6	2	Inpatient fall sustaining a moderate head injury.			
Sentinel	6	1	Inpatient fall contributing to patient death.			
Serious	6	2	Inpatient fall sustaining a fractured hip.			
Serious	6	2	Inpatient fall sustaining a fractured shoulder.			
Serious	6	2	Inpatient fall sustaining a fractured pubic ramus.			

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Inpatient with known risk of falling fell sustaining a fractured humerus.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.			
Serious	6	2	Inpatient with known risk of falling fell sustaining a fractured neck of femur.			
Serious	6	2	Inpatient fall sustaining a fractured rib and haemathorax.			
Serious	6	2	Inpatient fall sustaining a fractured hip and laceration to head.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.			
Serious	6	2	Inpatient fall sustaining a fractured trochanter.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur			
Serious	6	2	Inpatient with known risk of falling fell sustaining a fractured femur.			
Serious	6	2	Inpatient assessed as not a risk of falling fell sustaining a fractured femur.			
Serious	6	2	Inpatient fall sustaining a fractured femur.			
Serious	6	2	Inpatient assessed as not at risk of falling, fell sustaining a femoral shaft fracture.			

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Inpatient fall sustaining a dislocated hemi-arthroplasty.			
Serious	6	2	Inpatient fall sustaining a displaced subcapital hip fracture.			
Serious	6	2	Inpatient with known risk of falls fell sustaining a displaced fracture through the greater trochanter.			
Serious	6	2	Inpatient fall sustaining a fractured neck of femur.			
Serious	6	2	Inpatient fall sustaining dislocated shoulder.			
Serious	6	2	Inpatient fall sustaining fractured nose and laceration to forehead.			
Serious	6	2	Inpatient fall sustaining a compound fracture of the ankle.			

## South Canterbury

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	1	2	A report for an invasive x-ray was entered against two separate patients during the processing of the report. This resulted in one patient being credited with the wrong report and a subsequent colonoscopy performed based on inaccurate information.	The system used by the hospital did not interface with the system used by the contractor providing the report.	Upgraded software installed with access obtained from the 6 August 2008. Picture Archiving & Communication System (PACS) is a capital expenditure item for 2008/09. Contractor has put a new process in place using a collator who checks the report in the system is the same as the report in the contractor's system. Spot auditing of reports received undertaken by the Radiology Manager.	PACS implementation is planned for 30 November.
Serious	6	2	Patient fall resulting in a fractured hip.	Patient independently mobile prior to incident. Falls risk assessment completed on admission showed no increased risk of falls. Patient transferred to surgery for repair of hip.	Nil.	Falls prevention policy currently in draft. A working group will be established to implement the policy.
Serious	6	2	Patient fall resulting in a fractured hip.	Patient independently mobile prior to incident. Falls risk assessment completed on admission showed no increased risk of falls. No environmental factors. Patient transferred to surgery for repair of hip.		
Serious	6	2	Patient fall resulting in a fractured hip.	Patient mobilising independently prior to incident. Falls assessment completed on admission and assessed as minimal risk of falling. Appropriate actions taken following first fall to minimise risks associated with the patient's environment including use of a sensor mat. Patient transferred to surgery for repair of hip.		

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	11	2	Suicide of Mental Health outpatient. Coroner's case.	Unpredictable event. Appropriate level and frequency of care delivered. Level of family involvement good with satisfaction expressed by mother. Psychiatric service not notified in a timely manner by police which would have allowed for more timely family support.	Clinical Nurse Manager Community Psychiatric Service to liaise with police re communication process around community suicides. Current interface agreement with police under review.	Interface review progressing.
Sentinel	11	2	Suspected accidental overdose of community client. Coroner's case.	Client died of potential overdose of unknown substance. Patient had been seen and reviewed regularly by key worker and multi-disciplinary team. No problems identified with treatment planned or received.	Nil	NA
Serious	6	2	Patient complained of rib pain after a fall. Chest x-ray taken and indicated a fractured rib with collapse lung.	Falls risk assessment completed on admission and falls prevention plan in place, including bed at low level sensor matt and mattress by bed. Patient assessed morning following fall with no evidence of injury.	Reminder that all patients to be reviewed/examined by doctor following a fall.	Falls prevention policy currently in draft. A working group will be established to implement the policy.

