Taranaki District Health Board
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Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	6	Inpatient fall resulting in a head injury.	• Patient had multiple other illnesses. • Patient used a walking frame with minimal assistance but was experiencing very painful legs and had a temperature at the time of the fall. • There were no environmental hazards identified.	• Patient 'clip monitor' utilised to ensure patient did not mobilise without full assistance. • Placed in an area of high visibility within the ward.	Completed Completed
Serious	6	Inpatient fall resulting in a fractured upper arm.	• Patient was wearing their own socks and these, combined with the lino flooring, caused the hazard.	• All staff informed about the potential slipping hazard for patients who wear their socks with no slippers or other footwear. • Encourage patients to wear non-slip footwear when mobilising.	Completed Ongoing
Serious	6	Inpatient fall resulting in a fractured hip.	• Patient had secondary bone cancer. • Patient was very confused, disorientated and aggressive both verbally and physically. • Patient under a special watch but this caused more verbal and physical aggressiveness. Patient was more settled when not being accompanied. • There were no environmental hazards identified.	• Unable to determine any action which would have prevented the patient's fall and injury. Staff felt that their presence would cause more risk of physical harm to the patient and to themselves due to aggressiveness.	
Serious	6	Inpatient fall resulting in a fractured hip.	• Patient had dementia and not easily able to recognise their limitations. • Patient was wearing their own socks and these, combined with the lino flooring, caused the hazard.	• Close watch of patient implemented. • Encourage patients to wear non-slip footwear when mobilising.	Completed Ongoing
Serious	6	Inpatient fall resulting in a fractured ankle.	• Patient was confused and not easily able to recognise their limitations. • Patient was trying to get back into bed. and did not call for assistance. • Had been identified as a falls risk with the appropriate mitigation actions in place including being on a low bed.	• Reinforce need for patient to ask for assistance. • Patient moved to a more visible bedspace and close watch by nursing staff commenced.	Completed Completed

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Serious	6	Inpatient fall resulting in a further displaced fractured hip.	• Patient fell off bicycle in the community. • Four days later, they presented to the Emergency Department when unable to walk. A mildly displaced fractured hip was diagnosed requiring surgery. • A nerve block was given which removed a lot of the patient's pain. • An orderly transported the patient to the ward. • The patient was inappropriately directed into attempting a transfer from the trolley to the bed. The patient's leg gave way resulting in a fall. • There is nothing specific in the transfer protocols around orderly transfer of patients and criteria. • No handover or information given to the orderlies when they undertake transfer from the Emergency Department.	• More clearly define the guidelines and expectations for orderly transfers. • Review the 'Transfer of Pts from ED to the Wards' and 'Transferring/Escorting Pts to the Wards/Depts' protocols ensuring involvement of the orderly service, Emergency Department staff and ward Clinical Nurse Managers. • Remind orderlies to seek nurse assistance for patient transfers and to report any incident/situation to nursing staff.	Completed Completed Completed
Serious	4d	Patient developed pulmonary emboli (blood clots in the lung) following surgery.	• Patient had a number of high risk factors for the development of emboli. • Poor handover occurred between staff. • The patient's clinical record was not read by staff and therefore instructions were not followed, including medication to be charted. • Of note, due to the patient's high risk factors, even if the medication had been charted and administered, this may not have prevented the development of emboli.	• Discuss at complications meeting with all medical officers in attendance emphasizing the importance of: o effective handover to members of the next team o reading the clinical notes	Completed

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Sentinel	4f	Delay in transfer from satellite hospital to base hospital, resulting in delay in providing appropriate treatment. Patient subsequently died 11 days later.	• The patient suffered a severe traumatic brain injury that had significant mortality and morbidity associated with it. • The decision to take a traumatic brain injury patient to a facility with no means of providing either CT scan or emergency surgery is problematic. • The patient met clinical criteria to be transferred to Taranaki Base Hospital on arrival at the satellite hospital, however this did not occur. • Better communication with Base Hospital over delays and changes in the patient's status may have initiated transfer earlier. • There is an inbuilt delay in any transfer (time to arrange transport, call in staff and ready the patient) from a satellite to Base Hospital. • In the time it took to arrange and transfer, the patient deteriorated.	• Discuss with St John the level of care available to satellite hospital and clearly define criteria for taking a patient with major trauma directly to a definitive care facility. • Undertake a practice review (related to traumatic brain injury) with the satellite medical staff. • Explore, consult and agree a robust process to shorten transfer time from the satellite to Base Hospital. • Review and update the satellite/Base Hospital transfer policy and related activities. • Review and update the DHB's Head Injury Policy. • Ensure all front line medical Emergency Department staff are 'Early Management of Severe Trauma' course current. • Implement airway training for satellite medical staff with annual refreshers. • Implement traumatic brain injury measurement training for nursing staff. • Use the newly formed Trauma Committee to review and improve how major trauma is dealt with.	Work in progress Completed Completed Policy awaiting sign off Completed Ongoing Completed Completed In place
Serious	4d	Damage to major blood vessel (aorta) during surgery	• Event extensively discussed and reviewed at the Surgical Mortality & Morbidity meeting with the following contributing factors identified: o Trainee Surgeon o Umbilicus not sufficiently elevated o Incision too deep	• Ensure that the umbilicus is well elevated before gently incising.	Completed

