

DHB Summary of Serious & Sentinel Event Report 2007/08

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Northland

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
1	2	Serious	Suicide of mental health outpatient	Insufficient response to GP referral because of limited medical staff, insufficient communication with GP	Improved triage, with immediate access to medical assessment when requested. Risk assessment refresher course for staff.	January 2009 All new patients now must be booked to see a doctor. Additional staff training undertaken.
2	4B	Sentinel	Relapse of tuberculosis after missed doses of treatment, leading to multidrug resistance	Daily Observed Treatment (DOT) guidelines too flexible Nursing resource management Inpatient care and welfare problems	New DOT procedures Audit documentation Review nursing workloads Credentialing nursing workforce Assessment of isolation from a patient's perspective	March 2008 New DOT procedure adhered to, documentation audited monthly. Kaiawhena employed to assist with DOT, thus reducing the nurse travel workload. Credentialing and Competency structures under development. Multidisciplinary group working on improving psychosocial aspects of care.
3	4A	Sentinel	Stillbirth due to cord prolapse	External review undertaken: A known risk of undiagnosed breech presentation, clinical care met guidelines	Update of Spontaneous Rupture Membranes (SRM) Policy	March 2008 The SRM policy has been updated and is available on the Intranet
4	10	Sentinel	Ongoing problem of patients needing high dependency care remaining in ED as ICU beds not staffed	Insufficient specialist nurses to provide care and limited physical resources	Immediate process change to accommodate urgent patient egress into ICU with both physical and professional support for the staff	December 2008 After much discussion and review, a flowchart of options is available for these circumstances.

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5	10	Serious	Delays in emergency transfer for caesarean section, affecting baby welfare	Complex deliveries need to be transferred without delay. Role of visiting Senior Medical Officers (SMOS) at peripheral hospitals requires clarification	Education re immediate transfer of high risk patients to be emphasised. Guidance to SMOs regarding requests for advice at peripheral hospitals to be issued	October 2008 Memo to SMO re requests for advice at peripheral hospitals issued by Chief Medical Advisor. December 2008 Additional training to midwives at peripheral hospitals undertaken and ongoing
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Waitemata

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
6	2	Sentinel	Death of a patient	Inpatient with history of depression and past self harm attempt, admitted for medication revision as severely depressed from new medication. Referred to mental health team: denied experiencing suicidal ideation. Investigation found that clinical care and specialist input was appropriate. Subtle cues of self harm intent unrecognised.	No care issues were identified. Staff education increased to recognise potential self harm cues Inpatient spaces reviewed to remove hooks from general bathroom areas	Case review completed with staff Scenario used in wider staff learning to enhance vigilance
7	4B, 4C	Sentinel	Death of inpatient	Inpatient with severe chronic health problem admitted with pneumonia. Died after delay in responding to deteriorating condition. Investigation found that delayed resuscitation response was due to confusion of resuscitation status. Early warning score not implemented.	Staff education increased to recognise patient deterioration and reinforce referral processes. Review care planning for clients with severe chronic health problems who may require resuscitation. Document resuscitation status. Review staff confidence with resuscitation processes	Staff training completed Care planning processes reviewed and audited regularly Documentation of resuscitation status project underway
8	4B	Sentinel	Death of inpatient	Inpatient admitted acutely with suspected cholangitis. Prolonged hypotension in Emergency Department, not responding to treatment. Delayed referral to ICU. Cardiac arrest on arrival in ICU. Died the next day. Outcome may have been unpreventable but earlier referral to ICU team may have allowed	Review assessment processes and introduce Early Warning Score processes to ECC to ensure early alert system of deterioration. Staff education increased to recognise patient deterioration and reinforce referral processes.	Recommendations implemented. Regular auditing.

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				earlier intervention.		
9	4B	Sentinel	Death of inpatient	Inpatient experienced cardiac arrest while rehabilitating from major surgery. Autopsy showed spontaneous event and that actions may not have changed outcome. Investigation found with resuscitation equipment and staff confidence to respond	Resuscitation equipment reviewed with staff and practice effectiveness confirmed through teaching and assessment. Policy changed regarding movement of large people in collapse situations.	Changes implemented and effectiveness evaluated
10	8	Sentinel	Death of mental health patient in community care.	Community patient with long term mental health care in the community. Major life pressures placed client under extreme pressure. Client went AWOL. Found weeks later by Police – no suspicious circumstances. Investigation found that case management could have provided more support and more frequent case review by wider team and consultant for clients with complex needs.	Changes to ensure stronger case review procedures and team supervision.	Changes made to team processes and effectiveness being regularly audited
11	8	Sentinel	Death of mental health inpatient	Inpatient, with acute mental health issues, went missing from open ward. Police reported fall from motorway over-bridge. Patient had died at scene. Investigation identified that handover practices regarding risk statement and management plan (including leave status) needed improving. Increase use of trained interpreters should occur.	Special observations to be made by senior staff member on each shift. Primary nurse to be more clearly identified and these nurses to attend team planning meetings. Review of processes for granting and recording leave. Review AWOL Policy Staff education emphasised.	Nursing model changed to include handover and primary nursing requirements. Process for arranging intensive monitoring beds reviewed.
12	8	Sentinel	Death of mental health patient in community care	Community patient with major depressive disorder and substance abuse mental health issues died. Significant clinical	Establish regular and formal complex case review meetings to coordinate care of service users who receive care across teams &	Recommendations being systematically implemented through a consistent team

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				oversight was required by community team. Investigation identified issues relating to coordination of care, medication management, clinical oversight , integrated team planning and documentation identified as requiring review	with complex cultural needs. Increase monitoring processes. Staff training re: expectations. Ensure more regular Psychiatrist involvement, especially regarding medication use and adverse effects. Increase family communication & involvement. Add rationale to documentation of meetings & integrate notes. Review information about the amount of permitted substance use (whilst taking medications) and about recognising the variability in tolerance.	processes
13	9	Sentinel	Death of mental health inpatient	Inpatient found in courtyard of open mental health ward with bleeding nose, laceration to back of head. Unsure of cause of injury: not sure whether fell or had an altercation with another patient. Past head injury, had cranial softness. Police investigated but no charge laid. No care issues were identified.	Nil identified after investigation	Nil
14	11	Serious	Suicide at a rest home	Community patient referred for assessment. Placed on waiting list for admission. Died before admission. Findings found lack of resources to allow timely access to facilities for medically stable elderly to undergo full neuro-cognitive & adaptive assessment	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 between services	Access and referral issues reviewed Complex case review process formalised completed where there is multiple agencies involved
15	11	Sentinel	Death of mental health patient in community care	Community patient with long mental health history and past suicide attempt. Admitted for medical health	Review practice and protocols regarding medical review where mental health team involved. Review community respite follow	Case review completed with staff Scenario used in staff learning to enhance

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				problems. A few hours after discharge found dead. Investigation found that communication between the medical team and mental health team should be reviewed, especially where potential risk is evident in past history.	up and respite / early discharge	vigilance
16	11	Serious	Delay in treatment	Inpatient experienced post partum haemorrhage requiring hysterectomy to save life. Received large blood replacement prior to transfer for ICU care. Patient recovered well and discharged. Investigation found that while a reasonable supply of blood is available, improved back-up systems needed for supply of urgent additional units of blood for emergencies situations.	Laboratory emergency on-call systems reviewed. Increased stock of blood and blood products held in emergency fridge.	Reviewed. Action completed.

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Auckland

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
17	1	Sentinel	Patient incorrectly had all teeth removed rather than only several teeth as required	Inappropriate referral process from private to public Referral letter scanned under wrong patients name and number Not seen as public outpatient prior to surgery Mis-communication led to patient signing consent for full clearance	Confirm referral standards with all staff Double check NHI with other personal information Scan into both CRIS and Titanium computer systems "Open-ended" questioning to be promoted	In progress Established as policy Established as policy In progress
18	2	Sentinel	Apparent suicide while receiving inpatient psychiatric care (under consideration of the Coroner)	Psychiatric diagnosis uncertain Identified as high risk and placed in psychiatric ICU Inadequate observation Unclear process / roles in emergencies	Improved collaboration between Alcohol & Drug Services and Mental Health Changes to nursing handover & observation protocols Single multi-disciplinary treatment plan Change leadership structure Review balance between client autonomy vs duty of care Protocol to clarify medical roles Modify emergency response system Formal risk assessment and management system	Project in progress Completed Completed Completed In progress Complete Complete Implementation underway
19	2	Sentinel	Apparent suicide while receiving inpatient psychiatric care (under consideration of the Coroner)	Limited staff skill with Dialectical Behavioural Therapy (DBT) Risk and safety plan did not reflect community plan or involve service user Alcohol abuse not included in	Staff training for effective use of DBT Process and communication improvement to ensure consistency between community and inpatient treatment Develop relapse plans with service users whenever possible	Planned for 2009 In progress Implemented

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				treatment or risk plan Unclear responsibility for documentation of review meetings	Routine admission screening for substance use Process for timely documentation of clinical information	Initial screening implemented Implemented
20	3	Sentinel	Retained surgical swab requiring early re-operation. No long term effects.	Not seen on intra-operative X-ray but visible on first ICU film	No change in procedures required	Nil
21	3	Serious	Retained surgical swab for one month complicated by infection. No long term effects.	Swab count was reported as correct at the time of surgery	Add swab count to delivery unit process Consider alternate swab type Handover of swab count when transferring from delivery to OR	In progress
22	4A, C	Sentinel	Death of mental health inpatient from medical causes	Cause of death unclear Frequency of clinical observation / monitoring Level of internal medicine support for physical disease	Review of nursing observation policy Clarification of response of mental health doctors to medical emergencies Specialist physician for mental health ward	Completed Completed 0.2 FTE appointment made
23	4C	Serious	Significant skin damage to lower back / buttock due to pressure area. Required surgery.	High risk patient – poor nutrition, immobile, double incontinence Delay in obtaining pressure relieving mattress Poor documentation of risk	Earlier intervention for high risk cases Regular risk assessment for pressure area damage	Staff education completed
24	4B	Serious	Delay in giving anti-retroviral treatment to a baby of an HIV positive mother. No adverse outcome.	Incomplete handover to newborn medicine Lack of knowledge of appropriate procedures	Paediatric diary on post-natal wards HIV protocols to be in both mother and baby notes	Not implemented – ward improved use of current systems Implemented
25	4A	Serious	Histology result suggestive of cancer not noted for 2 months. Delayed treatment.	Hard copy results not sent to team leader No tracking system to follow important specimens	Switch to electronic system Dictated note as part of operation record. Needs formal tracking system - organisation-wide issue	Completed Implemented as temporary system
26	4A	Sentinel	Immigrant with TB reported by laboratory to	No system to provide clinical review of unusual TB culture	Revise laboratory procedures Clear communication system	Completed

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			have extensive drug resistant tuberculosis (XDR-TB). Very toxic treatment; required termination of pregnancy. NZ residency status denied and deported. Later found XDR-TB status was a laboratory error. Patient returned to New Zealand.	results Contamination of some laboratory samples Deficient laboratory processes	between laboratory and medical staff Update NZ TB Guidelines regarding communication issues and handling of possible multiple drug resistance	Implemented National guideline update in progress Using international guidelines in interim
27	4B	Serious	Pressure ulceration requiring plastic surgery. Complicating severe critical illness and prolonged intensive care stay	High-risk situation for pressure injury	Earlier use of air mattress may have helped	Good wound healing
28	4E	Serious	Failed termination of pregnancy not identified as tissue analysis result not received. Patient re-presented at 17 weeks into pregnancy. Long term outcome unknown.	Inadequate specimen labelling No consent documentation for testing of tissue	Improved tissue specimen documentation and consent process	Staff instructed regarding revised processes
29	4D	Serious	Accidental removal of breathing tube of ventilated patient.	Endotracheal tube not adequately secured. Re-intubated. No long-term injury	Review process for tube fixation with Department of Anaesthesia	Complete
30	4B	Serious	Inappropriate continuation of tricyclic antidepressants Patient re-presented with overdose. No long term harm.	Under review at present	Under review at present	Under review at present
31	4A	Serious	Three month delay in receiving a patient's histology results indicating pre-cancerous	Unclear responsibility for reviewing results	Histology results to be copied to the operating/supervising surgeon and GP. Improved handover processes for	Implemented

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			condition		leave	
32	4D	Sentinel	Accidental removal of breathing tube during CT scan with cardiac arrest. Patient fully recovered.	Responsibility for airway care unclear Failure to recognise extubation Lack of staff training	Checklist for transportation Multi-disciplinary workshop Revise junior doctor teaching programme	Completed
33	4D	Sentinel	Accidental bowel perforation during gallbladder surgery resulting in fatal multi-organ failure.	Under review at present	Under review at present	Under review at present
34	4D	Serious	Retained vaginal swab following repair of episiotomy, causing infection. No long term effects.	Diagnosed 23 days after delivery	Add swab count to delivery unit process Consider alternate swab type Handover of swab count when transferring from delivery to OR	In progress
35	4A , B	Sentinel	Maternal death from post-partum haemorrhage	Root cause analysis: Lack of cross-matched blood availability Delay in request for 'universal donor' blood (O-negative) Delay in definitive surgical treatment	Improved handover systems Structured risk assessment for post-partum haemorrhage Antibody positive mothers commencing labour have 4 units crossmatched Massive transfusion protocol Improved inter-disciplinary team culture	Independent external review completed. Recommendations have/are being implemented or under consideration
36	4B	Serious	Severe liver failure caused by treatment for tuberculosis. Patient recovered but may have residual liver injury.	Recognised risk of treatment Inconsistent guidelines for monitoring liver function	Increase frequency of monitoring liver function during treatment	Interim increased frequency agreed National TB guidelines under review
37	4D	Serious	Feeding tube misplaced into lung and feed administered causing lung damage. Lung injury resolved but patient died later of unrelated causes.	Lack of guidelines for assessing correct placement of NG tubes	Develop unit nursing competency process for NG placement	Completed
38	4B	Sentinel	Bone marrow suppression from radio-iodine treatment for metastatic thyroid cancer	Rare complication of treatment exacerbated by metastases being near bone marrow and previous radiotherapy to region	Consider modifying dosage for future cases to balance risks of treatment complications with risk of under-treatment of cancer	Departmental review complete

