

## Waikato DHB Serious and Sentinel Events occurring between July 2003 and June 2004

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
Sentinel	<p><b>Equipment used incorrectly</b> Irrigation fluid was left running during the final stages of eye surgery, instead of being clamped off. Further surgery required and the outcome for sight or improved sight is poor</p>	<ul style="list-style-type: none"> <li>• No written procedure for use of the equipment</li> <li>• The equipment design is not fail safe</li> <li>• Low lighting in the eye theatre due to surgical needs</li> </ul>	<ul style="list-style-type: none"> <li>• Written procedure for using this equipment to be developed to include an alert warning staff that there have been previous operating problems with the design of the equipment</li> <li>• An education programme to be developed to ensure all staff are competent to use all eye theatre equipment</li> <li>• Product supplier to be involved in staff training sessions</li> <li>• A culture of learning to be developed within eye theatre through regular inservice training</li> <li>• Investigate the provision of continuous lighting for the theatre nurse</li> </ul>	<ul style="list-style-type: none"> <li>• Procedure for use of the equipment has been completed</li> <li>• Concerns regarding equipment discussed with supplier</li> <li>• Education programme on eye theatre equipment implemented, involving product suppliers</li> <li>• Regular staff education sessions held in eye theatre</li> <li>• Continuous lighting has been provided for the theatre nurse.</li> </ul>
Sentinel	<p><b>Medication Event – not administered</b> Stock check of the immunisation fridge revealed that approximately 26 inpatient children received their 15 month vaccinations without the Haemophilus influenza type b component of their 15 month immunisation.</p>	<ul style="list-style-type: none"> <li>• Inadequate vaccine labelling and packaging</li> </ul>	<ul style="list-style-type: none"> <li>• Immediate action required to trace children who missed out on Hib immunisation and inform their parents and GPs</li> <li>• Immediate action required to prevent further incidents at Waikato DHB including:               <ul style="list-style-type: none"> <li>○ Sign out book by the fridge in NBU that prompts staff to choose the correct product/s and all batch numbers entered to allow tracking be instituted</li> <li>○ Weekly audit of immunisation fridge is completed by pharmacy</li> <li>○ Coloured chart to highlight the products required for 15 month immunisation is displayed on the immunisation fridge for staff reference</li> <li>○ Letter is sent to all nursing staff outlining correct product for 15 month immunisation including the photos from the packet insert.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• All children affected were located and offered another vaccination</li> <li>• Sign out book in place</li> <li>• Chart displayed on vaccination fridge</li> <li>• All staff signed and returned letter slip</li> <li>• Audit showed that immunisations were being given correctly</li> <li>• Written contact with IMAC, manufacturer, and MedSafe</li> <li>• Staff attended IMAC training</li> <li>• Training package and consent form updated</li> </ul>

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
			<p>A signed return slip attached to each letter to check that all staff have received and read the letter.</p> <ul style="list-style-type: none"> <li>• Immediate action to prevent incidents in New Zealand: <ul style="list-style-type: none"> <li>○ IMAC is contacted and asked to include specific requirements for 15mth immunisation in future training course</li> <li>○ The manufacturer of the vaccination is contacted and informed of the problems and asked to change their packaging</li> <li>○ Medsafe is informed of the incident</li> </ul> </li> <li>• Medium term action to prevent incidents at Waikato DHB: <ul style="list-style-type: none"> <li>○ all immunisers in paediatrics to complete the 2 day IMAC course</li> <li>○ the consent form is reviewed to include prompts for both batch numbers</li> <li>○ Changes are made to the self directed learning package for immunisation to include the specific requirements for 15mth immunisation</li> </ul> </li> </ul>	
<b>Sentinel</b>	<p><b>Management of patient care</b>  Patient recently diagnosed with asthma required readmission to Emergency Department Resuscitation Room on two occasions after admission to ED. Patient transferred to High Dependency Unit and then urgently to Intensive Care Unit. Patient had respiratory arrest and died.</p>	<ul style="list-style-type: none"> <li>• No protocol re use of assisted ventilation on an asthmatic patient in Emergency Department</li> <li>• Protocol requiring registrar communication with consultant not documented or included in registrar orientation</li> </ul>	<ul style="list-style-type: none"> <li>• Protocol to be documented</li> <li>• Protocol specifying registrar communication with consultant to be documented and made known to all current and future registrars within the service</li> <li>• High Dependency Unit Protocol to be reviewed</li> </ul>	<ul style="list-style-type: none"> <li>• Guideline for Management of Acute Adult Asthma has been documented</li> <li>• Protocol: Delegated responsibility of RMO's re when to call the Consultant documented and included in RMO handbook</li> <li>• Procedure: Admission and Patient Management in the High Dependency Unit reviewed</li> </ul>

