

Waikato DHB Serious and Sentinel Events occurring between 1st July 2004 and 30th June 2005

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
Sentinel	<p>Infection Death of baby from infection in New Born Intensive Care Unit (NICU) from Enterobacter Sakasakii identified from milk powder.</p>	<ul style="list-style-type: none"> • Reviewed by Infection Control Team. • The mode of infection transmission remains unidentified. • No breaches in policy or procedures re use of formula food were evident. • A good standard of hand hygiene was observed in staff and visitors to NICU. 	<ul style="list-style-type: none"> • Formula manufacturers to be notified. • New Zealand Food Safety Authority to be notified. 	<ul style="list-style-type: none"> • Formula manufacturers were notified and investigations undertaken at both plants. • The New Zealand Food Safety Authority did not deem it necessary to recall any product. • WDHB continues to use “ready-to-feed” formula and sterile containers for all neonates and infants. • During the event staff education was provided on infection control measures to prevent possible modes of transmission from all avenues.
Sentinel	<p>Patient Monitoring Patient admitted with myocardial infarction to rural hospital. Patient attached to cardiac monitor as per unit protocol. Patient found unresponsive on floor by nurse on night duty. Resuscitation unsuccessful.</p>	<ul style="list-style-type: none"> • Inadequate Cardiac Monitoring Protocol in place. • Failure of cardiac monitor to alarm • No documentation or cardiac monitoring records in patient’s clinical record. • Lack of documented purpose and operational management procedures within High Dependency Unit Room, including specification of the conditions under which the 	<ul style="list-style-type: none"> • Develop and approve a cardiac monitoring protocol for rural hospital which meets best practice and is aligned with the cardiac monitoring protocol at Waikato Hospital. • Obtain supplier company check of cardiac monitor which failed to alarm. • Document procedure for setting cardiac monitor alarm. • Ensure all staff familiar with alarm settings and functions. • Staff to be reminded of the need to document events as per Clinical Records Policy requirements and the requirements of the new Cardiac Monitoring Protocol when it is developed. • HDU Room purpose and operational management 	<ul style="list-style-type: none"> • Supplier company checked the cardiac monitor that failed to alarm and found it was not faulty. • Protocol developed re when to call the consultant.

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		<p>medical staff member should be called to review the patient.</p>	<p>procedures to be documented. This documentation to include the role of Senior Medical Staff, and the conditions under which nursing staff shall access medical staff to assess patients.</p>	
Sentinel	<p>Misdiagnosis Patient referred to Emergency Department by General Practitioner. Patient discharged from Emergency Department by House Surgeon (following telephone call with Registrar authorising to do so) with incorrect diagnosis. Patient died at home within 48 hours.</p>	<ul style="list-style-type: none"> • Misdiagnosis of patient condition • Registrar did not assess the patient in person • Waikato DHB Guidelines: Diagnosis and Management of Pulmonary Embolism not followed 	<ul style="list-style-type: none"> • Responsibilities of medical staff related to discharge to be clearly defined • Review the way in which House Surgeons work • All clinical guidelines to be on one electronic site 	<ul style="list-style-type: none"> • All medical staff informed that House Surgeons are not authorised to discharge patients from ED • Guideline available on Clinical Guideline intranet site
Sentinel	<p>Medicine Event – Wrong site Patient’s eye drops re-charted for administration to incorrect eye. Prescribing error identified six days later. Long term harm not known.</p>	<ul style="list-style-type: none"> • Medical staff used a short period in the morning to complete multiple tasks in a hurry in order to get to clinic on time 	<ul style="list-style-type: none"> • To review early morning work processes in ward and identify improvements to ensure doctors have correct information on patients • To review the relevant Waikato DHB Treatment Form and ensure that the eye to be treated is documented on each page • To ensure every patient in ward has a documented care plan in place and that the care plan includes clear identification and documentation of eye to be treated 	<ul style="list-style-type: none"> • Early morning work processes reviewed • Waikato DHB antibiotic Treatment Form revised • Audit process in place re care plan completion • Nursing admission / assessment / care planning documentation reviewed
Sentinel	<p>Generator Failure The Main Electricity Feed to the Waikato Hospital site was damaged by a Hamilton City Council contractor, resulting in the failure of electrical supply. Two of</p>	<p>Generator failure due to:</p> <ul style="list-style-type: none"> • Generator 1 suffered from water in the fuel supply • Generator 2 suffered a faulty voltage control system that prevented it from successful 	<ul style="list-style-type: none"> • To document and implement a plan for testing generators on full load • To document and implement plan for installation of Uninterrupted Power Supply • To ensure lifts between critical areas are on priority power supply in an emergency • To modify the template for Waikato DHB 	<ul style="list-style-type: none"> • Testing of generators on full load completed for Waiora and Kempthorne Buildings • Critical lifts are on emergency power • Template for emergency plans was revised to include

