

NMDHB Sentinel Events 1 July 2002 to 30 June 2007 (Embargoed to 3 am Thursday 21 February 2008) - 1 -

Event Severity	Description	Review findings	Recommendations/Actions	Follow up
2003/1	Child suffering from several disabilities and multiple medical problems was admitted for orthopaedic surgery to both hips. Surgery was uncomplicated and initial recovery satisfactory. On second day post-op their condition deteriorated and the patient died.	Regular paediatrician not notified. Not seen by anaesthetist prior to going to theatre. The issue of shared management of a complex patient was identified. Lack of pre-anaesthetic assessment. Lack of good IV access. Referral procedure to senior staff responsible for complex care of patient. Supervision and direction for nursing care	Establish pre anaesthetic assessment system. Education for nursing staff on presenting robust clinical case summary to present to senior medical staff. Review orientation programme for House Surgeons regarding when to refer to senior staff. Review shared senior care of complex cases. Review handover of care practice guidelines. Further education on patient assessment including fluid balance.	All recommendations implemented.
2004/1	Baby developed pulmonary complications following a waterbirth.	Waterbirth not planned antenatally, No information on risks/benefits provided. No written consent obtained.	Evidence based, contemporary practice with associated literature is to be provided to the Operational & Service Manager. Policy and related protocols to be developed. Develop patient information once policy decision made. Presence of second person for delivery to be included in protocol development. Current access agreement wording to be checked with	Recommendations Implemented.

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			Midwifery Advisor. Care plan required even in a wellness model, recognizing departure from wellness	
2004/2	Infant admitted with suspected non-accidental injury. New fracture identified 5 days after admission.	Inter agency communication and interface needs improvement. Improve awareness of early warning signs and appropriate response. Delayed reporting of new injury.	Debrief with other agencies regarding responsibilities for decision-making and communications. Review multi-agency policy and procedure. Ongoing intersectoral education sessions for staff regarding signs of abuse. Education to improve hand-over.	All recommendations implemented.
2004/3	Patient with Myocardial Infarction was given incorrect drug.	Medication checks not done by two RNs. MU doing too much (defib, drugs, IV line) Difficult to keep track of drugs given, drugs all in one drawer. Notes unclear of events. Position of patient too cluttered (partner and support person also present). Junior staff felt not able to question authority.	Review Cardiac Arrest policy and procedures in particular the management of: <ul style="list-style-type: none"> • Drug administration • Delegation of tasks • Charting of drugs and events • Note writing practices • Space around the patient • Managing family • Labeling and storage of drugs • Staff exhaustion • Clarify the nature of available support and how to access it 	Recommendations implemented.

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2004/4	Post mortem to determine reason for fetal demise not completed.	Staff unfamiliar with expected responsibilities. Daily monitoring of mortuary not carried out because new staff had not started. Mother unaware the post mortem was not carried out.	Policy and procedure to be developed together with education for staff involved. Responsibility for daily monitoring of mortuary clarified. Communications with mother on clinical findings.	Policy and education complete Clear job description. Obstetrician met with mother. Letter sent acknowledging failure undertake post mortem.
2005/1	Delay in reading and reporting on pathology specimens and slides may have adversely affected a patient.	Amputation was likely in any event. Original histology specimen not reported. Outstanding reports list not active. Patient was not notified	Histology workflows to be revised. Outstanding reports list to be activated. Physician to speak to patient	Recommendations implemented.
2006/1	Resuscitation of patient with tracheotomy.	Patient diagnosed with Guillain-Barre syndrome requiring long term ventilation. Developed respiratory arrest followed by cardiac arrest. Documentation did not meet required standards.	Training of staff on airway management of patients with tracheotomies. Consider purchasing mannequin to assist in such training. Improve documentation.	Recommendations implemented
2006/2	Medication error	Pregnant patient received insulin overdose.	Double checking of prescription and drug labels.	Recommendations implemented
2006/3	Incorrect operation	Different theatre lists in	System to be developed to	Time out policy

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		<p>circulation. Staff did not identify patient prior to commencing procedure. Documentation did not comply with acceptable standard of care. Notes not part of main patient record. Written consent not obtained. Staff continued to operate on other patients. Poor ongoing communication</p>	<p>generate a single theatre list for use by all theatre staff. Time out policy to be implemented. Available equipment to be used to dictate reports. Notation on main clinical records to indicate existence of other notes. Written consent to be obtained prior to patient arriving in the theatre suite. Whenever a serious situation occurs staff to be given time to recover and debrief.</p> <p>Incident reports must be followed up and feedback given to the writer.</p>	<p>implemented.</p>
2007/1	<p>A patient was admitted following a motor vehicle accident and required transfer. Bad weather across the country caused a long delay in obtaining blood products from Christchurch for the patient and delayed the air transfer of the patient to Wellington</p>	<p>The set of circumstances prevailing during this resuscitation was extremely rare and the team managed well under the circumstances. The patient responded well to treatment and was later successfully transferred.</p>	<p>Documented policy and process as to the management of trauma in general (roster, responsibility, location, communications with airport management and resuscitation team, links with other facilities in the district) Review the availability of platelets Review requirement for anaesthetic equipment in ED</p>	<p>Policy does exist. Will be reviewed.</p> <p>Platelet availability reviewed. Anaesthetic equipment requirement reviewed.</p>
2007/2	<p>An incident took place at a</p>	<p>The Sentinel Event Core</p>	<p>Acute colonograms to be</p>	<p>Capacity in place to do acute</p>

