

SUMMARY - Sentinel/Serious Events (July 05-June 07)

Bay of Plenty

Event Severity	Description	Review Findings	Recommendations/Actions	Follow Up
Sentinel 2005/2006	A baby in foetal distress was delivered by emergency Caesarean Section and later died. The pregnancy had been uneventful and this was an unanticipated outcome.	The level of foetal distress was not recognised. Contributing factors identified were <ul style="list-style-type: none"> <li>▪ Staff knowledge/training</li> <li>▪ Medical cover</li> <li>▪ Communication of the care plan</li> </ul>	Establish a training programme for heart monitoring  Review foetal distress protocols and circulated to staff  24 hour registrar cover available on site for maternity  Establish forums with a focus on improving relationships and communication established.	Completed  Completed  Completed  Completed
Serious 2005/2006	A patient was admitted for a removal of kidney. Initial surgery done then due to complications, returned to theatre where the patient subsequently died on the operating table. The primary causes were haemorrhage cardiogenic shock, severe sepsis with under lying conditions of ischemic heart disease, diabetes and chronically infected kidneys.	Contributing factors were identified as: <ul style="list-style-type: none"> <li>• Inadequate knowledge regarding pre-assessment processes</li> <li>• Incomplete patient documentation</li> </ul>	Review pre-assessment procedures and nursing guidelines for assessment and ensure that staff receive training on same.  Education of staff on the importance of accurate documentation	Completed  Completed
Serious 2005/2006	Patient presented to the hospital with headaches cause not established and patient was subsequently discharged home re-presented acutely and died soon after.	Patient had an undiagnosed frontal lobe brain tumour (Anaplastic Astrocytoma). Unfortunately this was a rare, rapidly progressing type which can evade even a comprehensive neurological examination.	Practices in regard to CT scans for patients that present with headaches to be reviewed.	Review completed and flow chart developed and circulated to staff.

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		CT scan was not performed prior to initial discharge, however even had the scan been performed and an appropriate diagnosis made the same outcome would have occurred.		
Serious 2006/2007	Following prolonged labour a baby was delivered by LSCS it required extensive resuscitation and subsequently died. Although there had been problems during the pregnancy this was an unanticipated outcome.	There were indications for active management of labour to have commenced earlier.  There were delays in the treatment of baby's pneumothorax due to delay in obtaining x-ray.	Active management of labour should commence where labour is slow to progress and meconium is present.  Establish processes for checking operational status of X-ray equipment	Staff education program undertaken re – management of labour  Process developed, implemented and monitored
Serious 2006/2007	A baby who had received intra uterine exchange transfusions died from complications of anaemia following discharge from hospital.	Continuity of care was compromised.  Contributing factors identified were <ul style="list-style-type: none"> <li>▪ Lack of appropriate follow-up in primary care system – family had no GP</li> <li>▪ Electronic systems – failure to report lab results as system automatically sends results to GPs</li> </ul>	Review processes for transfer of fragile patients to primary care and educate staff on processes  Education of staff about rhesus isoimmunisation and the electronic laboratory system	Completed  Completed

**Note:**

1. This is a list of serious and sentinel events identified from the DHB reporting systems during the period July 05-June 07. DHB reporting systems and criteria for reporting may have changed over that period.
2. ACC legislation broadened the definition of treatment injury in 2005. This may have changed reporting - note that not all treatment injuries are necessarily sentinel or serious events.
3. Some of the events listed have been, or are currently, the subject of HDC or Coronial enquiries.
4. It is possible that some events that are not currently included on this list and which are under review, internal or external, may be subsequently identified as meeting the serious or sentinel event criteria.