

Waikato DHB Serious and Sentinel Events occurring between July 2006 and June 2007

Abbreviations: ED = Emergency Department

Event Severity	Description	Review Findings	Recommendations / Actions	Follow-up
Sentinel	Communication Women's Health Outpatient Clinic Services ceased being provided at Thames Hospital in November 2006. No communication provided to local GPs or patients re same.	<ul style="list-style-type: none"> There was unclear responsibility for informing Thames patients. There was no agreed plan to manage the return of the service at Thames. 	<ul style="list-style-type: none"> Clarify responsibilities for service provision. Review the clinical record of every patient not seen at Thames Women's Health Outpatient Clinic and provide the services required. 	<ul style="list-style-type: none"> Responsibilities have been clarified. Completed. All Thames Women's Health Outpatients have been reviewed and services provided as needed.
Sentinel	Wrong side surgery Right side surgery consented for whereas Left side surgery required. Surgical site opened on wrong side. Before conducting any corrective surgery staff realised error and immediately closed wrong surgical site. Patient's next of kin informed. Consent received to continue with surgery on correct side. Adverse outcome for patient related to unnecessary skin and tissue opening. No permanent harm.	<ul style="list-style-type: none"> There was no DHB protocol which specifies the DHB's standards and responsibilities for ensuring correct-side surgery Ward preparation for surgery checklist did not specify side of surgery 	<ul style="list-style-type: none"> To develop DHB-wide correct side treatment protocol To develop protocols re preparation for surgery To implement verbal check between all theatre staff immediately prior to surgery re checking site and side 	<ul style="list-style-type: none"> Draft protocol developed. Ward pre-operation checklist updated and includes identification of side of surgery Time out process used in theatre to ensure verbal check between theatre staff re correct side for surgery
Sentinel	Perinatal Death Breech birth delivered in Waikato Hospital by independent midwives.	<ul style="list-style-type: none"> Medical assistance not requested soon enough by independent midwives. Birthing room used 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Major upgrade of Delivery Suite in progress. Advocate response to service following meeting with

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	Baby born alive but died soon after.	unsuitable for breech birth. <ul style="list-style-type: none"> • Patient expressed clearly her wishes that the medical team were not to be involved with her care • Team had advised baby to be born by Caesarean Section but this was not supported or accepted by patient. 		patient was positive.
Sentinel	Mental Health Inpatient Alleged Sexual Assault Patient alleged he was raped in his room. Medical examination found no obvious signs of assault.	<ul style="list-style-type: none"> • Police investigation undertaken 	<ul style="list-style-type: none"> • No recommendations received. 	
Sentinel	Procedure carried out on wrong patient Two patients with same first names and surnames presented at outpatient department. One patient underwent diagnostic procedure for which the other patient was booked. No patient harm apart from undergoing the procedure.	<ul style="list-style-type: none"> • The event occurred in an additional clinic session. There had been no risk assessment re conducting additional clinics to identify work process issues which might increase risk. • Use of the same coloured patient detail forms for more than one clinic of the same type created potential for selection of the wrong patient from the wrong clinic. • Standards for the procedure did not specify patient identification requirements. • Patient who mistakenly underwent procedure would 	<ul style="list-style-type: none"> • Develop and implement Patient Identification Policy • Service reviews use of coloured patient detail slips to ensure each clinic type has different colours 	<ul style="list-style-type: none"> • Policy developed and due to be completed by 1 March 2008 • All services have been requested by the General Manager Health Services to undertake and complete a risk assessment when providing additional clinics; or where there are significant changes to current clinic processes.

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		<p>have required same procedure in the future.</p>		
<p>Serious</p>	<p>Communication and Documentation Patient seen by health professional in outpatient clinic. Nil referral to relevant hospital service. Patient's leg subsequently amputated.</p>	<ul style="list-style-type: none"> • Patient's outcome was not influenced by the course of events. • Health professional did not complete clinical record documentation adequately. • Patient's healthcare plan was not communicated to patient's GP. 	<ul style="list-style-type: none"> • To ensure health professional improves clinical practice and documentation. 	<ul style="list-style-type: none"> • Service has plan in place to work with the health professional to ensure clinical practice and documentation meets required standards and policy
<p>Serious</p>	<p>Death of Mental Health Inpatient (on leave) Client left inpatient unit on approved unescorted leave but did not return. Service contacted next day by police to advise that client was found deceased. Later found to have died of natural causes.</p>	<ul style="list-style-type: none"> • Client allowed to go to shops unescorted • Client had history of telling Mental Health staff when she felt unsafe, and had reassured doctor that she would keep herself safe. Patient was alert and cognition was normal. 	<ul style="list-style-type: none"> • To ensure Mental Health procedure regarding permission for unescorted walks requires assessment of patient risk • Plan to be in place 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 	<ul style="list-style-type: none"> • Workforce planning and documentation re staffing during the Christmas period has been completed.
<p>Serious</p>	<p>Hospital-Acquired Pressure Area On admission, patient had no pressure areas on skin, but patient's pressure area risk was assessed as 16 (high). After 7 days in hospital, patient developed Stage 3 pressure areas on leg. Leg was amputated 2 days later.</p>	<ul style="list-style-type: none"> • Review findings concluded that the care this patient received did not contribute to patient's eventual outcome. 		