# Otago

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4A	1	Incorrect diagnosis, patient death.	<p>Patient attended the emergency department (ED) arriving by ambulance with hip pain and seen in the sub acute area of the ED in the midst of a busy shift.</p> <p>X-ray completed which was reviewed as normal and the patients pain responded well to simple analgesia.</p> <p>Patient was able to mobilise without concern and was diagnosed with a sprain injury.</p> <p>Patient re-presented to ED two days later unconscious and septicaemic. Admitted to the intensive care unit and a diagnosis was made of psoas abscess.</p> <p>Patient died despite surgery and intensive care.</p>	Query as to whether a blood test was indicated on the first presentation which may have revealed the underlying severity of this patients' presentation.	Incomplete.
Sentinel	11	2	Client suicide in the community.	Client's death was not due to any failings of the Mental Health Service.	No recommendations.	
Serious	11	2	Patient attempted hanging in the community.	The care provided at the Emergency Psychiatric Service was not found to be deficient or negligent. The client's care did not differ from treatment guidelines or how others would have been similarly managed with the same presentation.	This case highlights the potential to improve follow-up arrangements and information for potentially suicidal patients who return home to the care of their families.	In progress.
Sentinel	4C	2	Intrauterine death.	Investigation commenced.	Awaiting finalisation of report.	Incomplete.
Sentinel	11	2	Client suicide in the community.	Investigation commenced.	Awaiting recommendations.	Incomplete.
Sentinel	11	2	Client suicide in the community.	Client's death was not due to any failings of the Mental Health Service. The client's death could not have been predicted.	No recommendations.	
Sentinel	1	1	Wrong implant surgery.	<p>Relative unfamiliarity with the implant and the packaging.</p> <p>Package labelling difficult to read.</p> <p>Packaging of the system components does not easily identify the size or side which the implant is for.</p> <p>The company's representative was not available as a result of their resignation.</p>	<p>Lean thinking project applied to orthopaedic storeroom.</p> <p>Daily briefing between the Associate Charge Nurse Manager (ACNM) and both orthopaedic nursing teams in theatre to discuss the cases for the day.</p>	Completed.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
				<p>Delayed start to surgery as a result of difficulty with the spinal anaesthetic.</p> <p>The difficulty in everting the patella meant that a suboptimal view was obtained of the femoral component following implantation.</p> <p>Although the second circulating nurse did read out the size and side of the femoral implant, this was not checked against either the time out board or the intra-operative note.</p> <p>The case was relatively difficult therefore there was an element of fatigue by the time of implantation.</p> <p>Junior registrar assisting, it was his first knee replacement.</p> <p>Experienced orthopaedic nursing staff meant the surgeon relied on trusting the staff to bring the correct sided implant and therefore there was less checking by surgeon performed.</p> <p>Surgery was performed in the alternative theatre for orthopaedics and components kept in room next to the main operating theatre (MOT).</p> <p>There were issues about the counts prior to the start of the list with the tibial spacer missing which caused some distraction.</p> <p>There was confusion about the head sizes and stock/loan implants for the second case.</p> <p>Poor labelling on shelf for set up of left and right components.</p> <p>Surgeon, circulating and scrub nurse did not have a process of stating the side (left or right) when checking the size of the implant.</p> <p>Overcrowding of stock and equipment in the theatre store room and large pieces of equipment being stored in the storeroom.</p> <p>There were a lot of people coming in and out of theatre which caused distraction to those involved in the case.</p> <p>Patient did very well post surgery with no adverse effects caused.</p>	<p>A process for ordering the correct system to be used specifically for each case. The booking form must be accompanied by a special equipment request form completed by the surgeon.</p> <p>Timeout process mandatory at the start of every operation where the surgeon reads out the patient name, NHI, operation, side.</p> <p>When implants are being added to the sterile field the timeout checklist must be repeated and the implant matched to those details by the circulating nurse.</p> <p>Mobile trolley is used to have the list cases inventory of componentry available in the operating theatre storeroom.</p> <p>Contact made with company regarding labelling.</p>	