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39	4B	Serious	Deep muscle damage due to lack of mobilisation	Standard pressure care with air mattress but patient refused turns and mobilisation	Improve application of risk reduction techniques with staff and patient education	Staff feedback provided
40	5	Serious	Excessive dose of morphine (for back pain), resulting in over-sedation and re-admission with pneumonia. Patient fully recovered.	Inappropriate dose of morphine prescribed in a patient with poor kidney function	Staff education regarding circumstances requiring dose adjustment	Completed
41	5	Serious	Dispensing error of 200mg aspirin when 20mg dose (for allergy desensitisation) was intended.	Required hospitalisation for treatment of allergic reaction. Patient fully recovered.	Under review at present	Under review at present
42	6	Serious	Inpatient fall causing fractured hip requiring surgery	Use of falls risk tool & care plan inconsistent Falls more often in first 24 hours after admission Limited beds available in special nursing areas for high risk patients	Improve use of falls risk tool & care plan Early implementation of risk-reduction techniques More use of low beds	In progress In progress CAPEX for 09/10
43	6	Serious	Inpatient fall causing fractured hip requiring surgery	Use of falls risk tool & care plan inconsistent Falls more often in first 24 hours after admission Limited beds available in special nursing areas for high risk patients	Improve use of falls risk tool & care plan Early implementation of risk-reduction techniques More use of low beds	In progress In progress CAPEX for 09/10
44	6	Serious	Inpatient fall causing fractured hip requiring surgery	Use of falls risk tool & care plan inconsistent Falls more often in first 24 hours after admission Limited beds available in special nursing areas for high risk patients	Improve use of falls risk tool & care plan Early implementation of risk-reduction techniques More use of low beds	In progress In progress CAPEX for 09/10
45	6	Serious	Inpatient fall causing fractured hip requiring surgery	Use of falls risk tool & care plan inconsistent Falls more often in first 24 hours	Improve use of falls risk tool & care plan Early implementation of risk-	In progress In progress

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				after admission Limited beds available in special nursing areas for high risk patients	reduction techniques More use of low beds	CAPEX for 09/10
46	8	Sentinel	Apparent suicide while on unescorted leave from inpatient mental health care (under consideration of the Coroner)	Inadequate medication Handover issues No formal system for case handover when staff on leave Unclear process for deciding type of leave	Develop guideline for transfer of treatment from injection to oral medication Process improvement to ensure consistency between community and inpatient treatment Revise medical resource allocation Primary nurse allocation system Clarify care co-ordinator allocation and role Develop formal standard for case handover staff leave Revise client leave allocation process	In progress In progress Pilot in place Project underway In progress Implemented In progress

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Counties Manukau

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
47	1, 4D	Serious	Incorrect surgical checking systems Patient booked, checked and prepped for theatre and received a local anaesthetic block for a cataract procedure she did not require. No harm to patient.	Procedure had been carried out one month prior by another DHB and hospital not informed. Theatre booking process and check in procedures were not followed.	staff to document on Patient Information Management System (PIMS) at time of wait listing if patient shared care with other DHBs Prior to hospital procedure, theatre bookers to check if procedure completed and ensure wait list information is correct. Nursing and anaesthetic staff to clarify procedure on 'check in'.	Extensive Outpatient Procedure review and audit of booking processes completed Nov / Dec 08 and verified that correct processes are now being followed for shared care patients. Check in process reviewed with Charge nurse PACU (Pre / Pos Anaesthetic Care Unit) plus discussed as part of Education Training day.
48	1	Serious	Incorrect surgical checking systems Patient attended clinic for a preadmission visit, answered to the wrong name on several occasions and had an invasive urology investigation in error.	Policy was not followed and verbal only clarification was used to identify the patient on presentation.	Develop and introduce 'Active ID' programme	Active ID of patients' guideline for outpatients is currently being piloted and will be rolled out to all areas by March 2009.
49	2	Sentinel	Suicide of mental health inpatient.	Suicide while on unescorted leave from the ward The Serious Incident Review found that responsible and reasonable clinical decisions had been made. The risk of suicide had been	Considered safe for ward leave.	None

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				identified at admission, monitored throughout his stay and management adjusted appropriately		
50	4D	Serious	<p>Medication error – wrong route Following a bowel operation a patient was administered 500 mls of liquid feed into the vein instead of into her feeding tube. The patient survived the event with no immediate harm and was ultimately discharged home.</p>	<p>During surgery an IV line had been sutured into the bowel stoma instead of a feeding tube because none could be found. A ‘male-male’ connector was used to enable the feed to be administered into the IV line in the stoma. The new graduate assigned to the case received no bedside handover about the complex feeding arrangements. Lack of senior leadership on the ward due to lack of succession planning and support for new charge nurses. Importance of bedside handover process not recognised: handovers were brief and not standardised with respect to content and process. Vivonex is rarely used.</p>	<ol style="list-style-type: none"> 1. Formalised orientation for Charge Nurses. 2. Development of handover policy. 3. Patients with surgical wounds /stomas to have a diagram that is visible and forms part of the bedside handover. 4. Develop policy on feeding labels and audit use. 5. Redesign fluid balance chart to include enteral fluid as input. 6. Dieticians to be credentialed to chart Intravenous Nutrition (IVN). 7. Remove Male-male connectors from wards and ordering process. 10. Review enteral feeding tubing availability in theatre. 	<ol style="list-style-type: none"> 1. Orientation package developed. 2. Handover processes under review by Clinical Nurse Director Group. 3. Guideline for enteral feed labels completed. 4. Enteral tube feeding policy is in development. 5. Enteral feeds to be charted on the fluid balance charts. 6. Male - male connections removed from electronic ordering process. 7. Credentialing process to enable dieticians to chart Intravenous Nutrition (IVN) has been completed and will be implemented early 2009.
51	4B	Serious	<p>Delayed response to deterioration in patient condition: Delayed response to patient who had a very fast, irregular heart rate, with low blood pressure. Patient required cardioversion and transfer to Coronary Care</p>	<p>The patient was an outlier (not on the usual ward)and the ward was very busy. Junior medical staff reported not receiving the page from the ward about the patient’s condition. The nurse didn’t feel able to escalate care beyond the junior staff.</p>	<p>The Physiologically Unstable Patient (PUP) programme to be introduced which provides clear criteria for escalating care and calling the medical emergency team.</p>	<p>PUP programme operational in this ward since February 2008.</p>

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			Unit, no permanent physical harm.			
52	4D	Serious	Patient Fall: Anaesthetised patient fell from operating table while being repositioned during surgery. The patient was unharmed	The patient was positioned on more pillows than normal due to extensive injuries on both his front and back. No restraints were used; difficulty removing the drapes held together by Velcro.	<ol style="list-style-type: none"> 1. Review of all safety and positioning equipment. 2. Develop a 'Best Practice Guideline' for safe positioning. 3. Inclusion of a positioning check in time out prior to surgery commencing. 4. Education and training package to be developed and implemented for all theatre staff. 5. Provision of extra scissors for easier drape removal. 	<ol style="list-style-type: none"> 1. Safety and positioning equipment reviewed; new equipment ordered and due January 2009. 2. 'Safe Positioning Guideline' completed and will be posted on website early 2009. 3. Safe positioning check to be incorporated into time out checklist to be implemented in conjunction with Safer Surgery Initiative 2009. 4. Education & training package developed and delivered on ongoing basis to all theatre staff. 5. Scissors in place and being used to aid drape removal.
53	4D	Sentinel	A sick patient was sent from the ward to radiology for a Chest X Ray (CXR) because unable to obtain a portable CXR in ward. He deteriorated in radiology and subsequently died.	Lack of criteria to identify patients appropriate for portable film in the ward. Specialist nurses not used to escort of physiologically unstable patients.	Review policy for portable X-rays in ward Audit portable CXR requests. Develop scoring system for portable X-rays in conjunction with radiology Develop specific protocol for escorting physiologically unstable patients.	Clinical Nurse Specialists for Physiologically Unstable Programme can be asked to transport unstable patients when required. Further follow up required for other recommendations
54	4D	Serious	Incorrect surgical checking systems Patient had incorrect	Previous patient's notes were left in theatre. Lens size was checked in incorrect notes.	Documentation removed from theatre when patient leaves During check in lens size written	Verbal report that this is occurring. Audit in progress

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			sized lens inserted during eye surgery as staff looked at wrong set of notes. Error recognised before patient left theatre. Lens removed and correct size inserted.		on board prior to commencement of procedure.	Safer surgery imitative 2009 – include WHO checklist to prevent wrong site surgery
55	4D	Sentinel	Patient incorrectly connected to dialysis machine, died of an air embolus (air entered blood stream).	<p>Against advice, a patient self-connected to a dialysis machine during the 15 minute nursing handover period which all the nurses attended leaving the unit unsupervised. The machine alarmed and the patient was found collapsed; immediate CPR commenced; however this was unsuccessful and the patient died.</p> <p>Coroner's report confirmed air embolism as cause of death. A report completed by Gambro (provider dialysis machines) did not identify any faults in the dialysis machine. Patient's previous 'at risk' behaviours were neither clearly recognised nor documented and consequently adequate measures to minimise the risk were not implemented.</p>	<p>One nurse available to oversee patients at all times. Patient to be informed of the risk with patient / family education around it. All at risk behaviour to be fully documented in the clinical notes</p>	<p>Nurses attend handover in two shifts leaving adequate supervision on the floor. Patients are instructed to wait until their allocated nurse has finished handover and can assist them. Staff members have been informed about recognising, reporting and documenting at risk behaviour.</p>
56	4A,B,C	Sentinel	Medication error: omission Elderly woman admitted for knee replacement. Anti-ulcer medication was not continued in hospital and she died of complications from a	<p>RCA</p> <p>1. Diagnosis of perforated gastric ulcer was delayed as staff diagnosed constipation and didn't note that the patient had written on the pre-admission self assessment form that she had been prescribed losec for acid</p>	<p>1. Review pre-admission processes and documentation so that known risk factors are highlighted. 2. ICU to review processes for prioritising care of critical patients on the wards when in overload situations.</p>	<p>1. Surgical Admission Pack has been reviewed. Draft version to be circulated in New Year for consultation and comment. 2. ICU capacity has now been extended</p>

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			perforated ulcer. .	reflux. 2. Intensive Care Unit (ICU) capacity is limited and was compromised further that day with several patients waiting for admission to the ICU which was already 2 beds over census. 3. Errors in calculating and using the Physiologically Unstable Patient (PUP) meant that attending staff overnight didn't put out a Medical Emergency Team call.	3. Ongoing training of nursing staff will emphasise that the PUP scoring system is a guideline to be used in conjunction with clinical judgment. 4. Provide training to up skill nurse led Rapid Response Team (RRT) in recognition and management of critically ill patients	and an HDU will be opened late March 2009. 3. Modified PUP Programme to be introduced to Manukau Surgical Centre (MSC) 2009; 4. PUP training at MMH site on-going. 5. Plans in place to provide advanced training in care of critically ill patients to the PUP RRT.
57	4A,B,D	Serious	Blood clot in the lung - Pulmonary Embolus (PE) - following repair to achilles tendon in patient with prior history of post-operative blood clots - deep vein thrombosis (DVT) in same leg. No blood thinning medication given to prevent blood clots	Departmental Investigation including presentation at morbidity and mortality (M&M) meeting.	Orthopaedic team to review protocols for DVT prophylaxis (blood thinning medication).	Each orthopaedic team has provided their protocol to Orthopaedic co-ordinators for use in preadmission clinic. DVT preventative medication is charted preoperatively at the time of preadmission clinic as per the team /consultant protocol. The hospital is taking part in the National Venous Thrombo-Embolism (VTE) Prophylaxis Programme to assess and manage patients at risk of blood clots. As part of the Safer Surgery initiative the VTE risk assessment tool is now included in the pre-admission

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						surgical admission pack.
58	4A	Sentinel	Urology referral received for elevated Prostate Specific Antigen (PSA). This was sent to regional urology service for grading and was graded P2 which should be seen within 6 weeks. There was a 5 month delay at which time the scan showed that the cancer had spread to his bones (unclear whether such spread was present when referred).	Full investigation undertaken at request of HDC. Inadequate booking and waiting list management, administration processes and logging of referrals. Missing patient acknowledgement letters from PIMS (Patient Information Management System) individual patient record.	Audit urology wait list for past year to identify if any other patients have been clinically compromised. Review all other service waiting list booking practices, identify gaps and develop action plan to address issues.	Review completed and no other urology patients compromised. Outpatient review of referral processes has been completed and action plan developed. An outpatient project has been set up to complete action plans. This is in progress and it is anticipated all actions will be completed by mid 2009. The hospital will provide a Urology Service in the future. 'Optimising Patient Journey programme' has just identified national standards for outpatients, including management of inter-DHB referrals. .
59	4A,B,C,5	Sentinel	Medication error: overdose, inadequate monitoring GP referred patient with fainting episodes. Patient's blood was too thin as a result of poor monitoring and dose adjustment of his blood thinner (warfarin). Delay in reviewing INR (International Normalised Ratio) > 10 (greater than	Lack of recognition of shock syndrome. Incorrect management of warfarin overdose. INR not performed regularly in the community and warfarin dose not adjusted appropriately. Poor communication between laboratory and requesting clinician.	Education of GP and Registered Medical Officers (RMOs) re management of patients on warfarin therapy, including management of warfarin toxicity and recognition of shock syndrome. All relevant clinical details to be documented on lab request form, including requesting doctor contact details. Lab to phone critically abnormal results directly to the requesting	RMO education completed at handover meetings and contact made with GP liaison to raise issues. Follow-up complete with laboratory staff regarding directly communicating any abnormal results with doctor concerned. Letter sent to Clinical Head of haematology

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			5 indicates high risk of bleeding). Died from bleeding in gut.		doctor or team. Clinical pharmacist to identify chronic care patients on admission and use opportunity for patient education. Audit 'Warfarin Advice' box in Electronic Discharge Summary (EDS).	reinforcing that the lab reporting policy is followed in these cases. Audit completed and warfarin box on EDS completed in approximately 50% of cases. This will be followed up in 2009. 5. warfarin education project.
60	4A,B,C	Sentinel	Delayed response to deteriorating patient. Patient presented with pneumonia. There was delayed diagnosis and treatment and the patient eventually died of MRSA (methicillin resistant staphylococcus aureus) septicaemia.	<p>Root Cause Analysis: Delay (~ 1 hour) prior to triage due to high volumes of patients and no separate queue for patient enquiries. Initial triage score was incorrect, medical review was delayed and there was a further delay between charting and administration of antibiotics. Lack of awareness of the Community Acquired Pneumonia (CAP) scoring protocol and earlier Intensive Care Unit (ICU) referral therefore not initiated. Vital sign monitoring in Emergency Care (EC) was inadequate. There was no effective handover by the Medical HO to the Medical Registrar and no handover to the ward before transfer. There was poor communication with the family with respect to information in EC and subsequently after admission to ICU when the family felt they weren't given sufficient warning</p>	<ol style="list-style-type: none"> 1. Introduction of an information kiosk in EC manned by non-nursing staff to deal with enquiries and avoid delays to triage. 2. CAP protocol made accessible to all staff. 3. Physiologically Unstable Patient (PUP) scoring system to be introduced into EC. 4. Consider EC supervisor role to coordinate care within EC and between EC and other departments 	<ol style="list-style-type: none"> 1. Signage has been put in place directing people with enquiries to clerical staff, but this process is limited by the current EC design which is being reviewed. 2. The PUP Score will be rolled out to all of EC early 2009. 3. EC supervisor role has not been able to be implemented due to acute shortage of staff but EC are actively working towards this.

