Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Sentinel	12	Inpatient fall resulting in a fractured hip and post surgical repair the patient suffered a fatal heart attack.	• Patient had severe cardiac disease resulting in low blood pressure that occurred regularly, an inability to tolerate most medications and had been referred for palliative care. • An assessment of the patient's falls risk was completed on admission and resulted in a medium risk of falls. • Referral to and assessment by a physiotherapist had occurred and concluded that the patient was independent with mobility and utilised a seat when showering. • Patient was aware of the need to sit down if feeling dizzy and sit for awhile before mobilising. • There were no environmental factors identified. • Patient was a high risk of a cardiac event or death and the anaesthetic risk had been discussed fully.	• Unable to determine any action that would have completely safeguarded this patient from falling and sustaining a significant injury.	
Sentinel	12	Inpatient fall resulting in a fractured hip and post surgical repair, the patient suffered fatal cardiac failure.	• Patient was recovering from pneumonia, had multiple other underlying illnesses and was confused. • The first fall (no injury) occurred earlier in the night. • A reassessment of the patient's fall risk was undertaken and the patient was determined as a high risk and moved to a position of higher visibility. The patient's bed was lowered to the lowest level, a 'floor mat' alarm was placed by the patient's bed and the patient was checked every 10 to 15 minutes. • There were no environmental factors identified. • Patient was a high risk for a cardiac event or death and the anaesthetic risk had been discussed fully.	• Consider the use of a staff member to stay with the patient all of the time. • Implement 'intentional rounding' where by the patient is visited every hour and asked if the patient requires/needs assistance with anything eg toileting	Ongoing Progressing

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	12	Inpatient fall resulting in a fractured hip.	• Patient being investigated for history of falls by another DHB including a history of the left leg 'giving out'. • Admitted following a fall (leg gave way) resulting in a fractured hip. • Patient recovered well and was demonstrating increasing independence and nearing discharge. • Patient had finished showering independently and knew to ring the bell for assistance if required. • Nurse checked on patient and offered help/assistance which was declined. • Patient reached for gown and fell to floor sustaining a fractured hip. • Patient stated no preceding dizziness/faintness and did not slip just fell. • Patient had not undertaken balance and strengthening exercises with the physiotherapist as yet. • There were no environmental factors identified.	• Consider close supervision while a patient with a history of a leg 'giving out' is showering and immediately following a shower given tiredness may be a contributing factor. • Raise and discuss the event with all staff.	Ongoing Completed
Serious	12	Inpatient fall resulting in a fractured hip.	• Patient admitted with a history of reduced mobility and unsteadiness resulting in several falls at home. • Assessed appropriately as a high risk for falling. • A staff member stayed with the patient at all times. • When the patient stood up, the patient's knees gave way and the patient fell. • There were no environmental factors identified.	• Unable to determine any action that would have completely safeguarded this patient from falling and sustaining a significant injury.	

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	12	Inpatient fall resulting in a fractured hip.	• Patient undergoing rehabilitation after suffering a stroke. • Patient had improving mobilisation but continued to neglect the side of the body affected by the stroke. • Assessed as a high risk for falls. • Nursed close to the Nurses' Station • Bed at the lowest level. • Bed cot sides in use, however, patient climbed over the cot sides and fell to the floor. • Patient noted as being alert. • There were no environmental factors identified.	• Consider the risks and rationale of using cot sides and document accordingly in the patient's care plan. • Consider the use of a patient 'clip monitor' or a 'floor mat' alarm. • Consider the use of a staff member to stay with the patient all of the time. • Raise and discuss the event with all staff.	Ongoing Ongoing Ongoing Completed
Serious	12	Inpatient fall resulting in a fractured hip.	• Patient assessed as having a medium risk of falling. • Patient required assistance with transferring from bed to chair/chair to bed. • Patient utilised a walking frame to assist with mobilisation. • Patient was seen by staff five minutes prior to the fall. • Patient wanted to get clothes out of the locker so used the walking frame and fell while trying to turn around beside the bed. • No dizziness reported. • There were no environmental factors identified.	• Continue to educate and supervise the patient when transferring. • Implement 'intentional rounding' whereby the patient is visited every hour and asked if the patient requires/needs assistance with anything eg toileting. • Raise and discuss the event with all staff.	Ongoing Progressing Completed
Serious	12	Inpatient fall resulting in a fractured hip.	• Patient had progressed well towards independence and was for discharge the following day. • Had been assessed as being independent with mobility (used a super-stroller). • Patient stated while sitting, missed the shower stool and fell to the floor • There were no environmental factors identified.	• Patient encouraged to ring for assistance, however was being as independent as possible.	Ongoing