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Serious	<p>Death of Mental Health Inpatient Client found in bedroom not breathing. Resuscitation commenced but client did not survive. Cause of death unknown. Not thought to be suicide.</p>	<ul style="list-style-type: none"> Coroner findings 'natural causes being cardiac failure in a background of left ventricular strain and chronic obstructive airways disease' 	<ul style="list-style-type: none"> Teams to complete the red alert sheet at the beginning of patients' clinical records to include significant medical conditions Handover notes to be conveyed to staff on the next shift. Discuss developing a mechanism for the wards that would ensure important procedures such as physical exams are followed through 	Actions completed.
Serious	<p>Care and Treatment Patient admitted to hospital with pneumonia and severe cardiac failure. Patient was administered two doses of a medication instead of one, due to a prescription error. Later the patient was administered another medication without a prescription. Patient's condition deteriorated and despite active interventions died 2 days later.</p>	<ul style="list-style-type: none"> Guideline for treatment of Community Acquired Pneumonia not followed Non-compliance with Medicines Management policy (medication not prescribed for the correct date) X-ray not sent for reporting by radiologist, as this results in the X-ray not being available for use by medical staff in the ward Inadequate clinical record documentation 	<ul style="list-style-type: none"> Educate staff re Pneumonia Guideline and audit compliance Educate staff re medication policy and audit compliance (staff must not administer medications without a prescription) Establish feasibility of copying x-rays so that one copy remains on site for medical staff to refer to Develop and implement guidance for when to seek medical advice Information to be obtained from patient's GP if there are queries about previous treatment Medical staff to specify date when prescribing Nursing staff to clarify with medical staff if they have queries about a drug prescribed Sick patients should be handed over to the next shift staff so that they can be reviewed promptly. This handover should be documented in the clinical record 	<ul style="list-style-type: none"> Medical officers have had the Pneumonia Guidelines reiterated to them by both the Clinical Director and the medical Consultant All staff have received education re medication policy and compliance audits conducted Plan to introduce electronic X-ray reporting in August 2008. Guideline for when to call medical staff has been drafted. To be completed by March 2008. Medical officers have agreed to obtain information from patient's GP if there are queries. Medical staff have been reminded to comply with prescribing standards The ward round structure has improved significantly to ensure full handovers are occurring at the end of each

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				shift
Serious	Delayed Diagnosis Squamous cell carcinoma result from cervical smear taken in ED not followed up initially. Patient presented 7 months later and was diagnosed with cancer of the cervix.	<ul style="list-style-type: none"> • Team responsible for the test result follow-up were not identified on ED laboratory form. • Patient wanted discharge so follow-up of results delegated to GP - electronic GP details incorrect as patient not registered but the GP practice did send letter to patient advising her of result • Cervical Screening sent letter to last known address – no response. • ED has a Procedure for Review of Laboratory Results but this is only for blood results. ED consultant assumed GP would follow-up. 	<ul style="list-style-type: none"> • Working group to identify mechanism for managing test results ordered in ED • ED Procedure to be reviewed to include follow-up of all other diagnostic results 	
Serious	Patient fall Patient fell in ED and fractured hip.	<ul style="list-style-type: none"> • Incident reviewed. 	No recommendations made.	
Serious	Prescribing error – Wrong dose Patient was prescribed and administered overdose of IV antibiotic. Error was not detected until second time it was prescribed. No adverse outcome.	<ul style="list-style-type: none"> • Unfamiliar drug dose prescribed without correct reading of handbook information for correct administration route. • Drug not held by Pharmacy so external source contracted to supply it – sent directly to ward. 	<ul style="list-style-type: none"> • Medical staff to be reminded of need to check dose of unfamiliar drug using available handbook information. • Learnings to be shared through in-house publications and appropriate forums • Drug protocols from other hospitals to be approved by Waikato DHB before being used internally. 	<ul style="list-style-type: none"> • Prescribing education package developed and distributed widely to medical staff by Pharmacy. • Prescribing learnings shared through Pharmacy newsletter and Grand Round.

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		<ul style="list-style-type: none"> • Pharmacist was busy with multiple tasks and did not identify the prescribing error the first time. • Nurse queried dose but when confirmed thought dose a directive from the other hospital involved in the patient's care. 		
Serious	<p>Inaccurate Laboratory Reporting For a 33 month period 1,783 (17%) of diagnostic results of sequential laboratory specimens period may have been reported out of sequence when viewed electronically. Of the incorrectly sequenced electronic results, 29 or 0.27% of the total included more than 9 specimens and therefore had the potential for some results to be invisible on the electronic results viewer. These results were accurately reported on paper reports or when viewed directly in Laboratory software system.</p>	<ul style="list-style-type: none"> • Software interface issue • All results were correctly reported against the correct specimens. Only the sequencing was out of order. 	<ul style="list-style-type: none"> • To correct the software interface issues • To review the records of all patients where there may have been a risk of the medical staff not having accessed the full correct report. 	<ul style="list-style-type: none"> • A software patch was installed which ensured that: <ul style="list-style-type: none"> • all specimens displayed in the electronic results viewer were displayed in correct sequence • all specimens in a test were visible on the screen regardless of how many specimens were reported. • The clinical records of the 29 cases where more than 9 specimens were included in a test were reviewed individually to identify whether any results had been 'missed'. Most of these included clear evidence of all test results having been viewed by the clinician - usually in the form of a letter to the patient's GP or through discussion at a clinico-pathological meeting. In two cases where there was doubt,

