

## 2004-2005

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2004-2005 Serious	Died from cerebral bleed (maybe from fall)	Nurses across the room checking medications. Patient heard to fall onto floor from trolley. Fall - gash on forehead. Trolley cot side down	Review falls minimisation programme with department Ensure falls minimisation included in staff learning opportunities	Falls minimisation programme implemented
2004-2005 Serious	Suicide attempt – inpatient	Found hanging on regular 15/60 check. Resuscitated and transferred to ECC for assessment Good bystander CPR knowledge	Have ambulance scissors available on Resus Trolley Test a personal alarm for nurse doing 15/60 checks Communicate reason for 15/60 checks to all staff Review this type of emergency response scenario with staff for refresher/debrief	Emergency scenario included in teaching
2004-2005 Sentinel	Deterioration requiring ICU admission, died	GP referral did not identify serious undiagnosed respiratory disease - skilled triage and placement required. Monitoring of deterioration Direct GP referrals to Medicine not seen by ECC doctors High medical team & ECC workload – delay in first medical assessment Delayed antibiotic initiation IT outage resulting in delay in prioritisation of assessment	Case review and reinforce action for patient deterioration Review collaboration/ sharing of resources between Medicine and ECC. Clarify leadership and direction of ECC to ensure that all medical resources are utilised to meet patient priority Triage system to be applied to all patients regardless of referral route and medical assessment to occur within allocated triage time Review IT failure risk-mitigation strategies and back-up systems	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented Workload monitoring systems implemented IT contingency plan reviewed
2004-2005 Sentinel	Suicide – Community while on leave	Independent decision to allow an extended outing Discrepancy between documented management plan and events Discrepancy between information on clinical file, office whiteboard and legal tracking forms	Review competency of staff deciding on outing. Educate staff of escorted leave policy. Clarify process for selection for senior nurse in charge Audit nursing documentation. Review supervision / countersigning Review process & responsibility for updating office whiteboard and legal tracking review.	Procedures for decision making formalised.

## 2005-2006

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2005-2006 Serious	Deterioration over some hours. Delayed treatment. RMO and nurse provide care and monitoring. Recovered	Senior medical staff busy with multiple emergencies in ED. Could not attend as requested. Earlier identification of abdominal bleed would have resulted in earlier treatment Workload management difficulties overnight Patient recovered after specialty care after rehabilitation	Review procedures for on-call RMO when registrar busy in ECC. Reinforce use of medical emergency team if deterioration noted Revise role of General Medicine in responding to patients in another service	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented
2005-2006 Sentinel	Suicide – community while on leave	Assessment of readiness to be able to go on leave Assessment of risk	Review of procedures for MDT assessment for readiness for leave while in acute phase Staff debriefing Family support	Procedures reviewed and staff updated
2005-2006 Serious	Delayed follow-up procedure. Cancer diagnosis and treatment delayed	Review Clinic outcomes processes to ensure that patient follow-up requirements are immediately acted on Review clinic preparation to ensure investigation results available	Clinic outcomes processes reinforced and monitored Audit outcomes Review medical and nursing roles in clinic follow-up	Procedures reviewed and audited
2005-2006 Sentinel	Death after prolonged hypotension. Assessed in two hospitals and diagnosis delayed	Symptoms thought to be renal colic not gastric ulcer Prolonged hypotension should be investigated	Case review to support staff learning Remind of need to complete discharge summaries for patient who die to keep GP informed	Case reviewed completed. Included in learning programme as example
2005-2006 Serious	Bacteraemia after treatment for perforated gallbladder Acute renal failure as a result of high gentamicin dose	High Gentamicin trough level as a result of high prescribed dose of antibiotic. Condition deteriorated and required ICU admission for acute renal failure. Recovered after long rehabilitation Review system to alert medical and nursing staff to issues relating aminoglycosides and other drugs	Review Gentamicin protocol and clinical pharmacist review of therapeutic drug monitoring Review Pyxis alert system re: aminoglycosides and to ensure requirement to fax medication charts to pharmacy noted Use of stamps by RMO to increase clarity of signature/ID to improve legibility of signatures and difficulty of identifying treating doctors	Protocol reviewed. Case included in all education Stamps with name and council number issued each run
2005-2006 Serious	Low oxygen levels as a result of fractured Tibia / Fibula. Recognition and action on low oxygen levels/ deterioration slow Required ICU admission. Recovered	Low oxygen as a result of fractures. Identification and action would have resulted in earlier treatment. Staff should have activated the early warning score. Recovered after ICU treatment.	Ensure staff re-educated on NEWS processes Case Review for staff learning. Include education on complications in long bone fracture cases	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented