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
Sentinel	<p><b>Equipment</b> Suction equipment unavailable for patient who had become unresponsive and vomited during attempt to insert nasogastric tube. Patient resuscitation was not successful.</p>	<ul style="list-style-type: none"> <li>• Ward staff had not correctly assembled the wall suction equipment following cleaning</li> <li>• There was no organisational procedure relating to the maintenance of suction equipment at the bedside</li> </ul>	<ul style="list-style-type: none"> <li>• All Health Waikato ward staff to be informed of requirements and responsibilities re maintenance, assembly and use of ward equipment</li> <li>• Procedure for maintenance, assembly and use of suction equipment at the bedside to be documented</li> </ul>	<ul style="list-style-type: none"> <li>• Waikato DHB policy developed which sets the standards for Asset and Equipment Management, including cleaning, reassembling and use of equipment.</li> <li>• A new label developed for use across the DHB which must be attached to equipment that is not available for use / waiting for repair.</li> <li>• Widespread staff education re need to ensure equipment on wards is safe for use.</li> </ul>
Sentinel	<p><b>Unreported Histology Cases</b> Medical staff member who subsequently left the DHB did not report on the histology slides of 31 patients over a period of 10 years. Not aware of any adverse outcomes.</p>	<ul style="list-style-type: none"> <li>• Staff member had been repeatedly asked to read the slides but did not do so.</li> </ul>	<ul style="list-style-type: none"> <li>• Slides that still exist to be read and reported on, clinical case review to be conducted and reports provided to patient and GP</li> <li>• Clinical case review be conducted to identify whether repeat test required. Letter to be sent to patient.</li> </ul>	<ul style="list-style-type: none"> <li>• All cases were reviewed by the relevant Clinical Director.</li> <li>• No adverse outcomes identified</li> </ul>
Serious	<p><b>Medication Event – incorrect dose</b> During an operation to insert a Hickman catheter the patient was inadvertently administered a medication overdose. The patient experienced bleeding from the operation site for 12</p>	<ul style="list-style-type: none"> <li>• Theatre set up procedure not followed</li> <li>• Medications procedure not followed</li> <li>• Not all nursing staff had completed medication procedure training</li> <li>• Staff not aware of the</li> </ul>	<ul style="list-style-type: none"> <li>• To review set up procedure for insertion of Hickman line</li> <li>• To provide staff education re the use of set up procedures for all operations</li> <li>• Circulating nurse ensure that set procedure is used at all times</li> <li>• To provide staff education re medication management</li> </ul>	<ul style="list-style-type: none"> <li>• Set up procedure reviewed</li> <li>• Staff education held for theatre nursing staff on set up procedures and medication management</li> <li>• Staff involved in the incident completed medication procedure training</li> </ul>

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
	hours which required treatment with blood products. The patient also experienced extensive bruising over the chest area.	<p>criteria for the use of this medication</p> <ul style="list-style-type: none"> <li>Lack of clinical guideline stating that a general anaesthetic should be used for Hickman catheter insertion</li> </ul>	<ul style="list-style-type: none"> <li>All staff involved in the incident are to complete medication procedure training</li> <li>To ensure that Hickman lines are inserted under a general anaesthetic unless there are clinical reasons not to do so</li> </ul>	<ul style="list-style-type: none"> <li>Hickman line operations are undertaken using general anaesthetics</li> </ul>
Serious	<p><b>Communication / Discharge</b>  Patient admitted to ward with provisional diagnosis. After diagnostic testing the provisional diagnosis was changed. The new diagnosis was treated appropriately, but due to other conditions, patient was administered medications orally rather than intravenously with a plan to observe over the weekend to assess the effectiveness of this treatment. At patient's request, patient was discharged from hospital over the weekend as medical staff were unaware of the weekend plan to observe the effectiveness of the oral antibiotic treatment. Patient collapsed at home seven days later and was readmitted to Intensive Care Unit. Patient died 3 days later. It is unclear whether the patient's premature discharge</p>	<ul style="list-style-type: none"> <li>Weekend medical staff relied on the hand over notes on the ward notice board and did not consult the patient's clinical record.</li> <li>The hand-over notes were written Friday morning. The weekend plan had developed over that day. Hand over notes were not amended to reflect changes in diagnosis, the results of diagnostic testing or the weekend plan.</li> <li>Treatment by oral antibiotics differed from standard treatment which led the weekend medical staff to assume a different diagnosis.</li> <li>There was no verbal hand over between the week staff and the weekend team.</li> </ul>	<ul style="list-style-type: none"> <li>When treatment differs from the standard practice and/or when the case is complex there will be a verbal handover between senior to senior medical staff and between junior medical staff</li> <li>Weekend hand over notes no longer to be used. The only written material available is to be the patient's individual clinical record</li> <li>Weekend plans are clearly identified within the clinical record through the use of a 'weekend plan' stamp.</li> <li>The process for weekend planning and discharge is included in the ward and RMO orientation.</li> </ul>	<ul style="list-style-type: none"> <li>There is both a verbal and written handover of complex cases</li> <li>Senior and junior medical staff consider all information before a decision to discharge is made</li> <li>Weekend plans are readily identifiable in the patient's clinical record</li> <li>Weekend handover notes are no longer used. Plan is documented in the clinical record.</li> </ul>