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61	4A,C	Sentinel	Failure to recognise and act on deteriorating foetal heart trace during labour. The baby was delivered but died 3 days later from brain damage due to lack of oxygen during delivery.	<p>about her imminent death.</p> <p>Handover process between satellite birthing unit and main hospital was inadequate. Staff distracted by patient's birth canal infection and allergy to penicillin. Skills in interpreting foetal heart rate trace poor.</p>	<p>1. Develop 'Transfer and Review' policy with clear guidelines detailing the clinical review of patients transferred to hospital from the community birthing units, including the handover process.</p> <p>2. Education to bring foetal heart trace interpretation to competent level in all staff.</p> <p>3. Communication strategy to be clarified for women's health doctors to facilitate escalation of care when concerned.</p> <p>4. Education regarding protocols</p>	<p>1. Policy in place and transfers from community units analysed as a trigger in the obstetric risk management system. This means that the notes of all patients are reviewed the next day to look for quality issues – has improved the documentation of such transferred patients. .</p> <p>2. Women's health education programme incorporating the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Foetal monitoring programme is being rolled out across all department staff.</p>
62	4D	Serious	Renal dialysis patient, presented for removal of dialysis line which had been in place for four years. Part of line adherent to vein became detached and remained in situ. Developed an infection on heart valves (necessitating valve replacement),. Infection probably due to retained	Tethering of tunnelled line, only one case in literature, others have been identified. Increased incidence with time. Possibly associated with silicone rather than polyurethane lines. No problems identified with procedure.	Replace lines after no more than two years. Use polyurethane lines	Practice changed

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			line.			
63	4D	Serious	Patient had total colectomy (removal of bowel) for ulcerative colitis. Persistent post operative weakness & numbness in leg due to damaged nerve.	Probably related to positioning (Lloyd Davis) in long operation.	Review of operating theatre positioning techniques has been prompted by another case.	New positioning guidelines, equipment and education in place.
64	5	Serious	Medication error - overdose Patient administered 2 x 100 mg tablets of Morphine instead of 2x10 mg tablets. Dose was checked and administered by two nurses. Patient deterioration noted and antidote given. No lasting harm.	Different strengths of Morphine tablets packaged in similar sized boxes ('look-alike' packaging) and stored on same shelf.	Restrict ward stock of controlled drugs (CD) to limited approved list High dose / high risk drugs to be dispensed from pharmacy on a named patient basis in snap lock bag. To be stored in CD safe, and returned when no longer required. Clinical pharmacists to take active role in management of controlled drugs. Introduction of automated drug dispensing machines (Pyxis) on ward to prevent inadvertent selection of wrong medications.	Snap lock bag system introduced Sept 07 Restricted CD stock list introduced in Medicine Sept 07 Automated drug dispensing machines currently being piloted with anticipated roll out 2009. Safe and Quality use of Medicines committee held workshop with MedSafe to review look-alike and sound-alike drugs.
65	5	Serious	Medication error- wrong route Patient in the Intensive Care Unit (ICU) was administered two dissolved paracetamol tablets into his central veins, instead of into his feeding tube. The patient suffered no harm.	Lack of a standardised protocol in ICU for administration of oral paracetamol in the unconscious patient Lack of a reference to this in ICU orientation process. Use of staff to cover shortages leading to fatigue.	Develop standardised protocol for paracetamol administration in the unconscious patient. Appoint ICU Quality Improvement and Workforce Coordinators. Install automated dispensing machine (Pyxis) Ongoing recruitment of staff Review length of overtime shifts	ICU now using oral medication syringes for all feeding tube (enteral) medication administrations Quality Improvement and Workforce coordinators appointed Pyxis machine now operational within ICU Ongoing recruitment of staff for ICU Shift length to remain 12 h

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66	5	Sentinel	<p>Medication error – omission A patient with a complex medical history was in hospital for a month following a massive brain haemorrhage . After a prolonged hospital stay (months) she was discharged to a private rest home. Insulin was erroneously left off the discharge medications list in the Electronic Discharge Summary which was otherwise comprehensive. The patient died two weeks after transfer to private hospital, and the lack of insulin may have contributed to her death.</p>	<p>Poor care of newly diagnosed diabetic - no referral to diabetic service, still receiving sliding scale actrapid (quick acting insulin) at discharge, no insulin script written. Insulin charted on separate sheet and not seen during review process.</p>	<p>1. Multidisciplinary team members should contribute to the Electronic Discharge Summary (EDS) for complex cases using individual logins. 2. Insulin to be charted in regular drug chart supported by ward clinical pharmacist</p>	<p>1. Insulin to be charted on regular drug chart (to alert staff to separate detailed insulin chart) supported by clinical pharmacists 2. Planned national drug chart –insulin sheets to be stored with general drug chart.</p>
67	5	Serious	<p>Medication error: prescribing and dispensing error – wrong drug Patient prescribed and administered an antibiotic (penicillin-type) on discharge despite known and documented penicillin allergy. The patient suffered a severe allergic reaction at home, but recovered.</p>	<p>Antibiotic was prescribed despite documented allergy and then dispensed from ward stock by nursing staff. If the medication had been dispensed through pharmacy as is the hospital policy, the error would most likely have been identified.</p>	<p>1. Reminder to nursing staff that only the balance of current medications that are individually dispensed by pharmacy can be given to the patient to take home and that any other dispensing of medications is illegal. 2. Reminder to prescribers from Chief Medical Officer (CMO) of pharmacy’s ‘SWITCH’ campaign to switch patients from intravenous (IV) antibiotics to oral as soon as possible so that patients have commenced on oral antibiotic therapy prior to discharge. 3. Poster to alert nurses as to</p>	<p>Case presented at a mortality and morbidity meeting and discussed at the Medicine Advisory Committee (MAC) The “SWITCH” Campaign (IV to oral antibiotics) will be re-launched 2009. Poster in production</p>

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					which antibiotics should be avoided when patient is allergic to penicillin	
68	6	Serious	Patient fall. Suffered a fractured hip.	Patient found on toilet floor in ward having got out of bed despite bed rails in place Patient appeared confused and disoriented plus there were language difficulties. The patient had attempted to get out of bed twice during the morning shift while under a watch, but the watch for the pm shift was cancelled. Inappropriate use of bed rails	Organisational fall prevention programme February 2009.	Falls prevention coordinator appointed
69	8,6	Serious	Patient brought into Emergency Care (EC) by ambulance with head injury following an assault. Disappeared, broke a window latch and jumped out the window landing 20 feet below. He sustained a wedge fracture L1 (lower back) but was discharged home the next day following orthopaedic review.	This incident was only recently identified and no formal review had been undertaken. At the time of the incident a new reporting system had just been introduced and staff were unfamiliar with the process. There was no quality facilitator for medicine at the time	Implement new incident reporting system into EC Appoint quality facilitator to EC	Implemented Appointed

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Waikato

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
70	2	Sentinel	Suicide of a mental health inpatient.	The client's risk level was not accurately assessed on admission, resulting in inappropriately low level of client observation. Levels of patient observation were not clearly defined. There was a lack of consistent psychiatric overview of the client's care over the months prior to client's admission, resulting in inaccurate assessment of client's suicide risk.	To clarify definitions of each level of client observation, and specify how changes in levels of observation are communicated to all members of the clinical team. To develop guideline for managing patients who require full psychiatric assessment, which specifies required components of a management plan and ongoing psychiatric oversight of the client's care.	All actions completed
71	3	Serious	Swab left in patient during surgery. Swab later surgically removed and patient made good recovery.	Correct swab count not verified at end of surgery	Staff education re swab count error and open disclosure of error; review swab count forms used during surgery; audit compliance with swab count procedure and documentation standards.	Actions in progress
72	3	Sentinel	Swab left in patient during surgery. Swab was found inside patient during fifth operation within a week. Patient subsequently died. Cause of death not yet determined but unlikely to be related to retained swab.	Correct swab count not verified at end of surgery	Staff education re swab count error and open disclosure of error; review swab count forms used during surgery; audit compliance with swab count procedure and documentation standards.	Actions in progress
73	4B	Sentinel	Patient waited in Emergency Department	Insufficient nursing staff on shift resulted in triage / assessment of	To review triage processes in ED in line with Australasian College	In progress

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			for 2 hours before being triaged / assessed by clinical staff. Patient had many complex health conditions and died later in intensive care.	patients taking too long.	for Emergency Medicine Guidelines To review process from time of arrival at presentation to triage to handover to primary nurse.	
74	4G	Serious	Pregnant patient (approx. 23 weeks) was involved in a car accident which resulted in complications with her pregnancy. Patient was not obstetrically assessed. Baby died in utero.	Patient's assessment and care planning addressed her trauma requirements, but did not address her obstetric care requirements.	To develop and implement a protocol for management of obstetric trauma patients to ensure assessment and care includes obstetric services in the management of these patients.	In progress. Due to be completed April 2009.
75	4C	Sentinel	Patient developed complications during clinical procedure which were not recognised by staff early enough. Patient died 8 weeks later.	Failure of clinical staff to identify complication and notify senior medical staff of patient's deteriorating condition in a timely manner.	To ensure that nursing staff and junior medical staff are aware of the requirement to call senior medical staff to assess patient when patient's condition deteriorates. To include this service in the Early Warning Scoring System Project being established within Health Waikato hospitals.	Orientation for nursing and medical staff now includes information about when to call the consultant. Early Warning Score Project due for completion 2009.
76	4F	Serious	Client violently attacked a relative 11 days after discharge from mental health inpatient unit. Relative survived the attack. No other persons injured.	Lack of appropriate management plan to address risks of deterioration, non-compliance with treatment and potential for harm to others, including inadequate communication between inpatient and community services, and between mental health services and the client's family.	To review the service's structure, systems and processes to identify changes needed to ensure seamless, timely and effective service delivery to clients across the inpatient – community continuum. To implement actions to address recommendations arising.	In progress. Due for completion June 2009
77	4G	Sentinel	Patient died after	Patient's intravenous line was not	Undertake audit of IV	In progress. Due for

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			developing infection from intravenous line site.	replaced within the required timeframe. Inadequate nursing assessment and documentation of IV site.	replacement timeframes and ensure it meets the required standard set by Waikato DHB. Audit of completion of nursing assessments demonstrates completion of assessments within 24hrs of admission to ward.	completion March 2009.
78	4D	Sentinel	Patient had complications at the start of being anaesthetised and died 17 days later in Intensive Care Unit.	Patient was sent to Operating Theatre without all the required preparations having been completed. All clinical information about patient's condition was not known prior to anaesthesia being administered.	To specify the actions and communication required when patient preparation for Theatre is not complete at the time of transfer from the ward to Theatre. To ensure that relevant diagnostic test results are made known to Anaesthetists.	Actions in progress
79	4B	Serious	Delay in receiving treatment that might have saved vision in one eye	Blood test result was not looked at for 72 hours, which delayed diagnosis and treatment	DHB to ensure all clinical services acknowledge laboratory results electronically. Improve staff orientation regarding the timely acknowledgement of laboratory results.	Actions in progress
80	4G	Serious	Baby was involved in a road accident and sustained severe head injuries. Baby died shortly after delayed transfer to another DHB's special care unit.	No agreed inter-DHB approach to managing paediatric trauma cases requiring neurosurgery. Transfer process took too long.	To develop inter-DHB approach to ensure timely transfers for major paediatric trauma patients.	In progress. Due for completion March 2009.
81	4B	Serious	Elderly confused patient deteriorated and patient died the following day. Delay in assessment and diagnosis of patient	There was a time delay in nursing staff getting medical staff to review the patient.	To review monitoring / escalation process for unwell patients.	Completed. Process now in place to escalate any concerns to medical staff regarding patient's condition.

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82	4A	Sentinel	<p>Patient admitted to delivery suite with premature (29 weeks) twin pregnancy - review of blood results was delayed. Emergency caesarean section undertaken but one twin died.</p>	<p>Blood results were not reviewed or acted upon.</p> <p>There was no agreed process for ward round management e.g. preparation, diagnostic results availability etc</p>	<p>To implement electronic signing of all DHB lab test results.</p> <p>To ensure agreed ward round process is communicated to all staff and responsibilities are clearly defined and documented.</p>	Actions in progress.
83	4G	Sentinel	<p>Patient injured in car accident and presented to a regional hospital of another DHB. Delay in requesting CT scan, and five hour delay in transferring patient from regional hospital to hospital due to bad weather and communication failure, resulted in delayed access to neurosurgery. Patient died from his injury.</p>	<p>Intent of the hospital Head Injury CT Scan Protocol was not clear. There are no guidelines on the circumstances in which neurosurgery procedures may be carried out in regional hospitals.</p>	<p>With input from all local DHBs, develop and implement regional head injury CT Scan Protocol and regional guideline for expedient management of head injury patients</p>	Actions in progress.
84	4G	Serious	<p>Delays in typing letters referring patients for oncology services, from one outpatient department. Potential for delayed patient treatment.</p>	<p>Potential for delay in treatment - no actual harm reported.</p>	<p>Clinical Transcription Project established and in progress to improve typing turnaround times.</p>	Actions in progress. Significant reduction in clinical typing turnaround times has been achieved.
85	4G	Sentinel	<p>Baby was transferred from public Hospital to a private birthing centre</p>	<p>There was no one clinician in charge of the baby's overall management.</p>	<p>Medical and midwifery staff to review how the care for at risk babies and mothers is managed,</p>	Actions in progress. Due for completion June 09

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			before all blood results were known. Blood result showed that baby had infection requiring further action and management. Baby died of infection within 2 days of birth.		to ensure there is clear responsibility and accountability for management of women at risk of infection in labour. To identify the extent to which primary facility funding arrangements exert pressure to discharge women too soon and identify changes to discharge/transfer processes as required.	
86	4G	Serious	Baby died following emergency caesarean section. Baby was delivered at 25 weeks gestation and had a large growth on his spine that made delivery very complicated.	Roles and functions of Fetal Medicine Clinic and Special Baby Clinic are not clearly defined and the discussions and findings for these clinics are not incorporated into the obstetricians' management of care in a timely and effective manner.	To review role and function of the Fetal Medicine and Special Baby Clinic to ensure there is appropriate obstetric involvement. To develop a process to identify those patients where the delivery may be problematic and ensure there is a well-documented management plan available in the clinical record and delivery suite	Actions in progress. Due for completion June 2009
87	4E	Serious	Incorrect results (including duplications) from Point Of Care Testing (e.g. bedside blood gas tests) were being transmitted into the Laboratory information system and displayed to staff. This resulted in potential for misdiagnoses of patients' conditions. Review of care identified that no patient had been adversely affected by the problem.	Inadequate pre-installation testing to ensure Point of Care Testing (POCT) equipment linked correctly to laboratory system.	To review clinical care and clinical record of patients affected by identified problem. To review process for commissioning equipment, particularly with regards to pre-installation testing. The connection between POCT analysers and software programme was switched off until problem resolved.	All actions completed. Procedure developed that covers key requirements for checking equipment before installing. Changes were made to software to prevent recurrence.