## 2005-2006

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2005-2006 Serious	Delayed diagnosis as referral mislaid. Cancer diagnosis and treatment delayed	Review system for logging and tracking referrals from GPs Security of documentation when being transported needs review Patient options explained as delayed diagnosis has reduced options	Review referral process spreadsheet system for logging and tracking GP referrals. Review weekly by supervisor Change to hand delivery of referral in sealed coloured envelope	Systems reviewed. Regular review
2005-2006 Sentinel	Suicide - Community	Different approach to working with this complex client might have changed outcome, Systems issues identified. Triage and initial assessment process must be followed consistently. Need for process to identify urgency and acuity. Communication with GP. Carry over of planning between shifts Communication and team work between community service and outreach teams Need to integrate community electronic patient records with outreach records SMO shortages. Contingency plan to ensure clinical team see all correspondence Raise concerns where staff concerned about their safety when visiting patients in community	Flowchart for identifying non urgent and urgent cases developed. Implementation of traffic light system and clinical whiteboard to signal urgency of cases Daily handover process by duty clinicians improved to ensure explicit sharing of information, including combined full team meeting weekly. Risks addressed at handovers and clinical reviews. Duty clinician in crisis team supervises handover at end of shifts and ensures all clinical discussion entered into HCC. Clinical team see correspondence before filing. Team manager attends administrator meetings Integration of community records with outreach complete in HCC information system Recruitment of additional SMOs. Extra registrar cover arranged Creation of GP liaison role. Communication with GPs re discharge Use of alert box in HCC to identify safety issues for staff. Review of systems and processes at community service. Project Group convened to develop systems and processes to improve communication between community and outreach	Changes made to systems and audit done of implementation  Medical team leader role filled  Liaison with GPs enhanced
2005-2006 Sentinel	Suicide – Community	Triage and initial assessment process must be followed consistently. Need for process to identify urgency and acuity. Document steps if no phone contact can be made. Communication with GP. Carry over of planning between shifts	Processes established to monitor risk and complete assessment for every referral. Triage systems in community reviewed Professional conduct issues investigated	Systems changes made and audited of implementation Staff issues addressed
2005-2006 Sentinel	Suicide – community	Prompt follow-up to referral might have altered outcome Procedures when patient DNAs should have alert to lack of engagement	Case review undertaken with staff, emphasising DNA procedures and need to check electronic and paper patient records Community team to report DNAs to Multi disciplinary Team meeting	Case review completed Audit of DNA processes completed

## 2005-2006

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2005-2006 Serious	Breach of policy	Cell phone found in client's room. Room searches did not detect cell phone Client had cell phone contact with two staff members and alleged having sexual intercourse and using cannabis with one of these staff members while on escorted leave Informal reports of concerns about conduct of staff members were not documented or followed up	Staff behaviour addressed formally Policies reviewed with staff and ongoing in staff learning Team processes in unit addressed to ensure issues reported	Systems compliance monitored Team processes addressed
2005-2006 Serious	Client absconded while on unescorted leave (AWOL), rearrested 3 months later after alleged involvement in criminal offending	Client had access to money in week before going AWOL Client may not have been fully engaged with rehabilitation pathway Notification to police completed appropriately however police did not appear to have registered and maintained an AWOL listing for client after first notification	Procedures reviewed regarding client access to money and vigilance in actions indicating preparing to go AWOL Case review undertaken and procedures reinforced with the team Interaction with Police reviewed	Systems compliance monitored Case review completed and procedures reinforced Procedures re: communication with Police reviewed