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Serious	4b	Delay in treatment due to lost referral.	• Patient presented with a breast lump. A fine needle biopsy was inconclusive, so an excision biopsy was planned. • Unable to determine whether the online surgical referral form had been completed, if completed, whether it had been received electronically and if received, if it was not actioned. • Unable to determine where in the process the error occurred. • Once the DHB was aware of the delay, the patient was urgently scheduled for the biopsy that proved to be benign.	• Undertake a manual audit of all surgical referrals against the Booking Office waiting list from January 2009. • Implement a manual check of the surgical referral list that is formally signed off each day. • Update KPIs to include this check requirement. • Review the Booking Administrator process and ensure responsibility is clear. • Provide regular staff training to improve knowledge of work requirements and enhance team and individual support	Completed Completed Completed Completed Ongoing
Serious	3	Retained guide wire following cardiac procedure (angiogram).	• No procedure/checklist regarding the checking of equipment used at the end of procedure. • Limited space in which to work in. • A number of non-essential people present in the angiography room. • Clinician had restricted mobility at the time and therefore the routine process was affected.	• All wires used are to be visualised by both the clinician and scrub nurse at the time of removal. • All items used during angiography are to be visualised by the scrub nurse and circulating nurse before being discarded at end of the procedure and this checked off and signed for on the patient registry. • The number of non-essential staff in the angiography room at one time are to be limited. • Where the routine procedures might be affected, for whatever reason, the team will identify actions to be taken in advance to ensure a successful outcome.	Completed Completed Ongoing As the situation arises

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Serious	4b	Deterioration in baby's condition after administration of drug (Bupivacaine).	• Usual to use either no local anaesthetic or Lignocaine, however Bupivacaine is an acceptable agent for local anaesthetic. • Given recent peer discussion and evident pain, the Emergency Department Medical Officer believed use of intra-osseous Bupivacaine was local practice, however this was not the doctor's usual practice. • The Emergency Department Senior House Officer on duty, who normally worked as a Paediatric Registrar, likely contributed to a change in normal process for paediatric advice. • In this situation intra-osseous Bupivacaine is contraindicated.	• The Emergency Department protocols have been changed to clearly state that no local anaesthetic agents will used in intra-osseous lines and this has been communicated to staff. • On discussion with Paediatrics, it is expected that the Paediatric Consultant will be involved if an intra-osseous line is anticipated. Memo to be sent to all medical staff. • In the emergent situation where intra-osseous access is deemed to be required immediately, this will be an Emergency Medicine Senior Medical Officer decision and not be delayed awaiting paediatric involvement. Memo to be sent to all medical staff. • Regular paediatric follow up through the Child & Adolescent Centre to be arranged to monitor the baby's development that to date has been normal.	Completed Completed Completed In place
Serious	4a	Delay in diagnosis of lung cancer.	• Abnormality not noted by two radiologists on previous x-rays.	• This has been brought to the attention of the radiologists involved. • The images will form part of an audit, in which all radiologists have the opportunity to learn from this event.	Completed Completed

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Sentinel	4a	Delayed diagnosis of a patient who presented to the Emergency Department on three occasions. Patient subsequently died.	• No documentation in the clinical notes to support that consultation occurred between the Emergency Department doctor (providing care to the patient) and the Emergency Department Consultant. • Inadequate application/documentation of key patient observation protocols eg Early Warning Score protocol and Fluid Balance Chart. • There is some doubt as to whether an earlier admission may have improved the patient's chances of survival. This is supported by the post mortem findings that indicates the patient's cardiac condition combined with small bowel ischaemia suggested a poor outcome. • Coroner's review of the outcomes was to not open and conduct an inquiry.	• A 'Responsibility for Care of Emergency Medicine Patients' protocol to be developed. • Discuss with staff the application/completion of the DHB's Early Warning Score protocol and Fluid Balance Chart. • Undertake monthly clinical audit of the Early Warning Score and Fluid Balance Chart processes.	Completed
Serious	4d	Complication during the insertion of a pigtail chest drain, requiring emergency surgery.	• Upon reviewing the subsequent CTs of this patient, it appears that the patient had an enlarged heart and likely adhesions between the pericardium of the heart and the pleura of the lungs that led to the chest drain injury. • Of note, in a patient with unknown adhesions between the pericardium and the pleura, the risk of a similar complication remains high.	• The Department of Medicine have reviewed their protocol. Any patient requiring a chest drain will have an ultrasound and the site marked prior to insertion. • Chest drain insertion education for Medical Officers to occur. • Chest drain insertion and complications presentation to be given by the Registrar. • Journal Club presentation on this subject to be given by the House Surgeon.	Completed Completed Completed Completed

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Serious	02	Wrong joint implant cemented in.	• The incorrect implant was chosen by mistake despite a checking process being undertaken. • There was some difficulty finding the prosthesis on the prosthesis trolley in the store room that day. It was located in a different place.	• Three person checks to continue. • The Scrub Nurse is to put the implant and trial side by side so the surgeon can see they are the same before implantation. • The Circulating Nurse is to keep the boxes containing the implant so the surgeon can make an extra check at the end of the case, before the wound is sutured. • Implants are to be stored on trolleys so they match as a group thus decreasing the chance of mixing implants up. • The above recommendations are implemented across the Orthopaedic service.	Ongoing Completed Completed Completed Completed
Serious	11	Attempted suicide of a mental health inpatient.	• The patient was on 15 minute checks. • The patient had fashioned a 'rope' out of toilet paper.	• Different toilet paper (single sheet) to be sourced to prevent long pieces being torn off and fashioned into a 'rope'	Completed
Sentinel	11	Completed suicide of current Mental Health inpatient on leave from the Inpatient Ward	• In progress.	•	