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	radiology service whereby the period for reporting of a colonogram was inordinately long.	Group identified a number of issues. The period between the referral and procedure was unacceptable. The period between the procedure and the report was unacceptable. The system of arranging patient follow up after diagnostic procedures was inadequate.	done within 5 hours of referrals. All radiology reports to be available within 5 working days. Written procedure for daily monitoring of unreported results. Referrers notified of wait times. Review patient follow up arrangements.	colonograms within 5 hours. All reports are available within 5 working days. Procedure in place for daily monitoring of unreported results, with appropriate escalation to consultants.
2007/ 3	A Client on Client assault occurred.	The issues highlighted by this event illustrate the risks associated for both staff and clients where client behaviour is unpredictable and the environment is not fully purpose-designed. As services and supports for clients and families in the community are boosted in both quality and variety, those clients accessing specialised hospital care, of the type provided, are presenting later with more complex, acute physical and mental health symptoms. While this is often a positive	Install safety glass. Install sensor beams to alert staff to patient movement. Review the call bell system. Review the allocation of patients to rooms at the end of blind corridors. Review settling routines at night. Review the management of physical symptoms. Review shift guidelines. Review design of the facility for the client group.	Safety glass installed. The review of provision of psychogeriatric services is a priority within the 2007/08 District Annual Plan. A workshop was held to examine service structure. This process requires to be completed prior to any facility development.

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		outcome for clients and families who are able to stay together as a family for longer periods of time, it does mean that when hospital care is required it is at the more complex stage of illness.		
2007/ 4	An unexpected patient death was investigated. It is known that the patient died as a result of increased intracranial pressure.	The review panel considers the care given earlier in the year to be of an acceptable standard. However, these notes were not in the patient record when she presented two months later. Given the incomplete information available at the time, the review panel considers the care given initially to be of an acceptable standard. However, the care given after admission to the ward was not. At the time, the patient's drowsiness could not reasonably be attributed to the effects of medication. With regard to the events on the next morning, the review panel is of the view that the resuscitation response and transfer to CT was not of an acceptable standard.	Review the filing of notes to ensure early integration into the patient record. An agreed period and procedure by which patients in ED should either be admitted or discharged. Admitting consultant to apologise in writing and review their practice. Education plan to be developed for medical unit staff with regard to decreased level of consciousness and recognition and resuscitation of a neurological emergency. Escorting of sedated patients by nursing staff to be reviewed.	An education plan has been completed for all relevant staff with regard to decreased level of consciousness and recognition and resuscitation of a neurological emergency. The admitting consultant has apologised in writing to the family and reviewed practice in light of this incident. Escorting of sedated patients by nursing staff is to be reviewed.

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2007/5	An unexpected death occurred at a Community Hospital.	All parties were encouraged to engage in a review of the incident including staff at the medical centre at a lower level. Following reluctance of some parties to be involved the incident was elevated to a full sentinel review. The post mortem report indicates that the patient died of an acute myocardial infarction.	Lack of continuity of care both medical and nursing. Poor documentation. Observations were incomplete and further assessments were not initiated when it became apparent the patient was confused. Review Specialist support on antibiotic usage. Need to review standing orders.	Education sessions have been provided to the nursing staff on assessment and documentation. Nursing staff now meet monthly for peer review. Review of standing orders underway.
2007/6	Following notification of the death of an infant, an investigation was performed.	The cause of the death was thought to be due to the consequences of the combination of the abnormalities that affected the nose and the bedsharing during sleep. There was no indication that classic overlaying had occurred. The Sentinel Event Core Group is of the view that care given to both mother and baby was appropriate. The policy on bed sharing was not followed completely. The information on bedsharing was not discussed with the mother at the time.	Review of bedsharing policy. Improve documentation practice.	The policy titled "Bed sharing – Babies sharing their mother's bed while in hospital", has been expanded to incorporate risk factors and reference to the literature.
2007/7	An investigation was performed in relation to care	The child was transferred and the subsequent clinical	A protocol for Status Epilepticus to be readily	District wide interdepartment protocol for

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	and treatment of a four year old child with status epilepticus.	outcome was good. The reviewers believe that given the circumstances, it would have been appropriate to have called an anaesthetist earlier.	accessible on the ward and familiar to Medical and Nursing staff. Protocols should be standardised across the region and all drugs and related equipment named in the protocol should be available in the clinical area.	managing epilepticus in place. Required medications available on the unit.

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