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Serious	Deceased while AWOL	Initial risk assessments need to be fully documented AWOL procedures followed but escalation process needs review MOU processes with Police	Ensure initial assessments are accurate and fully documented Review/update AWOL procedures and clarify role of Police Ensure AWOL status and decisions relating to AWOL are clearly documented in patient's clinical record and communicated	AWOL Procedures reviewed Assessments audited
2006-2007 Serious	Patient with neutropenia sepsis deteriorated on transfer of care from Emergency Department, required admission to ICU Recovered	Documentation of critically ill patient needs attention – could have been assessed by ICU in Emergency Department Staff response to respiratory condition in Emergency Department prior to transfer to ward Early Warning Score not used by Emergency Department or ward to escalate timely medical review	Review care plan for critically ill patient, NEWS and escalation process Orient staff to neutropaenia sepsis pathway Ensure update for nursing staff to recognise deterioration in patient condition and referral to medical review and escalating concerns Re-educate staff on importance of documenting concerns and actions in response	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Sentinel	Suicide attempt by inpatient, admitted to ICU, died on ward some days later	Risk assessment undertaken but extent of self harm risk not clear Client on regular checks Call bell activated and staff found client in bathroom after unlocking toilet locking system Staff acted appropriately to release client and call emergency team for resuscitation	Review with staff check / observation processes, including environment checks. Include linen bag storage system Emphasise importance of documenting risk assessment and management processes to staff. Prioritise attendance of primary nurses at key assessment and review meetings. All staff to attend MOH training on risk assessment and management guidelines Debrief staff and review processes for responding to emergency call bell Investigate change locking system to toilet doors Monitor and report nursing vacancies on unit and evaluate impact of resource issues on service provision. Nursing resource issues and use of nursing bureau staff	Environmental safety systems checked and changes made Staff recruitment addressed
2006-2007 Serious	Eye injury to staff member from equipment cover	Equipment cover did not lock fully each time	Decision to change to alternative equipment across all facilities	Equipment replaced
2006-2007 Sentinel	Death following surgery for pressure area debridement	Significant co-morbidities. Admitted after fall. Condition deteriorated, developed pressure areas Issues with nutrition, pressure assessment & wound management processes Communication processes with family identified Patient placement for very unwell patients in ward setting	Reinforce expectations of initial assessment of all new patients including disabilities, care issues for highly dependent patients Review pressure area assessment and management, including pressure relieving devices/mattress, nutrition support & wound care. Plan to replace ward and ECC mattresses Review pain management in non-surgical situations Remind of processes for communication with family and need for family and staff debriefings Reinforce use of side rooms when patient condition deteriorates	Inpatient mattresses replaced Pressure prevalence and incidence audit done annually Waterlow assessment mandatory Included in staff learning
2006-2007 Serious	Death after prolonged hypotension, ICU admission	Admitted with symptoms suggestive of cerebrovascular accident but later identified as infective origin as significant neurological symptoms. Patient was treated according to provisional diagnosis. Prolonged hypotension over some days as very unwell. Blood cultures showed gram positive cocci / staph endocarditis Emergency Resuscitation Team not activated each time condition met criteria RMO shortages, multiple staff reviewed patient	Review RMO staff availability and model to achieve continuity. Review processes when locums used Remind staff/educate about prolonged hypotension, NEWS escalation and MET activation Review with staff importance of collecting information on NAT 2 form; put sign in waiting room re providing all names. Flag alias in chart and on Concerto Remind staff of importance of documenting and highlighting allergy information.	Contingency plan reviewed to ensure continuity Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Serious	Assault on staff member by patient on escorted walk	Client unpredictable. Staff failed to appreciate warning signs of violence and underestimated risk presented by client. Care planning processes fragmented, inconsistent and did not clearly identify core risk issues, leave approvals incompletely documented	Leave policies to be reviewed and decision making process/integrated team process reinforced; documentation standard reinforced. Rostering to be adjusted so care managers can attend team meetings. Communication devices to be used on all escorted leaves. Programmes Coordinator position to be established to ensure ward programmes run at all times Staff debriefing and learning reinforced	Policies reviewed Schedules changed Staff learning of risk assessment, planning Additional staff found
2006-2007 Sentinel	Deceased while AWOL	AWOL procedures were followed Interface with Police appropriate - AWOL for 11 days	Case Review with staff, emphasising initial assessments are accurate and fully documented, AWOL procedures, interface with Police. Reinforce requirement to record AWOL status and decisions relating to AWOL in patient's clinical record	Assessments audited Procedures emphasised in learning
2006-2007 Sentinel	Suicide - community	Decisions made were reasonable re: assessment & follow-up Need for medical review at least three monthly Communication/liaison with GP less than should be Support for staff seeing clients over long period	Patient files audited to ensure assessment, hazard alert and risk assessment and safety plan forms are complete. Regular audit files to ensure 3 monthly medical review occurs. Review staff case loads to avoid case isolation Procedures for complex case reviews to be developed Document all contacts with GP. GPs to get letter following all Medical reviews. Case managers to maintain regular contact with GPs and other agencies involved with patients.	Files audited Complex case review procedures reviewed Liaison with GPs promoted
2006-2007 Sentinel	Suicide - Community	Anglicised names used Triage / referral processes followed - review documentation Review interface between different patient databases	Case review with staff, reminded to ask if patient known by other names Staff reminded first contact to be by triage nurse. Reminded to complete full triage documentation Triage notes to be read in full. Staff reminded to fully document reason for referral. Patient information to be copied into patient database correspondence from ECC whiteboard by MHS staff	Assessment procedures reviewed. Audited regularly