<b>Event Severity</b>	<b>Description</b>	<b>Review Findings</b>	<b>Recommendations / Actions</b>	<b>Follow-up</b>
	played a part in her death. Death may have resulted from overdose of benzodiazepines.			
<b>Serious</b>	<b>Patient Fall</b> Patient fell out of hospital bed and sustained a fracture of the upper spine. Patient died 4 days post fall. Pathologist's verbal report stated that death was a result of respiratory failure due to bronchial pneumonia, congestive cardiac failure and injury to lower brain stem due to fall	<ul style="list-style-type: none"> <li>Inadequate assessment and management of falls risk</li> </ul>	<ul style="list-style-type: none"> <li>New Waikato DHB Falls assessment and management plan tool to be completed for all elderly patients admitted to ward</li> <li>The afternoon team leader will complete a ward walk through with night staff after each hand over to ensure all patients are safe e.g. for elderly patients beds are at their lowest level, cot sides are in place</li> <li>The findings and recommendations of this event review are communication to all Clinical Nurse Leaders at the next meeting</li> <li>These findings are communicated to the Falls Project Team with request that assessment form and process be completed as soon as possible</li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB Falls Assessment and Management Protocol implemented</li> <li>Audits of Waikato DHB Falls Assessment and Management Protocol are a component of the Star Wards Project</li> </ul>
<b>Serious</b>	<b>Communication</b> After transfer from another DHB patient experienced a solid swelling after a biopsy. Five days later the patient died unexpectedly. Patient had an extremely rare condition – less than 20 cases reported world wide.	<ul style="list-style-type: none"> <li>No protocol in place to specify requirement for consultant to consultant referral in certain circumstances</li> <li>No protocol specifying Waikato Hospital's requirements for Registrars to call consultants after hours</li> <li>Inadequate medical staffing / skill level on duty at night</li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB Admission, Discharge and Transfer Policy to be documented, and specify requirements for transfer documentation and communication</li> <li>Health Waikato to finalise and approve protocol specifying Delegated Responsibilities of RMOs. This must include requirement to inform consultant of patient arrest and death.</li> <li>Clinical Unit Leader to review the following: <ul style="list-style-type: none"> <li>Level of medical support rostered on night duty</li> <li>Supervision provided to Registrars on short term contract</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB Admission, Discharge and Transfer Policy developed and distributed</li> <li>Protocol developed and distributed re Delegated Responsibilities of RMO's When to Call the Consultant</li> <li>Clinical Unit Leader reviewed medical staffing arrangements</li> </ul>
<b>Serious</b>	<b>Infection Risk</b>	<ul style="list-style-type: none"> <li>Procedure room and scope</li> </ul>	<ul style="list-style-type: none"> <li>Update and review the procedure for cleaning prior</li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB Procedure</li> </ul>