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88	4E	Serious	Clinical test result outages (total of 31 hours on 7 different occasions) or very slow to access, causing significant disruption to clinical care, unnecessary patient admission to High Dependency Unit, prolonged patient hospital stay, and delayed patient diagnosis and treatment.	Technical problems with associated software.	To address software issues. To review IS incident management policy to ensure rapid escalation of IS performance issues.	Completed
89	5	Serious	Patient was administered five times the correct dose of an anti-coagulant. The patient was discharged but has since undergone further clinical intervention to remedy complications from this event.	Staff member misread the information on a vial of medication. Person double checking did not do an independent check.	Review availability of this medication and its use; place warnings in dispensary; review drug chart format to include dose administered. Staff education on medication and documentation.	Actions in progress.
90	5	Serious	Patient went into heart failure and required treatment by General Practitioner as a result of incorrect prescription of medications (betablocker) on discharge from hospital.	Lack of formalised process for checking of discharge prescriptions against patient medications on admission to prescription correct.	Review of which patients on the ward are prioritised to receive medication cards by pharmacist	Completed
91	5	Serious	Elderly patient used wrong insulin medication at home previously prescribed and dispensed. Patient recovered from this incident.	Patient used incorrect insulin (Protophane) which was stored in her home fridge	To establish a process whereby insulin held at patient's homes is removed when the insulin type is changed	Actions in progress.

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92	6	Serious	Patient admitted to hospital for treatment of post-operative infection. Patient fell and sustained a fractured hip. Following surgery to repair hip, patient died of blood poisoning secondary to urinary tract infection.	Patient was walking in room without assistance or staff knowledge and fell. Noncompliance with Inpatient Falls Assessment and Management Protocol.	To implement hourly nursing rounds and regular toileting as component of nursing model of care. To purchase floor alarms as appropriate for ward use. To conduct audit of Falls Risk assessment being completed within 24 hours of admission.	Actions in progress.
93	6	Serious	Patient fell and fractured her hip, requiring surgery to repair. Patient was later discharged back to resthome for ongoing care.	Nurse left patient in bathroom to attend to other patients' needs. Lack of appropriate stroke unit / rehabilitation beds for stroke patients at this time.	To raise the need for a stroke unit to Clinical Board.	Completed. Stroke unit implemented at Hospital in May 2008. It comprises: 8 acute beds; 4 step down beds; 10 rehab beds.
94	6	Serious	Patient admitted for surgery to repair broken hip. After surgery patient fell while returning from bathroom. Patient had further surgery to repair her hip and was transferred to rest home.	Patient unattended by staff while returning from bathroom, dropped pottle of water on floor, slipped and fell.	Implement hourly nursing rounds to ensure toileting and other needs are taken care of. Implement falls risk reduction actions.	Action in progress.
95	6	Serious	Patient fell and fractured right arm. No surgery required.	Patient very confused and did not call for assistance before mobilising.	To continue to implement the DHB's Falls Protocol.	Completed.
96	6	Serious	Patient fell and fractured his hip. Patient discharged home four weeks later.	Patient disoriented and lost his balance.	Nursing rounds and frequent patient toileting to be included in Inpatient Falls Assessment and Management Protocol and Model of Nursing Care Delivery.	Actions in progress.
97	6	Serious	Patient had fall in hospital and required surgery to repair. Patient discharged	Patient had high risk of falls due to his medical condition and other	Education and reminder to staff of the need to ensure plan of care is in place for patients who have	Actions in progress.

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			back to rehome.	associated problems.	mobility risks.	
98	6	Serious	Patient was admitted to hospital for surgery to repair hip fracture. Patient had a number of further falls whilst in hospital and required additional surgery to repair hip.	Patient was not assessed accurately to determine safe mobility	Hourly nursing rounds to be commenced to ensure toileting and other needs are addressed in a timely manner.	Actions in progress.
99	6	Serious	Patient had fall transferring herself from wheelchair to toilet. Patient broke her arm and elbow.	Patient had dementia and was left unattended while nurse attended to other patients' needs.	Education and reminder to staff of the need to ensure plan of care is in place for patients who have dementia and mobility issues.	Actions in progress.
100	6	Serious	Patient slipped from chair, fell and fractured hip. Died 3 days later as a result of medical conditions not associated with the fall.	All required assessments and observations had occurred. Patient had been identified as being at high risk of falling. Not enough staff to provide individualized care.	To continue to manage patients at high risk of falling as per the DHB's Falls Protocol.	Completed
101	6	Serious	Patient fell when he leaned against his bed and it moved. He fractured his hip and required surgery to repair.	Faulty bed brakes resulted in bed movement when patient leant back against the bed for support, resulting in patient loss of balance and subsequent fall.	Bed replacement project and ongoing bed replacement programme to be implemented. Pool of beds available to replace faulty beds.	Bed replacement programme underway. Due for completion 2010.
102	8	Serious	Client left inpatient unit on unescorted leave and found deceased.	Inpatient unit allowed client to go to nearby shops unescorted.	To include updating client risk assessment in Mental Health education programme. To ensure formal planning is documented for Mental Health inpatients in ward over the Christmas period when multidisciplinary team meetings may not occur as scheduled.	Actions in progress.

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103	11	Sentinel	Information system failure resulting in failure of electronic storage and significant loss of data and files used by staff.	This failure was caused by the combination of multiple factors, including: a power spike, inadequate documentation the network configuration, failure to comply with service request process, end of life hardware and backup tapes, miscommunication between staff by phone resulted in removal of the wrong disk.	Review Uninterrupted Power Supply maintenance and monitoring Replace SAN and backup tapes. Document operational procedures Increase staffing and skill levels Establish and report on key operational performance indicators Audit compliance with processes	26 of 27 actions have been completed. Remaining action due for completion in August 2009.
104	11	Serious	Client suffered an injury during use of restraint by staff. Patient was trying to attack and assault staff.	Non-compliance with restraint use procedures.	To develop staff performance plan.	Completed.
105	11	Serious	Process for detaining a patient under the Mental Health Act was not correctly followed. The medical certificate was invalid as the doctor did not assess or see the patient prior to completing the certificate.	Rural hospital Medical Officer unaware of all documentation requirements specified by the Mental Health Act.	Ensure all rural hospital Medical Officers are aware of the legal requirements for documentation relating to the Mental Health Act. Police to be advised of the need to take patients to the hospital for assessment.	Completed.

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Bay of Plenty

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
106	1	Serious	Wrong/extra teeth removed	Medical notes of patients other than that being operated on available in theatre resulting in wrong notes being accessed. Informed consent process not adhered to.	No files other than those of the patient currently being operated on to be in the theatre at any one time. Ensure "time out" policies adhered to.	Implemented
107	4B	Serious	Child with a moderately severe exacerbation of asthma admitted to hospital. Died as a result of cardio respiratory arrest.	The lack of standardised documentation/recording did not provide a clear picture of patient's condition which led to inappropriate treatment. The level of the doctor's experience/knowledge resulted in the severity of the patient's condition not been identified and adequately treated. The term "back to back nebulisers" may have different meanings to different health care providers	Documentation reviewed and standardised including implementation of a asthma severity score tool Ongoing education on management of asthma. Staff able to ring on call consultant to come in if they are concerned/not sure. Parental concerns about their child's condition to be taken extremely seriously. All prescriptions to be written using a defined time interval or the term "continuous nebulisers"	Implemented Currently subject to HDC investigation.
108	4G	Serious	Distressed baby with slow heart rate (fetal bradycardia) delivered and transferred to tertiary hospital and died.	Issues relate to period when under Lead Maternity Carers (LMC) care. Secondary care reviewed and found to be appropriate.	Review use of CTG (foetal heart) monitoring	Currently subject to coroner's inquiry
109	4D	Serious	An agitated patient who	Patient factors.	Actions included in risk register.	In progress

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			was being restrained cardiac arrested. He suffered severe brain damage and subsequently died in ICU.	Restraint policy breached –some staff involved untrained in restraint, unapproved techniques used.	Restraint minimisation training rolled out to all staff.	
110	6	Serious	Elderly patient with history of falls lost their balance after standing up. Fell backwards knocking the tea trolley and tipping teapots of hot tea and water over themselves. Received burns to upper body.	This incident was identified as a tragic accident which happened due to multiple risk factors occurring simultaneously. Tea trolley in clinical area with one staff member present. Patient factors dementia, size and high falls risk.	Processes for dispensing hot drinks reviewed. Outcome - In high risk areas drinks made individually away from the main clinical area and taken to patient. In other cases 2 staff present (1 remains by the trolley) when tea trolley in clinical area.	Implemented no further incidents.

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Lakes

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
111	2	Serious	Attempted suicide of a mental health inpatient	Risk assessment not up to date	Patient clinically reviewed and re-assessed for risk and monitored	Regular auditing to ensure appropriate mental health patients have completed risk assessments and that they are regularly reviewed. 1st Audit showed 20% compliance 2nd Audit showed 60% compliance.
112	4B	Sentinel	Bowel perforation while laparoscopic cholecystectomy being performed leading to infection (sepsis) and death.	Theatre technique reviewed. Timeliness of clinical review of deteriorating patients evaluated	Referred for review by senior clinical staff	Internal review and actions completed.
113	4D	Serious	Extensive skin loss of leg due to type of theatre drape used. Patient had skin graft and recovered.	Drape caused friction to fragile skin	Established skin integrity assessment. Dependant on assessment of skin integrity, three options of drape products now in use are available	Products are available in theatre. No further incidents.
114	4C	Sentinel	Development of pressure ulcers post-operatively due to DVT Prophylactic Compression Boots applied and not monitored appropriately. Outcome for patient was amputation below knee.	DVT Prophylactic Compression Boots applied and not monitored appropriately Consumables used twice against manufacturers instructions.	Increased assessment of patient is now to be undertaken Equipment supplier held education sessions on use of product. Consumables used to manufacturers instructions	Criteria for use of Prophylactic Compression Boots developed Consumers used according to manufacturers instructions

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115	5	Serious	Following pre-admission clinic patient's regular heart medications were omitted from chart. The patient went on to have a cardiac arrest following OT. Patient recovered	Charting error	Referred for review by senior clinical staff who develop education presentations as an outcome of this case.	All medication charting errors are worked through the RMO Intern Supervisors as part of the incident review process
116	5	Serious	Medication error, prescribing and administration causing anaphylaxis. Full recovery	Adult dose given to paediatric patient due to procedure not being followed	Paediatric Algorithm Chart made readily accessible in all resus rooms Resus Committee reviewing Paediatric Emergency Medication dosages	Audit undertaken to ensure Paediatric Algorithm Chart is available in all resus rooms. Paediatric Emergency Medication dosage review is completed.

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Tairawhiti

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
117	2	Sentinel	Suicide of a Mental Health Inpatient	Patients can access courtyard without staff knowledge Levels of observation requirements lack clarity. Lead clinician handover following weekend admission needs formalising.	Changes to physical environment to reduce access to courtyard without staff knowing. Review of policy and procedures relating to observation requirements. Improvement in handover arrangements between lead clinicians.	Ongoing implementation of recommendations from external reviews. Awaiting completion of coroner's investigation.
118	4G	Sentinel	Patient prescribed and administered antibiotics in the presence of a known allergy resulting in severe allergic reaction (anaphylaxis) and death.	Comprehensive assessment of allergy undertaken including discussion with patient regarding the benefits and risks of using the drug. On this information decision made to continue with drug of choice. Precautions taken to be prepared should reaction occur. Management of anaphylaxis appropriate according to guidelines however reaction to administration of IV drugs requires more aggressive response than the national guidelines recommend.	Review of anaphylaxis protocols Improved education regarding management of acute anaphylaxis Changes to protocols for testing of allergies. Notification to medical training schools regarding concern re knowledge of anaphylaxis.	Coroners investigation complete with no further actions/recommendations required.
119	4D	Serious	Measurements for ocular lens replacement documented in wrong patient records resulting in wrong lens being inserted. Required follow up surgical intervention to remedy error.	Process review identified opportunity for error through use of patient stickers being placed in measurement sheets in advance of measurement being carried out.	Change of procedures – measurements and patient name and details are all now written by hand. This is in line with procedures relating to blood transfusion where orders are handwritten by the person ordering the products.	Completed

