

# Waikato

Serious or sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C (not classified)	Description of event	Review findings	Recommendations/ actions	Follow up
Serious	5	1	Patient died as a result of an allergic reaction to medication.	Patient's allergy/adverse reaction status was not checked prior to medication administration.	Discussion to be taken to Medication Safety Forum and agree plan of action from there.	In progress.
Serious	11	1	Outpatient suicide after discharge from inpatient mental health facility.	No issues identified with care provided.	Nil.	N/A
Serious	11	1	Outpatient suicide after discharge from inpatient mental health facility.	Client was discharged from inpatient facility and not followed up by the key worker within the timeframe he was told would happen. Medical staff orientation did not include requirements of the key worker role.	To audit the time period clients discharged from inpatient facility to community mental health adult urban teams. To ensure that clients of team members who are on leave are allocated to another member of the team during the period of that leave. To develop a medical staff orientation process that includes requirements of the key worker role.	In progress.
Serious	11	1	Client committed suicide whilst on weekend leave from inpatient facility.	Non-compliance with treatment planning policy.	Community team staff to be informed of this learning arising from this event review.	In progress.
Serious	11	1	Inpatient suicide attempt that resulted in injury.	Handover did not include all relevant information including risk status. Risk management information is documented on a number of different forms including the clinical record but not in the MDT plan. Staff shortages led to reduced supervision of junior staff.	To revise and review handover process. To review staff workload and allocation processes. To review how the risk management is documented.	In progress.
Serious	11	1	Outpatient suicide six days after contact with service.	No findings.	Family advised of outcome from review.	In progress.
Serious	6	1	Patient fall resulting in an injury that required surgery to repair.	Patient's clinical condition contributed to the fall.	To undertake a DHB-wide project to identify best practice strategies to reduce patient harm from falls.	Implementation of falls project recommendations under way.

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Serious	6	1	Patient fall resulting in an injury that required surgery to repair.	Patient's clinical condition contributed to the fall.	To undertake a DHB-wide project to identify best practice strategies to reduce patient harm from falls.	Implementation of falls project recommendations under way.
Serious	4(b)	1	Patient had radiology investigation that was not followed up.	Failure to recognise and or action a significant incidental finding in this case an aortic abdominal aneurysm on an inpatient between May and June 2008.	The conclusion/impression section of radiology reports will firstly include the findings/ abnormalities in answer to the clinical question being asked and thereafter any other significant incidental findings should be listed.	In progress.
Serious	11	2	Patient injured by bed rail.	Patients underlying condition increased susceptibility of injury.	Ward to complete feasibility of assignment of padded bed rails to specific inpatient population. Include learnings from this event in the education schedule for the ward.	Completed.
Serious	6	2	Patient fall with resulting injury sustained.	Wet floor area caused patient to slip.	Non-slip lino to be replaced by end 2008 as part of property and infrastructure upgrade programme.	Completed.
Serious	6	2	Patient fall with resulting injury sustained.	Patient fell whilst attempting to turn television off. Patient left sitting in lazy boy chair for longer period than normal due to nurse workload.	Discussion to occur with staff on risks in use of televisions, and management of workloads. Controls to be documented for dealing with low staffing risks.	In progress.
<b>Serious</b>	6	2	Patient fall with resulting injury sustained	Incomplete risk assessment carried out and patients clinical condition contributed to the fall.	Ensure admissions are vetted for appropriateness and that a clear admission process is completed on admission. Sensor mats to be sourced.	In progress.
Serious	11	2	Patient hit leg on side of wheelchair. Required surgery to repair and ongoing plastic surgery treatment.	Review in progress.		
Serious	4b	2	Patient's condition deteriorating. Slow response from medical team to review.	Review in progress.		