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	<p>the generators for the site subsequently failed and the Waiora Waikato Building switchgear also failed. There was also a related failure in the water pumping system. The campus was without Mains power for approximately one hour and then on limited Mains supply for two days over the weekend.</p>	<p>Operation</p> <ul style="list-style-type: none"> Generator 3 was then presented with an excessive load causing it to trip. 	<p>Emergency Incident Response plans to include this information</p> <ul style="list-style-type: none"> To ensure information on the location of UPS and EPS and the requirements of equipment to have different power supplies is provided to new and existing staff. To amend the Waikato DHB Civil Defence / Emergency Management Policy to require departmental emergency plans to include aspects relating to equipment dependent on electricity. 	<p>emergency power supply information</p> <ul style="list-style-type: none"> Emergency management Month in March 07 focused on the updating of departmental emergency plans. March 08 Emergency Management Month planned to also focus on departmental emergency plan updating.
Sentinel	<p>Misdiagnosis Patient presented to rural hospital Emergency Department on two consecutive days complaining of chest pain. Known to be asthmatic. Diagnosed with 'flu' and discharged the first time. Diagnosed with respiratory infection and discharged the second time. Patient died two days later.</p>	<ul style="list-style-type: none"> No documented protocol re when to call medical staff to review a patient. Inadequate follow-up observations and length of time monitored. Staff did not follow Waikato DHB Asthma Guidelines for second presentation within 48 hours. Inadequate documentation of education given to patient and discharge planning. No discharge summary written for patient. 	<ul style="list-style-type: none"> Documented protocol on when to notify medical staff to be developed Ensure all staff aware of Asthma Guidelines and monitor use of these Discharge documentation to include patient education and discharge plan New triage form to be completed for each new presentation to ED <ul style="list-style-type: none"> Implement guideline for post-treatment observations Conduct audit of all patients seen after hours to identify whether they have been appropriately referred and reviewed by medical staff. 	<ul style="list-style-type: none"> Protocol on when to call the medical staff to see a patient has been developed. Monitoring of use of Asthma Guidelines has occurred. All staff have been advised of discharge information requirements New triage form is now completed for each new presentation to ED , with the exception of presentations for dressing changes Guideline for post-treatment observations has been developed. Audit has been completed of all patients seen after hours, and an action plan developed.
Serious	<p>Medication Event - extravasation Chemotherapy administered</p>	<ul style="list-style-type: none"> Acceptance of line placement was an error of clinical judgement 	<ul style="list-style-type: none"> Develop Protocol re preferred placement of a long line for chemotherapy Clinical team to formalise a process for 	<ul style="list-style-type: none"> Protocol developed re Placement of Hickman Lines and Portacath Insertions