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Sentinel	Suicide - Community	Complex client, difficult to engage across multiple services Management of acute withdrawal appropriate. Get toxicology screening Management of challenging behaviours and improvement of communications where multi-service involvement Risk assessment formulation and documentation appropriate. Review CADS triage assessments of medically unwell patients Processes for referring patients to CADS and communication when care transferred, including access to patient information database Communications with primary care on discharge and timeliness of documentation	Meeting occurred between multidisciplinary teams (Mental Health, CADS, Bureau Manager) to undertake case review and review of interface Ministry of Health Risk Assessment Tool Kit Training undertaken and tool implemented All staff working after hours to have PIMS logon and training. Reminder to all staff re access to past information about patients CADS triage assessments to be rescheduled if patient too unwell to participate. Toxicology screening to be performed where drug use suspected Staff reminded of standard for verbal and written communication between services when care transferred and for all patients identified with alcohol and drug issues. Reminded of clear and timely documentation. Telephone calls to patient's primary care team reinforced with staff when patient discharged to their care	Inter-service procedures reviewed and changes made Tool kits used Communication audited
2006-2007 Sentinel	Suicide – community	Documentation of contact with family and attempts to obtain clinical records identified. No collateral information available for assessment Patient record opened under aliases Delayed initial medical and psychiatric assessment on admission to inpatient unit. Failed appointments due to medical team unavailability	Staff reminded to record any contacts/attempted contacts with family. System for booking appointments reviewed Staff reminded to open files under proper name, not alias. Also reminded to record requests for clinical notes Staff reminded to keep community services files open while in inpatient unit Staff reminded to complete safety & risk assessments on admission to inpatient units and to keep to timelines (24 hours) for medical and psychiatric assessment post admission to inpatient unit	Documentation audited Booking systems reviewed
2006-2007 Sentinel	Suicide – Community	Documentation of clinical assessments to be improved Discussion or follow-up/transfer assessment by acute or MDT Documentation of contact with family/support people	Staff reminded of need to document in patient information databases as a transfer care, not a discharge if referring to another WDHB service Staff reminded to document in patient information databases all Multi Disciplinary Team meetings including details of DNAs and also document clinical information relating to non attendance at scheduled appointments Staff reminded to gather collateral information from family/support people where possible	Documentation audited Family inclusion emphasised