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Taranaki

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
120	4A	Sentinel	Misdiagnosis of patient who presented with acute indigestion /chest pain. Patient died one hour after discharge from a clot on the lung (Pulmonary Embolus).	<p>Patient treated for chest pain/acute coronary syndrome and discharged based on blood results.</p> <p>Identified features with this presentation which could lead to alternate explanations for the clinical findings.</p> <p>However, there were enough features to suggest that admission was warranted.</p> <p>Pulmonary Embolus can be very difficult to diagnose.</p> <p>Issues identified with the supervision of junior medical staff.</p>	<p>Case to be discussed as part of the Morbidity and Mortality review process.</p> <p>Changes to be made regarding the supervision and expectation of Junior Medical Officers, specifically handovers that are to include the Senior Medical Officer on Duty.</p> <p>A teaching session with current Junior Medical Officers in regard to the assessment and management of pts presenting with chest pain is to be organised</p> <p>Expectations and teaching sessions as outlined above will reoccur with each new group of Junior Medical Officers</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed and ongoing</p>
121	4E	Serious	Unexpected small chest abnormality identified during routine pre-operative chest x-ray in 2006 that was not followed up. Patient treated for lung cancer but died 15 months later.	<p>The radiologist reported no immediate adjacent lung changes and noted that this may represent a skin lesion that should be correlated with clinical examination.</p> <p>There is a process in place whereby the radiologists alert the appropriate clinician when they report findings that are suspicious. The radiologist did not believe that in this case there was enough suspicion to warrant using this process.</p>	<p>Commencing in 2007, copies of all x-ray reports are automatically sent to the patient's GP.</p> <p>Feedback to staff involved.</p> <p>Review of the Clinical Management of Tests & Investigation Results Protocol and updates to staff.</p> <p>Utilise the implementation of Éclair (an electronic repository of laboratory results) and information technology to enable the efficient referral of unexpected results.</p>	<p>Completed and ongoing</p> <p>Completed</p> <p>In progress</p> <p>In progress</p>

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				The report was read by several staff, however, it was not followed up.		
122	5	Sentinel	<p>Patient given an antibiotic that they were allergic to. The patient deteriorated and was unable to be resuscitated.</p> <p>Event notified to the Coroner</p>	<p>Patient's referral note identified allergy to Erythromycin, upon checking, the pt confirmed this but did not mention any other allergies.</p> <p>Assumption made that the GP and patient information given was correct and complete.</p> <p>Staff did not check the patient's electronic or paper records where allergy to another antibiotic was noted.</p>	<p>Responsibility to be assigned for checking patient's allergy status against information held by the DHB.</p> <p>Newly revised patient documentation to include a section for recording electronic record alerts.</p> <p>Explore whether patient allergy information held within the electronic record can be linked to the medication stations.</p> <p>Obtain the patient's paper clinical record for all medical referrals.</p> <p>Education sessions to be arranged that will include overview of the allergy identification policy, allergy reactions and the management of same.</p> <p>Audit to compare paper and electronic sets of information to be undertaken.</p> <p>Re-establishment of the Allergy Steering Group</p>	<p>Completed</p> <p>Completed</p> <p>Completed and not possible</p> <p>Ongoing</p> <p>Ongoing</p> <p>Completed</p> <p>Completed</p>
123	5	Sentinel	<p>Higher than normal dose of anti-clotting medication (Clexane) given to patient.</p> <p>The patient deteriorated and suffered a right sided stroke (Cerebral Vascular Accident) and died 10 days later.</p>	<p>GP was investigating patient's history of having dark stools (melaena)</p> <p>Contra-indications (absolute and relative) to the prescribing of anticoagulants not fully assessed.</p> <p>Higher than normal dose of Clexane initially prescribed and given.</p> <p>Difficulty accessing key laboratory tests during the night.</p>	<p>Anticoagulant Working Party to be formed to look at this event and pathways associated with the administration of Clexane in the chest pain pathway with the aim of increasing patient safety and therefore reducing reoccurrence.</p> <p>An on-call laboratory service is available., and needs to be utilised.</p>	<p>Progressing</p> <p>In place</p>

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124	6	Serious	Patient fall resulting in a re-fractured hip.	Falls Risk Assessment, completed prior to event, indicated that patient was high risk. Patient tried to walk without assistance. Close supervision had recently been discontinued.	Close supervision reinstated.	Completed
125	6	Serious	Patient fell resulting in fractured left part of the pelvis (pubic ramus).	Falls Risk Assessment, completed prior to event, indicated that the patient was a high risk. Patient been mobilising independently and felt that she was able to mobilise without staff assistance. Lost balance when attending to self cares.	Patient aware to ring the bell when requiring assistance Discussion at ward meeting	Completed Completed
126	6	Serious	Patient fell forward from sliding board resulting in fracture of the ankle (dorsal talus).	Patient not confident with sliding board transfer procedure One staff member assisting with the transfer.	Patient to continue to practice sliding board technique with the Physiotherapist. Two staff to assist with all sliding board transfers.	Completed Completed

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Hawke's Bay

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
127	5	Sentinel	Narcotic medication error contributing to death of patient.	Look-alike packaging of narcotic medication. Failure to recognise prolonged clearance of drug due to renal failure. Delayed reporting of error. Lack of knowledge regarding morphine preparations.	Debrief conducted for staff. Family meeting held. Professional competency review for staff. Individual packaging of high dose narcotic medication	Professional development completed. Individual packaging of high dose narcotic medication implemented
128	5	Sentinel	Medication error. Patient admitted with a heart attack (acute ST elevation myocardial infarction) treated with dissolution of thrombus medication (thrombolysis) and excessive anticoagulation died from a brain bleed (intra-cranial haemorrhage). Family advised. Review undertaken. Coroner informed.	Initial Emergency Department diagnosis of unstable angina. Patient treated with anticoagulant (low molecular weight heparin) as per unstable angina. Diagnosis then changed to acute ST elevation myocardial infarction after medical registrar review. Patient given thrombolysis followed by IV heparin as per acute ST elevation myocardial infarction protocol. Incomplete clinical handover leading to duplication of thrombolytic medication.	Amend the acute ST elevation myocardial infarction pathway to indicate that if a patient has received low molecular weight heparin, then IV heparin should be withheld until 12 hours post the low molecular weight heparin dose. Education of Emergency Department staff regarding the diagnosis and management of unstable angina and acute ST elevation myocardial infarction including: <ul style="list-style-type: none"> - Amendments to the unstable angina and acute ST elevation myocardial infarction pathways; - Checking for prior use of low molecular weight heparin and withholding IV heparin therapy until 12 hours post the last low molecular weight heparin 	Chest pain guidelines (unstable angina and acute ST elevation myocardial infarction) have been reviewed and updated. In-service education has been provided for medical and nursing staff (Emergency Department and Cardiology) and is ongoing. Coroner's inquiry completed and recommendations from HBDHB's review endorsed <ul style="list-style-type: none"> • Family meeting with explanation of the error.

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					<p>dose;</p> <ul style="list-style-type: none"> - The need for clear communication and handover between Emergency Department and Coronary Care Unit staff. 	
129	5	Serious	<p>Patient suffered an anaphylactic reaction to antibiotic medication.</p> <p>Patient successfully resuscitated.</p>	<p>Medication allergy alert not documented.</p> <p>Failure to follow correct procedure for medication prescribing and administration.</p> <p>Staff unfamiliar with PYXIS (automated drug dispensing machine) method of medication dispensing causing delays and resulting in time pressures.</p> <p>No medication alert on drug chart, clinical file or electronic patient record.</p>	<p>Competency review for staff members concerned.</p> <p>Memo to all medical and nursing staff regarding the documentation of medication allergies.</p> <p>Alert documentation to be completed and placed on patient's health record and NHI.</p>	<p>Competency reviews completed.</p> <p>Procedure for alert notification being reviewed by Health Record Committee.</p> <p>Family meeting undertaken by Clinical Director and Associate Director of Nursing.</p>
130	5	Serious	<p>Patient stopped breathing following pain relief medication.</p> <p>Patient successfully resuscitated. Parents informed.</p>	<p>Transfer of care inadequate.</p> <p>Medications administered by ambulance personnel prior to patient's transfer to hospital and repeated by Emergency Department staff.</p>	<p>Transfer of care procedure revised.</p> <p>Education programme to be conducted for ambulance, Emergency Department and paediatric service.</p>	<p>Education programme re: transfer of care implemented</p>
131	6	Serious	<p>Patient fall from bed.</p> <p>Lacerations to face and fractured hip.</p>	<p>Care plan revised.</p> <p>Surgical procedure required which resulted in an increased length of stay.</p> <p>Patient's relatives informed.</p>		<p>Patient required rehabilitation.</p> <p>Discharged home.</p>
132	11 other	Sentinel	<p>Suicide of a mental health patient whilst receiving care in a medical ward.</p>	<p>Inadequate documentation.</p> <p>Non integrated clinical file (separate medical and nursing documentation)</p> <p>Complementary files in Medical Services and Mental Health Services.</p>	<p>Clinicians working throughout HBDHB to re-familiarise themselves with National Documentation Standards and ensure these are followed.</p> <p>Medical and Nursing documentation to be integrated in</p>	<p>Linkages of medical and mental health record on electronic patient record actioned.</p> <p>All mental health referrals or requests for assessment are triaged</p>

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				<p>The term “medically clear” (as described by Crisis Assessment and Treatment Team) for discharge is confusing. Inadequate communication relating to transfer of care Insufficient Self-Harm assessment.</p>	<p>all clinical departments. The Medical and Mental Health health record should be merged into one health record. The use and practice of the term and meaning of “medically clear” by Crisis Assessment and Treatment Team to be discontinued. All referrals or requests for mental health assessment to be triaged depending on level of risk in relation to presenting circumstances and support available. Crisis Assessment and Treatment Team should engage and discuss assessment directly with referrer. All inter-ward transfers and related handover should be documented in the health record from ward of origin and ward of destination. Ongoing education plan around mental state assessment and risk assessment [including suicide assessment] to be developed and delivered to all registered nurses in medical and surgical areas.</p>	<p>depending on level of risk. The term “medically clear has been discontinued.</p> <ul style="list-style-type: none"> Development and implementation of education plan “Training in suicide assessments” has commenced with Consultation Liaison Nurse for Mental Health and Addictions working closely with Clinical Nurse Educators.
133	11	Sentinel	Suicide of a mental health patient in community care.	<p>Non engagement of client with Mental Health and Addiction Service. Family involved in client care and treatment plan.</p>	<p>Report and staff statements forwarded to Coroner.</p>	<p>Coroner’s findings include comment that deceased’s medication had run out 2 weeks prior to the deceased’s death and this did not appear to have been noted by the mental health key worker.</p>

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Whanganui

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
134	2	Sentinel	Suicide of a mental health inpatient.	No deficits in care. Regular risk assessments documented. Patient aware of relapse and recovery plan.	Nil recommendations from internal review. Awaiting Inquest.	Will be determined by Coroner's Findings.
135	4C	Sentinel	First pregnancy, prolonged first stage of labour. Anaesthetist called to insert a spinal anaesthetic. Baby's heart was not monitored for a 2 hour period. When monitoring of baby's heart was resumed, the baby's heart rate was found to be very low. Immediate caesarean section took place and full neo-natal resuscitation to no avail.	The gap in monitoring baby's heart rate made it impossible to identify the time that baby's condition deteriorated significantly. Once the emergency was recognised the team's response was excellent.	Epidural monitoring protocol developed for the maternity service, based on another District Health Board's protocol. External review conducted by an independent obstetrician and midwife.	Family have been provided with the full external review report.
136	4A	Serious	Failure to diagnose thoracic spine fracture, resulting in temporary paraplegia.	Miscommunication between patient and staff regarding readiness for discharge. Health and Disability Commissioner has found two doctors and the Whanganui District Health Board in breach.	Education sessions held on spinal fractures. Latest addition of trauma text book to be purchased. Handover procedures in Emergency Department reviewed and strengthened. Neurological examination template developed.	Study day on spinal injuries to be arranged for Emergency Department and Orthopaedic Department staff.
137	4B	Serious	Patient 23 weeks pregnant, assessed in Emergency Department for bleeding which	External review concluded that documentation of the assessment in Emergency Department was inadequate and mother should	Senior staff to document their assessment in the patient's health record. Ensure guidelines for the management of ante partum	Subject to Accident Compensation Corporation Treatment Injury claim and further

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			ceased. Antenatal outpatient appointment made, baby born 4 days later and lived for a short time.	have been admitted for observation, however, it is unlikely that the outcome would have been different.	haemorrhage are in place and followed.	review.
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MidCentral

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
138	4D	Sentinel	Information withheld to protect patient confidentiality			
139	5	Sentinel	Unintended overdose of an antibiotic eye injection due to an incorrect dilution from a formulation error. The patient has lost vision in the eye and may lose the eye.	Workload prioritisation: No system exists for Pharmacy to prioritise their work in line with staffing resources available Pharmacy environment cramped No system for answering phone calls. No electronic check for calculations	Develop a process for Pharmacy staff to undertake to prioritise their work Undertake an Occupational Health and Safety audit and a clinical risk review of the pharmacy environment to identify areas of risk to the individuals and to the department. Review of the phone system and the practise of answering phones Enhance the existing double check processes	Recommendations have been implemented. A whiteboard has been installed in a prominent area of the pharmacy. This has been ruled up to provide a daily overview of the dispensing and compounding tasks to be achieved in the pharmacy. Progress during the day is noted on the board. A formal prioritization of workloads plan has been drafted. Substantial progress is underway. A clinical risk assessment has been conducted and risks have been assessed and treatments identified. Pharmacist/Pharmacy Technician ratios are

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						<p>reviewed daily and services that are offered are modified accordingly. Stock imprest for consumables is in place. Recommendations have been implemented. A telephone system for call direction has been installed. Recommendations have been implemented. Three pharmacists independently check all calculations. An audit trail of these calculations is recorded, signed by each pharmacist and filed with the Master batch document. A complete review of the compounding Master documents have been undertaken.</p>
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Wairarapa

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
140	4E		Potential delay in diagnosis of cervical cancer	Visiting O&G expert undertook a clinical review.	Internal case review. With HDC for investigation. ACC application for treatment injury. Discussions with patient and family ongoing.	Patient receiving treatment – ongoing. Hospital policies and procedures reviewed. District wide review of policies in place for smear takers. College guidelines circulated.
141	4F		Critically ill patient suffered transfer delay due to weather conditions.	Internal review undertaken. Discussion with family.	Recommendations to Clinical Board. Report to Coroner completed	Awaiting outcome of inquest. Delay in transfer thought not to have altered clinical outcome. Clinical Board reviewing actions taken. Recommendations include better communication between; Air ambulance, Bed Manager and Clinical Team. Discussion with patient, family and clinical team if transfer is delayed.