<b>Event Severity</b>	<b>Description</b>	<b>Review Findings</b>	<b>Recommendations / Actions</b>	<b>Follow-up</b>
	Same endoscope used on two consecutive patients without the required cleaning and sterilisation occurring between uses. No transmission of infectious disease occurred as a result of this incident.	<ul style="list-style-type: none"> <li>were not cleaned as per usual procedure</li> <li>Scope was not readily identifiable as being clean, and ready for use</li> </ul>	<ul style="list-style-type: none"> <li>to scope procedures</li> <li>Provide education to staff re procedure and the necessity for all staff to be responsible for handling tasks or handing responsibility over to another staff member</li> <li>Identify a reliable method to enable the doctor and nurses to readily identify that the equipment is ready for use.</li> <li>Develop documented procedure for approval of go-ahead of endoscope procedure</li> <li>Attendant responsibilities in moving patients into Endoscopy Suite to be documented clearly and provided to attendants</li> <li>Ensure new staff are trained in regard to all service specific procedures within 1 month of starting work in the unit.</li> </ul>	<ul style="list-style-type: none"> <li>developed and distributed re Decontamination and Disinfection of Heat-labile Endoscopes</li> <li>Single person now responsible for cleaning scopes and handing them over to the user.</li> <li>Endoscopy procedures do not start until nurse is in the room.</li> <li>Attendant with clearly defined responsibilities now designated for Endoscopy patients.</li> <li>All staff receive orientation which is signed off by the Endoscopy Coordinator.</li> </ul>
<b>Serious</b>	<b>Retained Swab</b> Patient admitted to rural Hospital and had bowel surgery. A swab was found protruding from surgical site by the General Practitioner 20 days after surgery.	<ul style="list-style-type: none"> <li>Full review of this event was not able to identify causes</li> </ul>	<ul style="list-style-type: none"> <li>Procedure for swab counts to be consistent across the organisation. This procedure must: <ul style="list-style-type: none"> <li>address the risks of staff changes during the surgical operation</li> <li>indicate the method for counting swabs i.e. each nurse count individually, or together out loud</li> <li>be available in Service Specific folders</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB Policy developed re Surgical Count for Swabs, Sharps and Instruments. This addresses all learnings arising from this event.</li> </ul>
<b>Serious</b>	<b>Retained Swab</b> Retention of large gauze pack in wound following surgery. Wound was reopened and pack removed. Patient recovered and was discharged.	<ul style="list-style-type: none"> <li>Theatre procedure for swab count was not complied with</li> <li>Communication Failure</li> </ul>	<ul style="list-style-type: none"> <li>All Waikato Hospital Theatre staff to be made aware of need to comply with Theatre Swab Count Procedure</li> <li>Theatre Swab Count Procedure to be revised to ensure clarity of responsibility for communicating incorrect swab count</li> </ul>	<ul style="list-style-type: none"> <li>Staff communication re need to comply with procedure</li> <li>Swab Count procedure revised</li> </ul>
<b>Serious</b>	<b>Patient inadequately prepared for theatre</b>	<ul style="list-style-type: none"> <li>Inadequate documentation in</li> </ul>	<ul style="list-style-type: none"> <li>All nursing staff to receive education about the</li> </ul>	<ul style="list-style-type: none"> <li>Waikato DHB pre-operative</li> </ul>

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
	<p>Patient taken to theatre and given general anaesthetic in preparation for surgical procedure, before it was discovered that the patient had not been adequately (clinically) prepared for the surgery. Patient was required to return for surgery at a later date.</p>	<p>the patient's clinical record</p> <ul style="list-style-type: none"> <li>• Inadequate compliance with checking procedure prior to carrying out the procedure.</li> <li>• Non-compliance with patient's Care Plan</li> </ul>	<p>importance of comprehensive documentation and the need to document when protocols not complied with.</p> <ul style="list-style-type: none"> <li>• Regular audits of nursing documentation to occur in each ward.</li> <li>• Pre-operative procedure for ward nurses to be revised</li> <li>• Pre-operative preparation procedure for Theatre nurses to be developed</li> <li>• Pre-operative checklist (undertaken prior to anaesthetic being administered) to be revised for all Health Waikato hospitals to prompt staff to check that operative procedure-specific actions have occurred</li> <li>• All nursing staff in theatre to receive education in regard to this procedure and be informed of their responsibilities for checking</li> </ul>	<p>checklist has been revised</p> <ul style="list-style-type: none"> <li>• Nursing documentation audits have occurred</li> </ul>
<b>Serious</b>	<p><b>Patient Fall</b> Patient was mobilising with the assistance of 2 staff. Leg crumpled underneath patient, and patient sustained a fractured femur.</p>		<ul style="list-style-type: none"> <li>• Nil identified</li> </ul>	
<b>Serious</b>	<p><b>Misdiagnosis</b> Patient was admitted to Emergency Department following a sports accident. X-rays were ordered, but the upper spine fracture was not identified and patient was discharged as per the existing Spinal Trauma Patient Protocol. Correct diagnosis was subsequently made and</p>	<ul style="list-style-type: none"> <li>• Reason for misdiagnosis unable to be identified</li> <li>• Staff absence in Radiology resulted in a backlog of reporting waiting for reports to be dictated</li> </ul>	<ul style="list-style-type: none"> <li>• To be discussed with medical staff member who missed the diagnosis</li> <li>• Learning to be shared at Radiology meeting</li> <li>• Explore possibility of getting ED doctors to use a sticker on the x-ray film to state their interim diagnosis. This would then alert Radiology if a misdiagnosis has occurred.</li> </ul>	<ul style="list-style-type: none"> <li>• All actions completed</li> </ul>

<b>Event Severity</b>	<b>Description</b>	<b>Review Findings</b>	<b>Recommendations / Actions</b>	<b>Follow-up</b>
	appropriately treated.			