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Sentinel	Suicide attempted in community, died 8 days later	Need to ensure adequate communication and liaison between services where multiple services involved Need to ensure Transfer of Care Inter-DHB Memorandum of Understanding complied with Need to ensure Complex Case Review or Serious incident reviews takes place after serious self harm incidents	Staff reminded that a Complex Case Review must be held after any serious self harm incident Daily/weekly prescribing to be considered where significant risk of self harm also remind to review of discharge process re return of medications on discharge Review undertaken of CADS systems to ensure that referrals made to CADS 65+ team from other CADS services Procedures have been established to alert services that there is an open referral in another service and how to access clinical information from different systems MHSOA and CADS have developed a Regional Protocol re interface between services with consideration of shared care model, and staff reminded to ensure transfer of care processes consistent with Transfer of Care Inter DHB MOU	Systems reviewed for prescribing and monitoring with complex case situations Regional protocol for shared care reviewed and processes changed
2006-2007 Sentinel	Suicide – community	Care had been transferred to another DHB under their care Difficulty in managing patients involved with services in other DHBs especially where patient difficult to engage Patient's use of number of different names a complicating factor	Discussions held with other DHBs in region re management of patients involved with services in a number of DHBs. Reasons for referral to another service to be clearly stated. Service receiving referral to advise referring service of outcome of assessment Procedures for Case Conferences to be conducted for complex clients Advice to be sought from patient records administrator re management of patients using different names	Systems reviewed for shared care arrangements across multiple DHBs Systems in place for vigilance with different names
2006-2007 Sentinel	Suicide - community	WDHB "Family Pack" for family/whanau of new community MHS clients would be helpful Need for clinical teams to utilise acute psychosis team resources for young clients with first-episode psychosis. Clarify age threshold for access to early psychosis team (EPI) Discussion re pharmacological treatment of acute psychosis in community. Need for baseline investigation against a "metabolic syndrome" when atypical anti-psychotics used. Ensure all senior medical officers are aware of medications routinely carried by Acute Teams Documentation of planned interventions which are not carried through and late entry of notes in clinical notes	WDHB "Family Pack" produced by Family Advisory team Threshold for referral to EPI between clinical teams clarified Case review undertaken to discuss referral, pharmacological treatment of acute psychosis in community, medicines carried by the acute team and "metabolic syndrome". Staff reminded of the importance of documenting rationale for not following through planned interventions	Family Pack produced and available for use Case review completed and used for staff learning Documentation audit undertaken

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Sentinel	Suicide - community	Adequacy of intake documentation, including risk assessment. Documentation issues DNA procedure not well understood	Staff reminded about the quality required of intake documentation to ensure full demographic information, screening information, motivation, stability and risk issues and willingness to participate in group recorded. Internal audit undertaken of clinical risk identification and use of screening information and used in training about documentation (historical vs. recent risk issues) Templates used in groups, triage assessment and release of information form has been amended DNA process for group participants reviewed. Amend process to include follow up letters.	Documentation audit completed, including clinical risk DNA process reviewed
2006-2007 Sentinel	Suicide - Community	Interfaces issues between agencies involved in patient's management identified especially patients difficult to engage and there is conflicting views to care planned Consistency of review and planning following assessment identified, including need for collateral information to be obtained from other agencies and adequacy of clinical summaries Process for flagging patients referred on multiple occasions and for follow up of clients	Meetings held with different agencies to agree communication processes. Barriers to engagement identified. Agreed use of facilitated meetings where disparity of opinions evident Assessment structures have been formalised. Staff reminded to obtain collateral information as part of assessment process and to work collaboratively in discharge process. Clinical summaries (risk, goals) have been audited System developed for flagging system for patients referred more than twice. Also software used to identify clients who have not been seen for 90 days and ensure follow up.	Communication in shared care arrangements reviewed Assessment structures reviewed and reinforce in staff learning Systems in place for vigilance with different names
2006-2007 Sentinel	Suicide – community Presented to ECC x 12	Clinical documentation unclear about clinical liaison between MHSOA & CADS - communication between services Concerto notes not automatically sent to CADS clinician as sent to GPs IT systems need to integrate better	Staff reminded of need for clear identification of clinicians name and designation where liaison occurs. Improved communication between inpatient and outpatient units Risk related to transfer of information across multiple records systems raised with management team Mechanism for communicating between services where clients multi-present to acute services is under review i.e. linking different service consults for full picture. CADS SMOs have access to Concerto	Documentation audit completed Shared care processes reviewed, including access to databases
2006-2007 Serious	Side effect of medication	Client admitted to surgical services for treatment of medical condition arising from side effect of psychotropic medication Client reluctant to report symptoms	Contribute case study to national review of clients experiencing side effect of the medication Include in staff training and reinforce need for vigilance	Clinical review completed and vigilance reinforced