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Serious	11	2	Physical assault by patient whilst on leave from inpatient facility.	Ensure appropriate accommodation on discharge.	Ensure discharge planning process considers appropriate discharge accommodation.	In progress.
Serious	4b	2	Patient had x-ray of hand and there was a delay in taking action of the result. Had fractured hand.	Review in progress.		
Serious	6	2	Patient fall with resulting injury sustained.	Review in progress.		
Serious	11	2	Patient had neurosurgical drain removed in error. Patient had to return to theatre for re-insertion.	Drain very similar in colour to other drains in use, making it easy to remove incorrect drain.	Change drain type to coloured to reduce risk of similar event recurring.	In progress.
Serious	4a	2	Delayed diagnosis and assessment of patient due to self discharge and incomplete assessment by staff.	No follow-up provided – was to be discussed at mortality and morbidity meeting.		
Serious	4g	2	Communication issues between departments.	Review in progress.		
Serious	11	2	Wrong body uplifted from mortuary.	The funeral director did not check the identification of the body being uplifted. The procedures describing the process for persons uplifting bodies are not readily accessible at the point of transfer in the mortuary and have not been circulated to relevant parties such as funeral directors. This contributed to the confusion regarding who was responsible for identifying the body.	Review mortuary procedures relating to persons depositing or removing bodies plus DHB Care of deceased policy and procedure.  Draft mortuary procedures to be circulated to funeral directors for comment. Controlled copies of final procedures to be distributed to funeral directors.	In progress.
Serious	4g	2	Patient's discharge was unsafe from private hospital. Care was being provided under contracted service.	Review in progress.		
Serious	4f	2	Unwell patient transferred to another hospital without nurse escort.	Incomplete patient assessment carried out by team involved.	Audit clinical records to determine compliance with transfer requirements.	In progress.

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Serious	11	2	Child patient sustained an injury while attending clinic.	Item had wooden frame on end that fell on child. Children assist with clearing items as part of therapy.	Hazards clearly identified in area. Children supervised moving or carrying objects.	Completed.
Serious	4f	2	Deteriorating patient transferred from ICU to ward and then had to be readmitted to ICU.	Review in progress.		
Serious	4d	2	Patient injury occurred during nasotracheal intubation procedure.	Review completed and was unfortunate episode. Staff involved were very experienced.	Nil.	Family advised of findings and ongoing support provided to them.
Serious	4b	2	Deteriorating patient. Medical team did not respond in a timely manner to review patient.	Review in progress.		
Serious	4b	2	Patient diagnosed with invasive cancer on follow-up appointment.	Review in progress.		
Serious	4f	2	Patient transferred to another hospital in very unstable condition.	Staff did not recognise deteriorating patient condition. Communication between hospitals was not thorough or effective.	Escalation process in place. Include learnings from this event in staff education forums.	In progress – DHB wide project in place for deteriorating patient.
Serious	4c	2	Paediatric patient suffered injury due to tracheotomy tape placement.	Not thoroughly checking under the full length of the trachy tapes to include the back of the neck. Care plan documented that trachy dressing to be changed and cleaned every shift. General oedema limiting staff ability to easily view the neck.	Staff education particularly when a trachy is newly inserted. The care plan and all the trachy care instructions neglected to specifically highlight that the back of the neck or the whole neck needs to be checked underneath the tapes.	All actions completed.
Serious	11	2	In appropriate monitoring use of external ventricular drainage (EVD).	Inconsistent process for management of EVD and procedure was not clear for staff to follow.	Extensive education to ensure correct procedure is followed. CNM/educators to assist staff with all admission requiring EVD. Audit to be carried out on management of EVDs in ICU.	In progress.

