

**Waikato District Health Board Summary  
1 July 2011 to 30 June 2012  
Serious and Sentinel Events**

	<b>Serious or Sentinel</b>	<b>Event code* (See below)</b>	<b>Description of Event</b>	<b>Review Findings</b>	<b>Recommendations/Actions</b>	<b>Follow Up</b>
<b>1.</b>	Serious	5	Patient was discharged home with a medication that he should not have had. This then caused complications for him and he needed to be re-admitted to hospital	The discharge information was not updated or checked before patient left ward.	Discussions to occur on ways of improving current discharge process –include pharmacy in this process and how relief/locum staff are made aware of the process  Escalate the discharge process issue to Patient Safety Board for further discussion	In progress
<b>2.</b>	Sentinel	3	Patient had medical device left behind following a surgical procedure. Patient required a further surgical procedure to remove device.	The medical device was not counted in/out which led to the device unintentionally being retained in the peritoneal cavity	Develop a set up pack and a checklist for the this procedure and include this medical device as part of this pack  Ensure this setup and checklist is communicated to staff within the theatre areas  Ensure staff made aware of this new procedure through team meetings and/or in-services.	In progress
<b>3.</b>	Serious	4 a/e	Patient had a diagnostic test and results showed that	Significant findings of lung nodule on	Team to discuss, define and agree a CT radiology staging protocol.	In progress

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			patient needed further follow up. This did not happen and patient presented approx two years later and cancer was diagnosed. Patient died	chest CT scan was reported and acknowledged, recommended follow up was not arranged.	<p>Implement revised CT protocol and undertake audit to ensure implementation of the protocol has occurred</p> <p>A standardised template to be developed and implemented for use at the service meeting</p> <p>Template to be stored in electronic format for quick easy reference for team. The DHB has implemented a Missed Diagnoses Project and this project is underway</p>	
4.	Serious	4 a/b/e	Baby's blood result not recognised as abnormal, which led to the baby being admitted to another hospital following discharge.	Failure to follow up on requested "Add-on" lab tests led to a failure to note the increase (153mmol/L) in the sodium level	<p>Discussions to occur and to include the following;</p> <p>Not all abnormal results to be displayed in red, only the agreed important ones. This has been discussed with the CD of Pathology and may not be feasible but should be revisited.</p> <p>Sodium phoning threshold has since been brought down to &gt;149mmol/L and the normal range has been adjusted to 135-145mmol/L.</p> <p>The DHB has implemented a Missed Diagnoses Project and this project is underway</p>	<p>In progress</p> <p>Completed</p>

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5.	Serious	4a/e	Patient attended Emergency Department with a sore knee. A sample of the fluid from his knee was taken and sent for testing. The results were not followed up. This resulted in the patient having to have surgery to treat the problem and needs ongoing care.	Failure to follow up aspirate result resulted in delayed treatment for patient with septic arthritis	<p>Review and implement an agreed process to manage diagnostic results within the Emergency department</p> <p>Ensure all new medical staff orientated to e-acknowledgement.</p> <p>Lab manager checks E acknowledgement issues weekly Clinical Director informed if there are any issues</p> <p>The DHB has implemented a Missed Diagnoses Project and this project is underway.</p>	<p>Completed</p> <p>Completed</p>
6.	Serious	4 b/c	Patient had a medical device attached because of a fractured neck. Patient developed pressure ulcers in multiple areas and required additional medical care as a result of this.	Poor nursing care and lack of monitoring for pressure ulcers resulted in the patient developing pressure ulcers on her right mandible	Education of nursing staff re different cervical braces and management and nursing care of patients with braces	In progress
7.	Serious	4 a/b/c/f	Baby admitted to emergency department with history of vomiting and diarrhoea- kept overnight and discharged home next day-baby was taken back to ED same day very unwell and died.	Baby's condition was not recognised by staff as being so unwell. This led staff to discharge baby home.	<p>To make sure staff working with babies/children are able to recognise and understand when a baby/child is very unwell as they may not show obvious signs of this.</p> <p>Current staff education to include the above.</p> <p>Staff working with babies/children to agree a</p>	In progress

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					<p>plan for managing vomiting/diarrhoea and that this plan is known and used by all staff</p> <p>Staff to look at how they pass on important information regarding patient care and make sure this is clear and simple to use.</p>	
8.	Sentinel	2	Inpatient suicide	<p>The fact that there was no calling tree for situations such as this, combined with the difficulty accessing the roof of the corridor may have contributed to the patient demise.</p> <p>The building noise on site at Waikato Hospital at the time of this incident, lead to the staff not identifying the sound of breaking glass was someone on the ward breaking a window.</p>	<p>Improvements identified to internal emergency response processes:</p> <p>Develop an additional page for the emergency flip chart to respond to situations such as these</p> <p>Roll out plan to be developed and implemented</p> <p>Need to identify areas of hospital grounds/buildings that may be difficult to access in a emergency situations and have appropriate response plans in place to address.</p> <p>Spreadsheet to be developed and shared with key departments</p> <p>If there are access issues call fire department-add to calling tree above.</p> <p>Mock scenario training to be held between Waikato Hospital and other services ( fire,</p>	<b>In progress</b>