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Capital & Coast

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
142	1	Serious	Craniotomy incision (cut) made on the wrong side, staff realized error, sutured wound and commenced procedure on correct side.	DHB logged as serious event following ACC case review August 08. No imaging available in theatre at time of surgery. Incorrect assumption due to presentation of the depressed fracture.	Systems implemented since this event occurred are considered to mitigate risk ie. Electronic radiology images available across hospital services, Universal Safety Protocol implemented in Operating Theatres and electronic reportable events system implemented across DHB.	No action plan as issues addressed
143	1	Serious	Wrong approach to remove filter-treatment injury resulted in small cardiac tear, required admission to intensive care unit – the injury resolved and the patient returned to ward care.	Review found the procedural team went to extraordinary lengths to ensure the patient had the procedure in time for surgery. Deficiencies in equipment supply systems and checking were identified.	Review recommended maintenance of supply system changes implemented since the event and further planned improvements, development of a checking system for out of hours procedures, in service education and follow up on delays in supply be completed.	In progress
144	4B	Serious	Patient assessed in community as requiring acute admission. Patient absconded. Death in community.	Review found that the decision to leave the patient to arrange admission, while carefully considered, was flawed. The lack of availability of a Duly Authorised Officer to enact the Mental Health Act resulted in delayed assessment during which the patient absconded. There were communication misunderstandings with the Police and it would have been appropriate to attend the patient	Review recommended full assessment by psychiatrist within 48 hours of crisis assessment, that crisis assessment non medical staff be required to be Duly Authorised Officer and a clearer timeframe from CATT staff appointment to achieve DAO status, that communication with Police be written and feedback to the service and staff of the learnings from this event.	The requirement for full assessment by psychiatrist within 48 hours of crisis assessment and that CATT non medical staff are to be/or be trained to be Duly Authorised Officers has been communicated to the service. This will be audited in March 09. Feedback to the service

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				and gain Police assistance if needed.		is in progress.
145	4A, 4B	Sentinel	Death of baby during childbirth- unexpected breech vaginal delivery	Review found that criteria to deliver at primary birthing unit were not met. Identification of fetal position in time to effect transfer to tertiary hospital was missed.	DHB policies related to booking criteria, water birth and obstetric emergencies be followed by access holders. Improvement in communication process for obstetric emergencies. 15 recommendations for DHB and access holders, and one for the NZ College of Midwives.	All DHB recommendations have been allocated and are in progress.
146	4B	Serious	Review of patient deaths on Cardiothoracic Waiting List.	Two separate reviews were conducted: -External (MOH) and -Independent (hospital requested) Both reviews found that for a number of patients reviewed the wait could have impacted on the outcome, and identified processes improvements, the need for audit and continued focus on achieving throughput.	Recommendations included active management of wait list to maintain throughput, audit of deaths of wait list patients, and improvements to the waiting list management system.	Review has been completed of the cardiothoracic referral process, acceptance criteria for the cardiothoracic wait list and ongoing responsibility for patient care while on the wait list. Patient progress is documented and minuted following cardiac meetings and minutes are distributed to all referring DHB's. The DHB is compliant with the Expected Service Performance Indicators for cardiothoracic surgery and reports weekly to the MOH, regarding the status of the entire cardiothoracic wait list.
147	4C	Serious	Patient sustained a grade 2 pressure ulcer during recovery from surgery, this subsequently	DHB logged as serious event following ACC case review August 08. Review identified lack of comprehensive nursing	Recommendations included presentation of case study to nursing staff to increase awareness.	Case Study - Training meetings have been completed and case study scheduled for Nursing

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			resolved.	assessment and subsequent lack of a comprehensive care plan, in particular relating to skin integrity.	Ongoing and further review of the Patient Admission to Discharge Plan to improve documentation and review utilisation of clinical nurse specialist in wound care.	Grand round April 09. Ongoing review since introduction of Patient Admission to Discharge Plan continues led by Nurse Leader Surgical Directorate.
148	6	Serious	Patient fall with resulting fractured hip (neck of femur)	The review team found that patient was being appropriately assisted by a Registered Nurse at the time of the fall, was appropriately assessed and treated by medical staff following the fall, DHB patient falls risk management strategies were being applied.	There were no specific recommendations that would have prevented this fall from occurring.	Complete
149	6	Serious	Patient fall with resulting fractured hip (neck of femur)	Review found care pre and post fall was of a good standard including evidence of good assessment and planning (medical and nursing). No specific factors contributed to the fall. Some documentation inadequate.	Recommendations include audit of the Patient Admission to Discharge Plan to improve documentation.	Complete. Falls audit completed in response to a number of falls identified as serious events. Outcome was favourable comparison to conservative international benchmark. Many audit findings in line with international findings. Identified two month period of high falls in one ward which is being further looked into. Action plan developed to further minimise falls risk.
150	6	Serious	Patient fall with resulting fractured upper leg (shaft of femur)	Review found overall care and management was of a good standard. Falls assessment and prevention strategies were in	Recommendations include audit of documentation, review of falls in the service, staff education about Falls Prevention and	Complete. Falls audit completed in response to a number of falls identified as serious

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				place. Some documentation was incomplete.	Management policy and a review of the orientation programme for new staff.	events. Outcome was favourable comparison to conservative international benchmark. Many audit findings in line with international findings. Identified two month period of high falls in one ward which is being further looked into. Action plan developed to further minimise falls risk.
151	6	Serious	Patient fall resulting in ruptured achilles tendon	Review found that the fall was likely to have been related to incorrect use of equipment. Some documentation was inadequate.	Recommendations include - education of staff re use of equipment, audits of documentation, review of falls in the service and review of policies with staff.	Complete. Falls audit completed in response to a number of falls identified as serious events. Outcome was favourable comparison to conservative international benchmark. Many audit findings in line with international findings. Identified two month period of high falls in one ward which is being further looked into. Action plan developed to further minimise falls risk. Other actions in progress

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152	6	Serious	Patient slipped from operating table sustained minor injury but required extended hospital stay	Review found that straps used to secure patients on the operating table were not routinely used and were not in place in this case. Restraints used were released without precautions to prevent subsequent patient movement	Clinical staff made aware of risk of patients not being secured on operating table and that this is a team responsibility. Relevant policy documentation has been updated.	Completed
153	6	Serious	Patient fall with dislocation and fracture of ankle	Review found that the risk of falling was identified and the patient preferred their cot side down, that evaluation after the first fall was insufficient and some communication and documentation was inadequate.	Review recommended feedback to staff and the patient.	Complete
154	8	Serious	Inpatient awaiting transfer to detoxification unit walked out. Found deceased in community some days later.	Review found that the patient was compliant, agreed to the plan for care, did not indicate an intention to leave. Risk evaluation, communication and filing systems could be improved and that some documentation was inadequate.	Recommendations include completion of evaluation of the need for a watch where there is a plan to manage the risk of a patient leaving, improved communication filing and documentation, feedback to family.	In progress
155	11	Sentinel	A large number of radiology reports did not print as expected at the ordering destination over 8 month a period. Although reports were available electronically, some clinicians relied on hard copy report to prompt next step of patient management. No patient harm known to have resulted.	Review found a number of technical root causes related to the implementation of the electronic health record and the replacement of a number of IT systems at that time.	Immediate risk management included printing and review of all unprinted reports and a process change so reports printed and were distributed centrally. Changes recommended include clearer communication lines between Information Services provider and DHB, use of project methodology, development of standard operating procedures.	In progress AND combined with SAN upgrade failure action plan below
156	11	Serious	Planned upgrade of main electronic information data storage facility for DHB resulted in a	Review found the extent of the outage was unexpected, a known fault had not been communicated to the ICT provider,	Change recommended included improved DHB and information technology provider joint planning for such events, the need to	In progress and combined with Print Failure above

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			widespread, long lasting outage of computer services and the irretrievable loss of some radiology images and data. No patient harm known to have resulted.	communication and response procedures could be improved, not all areas had current accessible down time procedures.	improve the resilience of some applications, development of current accessible down time procedures in all services, other measures to improve response to such events (information accessible, stand alone functionality in key locations)	
157	11	Serious	<p>Two discharge summary events</p> <p>GPs advised that they were not receiving Emergency Department discharge summaries consistently – it was found that some discharge summaries were being provided to GPs.</p> <p>GPs advised they had not received some inpatient discharge summaries – it was found that over a period of one month discharge summaries had not been produced.</p> <p>Due to the number of patients involved and the risk that ongoing patient care was not informed by hospital discharge summaries this was managed as a serious systems event.</p>	Review found data flow and technical faults led to the two separate problems. No instances of specific patient harm were identified	Recommendations included risk management processes for both events, technical fixes and regular audit (ongoing).	Complete

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Hutt Valley

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
158	2	Sentinel	Suicide of a mental health outpatient in the community.	Internal review highlighted need for improved coordination and care of clients on home leave.	Improved care and coordination and care of clients home on leave. Establish Transition Liaison Nurse positions within the Mental Health Inpatient Unit, ensuring position/s has clear objectives, scopes of practice, documentation requirements and processes that involve the clients and their families in leave planning. Review the Mental Health Service, Inpatient on Leave Policy. Review the postvention (post-suicide) service offered to families, ensuring clear staff responsibilities. Continue with Mental Health Service Family Educations Sessions.	All recommendation in action plan – progress as at December 2008: Team of 3 Transition Liaison Nurse positions in place. All other recommendations ongoing but with clear timeframes for completion.
159	4B	Sentinel	Pregnant woman under the care of a private obstetrician presented to ED with bleeding. Radiologist report of ultrasound stated ectopic pregnancy. Patient given drug to end pregnancy. Follow up ultrasound showed pregnancy was	Independent external review suggested that in cases where a specific rare type of ectopic pregnancy is diagnosed (which research shows is difficult to diagnose), a second ultrasound should be performed to confirm the diagnosis before steps to end the pregnancy are commenced.	Policy to be reviewed and updated to ensure that two ultrasounds are undertaken prior to any decision regarding termination.	Policy review completed and in place by October 2008.

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			not ectopic, but in an unusual position in the uterus, but as the drug to end the pregnancy had already been given, the pregnancy was ended.			
160	4A	Serious	<p>Patient presented to ED with head injury, discharged without a CT scan. Re-presented two further occasions. On third visit CT scan showed evidence of a bleed in the brain which required surgery.</p>	<p>HDC investigation found ED Consultant in breach of code for failing to follow accepted best practice of CT scan for head injury and for inadequate documentation of assessment. DHB held in breach for failing to ensure continuity of care for patient.</p> <p>Claim for treatment injury accepted by ACC.</p> <p>Patient fully recovered from injury.</p>	<p>Develop ED guidelines for assessment of headache. Develop ED guidelines for use of electronic discharge summary. Ensure ED staff aware of relevant guidelines for CT scan and electronic discharge summary. Review staffing model for night shift in ED. Review processes for internal referrals of diagnostic results.</p>	<p>All actions complete and forwarded to HDC.</p>
161	6	Serious	<p>Patient having shower in commode chair, fell. Health Care Assistant with him protected his head, preventing a head injury. Subsequent X-Ray showed fractured hip. Patient underwent surgery for repair of same.</p>	<p>Patient was positioned awkwardly in chair, and Health Care Assistant leant him forward to put on his cardigan. Commode was in the “dished” part of the shower (floor has a central depression to allow water drainage). Change of patient’s position combined with uneven floor surface caused commode chair to topple.</p>	<p>Meetings held with staff to discuss the risk of equipment and environment with staff.</p>	<p>All staff attend annual training for manual handling. Ongoing education in place regarding falls risk assessment completion and falls prevention strategies.</p>
162	6	Serious	<p>Independently mobilizing patient fell in bathroom. Fall unwitnessed. Patient fell forward onto face, sustaining superficial lacerations, bleeding nose, subsequent x-ray confirmed fracture of</p>	<p>A CT scan of the head was done on same day to exclude further head injury – none found. ACC notified.</p>	<p>A re-assessment of the patient post fall recommended actions to prevent reoccurrence.</p>	

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			nose.			
163	6	Serious	Patient attempting to mobilize without required nursing assistance fell and was found on the floor. Complained was subsequently found to have a fractured hip.	Patient transferred to Orthopedic ward for surgery then to Rehabilitation ward. ACC notified	Review showed that a falls risk assessment had been done, but the requirement for a minder had not been identified.	Follow-up education for staff regarding assessment of need for a minder.
164	6	Serious	Patient fell on Rehabilitation ward while reaching to hang up oxygen tubing. Lost balance and fell, resulting in a fractured hip.	Patient transferred to Orthopedic ward for surgery then returned to Rehabilitation ward. Patient subsequently discharged to Residential Care facility.	A re-assessment of the patient post fall recommended actions to prevent reoccurrence.	

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Nelson / Marlborough

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
165	1	Serious	A patient underwent an unnecessary cystoscopy.	The urologist was unaware that the procedure had been performed earlier. It became apparent that the operating list was collated and booked incorrectly. Furthermore, the operating note of the previous procedure had not yet been filed in the patient record.	Review the filing of patient records Review secretarial support to the urology service	<i>Admin project underway</i> <i>Secretarial support improved</i>
166	1	Serious	A patient underwent a radical prostatectomy unnecessarily. The patient suffered post operative consequences.	Decision to do radical prostatectomy was based on a prostate biopsy report which stated clear evidence of adenocarcinoma. After the procedure, prostatic tissue revealed no evidence of malignancy. The biopsy result was reported in error	Laboratory to implement a system whereby all prostate biopsies are reported by two pathologists. Laboratory develops a policy covering processes relating to biopsy interpretation, including prostate and other malignancies.	Prostate biopsies double read. The Health & Disability Commissioner is investigating.
167	1	Serious	A patient underwent wrong site surgery. Surgeon commenced incision on 2nd toe instead of 3rd toe.	The Time Out procedure was not adhered to. The written operation note in the clinical record did not refer to the error and was therefore incomplete. The typed operation record did not state the name of the operating surgeon clearly.	The Time Out policy should be reviewed along with effective implementation Resident Medical Officers should be reminded of the importance of complete written documentation. Theatre typing staff should ensure that the name of the operating surgeon, supervising	Time out policy reviewed. Plan to audit adherence RMOs reminded Admin project underway

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					surgeon and assisting surgeon is always clearly indicated in operation notes in a consistent manner. Medical staff who dictate these notes should be reminded of the importance of ensuring that this is clearly indicated.	
168	2	Sentinel	Suicide of a mental health in-patient. The client was on 3 hours leave at the time of the incident	The care provided was of a good standard and all factors were taken into account when allowing leave.	None	None
169	4A	Sentinel	A client from Intellectual Disability Support Services, involved in a car crash, was seen in the Emergency Department. The client died, unexpectedly, two days after the accident from causes relating to the injuries and pre-existing conditions.	Care in ED was of an acceptable standard. However, this event has raised some opportunities for improvement.	<p>An education programme be initiated for the multi-disciplinary ED team, to include:</p> <ul style="list-style-type: none"> - the level of care available in community homes - How to maximise communication with people who have an intellectual disability <p>A physiotherapy and social work service be attached or readily available to the emergency department</p> <p>The emergency service introduce a policy that patients with abnormal vital signs, in the setting of trauma, be reviewed by a Senior Medical Officer</p> <p>The DHB secures an agreement with primary care providers, through the two PHO organisations, to enable co-operation with sentinel event investigations</p>	<p>Education completed</p> <p>Services to be considered for next budget year</p> <p>Vital signs policy implemented</p> <p>Agreement with primary care sought through National QIC</p>