Sentinel	2	1	Suicide of an inpatient on leave.	Investigation commenced.	Awaiting recommendations.	Incomplete.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	5	2	Anaphylaxis from wound treatment.	<p>Registered district nurse was attending to the patient for care of pilonidal sinus wound with skin excoriation due to wound exudate. Patient presented to the emergency department with difficulty swallowing and tightness in her chest. She was treated for an allergic reaction thought to be related to an allergy to the zinc cream.</p> <p>The patient had been identified as having a peanut allergy on the electronic alerts, but it was not written on her referral form. The zinc cream had a very small alert printed on it that it contained peanut oil. The nurse asked the patient about any allergies but had failed to recognise the ingredient of the treatment.</p>	<p>Information sent to the Centre for Allergy Reports and Monitoring and advised the warning label on the cream was insufficient.</p> <p>Change all stock to peanut oil free product.</p>	Completed.
Serious	2	2	Inpatient death from overdose of non-prescribed drugs.	<p>Patient acquired methadone prescribed for someone else. The most likely source of the methadone seems to be from another patient he was associating with, although this cannot be verified.</p>	<p>Review process for self-managed medication in accordance with medication management policies.</p> <p>Staff education around the medication management policy.</p> <p>Regular medication chart audits.</p> <p>Review documentation and care plans for patients admitted for respite care.</p> <p>Clarify medical responsibility for this patient group.</p> <p>Staff education around responsibilities for this patient group.</p> <p>Review service specification and contracts for respite care.</p>	Incomplete.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4C	2	Patient's deterioration not communicated to medical team.	Terminally ill patient admitted for 'comfort cares'. Assumption by staff that admission was for palliative care. Patient deteriorated overnight into unconsciousness and died shortly after. Routine monitoring occurred, however, the medical team was not informed of patient's deterioration due to nursing staffs' understanding that the patient was for palliative care.	Education plan for nursing staff relating to palliative care and comfort cares. The internal medicine service consider whether there is a need for oxygen guidelines for the service. The nursing team within the internal medicine service review its handover processes. Consideration needs to be given to the collaborative model of nursing care, and other related processes. The handover processes need to have a means of auditing and feedback to staff. The early warning scoring system is being developed. Once the process is ready for implementation, the Internal Medicine service will actively implement the system and evaluate nursing staff on this.	Completed Ongoing implementation of recommendations.
Serious	4D	2	Patient restraint/ fractured arm.	Patient became confused and aggressive toward staff, assaulting an orderly and security guard. The patient was being restrained by his arms in the approved method. While the patient was being placed on the bed, the patient twisted suddenly and an audible crack was heard. The patient verbally expressed his discomfort in his left arm and security officers immediately sought nurse assistance.	Updating and review of de-escalation practises for staff.	Incomplete.
Serious	1	1	Wrong site procedure.	Femoral nerve block indicated for the patient due to significant pain issues not resolving by the use of oral analgesia, position changes and traction. House surgeon advised by medical team to administer femoral nerve block and the patient was referred to the pain team for ongoing management. House surgeon asked the patient which leg was painful to which the patient reported the left leg (current issue was fractured distal right femur) as a stent was recently inserted in the patients left leg for treatment of peripheral vascular disease. A nerve block was then administered to the incorrect leg.	Fracture site must always be identified by an arrow and date by the medical team using a permanent marker. Administration of all medications must follow the hospital guidelines using the five rights.	Completed.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	4B	2	Patient burned.	Patient in labour cared for by a lead maternity care midwife developed complications and required a caesarean delivery. On the way to the anaesthetic room burns to the patients' upper thighs and stomach were sighted by the midwife. The burns were identified as being caused by over heated and prolonged use of heat packs. The burns required dressing.	Review the maternity wards protocol for use of heat packs and advise the midwife to adhere to these. Education session for all midwives on the correct use of heat packs in labour.	Completed.