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				the relevant medical staff were contacted and they advised that they were aware of the results.
Serious	Medication Event Patient not given antibiotics before or after emergency caesarian section and was subsequently readmitted for serious wound infection and debridement.	<ul style="list-style-type: none"> No documented standard in Waikato DHB re prophylactic antibiotics for emergency caesarean sections. 	<ul style="list-style-type: none"> To develop protocol / guideline for prophylactic antibiotic use for emergency caesarean sections and ensure all appropriate staff are made aware of it. 	<ul style="list-style-type: none"> Prophylactic Antibiotic Use Protocol developed and implemented in service.
Serious	Medication Event – Wrong Dose Overdose of medication administered to newborn. No adverse outcome.	<ul style="list-style-type: none"> Medication protocol required nurses to complete unnecessarily complex calculations. Dose calculation relied on incorrect information from staff on previous shift. 	<ul style="list-style-type: none"> To revise medication protocol to simplify calculation required To educate staff re new protocol To remind staff of safe medication administration practice as required by Waikato DHB Medicines Management Policy 	<ul style="list-style-type: none"> All actions completed
Serious	Patient Monitoring Patient admitted to hospital with three medical conditions. Patient became unrousable requiring urgent care. Lack of patient observations documented on ward. Plan of care not adhered to. Patient deceased.	<ul style="list-style-type: none"> Inadequate taking and recording of patient observations. Delay with transfer to another hospital - unable to transfer by helicopter due to patient's weight No protocol to assist nursing staff re when to call for medical staff input 	<ul style="list-style-type: none"> To revise Transfer Procedure to include requirement to notify retrieval team of patient's weight / size. To ensure compliance with appropriate transfer procedure. To provide guidance on how to manage transfer aspects of obese patients. To conduct monthly audits of care planning and observations for the next 6 months. Develop protocol re when nursing staff should call for medical input 	<ul style="list-style-type: none"> Staff reminded of their professional obligations to complete care plans for all patients and carry out patient observations as required. One audit of care planning and completion of observation charts was completed. Protocol for when to call for medical input has been developed
Serious	Death of Baby Mother had rare condition and hospitalised during pregnancy. Baby bleeding before birth. Delay in doing caesarean may have caused	<ul style="list-style-type: none"> Service very busy – 3 emergency Caesars required at same time. This patient was prioritised as being the least urgent. 	Yet to be reviewed by Serious Event Panel	

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	baby's death (aged 3 days, in New-born Intensive Care Unit)			
Serious	Patient Security Family member disconnected patient's breathing tube. Patient died. Police notified and CIB investigation underway. Referred to Coroner.	Police investigation in progress		
Serious	Patient Fall Mother was breastfeeding baby. Mother fell asleep and baby fell from bed, sustaining a fractured skull. Did not require any treatment/intervention.	<ul style="list-style-type: none"> No physical barrier to prevent baby falling from bed. 	<ul style="list-style-type: none"> To identify and obtain suitable barrier to use on hospital beds Update unit specific protocol for bed sharing to include safety requirements for baby in adult bed 	<ul style="list-style-type: none"> Service has trialled various barriers and is in the process of purchasing the most suitable product
Serious	Patient Harm in Emergency Department Patient sustained fracture and extradural haemorrhage when another patient (very obese) fell on her.	<ul style="list-style-type: none"> Review indicated that this was an accident and no further action required. 	<ul style="list-style-type: none"> No recommendations 	
Serious	Equipment Reused Surgical equipment (scissors and tweezers) re-used on second patient. Bloods taken from both patients and Infection Control Service advised.	<ul style="list-style-type: none"> Unclear procedure regarding preparation of equipment for this theatre. 	<ul style="list-style-type: none"> Develop protocol to ensure equipment is prepared and managed safely. 	<ul style="list-style-type: none"> Protocol completed
Serious	Patient Fall			<ul style="list-style-type: none"> Waikato DHB Falls Protocol

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	Patient fall following stroke resulting in a fractured skull.			developed. This specifies requirements for a falls risk assessment to be completed, and actions taken to minimise the risk of a fall.
Serious	Destruction of a specimen Tissue specimen taken at the time of a patient's limb amputation in Theatre should have been sent to the Laboratory for testing but was destroyed. Patient has had to undergo further tests eg MRI	<ul style="list-style-type: none"> Incident reviewed by service 	<ul style="list-style-type: none"> When policy relating to return or disposal of body parts / tissue is reviewed, ensure the matter of large tissue specimens is dealt with to prevent recurrence of this incident. 	<ul style="list-style-type: none"> Policy due for review in August 2008