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	via Hickman line inserted in the wrong position resulting in extravasation (leakage of blood and fluid into surrounding tissue)	<ul style="list-style-type: none"> Clinical team should have questioned the line placement for administration of chemotherapy 	<p>independent sighting of post procedure x-ray to ensure correct placement prior to the administration of chemotherapy</p> <ul style="list-style-type: none"> Unit nursing and medical staff to receive regular education/reminders about the importance of comprehensive documentation Review of educational information provided to staff to ensure troubleshooting Central Venous Lines process is clear Promote 'Delegated responsibilities of RMO's: when to call the consultant' document. Waikato DHB extravasation flowchart to be revised Cytotoxic Drug Protocols to be in controlled document format 	<ul style="list-style-type: none"> Staff education provided on clinical records documentation Education information on Troubleshooting Central Venous Process reviewed Protocol: Delegated responsibilities of RMO's When to Call the Consultant in orientation programme Waikato DHB extravasation flowchart revised Cytotoxic Drug Protocols in controlled document format
Serious	Equipment related Patient had perforated colon following colonoscopy procedure. Patient died 10 days later from infection and cardiac complications.	<ul style="list-style-type: none"> Coroner's review and Health and Disability Commissioner's investigation resulted in no recommendations or breach findings. Waikato DHB review resulted in some recommendations: Diathermy machine settings were incorrectly calibrated by manufacturer. No documented process in place to ensure staff are appropriately trained before they are authorised to use equipment. No diathermy procedure 	<ul style="list-style-type: none"> Memo to be sent to Service Managers to remind them that the Biomedical Service must test calibration of all new clinical equipment to ensure it is fit for purpose. To ensure all staff have appropriate training with new equipment prior to use and that this is documented. <ul style="list-style-type: none"> To conduct an audit of staff equipment training records. To ensure Diathermy procedure is developed for use DHB wide 	<ul style="list-style-type: none"> Memo sent to managers. New Asset and Equipment Policy includes requirements for staff training. Audit of staff training records completed. Diathermy Procedure has been developed for use DHB wide.
Serious	Medicine Event – wrong dose	<ul style="list-style-type: none"> Hickman Line Insertion Set-Up not updated to reflect IV 	<ul style="list-style-type: none"> Hickman Line Insertion set-up documentation to be updated. 	<ul style="list-style-type: none"> Set Up documentation for Hickman Lines documented

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	Patient administered overdose of medication following Hickman Catheter insertion in theatre.	<p>Manual Procedure or new Theatre Protocol for Hickman Lines.</p> <ul style="list-style-type: none"> Name of medication was not clearly stated in the set-up procedure Lack of a medication checking procedure in Theatres. The review noted that a theatre nurse notified the medical staff member verbally that the dose may be incorrect, and that this was not acted upon. 	<ul style="list-style-type: none"> The name of the medication, and the dosage, to be clearly stated in all medication protocols in use anywhere in Waikato DHB When Medicines Management Policy is next reviewed, consideration must be given to implementing a mechanism whereby staff aware that an error will occur can stop proceedings prior to the error occurring. Develop documentation on role of theatre co-ordinator and role of theatre staff in providing /seeking assistance All theatre staff to be required to ask theatre co-ordinator if they are unfamiliar with any aspect of theatre 	<ul style="list-style-type: none"> Relevant medication protocols appropriately revised Medicines Management Policy has been revised to include requirement for staff to notify a team member if they become aware that a medication error is about to occur. Role of theatre co-ordinator documented Staff education on requirement of staff to communicate with coordinator completed
Serious	<p>Medicine Event – wrong route Medication administered incorrectly through epidural line</p>	<ul style="list-style-type: none"> Reviewed by service 	<ul style="list-style-type: none"> To review use of epidural lines across the organisation To reviewed preceptor role in the service 	<ul style="list-style-type: none"> Changed to yellow epidural lines across the organisation Reviewed preceptor role in the service
Serious	<p>Near Miss Blood Transfusion Incorrect labelling of blood sample. Urgent cross match specimen collected from patient A was labelled with patient B details. Discrepancy in patient blood type identified by Blood Bank staff preventing administration of incorrect blood type.</p>	<ul style="list-style-type: none"> Non-compliance with Waikato DHB 2003 Procedure: Collection of Blood & Blood Products from the Blood Bank 	<ul style="list-style-type: none"> To provide in-service education for staff, including how to label the specimens in line with the procedure and the need to correctly identify the patient. To ensure communication between staff in emergency situations is specific, directed and acknowledged by developing and implementing a communication template to ensure key areas of potential confusion are clarified when communication occurs. 	<ul style="list-style-type: none"> In-service education provided to staff Colour coded cards for communication with Blood Bank implemented.