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West Coast

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
170	4B	Serious	1x Child on dental inpatient list given IV morphine (not usual DHB procedure) – resulted in extended time for patients to wake up; no adverse effect on patients	Locum staff unfamiliar with DHB processes	Revision of locum staff orientation process	Completed
171	4B	Serious	1x Child on dental inpatient list given IV morphine (not usual DHB procedure) – resulted in extended time for patients to wake up; no adverse effect on patients			
172	4B	Serious	1x Child on dental inpatient list given IV morphine (not usual DHB procedure) – resulted in extended time for patients to wake up; no adverse effect on patients			
173	4B	Serious	1x Child on dental inpatient list given IV morphine (not usual DHB procedure) – resulted in extended time for patients to wake up; no adverse effect on patients			
174	4C	Serious	Post operation patient with low urinary output – observations not monitored and recorded for entire nursing shift;			

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			once discovered observations commenced & no adverse effect on patient			
175	4B	Serious	Whilst transporting patient to Xray staff discovered O ₂ tubing had been previously attached to air outlet (and not O ₂ outlet)	Correct DHB procedure not followed	All staff in Unit undertook education re O ₂ & suction equipment; notification made to other Units/Wards to ensure correct Procedure is followed	Completed
176	10	Serious	Obstetrics patient – difficulty in arranging transfer (as per O&G instructions) due to weather & staff shortages – patient transferred to another local hospital instead of other centres. weather improved next morning to allow air transfer to occur; No adverse outcome for patient	Weather conditions prevented air transfer (unavoidable) & staff shortages meant transfer to another hospital unable to be undertaken	Increase in nos of staff available to cover transfer of patients	Completed
177	11	Serious	Operation commenced on patient before all informed consent documentation had been completed. No adverse outcome for patient	Locum staff unfamiliar with DHB process	Revision of locum staff orientation process	Completed
178	11	Serious	Instruments from CSSD (had been sterilized) were delivered to clinical area in unsealed pouches (i.e. sterile condition not maintained; error discovered prior to use on patients) No adverse outcome for patient	Staff involved unfamiliar with correct process for checking of sterilised items	Revision of locum staff training process	In process
179	11	Serious	Air conditioning (Hepa	Trades Dept had not changed	New filters installed; New planned	Completed

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			Filters) in x2 Operating Filters failed air conditioning validation test	filters at due date	maintenance schedule developed and implemented	
180	11	Serious	Concerns raised by clinical staff over management of patient waiting lists	External review undertaken	Range of recommendations made around improvements to be made to operation of Central Booking Unit, including revised referral system	Completed

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Canterbury

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
181	1	Serious	Eye procedures performed on the incorrect eyes for a patient	A number of distractions in the operating theatre impaired completion of a full "time out" process to check planned procedures before commencing.	<p>Operating Theatre Correct Patient, Correct Site, Correct Procedure document be revised to ensure the requirement for entire operative team to stop and actively participate in the "Team Time Out".</p> <p>That the education on Correct Patient, Correct Site, Correct Procedure process occur across the operating theatre department.</p> <p>That consideration be given to other visual cues to assist in reminding surgical team of correct site and correct procedure where the procedure involves more than one site.</p> <p>That the learning from this incident be shared across all DHB Hospitals.</p>	All of the recommendations in this report relate to the application of the Correct Patient, Correct Procedure, Correct Site process. A working group for the Operating Theatres is to be established to review current practice and develop an action plan to ensure that this process meets current standards and is consistently applied across all specialties.
182	1	Serious	Minor operative procedure carried on the incorrect ear of a patient. This was reversed with no long term harm	Patient was to receive two procedures. A failure of the checking and "Time Out" processes led to this commencing on the incorrect side.	That the Operating theatre team develops a strategy to communicate the risk of incorrect site surgery in circumstances where a patient undergoes a bilateral examination with a	All of the recommendations in this report relate to the application of the Correct Patient, Correct Procedure, Correct Site process. A working

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					<p>different procedure on each side.</p> <p>That the Operating Theatre Correct Patient, Correct Site, Correct Procedure document be revised to ensure the requirement for entire operative team to stop and actively participate in the "Team Time Out".</p> <p>That the education on Correct Patient, Correct Site, Correct Procedure process occurs for all clinical staff working in the Operating Theatre.</p> <p>That the final "Team Time Out" process be performed prior to the commencement of each procedure where more than one procedure on the same patient is planned.</p> <p>That consideration be given to other visual cues to assist in reminding surgical team of correct site and correct procedure where the procedure involves more than one site.</p> <p>That the learning from this incident be shared across all DHB Hospitals.</p>	<p>group for the Operating Theatres is to be established to review current practice and develop an action plan to ensure that this process meets current standards and is consistently applied across all specialties</p>
183	2	Sentinel	Suicide of a mental health inpatient	Inaccurate risk assessment.	Training on suicide risk assessment.	Implementation underway.
184	2	Sentinel	Death of a mental health inpatient after a fire	Patient smoking in a non-designated smoking area resulting in clothing based fire.	<p>Assess flammability of hospital wide nightwear.</p> <p>Review junior doctor roster</p>	<p>Actions completed</p> <p>Hospital nightwear non-flammable</p>

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185	2	Sentinel	Suicide of a mental health inpatient		Independent external review commissioned Multiple recommendations	Project underway for implementation
186	2	Sentinel	Suicide of a mental health inpatient		Independent external review commissioned Multiple recommendations	Project underway for implementation
187	2	Sentinel	Suicide of a mental health inpatient		Independent external review commissioned Multiple recommendations	Project underway for implementation
188	3	Serious	Surgical drape left in patient Second operation required to remove the drape	Surgical drape had not been included in the surgical count as it is not commonly used internally.	Count policy revised to more clearly indicate the requirement for all items used in an operative procedure as defined in the Surgical Count Policy. Operating theatre Staff receive education on the Surgical Count Policy and processes. Seek alternative products to avoid use of drape internally.	Actions completed
189	4D	Sentinel	Death of a patient due to perforation of the heart by an intravenous long line (PICC line)	Line was placed whilst the patient was in theatre using an image intensifier to confirm placement and in this context a confirmatory chest x-ray was not requested.	That the DHB adopt a policy that specifies that centrally placed intravenous catheters will be secured with the tip above the heart. X-ray images generated in the process of inserting a long line be loaded onto the computer system and be reported by a Radiologist within 24 hours. That if an Image Intensifier Image or plain X-Ray has been	Policies revised Staff advised of risks

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					<p>performed on a patient with long line the reporting Radiologist must comment on the position of the tip.</p> <p>That the education package relating to PICCs be reviewed to ensure that adequate awareness of the recognition and management of complications is included.</p> <p>That the policy relating to blood sampling through PICCs be reviewed to include action to be undertaken if blood is unable to be drawn through one.</p> <p>That all staff placing PICC lines be credentialed in this procedure.</p> <p>That Health Professionals are reminded that although PICCs are convenient they do have associated morbidity and mortality.</p> <p>That the use of PICCs be subject to regular audit.</p>	
190	4D	Sentinel	Patient suffered a major stroke following carotid arterial surgery and remains disabled by this.	Initial symptoms were not appreciated as serious and the opportunity to potentially avert the complication may have been missed.	<p>Amendment to the published policy for the post operative care of patients undergoing arterial surgery. Direct communication with a vascular surgeon if there are new neurological symptoms.</p> <p>Consideration to be given to employment of a 4th vascular surgeon.</p>	<p>Policy amended</p> <p>Planning in process for additional surgical appointment.</p>

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191	4A	Serious	Delay in the diagnosis of concussion and fractures. Patient discharged and returned to hospital. No long term harm caused by the delay.	Failure to appreciate the severity of the accident and therefore the likelihood of more serious injuries.	Family to meet with senior staff to discuss the case and issues arising around the management of the patient. Patient's mother to attend a clinical medical education session to share her perspective as a family member.	Actions completed. In response to the medical education session a first year intern has written a 'reflection' piece to share with other colleagues. Currently exploring the opportunity for the Patient's mother to speak with Polytechnic Undergraduates about 'caring and communication'.
192	4A	Serious	Missed leg venous thrombosis on ultrasound – patient recalled to hospital and treated – no harm caused.	Verbal ultrasound scan report incorrectly communicated.	Sequence of events reviewed with staff involved.	Actions completed.
193	4B	Serious	Delays in arranging surgical outpatient appointments for a patient with malignant skin conditions. Potential for worse outcome due to the delay.	Complexity in the booking processes and lack of clear guidelines.	Changes to the service to stream patients requiring urgent assessment and treatment.	New unit for treatment commissioned.
194	4B	Sentinel	Patient had an out of hospital cardiac arrest. This patient had been referred to cardiology 4 months prior. Patient recovered but remained disabled	Referral letter not received in Cardiology. No requirement for confirmation of receipt of internal referral.	Changes to processes to ensure that there is a closed loop system.	Referrals project underway to restructure all referrals.

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195	4D	Sentinel	Fatal postoperative infection in a patient caused by an anaerobic bacteria that is always sensitive to Penicillin	Patient possibly allergic to the standard prophylactic antibiotics, therefore given another that would not have covered for this unusual infection	Review second choice preventative antibiotic to ensure that patients with antibiotic sensitivity have broad cover for important potential infections	Recommendations around the use of an antibiotic in the presence of an existing allergy to penicillin is being considered.
196	4A	Serious	A number of radiology reports not sent out over several years.	Radiology Department were unaware that the computer programme required a second signature prior to the release of 'amended' reports.	Active review of all affected reports to be undertaken and further clinical record based review, where required. Clinicians contacted where there was potential for harm. No harm identified.	In cases of identified potential risk, Clinicians have been requested to assess their patient's requirements for further action and follow-up.
197	5	Sentinel	Child receiving palliative care given too high a dose of a sedative with a fatal outcome.	Dosing error was not picked up in the process of administration.	Implementation of additional support role. Extend reception hours to reduce interruptions of staff. Drug dose limits clarified and made available to staff. Improve orientation for staff. Encourage questioning of drugs and dosages.	Most recommendations implemented.
198	5	Serious	A patient was inadvertently administered an anaesthetic drug instead of an antibiotic during an operation. No long term harm.	Drug mis-identification in the context of differing arrangements for storage across theatres.	Change of layout of the drug draws to be identical in all theatres Specific anaesthetic drug that require to be kept refrigerated will be stored in readily identifiable containers.	Recommendations implemented
199	5	Serious	Patient suffered	Residual anaesthetic drug in the	On handover to the Post	System in place

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			respiratory arrest post operatively – recovered.	IV line was flushed in with a subsequent IV injection	Anaesthetic Care Unit there would be a formal process put in place to check that all IV lines have been flushed by the Anaesthetist. Systems to support this will include having a checkbox added to the Anaesthetic Record and if it is not ticked, the Anaesthetist will be asked to flush all of the lines at this point.	
200	6	Serious	Inpatient fall with fractured pelvis and vertebrae.	The number of injury causing falls remains high and requires review by an expert group	Formation of an expert working party to review falls risk across all DHB premises, international literature and recommend strategies and action to reduce these	
201	6	Serious	Patient fall with fractured femur.			
202	6	Serious	Patient fall with fractured pelvis			
203	6	Serious	Patient fall with fractured femur			
204	6	Serious	Patient fall with fractured femur			
205	6	Serious	Patient fall with fractured femur			
206	6	Serious	Patient fall with head injury			
207	6	Serious	Patient fall with fractured femur			

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208	6	Serious	Patient fall with fractured femur			
209	6	Serious	Patient fall with fractured humerus			
210	6	Serious	Patient fall with fractured femur			
211	6	Serious	Patient fall with fractured shoulder			
212	6	Serious	Patient fall with fractured forearm and head injury			
213	6	Serious	Patient fall with fractured clavicle, ribs and head injury			
214	6	Serious	Patient fall with fractured femur			
215	6	Serious	Patient fall with fractured femur			
216	6	Serious	Patient fall with fractured toes			
217	6	Serious	Patient fall with fractured femur			
218	6	Serious	Patient fall with fractured femur			
219	11	Sentinel	Neonatal death	Due to Umbilical Cord Compression.	Audit the percentage of staff who have attended training on electronic foetal monitoring. Remind staff of current best	Recommendations underway.

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					practice regarding foetal monitoring and the availability of the online education package regarding foetal monitoring. That electronic foetal monitoring education is reviewed to ensure that the importance of other markers of foetal distress are appropriately emphasised.	
220	11	Sentinel	Suicide of a mental health patient.	Potential for additional assessment to avert this event Communication issues between agencies involved.	Full refresher training of all front line staff. Full review of court liaison. Review admission rights for frontline staff. Review medical support to courts. Investigate if there is an option of handover of client from one assessor to another. Investigate means of recording handover. Practice on interviewing family separate to the patient to be considered.	Recommendations implemented or underway.
221	11	Serious	Failure of autoclave to complete full sterilization cycle One patient required further procedure to be assured of no infection	Changes during maintenance led to incorrect operation of autoclave	Amendment of maintenance sheets to ensure autoclave is fully reset	Actions completed

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South Canterbury

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
222	4A	Serious	Patient discharged from emergency department following a motor vehicle accident with serious bruising. Admitted to Christchurch hospital following day with fractured neck.	Neck x-rays had been reviewed by both the emergency department doctor and specialist radiologist with no indication of fracture. Follow up plan of care was for further x-rays and CAT scan if pain persisted. This occurred which revealed a complex cervical fracture.	Details of case discussed at an emergency department meeting where the importance of patient understanding the appropriate follow-up management was reinforced.	All presentations assessed and treated by junior medical officers are reviewed by the casualty officer with patient recall if required.
223	4A	Serious	Missed hip fracture resulting in delayed treatment.	Patient had a history of falls prior to and during admission. Unable to determine whether fracture occurred prior to or during admission. X-ray not taken on admission. Co-morbidities masked injury.	Standing guidelines suggest x-ray to occur following a fall where there is presentation of pain.	Junior medical staff orientation re clinical practice requirement.
224	4D	Sentinel	Compromised resuscitation of a patient.	Staff had difficulty accessing the contents of the resuscitation trolley, knowledge as to resuscitation equipment usage and knowledge in resuscitation practice. Not all equipment and information on the resuscitation trolley was correct nor was additional essential equipment readily available. Patient died. Patient had significant co-morbidities which contributed to their death.	A clinical services approach was taken with full review of all resuscitation and bedside suction and oxygen equipment throughout the hospital resulting in the purchase of additional hi-suction units and an AED unit for the Mental Health Service and the introduction of pre-cut suction tubing. Staff life support competency requirements have been reviewed with re introduction of mock arrests exercises and timely rostering of staff for life support training appropriate to their clinical environment. Resuscitation trolley and	Resuscitation audit undertaken with implementation of corrective actions being monitored by the Resuscitation Committee.