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				Coroner has made final findings on this death.	<p>police ambulance). As a result of this scenario training the following points will be clarified and the new process documented as part of the emergency management process</p> <ul style="list-style-type: none"> <li>-Who should lead these situations</li> <li>-How the emergency management process should work</li> <li>-What the process for notification to the families should be and who does this</li> </ul>	
9.	Serious	4a 4b 4c 4d	Patient had medical device inserted and was admitted unwell two weeks later. Patient's condition deteriorated and she died.	<p>Pericardial effusion not recognised or reported</p> <p>Lack of timely response to patient's deteriorating condition as identified by the escalation of the Early Warning score process with the background of uncertain diagnosis</p>	<p>Share learning's of this case with radiologists who report CT at the radiology audit meeting. The learning from this case: alternative differential diagnosis for the patient's symptoms should be considered and reviewed, if the original diagnosis has been excluded.</p> <p>Share this learning at the Midland Radiology regional forum.</p> <p>Develop a systematic approach for approving and reviewing reports and results before they are released to teams.</p> <p>Discuss having an annual audit programme in the region.</p> <p>Education of escalation and the response required for deteriorating patients</p> <p>Include the observation chart and escalation</p>	

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					process as part of the clinical orientation programmes for all nurses/doctors	
10.	Serious	4a/c	Woman admitted in labour and fetal distress was diagnosed upon admission.– It is unknown how long the baby was distressed before admission. There were delays in getting the woman into theatre for an emergency caesarean section. Baby died two days later.	<p>No root cause identified.</p> <p>Other learnings identified included:</p> <p>Delivery suite escalation plan to be revised and add prompts on the standard information that needs to be communicated between the theatre and delivery suite</p>	<p>Current escalation plan to be reviewed and changes made to ensure key staff are notified and the process is clear as to roles and functions required of staff</p> <p>Escalation process to theatre to include the agreed communication prompts/information required between staff to ensure correct and timely decision making</p> <p>Implement and communicate the revised escalation plan to all staff, in delivery suite and Main operating theatre, through staff meetings, at handovers and is included in key staff roles for orientation</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>
11.	Serious	4a/c	Woman was admitted because her waters had broken a day earlier. Woman was in labour. Fetal heart rate was not noticed by staff as being a problem and this resulted in a delay in getting the baby delivered	The lack of recognition of abnormal fetal heart rate during labour led to a delay in delivery of baby which compromised the outcome for the baby	<p>Implement a training programme, which is specific for staff in reading and understanding fetal heartbeat monitoring.</p> <p>Complete the review of the electronic fetal monitoring document , which is to include the sticker that shows fetal heart rate has been looked at by staff</p> <p>Include the above requirements in unit</p>	In progress

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				Available birthing capacity in the assessment unit could not be utilised as an option for delivery, due to inadequate levels of staffing resulting in a delay in delivery. Epidural procedure requires additional assistance/support to ensure maternal/fetal monitoring takes place	orientation for all staff-midwives/medical staff Managers to look again at what resources the unit needs to deliver the best care to women in labour. Make sure the resources are available to monitor mother and baby when mother having an epidural put in.	Completed
12.	Serious	8	Patient subject to the Mental Health (CAT) Act absent without leave from the Acute Adult Inpatient Unit	No Root Cause was clearly identified, however a number of associated learnings resulted in identified corrective actions.	All patients admitted to the inpatient unit must have a comprehensive risk assessment and treatment plan within 48 hrs of admission, changes in policy and process are required to implement this. Changes to the procedure for levels of observation to be made to ensure these can only be reduced in consultation between the	This action completed.  In process.

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				<p>This included possible delays in the completion of comprehensive risk assessment and the development of an appropriate treatment plan, ambiguity and lack of clarity in the current procedure for allocation of levels of observation, insufficient senior medical staff availability on occasion due to unplanned leave/sickness, etc.</p> <p>An absence of consultant oversight in the early part of treatment in the community meant</p>	<p>psychiatrist and senior nursing staff. Full review of the procedure to minimise further risk, where possible.</p> <p>Changes required to the current process of family advocacy referral and access.</p> <p>Changes to the staffing configuration and particularly psychiatrist allocation and cover arrangements for the adult inpatient unit</p> <p>Review of the guidelines provided to community teams to ensure psychiatrist overview of potentially complex cases.</p>	<p>Completed</p> <p>Completed.</p> <p>In process.</p>