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Serious	<p>Medication Event – incorrect dose Newborn baby administered overdose of medication. Potential for hearing loss. Hearing check completed at 36 weeks-corrected aged indicated no harm at that stage.</p>	<ul style="list-style-type: none"> Loss of staff concentration due to distraction arising from workload pressure 	<ul style="list-style-type: none"> Increase staff awareness of the importance of vigilance when administering medications. Development and display of poster which gives staff permission to take their time to get drug doses correct, to expect to be uninterrupted when administering medications, and to start again if interrupted To provide education to staff re need to be aware of specific drugs used in area that are prescribed and administered in minute doses. To review the medication protocol and add 2 extra steps to the process of drawing up the drug To ensure the unit IV certification process focuses specifically on such drugs, using this event as an example 	<ul style="list-style-type: none"> Need for staff vigilance communicated in communication book and in education sessions Medication safety poster developed and made available throughout Waikato DHB Education and orientation information updated on specific drugs requiring increased awareness Medication protocol revised Unit education uses this event as an example.
Serious	<p>Medication Event – wrong route Patient administered medication through central line instead of orally. Patient at risk of infection and embolism from this event.</p>	<ul style="list-style-type: none"> Loss of concentration due to distraction arising from workload pressure 	<ul style="list-style-type: none"> Increase staff awareness of the importance of vigilance when administering medications. Development and display of poster which gives staff permission to take their time to get drug doses correct Peripheral IV Cannula Procedure to be revised to require use of an appropriate container to transport medicines to bedside/patient To ensure Medicines Management Policy review includes information that syringes must be labelled at time of preparation, and one at a time (i.e. it is not acceptable to draw up 2 or more syringe medications and THEN label them.) If there is a time delay between drawing up the syringe and labelling it, the syringe and medication must be discarded. 	<ul style="list-style-type: none"> Need for staff vigilance communicated in communication book and in education sessions Medication safety poster developed and made available throughout Waikato DHB Peripheral IV Cannula Procedure updated Information included in Waikato DHB Medicines Management Policy
Serious	<p>Patient Fall Patient watch attendant</p>	<ul style="list-style-type: none"> No documented protocol or guideline for management of 	<ul style="list-style-type: none"> To develop guideline for managing head injury patients which includes need for skull helmet 	<ul style="list-style-type: none"> Review of watch attendant resource completed

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	removed during night shift whilst patient asleep. Nurse was phoning for watch attendant to be reinstated at 0600 hrs when patient fell out of bed by climbing over the bed rails. Patient sustained indentation to left frontal lobe and lump to left forehead.	head injury patients	<ul style="list-style-type: none"> To undertake review of watch attendant resource Memorandum to be distributed to advise of need to comply with the Watching of Patients at Risk of Being Harmed or Harming Others Policy 	<ul style="list-style-type: none"> Memorandum distributed to raise awareness of Watching of Patients at Risk of Being Harmed or Harming Others Policy
Serious	Blood Transfusion One unit of incorrect blood transfused and almost completed to patient undergoing urgent procedure in theatre. Patient's blood results showed evidence of transfusion reaction.	<ul style="list-style-type: none"> Non compliance with the Waikato DHB Medicines Management Policy and the Waikato DHB procedure Administration of Blood or Blood Products 	<ul style="list-style-type: none"> To ensure all anaesthetic department staff understand Waikato DHB's blood administration requirements. To remind all theatre staff to dispose of or re-file patient labels promptly into the patient's clinical record To document and distribute a procedure to ensure cardiac patient ID labels are easily accessed by staff in theatre To document the theatre procedure re how staff manage in emergency situations the patient identity requirements for the blood gas analyser 	<ul style="list-style-type: none"> All actions completed.
Serious	Patient Fall Patient found on floor beside bed. Fractured hip and sustained skin tear to left elbow.	<ul style="list-style-type: none"> Nil Root Cause identified 	<ul style="list-style-type: none"> To maintain staff knowledge of Falls assessment, prevention and management via continuing education. To carry out an audit to assess how often non-compliance occurs, establish possible reason(s) for non compliance and identify possible solution(s) 	<ul style="list-style-type: none"> Waikato DHB Falls Protocol and Risk Assessment Tool developed and implemented Wards audit compliance with this.
Serious	Medication Event – Administration For a period of 2 hrs and 15 minutes a patient was administered the same	<ul style="list-style-type: none"> Non compliance with the Waikato DHB Medicines Management Policy – due to attentional slip Non compliance with IV 	<ul style="list-style-type: none"> To revisit unit practice of how IV drugs are prepared and checked to ensure compliance with the Waikato DHB Medicines Management Policy To review unit Infusion Management Information ensuring above changes are incorporated 	<ul style="list-style-type: none"> All of the recommended actions have been completed

