

Waikato District Health Board

The classification and number for the following event codes:

1	Wrong patient, site or procedure	-
2	Suicide of an inpatient	1
3	Retained instruments or swabs	2
4	Clinical management problem:	16
	By sub-code:	
A	Diagnosis (including delayed and misdiagnosis)	1
B	Treatment (including delayed and inadequate)	3
C	Monitoring/observations (not performed and/or actioned)	1
D	Procedure associated incident or complication	1
E	Investigation (delayed, not ordered or actioned)	2
F	Discharge and transfer	1
G	Other	7
5	Medication error	3
6	Falls	10
7	Blood transfusion reaction	-
8	AWOL patient	1
9	Physical assault on patient	-
10	Delays in transfer	-
11	Other	3
	Total	36

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	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

			retained swab.			
73	4B	Sentinel	Patient waited in Emergency Department for 2 hours before being triaged / assessed by clinical staff. Patient had many complex health conditions and died later in intensive care.	Insufficient nursing staff on shift resulted in triage / assessment of patients taking too long.	To review triage processes in ED in line with Australasian College for Emergency Medicine Guidelines To review process from time of arrival at presentation to triage to handover to primary nurse.	In progress
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	Lack of appropriate management	To review the service's structure,	In progress. Due for

			relative 11 days after discharge from mental health inpatient unit. Relative survived the attack. No other persons injured.	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.	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.	completion June 2009
77	4G	Sentinel	Patient died after developing infection from intravenous line site.	Patient's intravenous line was not replaced within the required timeframe. Inadequate nursing assessment and documentation of IV site.	Undertake audit of IV 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.	In progress. Due for 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.
82	4A	Sentinel	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.	Blood results were not reviewed or acted upon. There was no agreed process for ward round management e.g. preparation, diagnostic results availability etc	To implement electronic signing of all DHB lab test results. To ensure agreed ward round process is communicated to all staff and responsibilities are clearly defined and documented.	Actions in progress.
83	4G	Sentinel	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	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.	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	Actions in progress.

			hospital due to bad weather and communication failure, resulted in delayed access to neurosurgery. Patient died from his injury.			
84	4G	Serious	Delays in typing letters referring patients for oncology services, from one outpatient department. Potential for delayed patient treatment.	Potential for delay in treatment - no actual harm reported.	Clinical Transcription Project established and in progress to improve typing turnaround times.	Actions in progress. Significant reduction in clinical typing turnaround times has been achieved.
85	4G	Sentinel	Baby was transferred from public Hospital to a private birthing centre 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.	There was no one clinician in charge of the baby's overall management.	Medical and midwifery staff to review how the care for at risk babies and mothers is managed, 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.	Actions in progress. Due for completion June 09
86	4G	Serious	Baby died following emergency caesarean section. Baby was delivered at 25 weeks gestation and had a large	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	To review role and function of the Fetal Medicine and Special Baby Clinic to ensure there is appropriate obstetric involvement. To develop a	Actions in progress. Due for completion June 2009

			growth on his spine that made delivery very complicated.	into the obstetricians' management of care in a timely and effective manner.	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	
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.
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	Technical problems with associated software.	To address software issues. To review IS incident management policy to ensure rapid escalation of IS performance issues.	Completed

			diagnosis and treatment.			
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.
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	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	Actions in progress.

			urinary tract infection.		within 24 hours of admission.	
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 back to resthome.	Patient had high risk of falls due to his medical condition and other associated problems.	Education and reminder to staff of the need to ensure plan of care is in place for patients who have mobility risks.	Actions in progress.
98	6	Serious	Patient was admitted to hospital for surgery to	Patient was not assessed accurately to determine safe	Hourly nursing rounds to be commenced to ensure toileting	Actions in progress.

			repair hip fracture. Patient had a number of further falls whilst in hospital and required additional surgery to repair hip.	mobility	and other needs are addressed in a timely manner.	
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.

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.	<p>Review Uninterrupted Power Supply maintenance and monitoring</p> <p>Replace SAN and backup tapes.</p> <p>Document operational procedures</p> <p>Increase staffing and skill levels</p> <p>Establish and report on key operational performance indicators</p> <p>Audit compliance with processes</p>	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.