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Serious	4d	2	Patient harm following surgical procedure.	No root causes identified.	Clinical audits in place. Learnings from case discussed with colleagues.	In progress.
Serious	6	2	Patient fall with resulting injury sustained.	Patients clinical condition contributed to the fall.	Implement falls management risk strategies.	Implementation of falls project recommendations under way.
Serious	4f	2	Patient self harmed on discharge from unit.	Review in progress.		
Serious	6	1	Patient fall with resulting injury sustained. This was not diagnosed until patient was discharged from hospital. Patient readmitted for surgery.	Patients confused and tried to mobilise without calling for staff assistance. No falls risk assessment. No falls mitigation strategies documented or implemented. Neither the falls risk assessment nor the mitigation strategies were reassessed and revised after fall.	Staff members to sign that they have read and understood the Inpatient Falls Assessment and Management Protocol. Falls Protocol to be complied with as evidenced by compliance audit results. Audit to be conducted by Q&R Standards and Audit Facilitator. Hourly rounds to be implemented as part of nursing model. Falls risk management education to be provided to all staff.	Implementation of falls project recommendations under way.
Serious	6	1	Patient fell and sustained fractured hip and required surgical repair.	Patients confused and tried to mobilise without calling for staff assistance.	Falls protocol to be complied with as evidenced by compliance audit results.	Implementation of falls project recommendations under way.
Serious	6	1	Seven patient falls events.	Falls project completed November 2009.	Increase compliance with existing Waikato DHB falls risk minimisation strategies through audit, education and nursing rounds. Ongoing monitoring of falls and compliance with organisational requirements.	Implementation of falls project recommendations under way.
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		
Serious	4c	1	Patient was not monitored as per requirements.	RCA review in progress.		

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Serious	4a	1	Surgery delay for patient with severe finger injury.	Multiple missed opportunities, to recognise the severity of the patient's infected finger combined with theatre delays contributed to the patient's finger being severely infected preoperatively and the patient having decreased functional use of his left index finger post operatively.	Referral system be reviewed and improved to ensure more timely and formalised booking process.  Medical handover process to be developed.	In progress.
Serious	4a	1	CTG not recognised as abnormal – baby died two days later.	RCA review in progress.		
Serious	11	1	Client attempted suicide within the inpatient facility and died later from her injuries.	RCA review in progress.		
Serious	3	1	Retained needle following surgical procedure.	No root causes found. Other learnings identified.	Open disclosure education package to be developed and provided to clinical staff.	In progress.
Serious	11	1	Outpatient suicide one day after contact with service.	RCA review in progress.		
Serious	4a	1	Delay in diagnosis due to delay in accessing imaging result.	RCA review in progress.		
Serious	1	1	Wrong patient had investigative procedure.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of discharge from inpatient area.	RCA review in progress.		
Serious	4a	1	Patient died from sepsis. Had presented multiple times to hospital and was reviewed by numerous teams.	Multiple missed opportunities to recognise the patient's deterioration and missed opportunities for more senior and experienced staff to intervene and manage the patient's deterioration in a timely and effective way contributed to the patient's death from overwhelming sepsis.	The development and implementation of a new in-hospital rapid response system.  Development of an 'early recognition and management of sepsis' pathway for the emergency department.	In progress.
Serious	4g	1	Patient required surgical intervention following post cardiac catheterisation.	RCA review in progress.		

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Serious	4g	1	Patient died during pacemaker surgery.	RCA review in progress.		
Serious	11	1	Patient sustained ruptured uterus during surgery.	RCA review in progress.		
Serious	4b	1	Staff did not recognise patient's deteriorating condition.	Patient's deteriorating condition was not escalated in a timely manner.	Develop process for ED staff to escalate deteriorating patient information.	In progress.
Serious	4g	1	Patient was transferred from ICU to ward. His condition deteriorated shortly after admission to ward and there was a communication issue within the team. Patient died.	RCA review in progress.		
Serious	8	1	Client was admitted under Mental Health Act went missing and was returned to inpatient area.	RCA review in progress.		
Serious	11	1	Outpatient suicide within four days of last contact with service.	RCA review in progress.		
Sentinel	2	1	Client committed suicide within hours of admission to inpatient facility.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		
Serious	1	1	Patient had HRCT scan in error.	RCA review in progress.		
Sentinel	1	1	Wrong body part removed in error.	RCA review in progress.		
Serious	11	1	Outpatient suicide within seven days of last contact with service.	RCA review in progress.		