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	<p>medication via two syringe pumps instead of one medication in one and another medication in the other. No known long term adverse outcomes.</p>	<p>Additive Administration Policy</p> <ul style="list-style-type: none"> • Infusion prepared by another staff member not involved directly with the care of the patient 	<ul style="list-style-type: none"> • To audit compliance with requirements and send copy of audit results to Quality and Risk Service • To establish and document a standard handover process that covers e.g. background, treatment plan, medications, including visually checking medication syringes and infusions against treatment charts • To review and update all treatment sheets currently in use and ensure compliance with Waikato DHB Medicines Management Policy • To remind staff at staff/unit meetings to ensure changes to treatment sheets are documented correctly • To review label usage to ensure syringes are labelled correctly and placed to allow easy checking/viewing by staff • To advise patient / family of this medication error • To remind all unit medical and nursing staff of the requirement to notify patient, and where appropriate family, of any adverse events affecting their care. 	
Serious	<p>Medication Event – Administration For a period of 1 hour and 45 minutes a patient was administered the same medication via two syringe pumps instead of one medication in one and another medication in the other (different medications from the above event).</p>	<ul style="list-style-type: none"> • Non compliance with the Waikato DHB Medicines Management Policy – due to attentional slip of action 	<ul style="list-style-type: none"> • As for above event. 	<ul style="list-style-type: none"> • Recommended actions completed
Serious	<p>Medication Event – prescribing and</p>	<ul style="list-style-type: none"> • Prescribing error due to use of trailing zero i.e. should 	<ul style="list-style-type: none"> • To include the WDHB Requirements for all prescriptions - in particular avoiding use of a 	<ul style="list-style-type: none"> • Clinical Prescribing Education Handout provided to medical