Serious	4B	2	Patient burned.	Patient was in the delivery suite and complained of leg cramps. The lead maternity midwife applied heat packs. Post delivery the patient complained of painful legs. On examination patient was found to have burns on both legs. The burns did not require dressing.	Update for all midwives on the dangers of incorrect heat pack use and the importance of correct positioning of women in lithotomy.	Completed
Serious	4B	2	Delayed post partum treatment	Patient had delivered a baby under care of a self employed midwife in the delivery suite where the retained placenta caused postpartum haemorrhage. Bleeding was ongoing for over two hours before the midwife informed the obstetric team who then informed the anaesthetic registrar. During this time the patient bled an estimated 1.5 litres blood. No observations of vital signs were taken during this period no intravenous access was obtained, and no blood tests were sent for cross match. The patient underwent manual removal of placenta under spinal anaesthetic. The patient also required two units of red blood cells.	Run education sessions specifically to address issues around post partum haemorrhage and management of same. These are for core midwives, LMC midwives and medical staff and include an open discussion of issues noted in recent cases and also skills, drills, and scenario based activities. Promotion of the importance of Team aspects of caring for women in the maternity ward as existing with particular emphasis on support for access holders. Team building exercises to be incorporated into usual education activities.	Completed.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Patient fall, head injury	<p>Acute cardiac inpatient was referred to the eye clinic for assessment of his cataracts was assisted to the toilet in a wheelchair and transferred back to the clinic room.</p> <p>Patient reported feeling light headed to a trainee intern who was unsure what to do so he went to tell a nurse. Nursing staff did not know of the patients circumstances which left an inexperienced trainee intern responsible for an acutely unwell patient.</p> <p>During this time the patient fell head first on to the floor sustaining a large laceration to his head.</p> <p>Consultant was called to assess patient who was then transferred back to the critical care unit.</p> <p>It appears the patient was not stable enough to attend an out patient department eye examination.</p>	<p>Request future communication to occur between unit manager and nursing staff before an inpatient is booked for an appointment.</p> <p>Acute patients to be assessed by the supervisor prior to coming to an outpatient appointment.</p> <p>Review guidelines around supervision and direction for trainee interns.</p>	Completed.
Serious	6	2	Patient fall, fractured neck of femur requiring surgery.	<p>Patient's mobility had improved since admission and patient had been mobilising around the ward independently, following a physio assessment. Fell to floor whilst dressing.</p>	<p>Falls prevention programme now in pilot phase.</p>	In progress.
Serious	6	2	Patient fall, fractured arm.	<p>Patient was a known high falls risk and had the call bell within reach, and bedsides insitu at night, to reduce the likelihood of mobilising independently.</p> <p>Patient had rung the bell for assistance but got out of bed unaided and was witnessed slipping to the floor as nursing staff got to room.</p> <p>X-ray examination confirmed a fractured Colles that required surgical intervention.</p>	<p>All patients that are assessed to be high falls risk should have a falls alarm in situ.</p> <p>Ensure all patients that are assessed to be high falls risk are toileted before settling at night.</p> <p>Falls prevention programme now in pilot phase.</p>	<p>Completed.</p> <p>In progress.</p>
Serious	6	2	Patient fall, fractured left proximal femur.	<p>Patient was being conservatively treated for a fractured left proximal femur, recently transferred to the rehabilitation ward.</p> <p>While admission process was taking place including a revision of the patient's mobility assessment, patient lost balance and fell while transferring chair to bed.</p> <p>X-ray confirmed another fracture of the left proximal femur and surgery (revision of the patients left total hip replacement) was then required.</p>	<p>Admitting house surgeons made aware of the importance of requesting nurse or physiotherapist assistance for mobility assessments.</p> <p>Falls prevention programme now in pilot phase.</p>	<p>Completed.</p> <p>In progress.</p>