## 2006-2007

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2006-2007 Serious	Client absconded from unit while other clients and staff involved in outside activity	Communication failures in relation to swapped duties, handover of responsibility for observation No staff member present on ward at time of escape. Complacency about degree of security offered by high security environment of unit. Difficulty of balancing unit's role in providing rehabilitation pre discharge and support to clients with chronic long term care needs Difficulty in predicting client's ability to plan and execute escape and assessing client's physical strength and agility. Possible failure to take into account client's cognitive impairment and fixations fully in nursing management	Systems and rostering processes were reviewed Staff reminded of procedures	Systems implementation audited and included in staff learning
2006-2007 Serious	Special Patient absconded while on unescorted leave	Client did not return as scheduled from routine unescorted leave. Search initiated but initiation of formal AWOL procedures delayed by an hour. Client located at mother's house and returned the following day. Client may not have been fully engaged in rehabilitation pathway	Client engagement in rehabilitation reviewed Systems were reviewed and staff reminded of procedures	Systems implementation audited and included in staff learning

## 2007-2008

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2007-2008 Serious	Attempted suicide – inpatient unit, transferred to ICU	Re-admitted and was placed on 15/60 checks. Noise heard from room and client found attempting self harm. Resuscitated and transferred to ICU. Recovered Difficult judgements required when acute pressure on beds makes it necessary to move patients Slight confusion when calling ambulance	Review practice and protocols regarding medical review post admission. Review community respite follow-up and respite / early discharge Remind staff of emergency numbers reminder. Review intubation equipment	Case review completed with staff Scenario used in staff learning to enhance vigilance
2007-2008 Sentinel	Suicide in ward	Admitted as experiencing severe physical side effects to psychiatric medications. Alternative medications not as effective in managing mood. Good staff interactions/relationships. Good specialist team input. Subtle cues unrecognised of self harm intent. Found in locked toilet. Suicide notes found later in locked	No recommendations  Staff debriefing and supported learning to recognise cues	Case review completed with staff Scenario used in staff learning to enhance vigilance

## 2007-2008

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2007-2008 Serious	Deterioration following gastric feed tube insertion. Deteriorated and died	Developed symptoms that suggested tube was displaced. Staff knowledge of what to look for was limited and treatment was delayed.	Review post procedure care with staff, assess knowledge and reinforce expectations Review education for use of NEWS escalation system Reinforce clinical team review frequency and processes	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented
2007-2008 Sentinel	Serious chronic health problem. Admitted with pneumonia and had low oxygen levels. Deteriorated and died	Significant co morbidities. Became short of breath and had low oxygen levels. Staff did not call for medical review in a timely manner. Deceased. Resuscitation status not clarified Early warning score escalation inadequate	Reinforce requirement to discuss and document resus status with patient and family. Remind staff emergency response required for all patients unless documented NFR Review/educate NEWS escalation requirements with staff to clarify that activation necessary even if patient appears to respond to treatment. Add compliance with NEWS score to monthly ward/unit audit schedule Remind staff of processes for referral of deaths to Coroner	Resus status processes reviewed Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented
2007-2008 Sentinel	Serious asthmatic condition. Treated acutely. Precipitously deteriorated. Died	Fragile asthmatic condition. Recovering after acute presentation. Transferred to ward on salbutamol infusion. Soon after warding developed acute respiratory distress. 777 call made. Unable to be resuscitated. Had been outside smoking prior to warding Transferred to ward at handover time. Did not affect sequence of events but staff busy at time transit staff were handing over care	Review guidelines for management of patients with acute asthma Review management of patients prescribed intravenous Salbutamol Review timing of transfers to wards not to coincide with handover Introduce NEWS scoring system in ECC for use when patients handed over from ECC to wards. Develop NEWS System teaching package for use by Nursing Agencies. Review guidelines for management of acute patients who smoke	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented
2007-2008 Sentinel	Death - Injury occurred during the laparoscopic phase of the procedure	Vascular injury was probably caused by the sharp dissecting blade and loss of pneumo-peritoneum Every effort made to stop bleeding, including calling vascular surgeon	Develop patient information pamphlets for pts undergoing laparoscopic procedure Consider whether a greater range of vascular equipment or instruments should be held Review the indications for laparoscopic procedure	
2007-2008 Serious	Deterioration in condition with respiratory distress, admission to ICU	Respiratory distress deteriorated. NEWS escalation activated. ICU Outreach team responded. Recovered with intensive support Communication of concerns between nurse and doctor	Case review with nurse and doctor to discuss how best to communicate NEWS scoring findings and achieve timely response Audit documentation	Education on patient deterioration recognition /early warning introduced ICU Outreach programme implemented