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	<p>administration Baby received overdose (10x) of medication.</p>	<p>have been 90mg but 900 mg was administered when decimal point not clear.</p> <ul style="list-style-type: none"> Nursing staff administered a drug they were not familiar with. Non-compliance with the WDH B Medicines Management Policy which clearly states that trailing zeros must not be used in prescriptions 	<p>trailing zero - in the medical staff orientation to Child Health Service</p> <ul style="list-style-type: none"> To ensure all paediatric and neonatal prescriptions include the dose/kg on the prescription charts To ensure Clinical Prescribing Education Handout being developed by pharmacy is included in orientation and available to medical staff To include in the Pharmacy Bulletin Interact (newsletter) the need to prescribe clearly when a decimal point is required in the dosage To promote expectation that nursing staff will check all drugs they are not familiar with prior to administration To promote questioning of unfamiliar drug doses especially IV drugs ‘if in doubt, check it out’ To ensure staff use information sources available to assist them when using unfamiliar drugs e.g. senior staff, handbooks 	<p>staff</p> <ul style="list-style-type: none"> Pharmacy Bulletin included information on the need to prescribe clearly when a decimal point is required in the dosage Nursing staff advised to check all drugs they are not familiar with prior to administration and to question unfamiliar drugs Staff in ward provided with Medication Handbook
<p>Serious</p>	<p>Patient Fall Patient admitted with history of recurrent falls. Patient fell on tenth day in hospital whilst going to bathroom. Sustained a fractured hip.</p>	<ul style="list-style-type: none"> Nil Root Cause identified 	<ul style="list-style-type: none"> To undertake Review of Watch Resource To request replacement of flooring with non slip flooring To explore option of the provision of non-slip socks to patients identified at risk of falls To progress with provision of hand rails along the corridors To complete the Falls Project-including protocol and associated documentation To implement protocol and falls documentation in all areas 	<ul style="list-style-type: none"> Watch Resource review completed Non-slip flooring and handrails requested Waikato DHB Falls Assessment and Management Protocol developed and implemented
<p>Serious</p>	<p>Patient Fall Patient fell twice overnight. Sustained a fractured hip from second fall. Patient died twenty six days post surgery.</p>	<ul style="list-style-type: none"> Inadequate nursing assessment and care planning on admission. 	<ul style="list-style-type: none"> To undertake service audit of nursing assessment and care planning process currently in place To develop a standardised nursing assessment framework across the Waikato DHB hospitals. To remind all staff of need to comply with the Restraint Use Policy including monitoring form. 	<ul style="list-style-type: none"> Care Planning Project established to develop standardised nursing assessment and care planning documentation which meets the required standard.

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			<ul style="list-style-type: none"> • To remind all staff of need to comply with Waikato DHB Watching of Patients at Risk of Harm to Themselves or Others Policy 2004 • To complete the Falls Project, including protocol and associated documentation • To implement protocol and falls documentation in all areas 	<ul style="list-style-type: none"> • Use of Restraint Self Directed Learning Package included in ward orientation programme • Staff reminded to comply with Waikato DHB Watching of Patients at Risk of Harm to Themselves or Others Policy • Falls Project completed. Waikato DHB Falls Assessment and Management Policy developed and implemented
Serious	Medication Event – administration Patient received 60% of dose of chemotherapy drug. Long term effect of reduced dose is not known.	<ul style="list-style-type: none"> • Medication was dispensed from protocol that was not the new protocol initiated for this patient. • Prescribing and administration staff identified incorrect type of fluid that medication was delivered in but not incorrect amount of fluid. 	<ul style="list-style-type: none"> • To ensure patients have chemotherapy dispensed off Waikato DHB approved Oncology protocols only • Staff to be educated in relation to prescription practice • Oncology prescription charts to be reviewed • Oncology and Haematology medical staff to be informed of prescription chart requirements • Medical and nursing staff to be aware of and comply with requirements of Clinical Record Policy • Regular audits of randomly selected records to occur 	<ul style="list-style-type: none"> • Prescription charts for Oncology reviewed • Focus Board for staff in ward on requirements of Clinical Record Policy
Serious	Patient care management Baby aspirated milk as a result of a tube feed being administered by a third year student nurse. Baby’s heart rate dropped requiring staff to perform resuscitation. Baby was transferred to level 3 Nursery for	<ul style="list-style-type: none"> • Nursing Standard & Procedure, Enteral Feeding: Level 111, Level 11 & Level 1, Newborn Intensive Care Unit Waikato Hospital 2004 does not identify competency or supervision requirements. • Student nurse was not 	<ul style="list-style-type: none"> • To review student nurse allocation numbers for unit to ensure appropriate RN supervision is provided. • To review current rostering pattern to ensure requirements for Nursing Scopes of Practice are complied with. • To request Nursing Council review of conditions on Scope of Practice to allow direction from Registered Nurse. 	<ul style="list-style-type: none"> • Documented standard for number of students in unit • Roster changes made • Letter sent to Nursing Council re Scope of Practice • Nursing Standard & Procedure Enteral Feeding updated • Staff education audit on checking tube positions prior