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					defibrillator checks have been increased to daily with random auditing undertaken by a designated resuscitation champion. This is in addition to regular quarterly quality monitoring. Resuscitation committee re-established.	
225	4A	Serious	Missed collapsed right lung (pneumothorax) following trauma resulting in delayed recovery and longer length of stay.	Patient not reviewed by a general surgeon on initial presentation as is protocol for fractured ribs.	Full review of protocols of management of trauma presentations with special emphasis upon fractured ribs. Education for staff on the potential significance of fractured ribs and high speed injuries.	All presentations assessed and treated by junior medical officers are reviewed by the emergency department physician with patient recall if required
226	6	Serious	Aged care hospital level resident fall from bed sustaining a fractured hip.	The incident was the result of deterioration in the resident's ability to mobilise related to the progression in their disease process.	On discharge back to the aged care hospital facility, the resident was relocated to a specialised dementia care unit with the plan of care changed to indicate the increased falls risk and the requirement to use a hoist and two staff to mobilise.	Incidence of falls continues to be monitored.
227	6	Serious	Patient fell on their way to the toilet sustaining a fractured hip.	Mechanical fall. Mobility assessment indicated ability to mobilise independently with a low frame.	Patient independently mobile with a low frame.	Falls assessment completed on admission with those identified as high risk referred for full occupational therapy and physiotherapy assessment.
228	6	Serious	Patient fell from trauma trolley resulting in a loss of consciousness.	During suturing of a leg wound the patient was asked to roll over to improve access. No physical barrier in place. Patient under went CAT scan and observed in the emergency	Bedsides now in place for any patient activity or movement.	Nil further incidences reported.

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				department for 4 hrs, no injury sustained as a result of the fall.		
229	6	Serious	Patient fell from bed sustaining a fractured hip.	Patient was slightly confused & disorientated. The bed was set appropriately at the lowest level.	In line with restraint minimisation practice bed kept at lowest level against the wall, crash pad in place.	Falls assessment completed on admission with those identified as high risk referred for full occupational therapy and physiotherapy assessment.
230	6	Serious	Aged care hospital level specialised dementia care unit patient fell from bed resulting in a fractured hip.	The resident concerned had a mental illness combined with cognitive impairment, and at the time of incident was experiencing an elevated mood with associated increase in activity. The fractured hip was surgically repaired. Care plan indicated resident at risk of falling.	Independently mobile resident with a documented high risk of falling. Residual risk remains restraint not an option.	Incidence of falls continues to be monitored.
231	6	Serious	Patient fell while mobilising with walking frame sustaining a fractured hip.	Mechanical fall. Physiotherapy assessment had been completed with patient mobilising independently.	Patient independently mobile.	Falls assessment completed on admission with those identified as high risk referred for full occupational therapy and physiotherapy assessment.
232	11 equip	Serious	Wheel broke on toilet chair causing patient to fall to the floor sustaining a fractured arm, facial contusions and bruising.	Company notified and product removed from service. Maintenance check and repairs undertaken.	Opinion of company that castor had experienced impact damage. Company had not endured this problem prior to this notification.	Ward staff regularly check chairs for safety and functionality.
233	11 equip	Serious	Water leakage through floor in surgical ward, tracking through ceiling space into theatre below during a surgical procedure. The water ran down the operating	Floor above was having carpet (flowtex) cleaned by method used since 2000 (Floor flooded with water then sucked up). Product supplier confirmed this was the only effective method to clean soiled flowtex flooring. The carpet	Cleaning strategy modified in affected rooms until carpet replaced by vinyl and validated by the Infection Control Nurse. This is scheduled for December 2008. Physical barrier between floors	Carpet scheduled to be replaced between the 24Dec 2008 and 4 Jan 2009. Nil repeated incidences in the interim.

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			theatre light support, missing both the surgeon and the operative field	layer confirmed the floor layers beneath the carpet were intended to seal the floor surface. The maintenance manager and infection control nurse noted that the way the carpet had been laid did not seal the edges at the wall and this enabled water to track down via the services coming through the floor plates. Maintenance checked the theatre light and found no water had leaked into it. Maintenance staff inspected the ceiling space and noted there was no physical barrier to prevent leakage into theatre.	would require extensive facility alterations – not be progressed at this stage.	
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Otago

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
234	3	Sentinel	Retention of surgical item used in closing abdominal incision	Item not added to surgical count	Ensure all items added to the surgical field are added to the count In addition we emphasize the necessity to record and count any item which might inadvertently be left in a surgical wound. We have audited the count sheet following this incident for accurate documentation of counts in accordance with the count policy. Last audit 100% compliance. Recommend that surgeons evaluate the use of disposable abdominal visceral retractor (with an attached string and plastic ring as recommended by the Royal Australasian College of Surgeons (sought by the HDC) Contacted the manufacturer of the item with our concerns about the high risk of retention.	Complete Ongoing auditing in place
235	4A	Sentinel	Screening test result initially reported as normal. Subsequent readings identified malignancy. Incorrectly coded as normal on patient information system. Patient receiving ongoing treatment	Manual entry of data was required due to technical difficulties with the Radiology Information System. The follow up check between data entry and paperwork did not occur. The incident has highlighted the potential risks when moving from a paper based process to a digital environment. Review of the	Revision of procedure for report coding by Radiologist Key message in both GP and women's letter is bolded Computer enhancement request to vendor Follow up with vendor to ensure this is undertaken Review of procedures for radiologist reporting process	Complete Complete Complete Ongoing

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				letters sent to the GP and women indicated that the format and bolding of the result would highlight the result to the reader.	Radiologist review form developed for audit outcome All patient files from the commencement of digital mammography were reviewed and no further clinical issues were identified.	Complete Complete Complete
236	4G	Sentinel	Patient overdose of self administration supply of prescription medications in rehabilitation facility.	The investigation did not reveal significant systems gaps or risks that could have prevented this incident. One minor systems issue relates to ensuring that only the medications being used are included in self medication stocks.	Staff requesting pharmacy orders for self medication to check if prn medication such as paracetamol is being used so that minimal stock is available.	Complete
237	4C	Sentinel	Concern regarding clinical monitoring of patient prior to cardiac arrest	Investigation complete. Findings and recommendations need to be discussed with the family prior to publication		In progress
238	4C	Serious	Delayed release of tourniquet during surgery.	Staff believed the tourniquet had been turned off however it remained on. No failsafe system built into machinery to ensure automated monitoring.	New machines purchased that monitor the tourniquet on a time basis. Staff training in the use of new machinery and monitoring requirements	Complete Complete
239	8	Sentinel	Patient allegedly committed arson while on unauthorized leave	External review	Should a similar case occur in the future, a conference, which could be conducted by video, or teleconference, between Forensic Staff and Mental Health staff, could prepare a management plan; in particular, how transition from prison is best managed given that female offender patients will serve their sentence in the Women's Prison. Patients such as this one pose	In progress

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					too great a challenge for general mental health service and consideration should be given to a greater role for forensic services in such cases.	
240	11	Sentinel	Suspected equipment failure with intravenous infusion may have contributed to severe drop in blood pressure which was successfully treated and patient was discharged from ICU.	Initial review established that there was no equipment failure but was otherwise inconclusive. The investigation has been re-opened for further review.	Awaiting recommendations	

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Southland

Ref#	Event Code	Serious / Sentinel	Description	Review findings	Recommendations / Actions	Follow up
241	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
242	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
243	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
244	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
245	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
246	1	Sentinel	Wrong lens insertion during cataract operation. Corrective intervention undertaken.	Incorrect measurements due to equipment setting	Revised procedure to ensure correct use of equipment and identification of readings Staff education	Review findings revisited in the light of subsequent events
247	1	Sentinel	Further case of incorrect lens inserted into eye during cataract surgery. Corrective surgery undertaken	Full RCA undertaken Inadequate pre-operative check to ensure correct procedure Results misread	Time out procedure implemented in eye theatre Biometry results to be highlighted Biometry procedures to be documented and completed at	Completed Completed

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				<p>Lack of standards and processes for admin staff to manage clinics</p> <p>Poor teamwork within department</p> <p>Non-compliance with notification of treatment injury to organisation and externally</p>	<p>within departmental standard time.</p> <p>Processes to be documented in desk file</p> <p>Team building to be included in service plan for 08-09</p> <p>Reminder to staff to observe DHB policy and comply with ACC requirements</p>	<p>Implemented</p> <p>Completed</p>
248	1	Sentinel	Complex cataract case with extensive pre-operative workup. Anaesthetic commenced then lens strength reviewed and choice found to be unavailable. Subsequent procedure with unintended clinical outcome	Patient assisted with ACC claim	Awaited	
249	4A	Sentinel	Delay in obtaining viral load results after high risk needle stick injury led to increased distress for staff member, extended anti-retroviral treatment and active immunisation that was later found to be unnecessary when results available.	<p>Incomplete information about first sample led to incomplete processing</p> <p>Delays in both local and specialist laboratories for different reasons</p>	<p>Clinical safety practices to be reviewed in outpatient and community clinics</p> <p>Staff education</p> <p>Post exposure procedures to be reviewed with Infection Control Occupational Health team and reminders to representatives in all areas about reporting, risk assessment and where to get assistance.</p> <p>Health and safety observation audit to identify any further prevention techniques or</p>	<p>Completed</p> <p>Completed. Also case presented at national Health & Safety conference to share lessons</p> <p>Completed</p> <p>Finishing January 2009</p>

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					<p>equipment to further reduce risk</p> <p>Investigations and corrective actions requested from both with reports at conclusion</p> <p>Laboratory processes reviewed, reminder to all laboratory staff about receipt of samples, processing and notification of results.</p> <p>All confirmatory testing now goes to one lab. Infectious diseases physician has link to virologist for advanced advice on prophylaxis management</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>
250	4D	Sentinel	Respiratory arrest during supervised alcohol withdrawal; immediate resuscitation and intensive support but died 16 days later	<p>Definitive cause of respiratory arrest and subsequent failure to respond reviewed in depth but remains uncertain. However, review highlighted improvement opportunities:</p> <p>Medication use and charting unclear during alcohol withdrawal protocol</p> <p>Nursing care plan contained little information</p>	<p>Alcohol withdrawal chart, used to monitor progress, requires design improvements</p> <p>Other ancillary clinical documents should be reviewed for appropriate standards /safety</p> <p>Education session required on management of alcohol withdrawal</p> <p>Review of document required, then education on appropriate use</p> <p>Standards for retrospective documentation established and promulgated</p>	In progress
251	4G	Serious	Second miscarriage. Patient had miscarried once before, and the possibility that was due to	Clinical records note incompetent cervix as a possible contribution to first miscarriage; not recorded during second pregnancy.	Reminder of need for comprehensive history and documentation required for every out-patient	Completed

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			an incompetent cervix raised.		Plan documented for any future pregnancies for this patient and also given to patient herself	Completed
252	4D	Sentinel	Perforation of uterus during operation for retained tissue; traumatic excision of R fallopian tube.	Perforation is known complication of this procedure. Use of particular equipment, while probably not the root cause, may have increased the risk. Unlikely to have long term effect on fertility.	Apparatus to be reviewed and changed to improve ability to adjust suction strength and improve safety of equipment.	
253	4D & 4C	Serious	Slowed heart rate and brief cardiac arrest due to over-inflation of abdomen during laparoscopic surgery Immediate resuscitation – patient fully recovered.	Equipment not checked before commencing procedure. No default setting on equipment.	Theatre staff to be reminded about vigilance to check settings before procedure alert other DHBs Equipment to be checked by biomedical engineering	Completed
254	4B	Serious	Specialist's appointment instruction misread leading to delayed appointment. Appointment expedited as soon as error notified. Patient fully recovered.	Service significantly disrupted by staffing changes at this time.	Extensive review of administrative procedures undertaken All cases in progress during this period reviewed to ensure no other similar errors.	Recommendations Implemented
255	4A	Sentinel	Missed diagnosis despite clinical assessment and several hours' observations. Patient discharged and deceased from meningitis. Notification to family did not follow appropriate process	Infant already immunised against meningitis B, reducing suspicion. Fever- reducing medications may have masked clinical signs. No clear process for ensuring multiple community and hospital agencies communicate and follow agreed communication pathway	No clinical recommendations Relevant agencies to review alert process and agree suitable communications pathway.	In progress
256	4D	Sentinel	Acute appendicitis in mother in perinatal period resulting in pelvic	RCA in progress ¹	Awaited	

DHB Summary of Serious & Sentinel Event Report 2007/08

In order of DHB

			abscess and complicated post-operative recovery including ICU admission. Patient recovered but future fertility may be affected.			
257	4E/G	Serious	Requested cross-matched blood not available at time of theatre; operation commenced before notification. Patient unaffected.	<p>RCA completed end Jan 09</p> <p>Group and hold only requested for procedure requiring cross-matched blood</p> <p>Organisational uncertainty about responsibility for reviewing and acting on routine clinical tests Local laboratory staffing mix affected by sick leave</p> <p>Abnormal results in electronic display overlooked</p>	<p>Staff education/ orientation to ensure guidelines for speciality patients are consistently followed</p> <p>Clinical directors to agree policy and promulgate</p> <p>Clarification about laboratory processes for senior cover and also for notification of abnormal results requiring remote laboratory involvement Presentation of abnormal results in electronic reports to be reviewed to highlight abnormal findings</p>	<p>Immediately and repeated regularly for new staff</p> <p>March 09</p> <p>March 09</p> <p>March 09</p>
258	6	Sentinel	Member of public tripped and fell in DHB grounds, sustaining high neck fracture. Delay in retrieval. Admitted to ICU, subsequently died	<p>Delay in retrieval due to confusion about procedure.</p> <p>Full RCA in progress</p>	<p>Staff education</p> <p>Awaited</p>	Completed