## 2007-2008

Event Severity	Description	Review Findings	Recommendations / Actions <i>These recommendations were written at the time of the review and will have been implemented as corrective actions since then</i>	Actions completed
2007-2008 Serious	Unanticipated risky behaviour – community	Risky behaviour in the community causing harm Differences in opinion re management identified, differences in approach to use of compulsory treatment Need to improve documentation and improve communications between inpatient and community teams	Framework for dealing with differences in clinical opinion developed - Complex Case Review and second opinion to be undertaken if necessary. Reminder to use tools for ensuring clients showing early warning signs are alerted to the crisis team Staff (inpatient and community teams) reminded to review Clinical Review process to ensure all relevant information shared and considered and maintain high standard of documentation	Systems for complex case review revised and reinforce in staff learning
2007-2008 Sentinel	Patient suicide	Lack of timely access to facilities for medically stable elderly to undergo full neuro-cognitive & adaptive assessment No meeting of all parties involved in patient's care during admission even though case identified as complex Lack of certainty regarding what constitutes a further opinion	Review undertaken of the resource/pressure issues limiting access for elderly to appropriate assessment settings Strategy developed for identifying complex cases and establishing Complex Client Case Reviews to be agreed between services	Access and referral issues under review Complex case review where there is multiple agencies involved, under review
2007-2008 Sentinel	Suicide – in community	Uncertainty of diagnosis Early refills of prescriptions requested GP and other medications prescribed not known Information not in clinical record DNA not followed up	Identify and undertake clinical review MHS patients active in service for more than 2 years. Reduce duplicate and excessive prescribing by discussion at Consultants Meetings and reminders to clinicians re prescribing obligations. Ensure Primary Care sector know patients enrolled with MHS. Develop pathways to educate GPS and PHOS on how to check whether patients enrolled with MHS.	Case review processes reviewed Liaison with GP reinforced in staff learning

## Abbreviations

AWOL	Absence without leave	LSCS	Lower section caesarean section
CADS	Community Alcohol and Drugs Service	MET	Medical Emergency Team
CADS	Community Alcohol and Drugs Service	MHSA	Mental Health Services for Older Adults
CCN	Clinical Charge Nurse	NEWS	Northshore Early Warning Score – vital signs criteria and escalation protocol
CMHT	Community Mental Health Team	NSH	North Shore Hospital
CNM	Charge Nurse Manager	PIMS	Patient Information Management System
DNA	Did not attend scheduled appointment	RMO	Junior medical staff
DON	Director of Nursing	QRT	Quick Response Team
ELSCS	Emergency lower section caesarean section	SCBU	Special Care Baby Unit
HCC	electronic patient record system used in Mental Health Services	SIRP	Significant Incident Review Process
ICU	Intensive Care Unit	SMO	Senior Medical Officers
		WTH	Waitakere Hospital