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	Continuous Positive Airway Pressure and antibiotics commenced to cover risk of baby developing aspiration pneumonia.	adequately supervised for procedure she was undertaking and her Scope of Practice was not complied with	<ul style="list-style-type: none"> To review current procedure ensuring competency and supervision requirements are included. This needs to clearly identify requirement for direct supervision of students undertaking this procedure. Procedure to be authorised as per WDHB Management of Policy, Procedures, Protocols and Guidelines Policy 2003. <ul style="list-style-type: none"> To ensure all staff and students aware of checking tube position prior to feed. 	to feed
Serious	Retained Swab A small swab was retained in the patient's abdomen, and a laparoscopy procedure was performed to remove the swab.	<ul style="list-style-type: none"> Scrub nurse was performing surgical assistant role in addition to her scrub nurse role without availability of another assistant Surgeon started without appropriate assistance in place 	<ul style="list-style-type: none"> To ask Head of Surgery to advise all surgeons (via memo) of need to ensure assistance is available in theatre and not to start without an assistant To develop theatre assistant role description To review rostering and avoid rostering conflicts To review nursing staff rotation to ensure staff have appropriate information and knowledge to work within theatre areas To educate theatre nursing staff re accessing assistance 	<ul style="list-style-type: none"> Memorandum sent advising of need to ensure assistance is available in theatre and not to start without an assistant Process documented to ensure nurses in theatres remain competent for tasks required
Serious	Hospital administration Patient on waiting list for Radiation Oncology. Department was informed that the patient was deceased, so removed patient from the waiting list. Patient rang to ask why she had not been seen.	<ul style="list-style-type: none"> Reviewed by service 	<ul style="list-style-type: none"> Procedure to be documented and education provided to clerical staff regarding removing deceased patients from the waiting list. 	<ul style="list-style-type: none"> Service specific procedure documented: Deceased Patients Removal from Oncology Waiting List. This specifies the standards and processes for removing patients from the Oncology Waiting List.
Serious	Patient Fall Blind patient in continuing care hospital fell attempting to locate walking frame. Swelling to upper left arm			<ul style="list-style-type: none"> Primary nurse assigned to each patient Sensor mats purchased to detect when patients are attempting to get out of bed.

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	<p>noted. At 0100 hrs patient was taken to the toilet where she fell again and fractured left humerus. Patient died 8 days post fall. Cause of death – sepsis, multi-system failure, stroke.</p>			<ul style="list-style-type: none"> • Waikato DHB Falls Assessment and Management Protocol implemented with appropriate monitoring and compliance
Serious	<p>Patient Fall Patient slipped while stepping off the weighing scale by the bedside in continuing care hospital. Seen by the doctor on the day and again two days later. On both occasions no clinical fracture was diagnosed. Patient discharged home and five days later bilateral fractured wrists diagnosed on x-ray in Emergency Department.</p>			<ul style="list-style-type: none"> • Sit-on scales repaired, maintained and modified. • Staff have been made aware it is not safe to wheel patients around on scales.
Serious	<p>Retained surgical item On post mortem a plastic retractor used in an elective surgical procedure was found in the patient. This did not contribute to the patient's death.</p>	<ul style="list-style-type: none"> • Plastic retractor is not part of the surgical count 	<ul style="list-style-type: none"> • To review current Waikato DHB surgical count procedure in line with best international practice • To ensure staff in all Waikato DHB theatres have been educated in regard to the revised procedure 	<ul style="list-style-type: none"> • WDHB Policy Count for Swabs/Sharps and Instruments revised in July 2007 in line with best practice to include accounting for all swabs, sharps and instruments (or parts thereof) at the completion of the procedure.
Serious	<p>Mental Health Event Patient sustained fractured arm during calming and restraint procedure</p>	<p>Reviewed by service</p>	<ul style="list-style-type: none"> • To ask the Calming & Restraint instructors at Health Waikato to examine carefully the process and practice of Calming & Restraint particularly in regard to those clients who may have a pre-existing weakness or disability which may render them more vulnerable 	<ul style="list-style-type: none"> • Action completed. Learning incorporated into Calming and Restraint training.

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			during a restraint procedure.	