## Southland

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	1	1	Wrong site surgery.	Patient required readmission and extended stay. No long-term consequences.	RCA in progress.	Awaiting final report.
Serious	4b	2	Baby delivered in helicopter enroute to secondary maternity facility, baby required resuscitation by LMC.	Patient presented to rural hospital in pre term labour (scheduled for caesarean section in private facility due to past history of uterine tear). Transfer delayed due to incomplete clinical assessment. Resuscitation kit not available when required.	Hospital emergency kit to accompany patients during transit, equipment must be accessible at all times. Transfer policy and procedure documents to be updated.	Complete.  Complete.
Serious	4g	2	Blood results misread which resulted in anti D omission.	Blood group incorrectly transposed to clinical notes.	Clinical record updated to include correct information. Medication provided and blood tests facilitated as follow up to patient. Issue reviewed with staff member involved. Increased risk for mother in future.	Complete.  Medication provided six days post event. Complete.
Sentinel	11	1	Suicide of community mental health patient.	Investigation completed. Referral management process inconsistent. Delay in presenting patient assessment at intake meeting.	Review of CMHT referral management pathway procedure. Process for managing referrals reviewed and changes implemented to ensure consistent and thorough process. All comprehensive assessments for patients will be presented to the multi disciplinary clinical review team within one month of the patient being referred to the service. Interface agreement to be developed between provider arm mental health service and primary mental health team which clearly defines agreed pathways and role responsibilities.	Complete.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Sentinel	11	1	Likely suicide CMHT patient. Sudden death review undertaken. Last contact with service within seven days of death.	Discharge did not take into account requirements for family input, patient had also recently changed address and a key worker was not allocated. This was rectified soon after discharge – good follow-up was then commenced.  The patient was visited on three consecutive days, within the week prior to his death and no untoward behaviour was observed.	A review of the incident was undertaken this identified the arrangements for discharge did not contribute to the patients death however, the review did identify recommendations and coincidentally gaps have been identified in the discharge process.  All clients shall have a key worker on discharge which must be from the community mental health team covering the area the patient is residing in.  Provision of education for inpatient unit staff regarding the Mental Health (Compulsory Assessment and treatment) Act process, including Section 30 family involvement and planned discharge.  Family involvement is essential when planning discharges from inpatient unit and consideration must be given to allow for travel.	All recommendations completed.  Ongoing audit and monitoring occurring.
Sentinel	11	2	Suicide by community mental health patient. Last contact with service within seven days of death.	Sudden death review undertaken.	Clinical and management decision making appropriate.	Complete
Serious	6	2	Patient fall resulting in fractured patella.	Patient had been placed on low electric bed, cot sides were in place and call bell available. Patient checked hourly during the duty.	Staff reminded of management of patients suspected to be a falls risk.	Complete
Serious	6	2	Patient fall resulting in fractured neck of femur.	Miscommunication regarding need for patient watch.	Patients to be assessed by staff for need to wear a personal patient falls alarm.  Standardisation of handover undertaken.  Staff must ensure relatives informed in a timely and appropriate manner of any incidents.  Ensure ACC treatment injury forms are completed in a timely and appropriate manner.	Complete
Serious	6	2	Patient fall resulting in fractured humerus.	Patient assessed as high falls risk on admission.  Multiple measures put in place to mitigate risk, (including patient watch, low bed and mattress on floor as buffer).	Mattress that had been utilised as a buffer for fall may have contributed to fall therefore mattress removed.	Complete.

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	6	2	Patient fall resulting in fractured neck of femur.	Multiple measures in place including patient watch and planned restraint. Family was not notified of fall until following day.	All falls resulting in fractures over six-month period reviewed. Falls alarms purchased for area. Processes for management of at risk patients reviewed, review of clinical documentation undertaken. Research has been undertaken resulting in the purchase of falls management alarms to minimise the potential of patient falls. Laminated instructions for use of physical restraints are displayed by "at risk" patients bedsides. Meeting held with family and formal apology given by organisation.	Complete
Serious	6	2	Patient fall resulting in lacerations to face and fractured C1 and C2.	Falls assessment had been completed, patient was deemed medium risk. Unstable toilet frame may have contributed to fall.	Ensure all appropriate patients have commodes beside bed at night.  Toilet frames to be checked by occupational therapy department – nil deficiencies found.	Complete.  Complete.