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				the level of complexity and potential risk issues were not managed collaboratively		
13.	Serious	11	An acutely unwell patient assaulted a staff member and required immediate restraint	An acutely unwell patient assaulted a staff member and required immediate restraint. During the restraint episode the patient was noted to have stopped breathing. Emergency procedures were initiated. A full review failed to identify immediate cause during restraint, however a number of areas of improvement were identified. Patient has subsequently	<p>Issues were identified in relation to communication of risk at handover. Specific training is required to ensure the tools in the handover procedure to ensure communication are fully utilised.</p> <p>The current review of staffing and skill mix must include a mechanism for consideration of staffing numbers and resource requirements which may fluctuate, based on patient acuity.</p> <p>Training for staff in relation to the use of restraint, requires review to include specific reference to roles and responsibilities in an emergency situation.</p>	In process

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				made a full physical recovery.		
14.	Serious	5	Patient given a medication that is believed to have caused patient to temporarily lose hearing	<p>There was an absence of formal education/ training for nursing staff regarding the risk factors of gentamicin toxicity and the reporting on concerns</p> <p>There was no guideline for gentamicin monitoring</p> <p>This was a contributing factor leading to the patient receiving 3 doses of gentamicin without the blood toxicity levels being checked</p>	<p>Education provided to staff</p> <p>Gentamicin Procedure developed and implemented in areas</p>	All actions completed

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15.	Serious	6	Patient walked to toilet without assistance. Whilst in bathroom, she fell and fractured her hip as a result. Patient needed surgery to repair the fractured hip	Patient was known to be at high risk of falling. All preventative measures were in place.	No recommendations identified	Falls reduction strategies continue in areas.
16.	Serious	6	Patient had fall and broke her wrist. Patient did not need surgery and had a plaster cast put on her wrist	Patient was known to be at high risk of falling because of her clinical condition. However all measures were in place.	No recommendations identified	Falls reduction strategies continue in areas.
17.	Serious	6	Patient had a fall while moving from chair, patient was still sleepy from medications that had been given as part of a procedure carried out. This fall caused patient to have a bleed in the abdomen and patient died next day.	Patient required medical attention because of the medications given for the procedure needed.  Staff used different monitoring charts to monitor patient after her	Check that the monitoring of patients who have had medications after procedures is enough and make changes if needed  Use the standard ward intervention chart that shows if patients need to be seen a doctor  Junior doctors to make sure they tell the senior doctors all the necessary information about the patient when talking with them  Teams involved with patient discharge need	In progress

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				<p>procedure.</p> <p>Teams involved in patient's care during her previous admission did not talk with each other about management plan before patient was discharged</p>	to make sure they include all the right people and have this information documented	
18.	Serious	6	Patient walked from his bed to the bathroom without assistance had an un-witnessed fall resulting in a fractured hip. Patient needed surgery to repair the fracture.	Unpreventable fall-all appropriate actions had been taken by staff to try and prevent this patient falling	No recommendations identified	Falls reduction strategies continue in areas.
19.	Serious	6	Patient was found on the floor having had a fall. Patient fractured her hip and other bones in her face as a result of this fall and required surgery to repair the fracture to her hip. Patient was discharged back to rest	<p>Unpreventable fall. Appropriate fall prevention strategies in place.</p> <p>Detection of facial fractures delayed due to patients dementia and</p>	<p>No recommendations identified</p> <p>Delay in availability and acknowledgement of hip x-ray results has been flagged to 'missed-diagnosis' patient safety project manager</p>	Falls reduction strategies continue in areas.

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			home after surgery	symptoms of poor eating resembling behaviour associated with dementia		
20.	Serious	6	Patient got up to pull curtain around bed and fell onto floor. Patient broke hip as a result of the fall and needed surgery to repair the break.	<p>A patient who required supervision with mobility due to poor balance got out of bed without calling for assistance to pull her curtains. This resulted in a fall to the floor and patient suffered a fractured hip.</p> <p>Review process identified improvements with how ward sends fax requests to radiology.</p>	<p>No recommendations identified</p> <p>After hours Radiology fax number to be displayed by fax machines.</p>	Falls reduction strategies continue in areas.
21.	Serious	6	Patient was confused and	A patient	No recommendations identified.	Falls reduction

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			walked on her own with walking frame. Patient had a fall and broke her hip and needed surgery to repair the break.	sustained a fractured hip following a sudden collapse due to being able to mobilise to the bathroom unobserved and unassisted by staff		strategies continue in areas.
22.	Serious	6	Patient had a fall on way to bathroom and fractured a bone in the pelvic area	Patient was being supported in her mobility and she was keen to show she could do it. Patient mobilised without assistance and fell whilst nurse was out of room.	No recommendations identified	Falls reduction strategies continue in areas.
23.	Serious	6	Patient had a fall on way to bathroom and fell. Patient fractured her hip as a result of the fall and needed surgery to repair fractured hip.	Appropriate interventions to reduce harm for high-risk fall patient not implemented.	Use the key learning from this event to reiterate the importance of thorough clinical assessment to identify risks for patient and to have appropriate plan of care in place. Audit programme in place	Completed  Falls reduction strategies continue in areas

**Event Codes:**

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