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	12	Inpatient fall resulting in a fractured hip and fractured wrist.	• A falls risk assessment had not been undertaken prior to the fall. • Post fall risk assessment indicated a medium risk. • A physiotherapist assessment had been undertaken and indicated that the patient required supervision when mobilising with the frame and assistance if intravenous fluids were running. • The staff member did not realise the patient had socks on when supervising the patient walking to the bathroom. • The patient was asked to ring when the patient was ready to return to bed. • The patient decided to be independent, slipped and fell sideways. • Delay in the patient being found. • The patient complained of wrist pain on several occasions following the fall event. Six days post fall, an x-ray indicated a fractured wrist. • There were no environmental factors identified.	• 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. • Encourage patients to ring for assistance. • Raise awareness about checking on patients in the toilet regularly. • Raise awareness about ensuring all potential injuries are followed up appropriately. • Raise and discuss the event with all staff.	Completed Ongoing Ongoing Ongoing Ongoing Completed
Serious	02	Recommended repeat chest x-ray (due to poorly defined opacity identified in the x-ray) not performed therefore potential delay in malignancy diagnosis.	• Patient did not have a GP. • Radiology report identifies the nodule and recommends a repeat x-ray in 4-6 weeks. • Chest x-ray report not viewed at the time. • A chest x-ray taken 12 months later indicated that the small density had been stable. It is not clear whether a repeat x-ray at 6 weeks would have changed the course of the disease. • When chest x-rayed due to another procedure, the nodular opacity was reported to be more prominent than in previous examination and the patient was referred for respiratory follow up. • CT performed showed multiple lung nodules consistent with metastatic disease.	• We continue to work jointly with the Primary Care Organisation to reengage patients with GPs. • Chest x-ray results are available to GPs and follow up by the GP is promoted. • We have adopted the Australasian College of Emergency Medicine's guidelines for test review follow up. These have been raised with staff and GPs through education and via meetings. • The ED Head of Department takes responsibility for reviewing the results of any locum doctors, doctors on leave or those that have left the DHB's employment.	Ongoing In place In place In place

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	02	Patient's fractured humerus advanced to a compound fracture	• Patient admitted following a fall resulting in a right fractured hip and a left fractured humerus. • Successful hip surgery and acceptable humerus alignment achieved conservatively (plaster cast and collar and cuff). • Patient had several underlying illnesses including Parkinsons, stroke and cardiac disease as well as poor mobility, need to use hoisting equipment, unable to sit for periods therefore constant/consistent hanging traction not possible and a lot of time spent in bed. • Unable to determine a direct cause for the compound fracture.	• That surgical treatment, acknowledging the risks that surgery poses needs to be carefully considered as a means of fracture management.	Ongoing
Serious	02	Patient discharged from ED with a diagnosis of a urinary tract infection. Represented two days later with a perforated bowel.	• Care and treatment reviewed by the ED team. • It was determined that the patient had presented with high risk abdominal pain and was not reviewed by a Senior Doctor prior to discharge. • As well, there was no formal follow up process to check on discharged patients with high risk abdominal pain.	• Two new policies have been implemented: ○ High risk patients, including all patients 65 and above, with abdominal pain will be examined by a senior doctor prior to discharge from ED. ○ All high risk patients, including all patients 65 and above, with abdominal pain discharged from ED will be telephoned the next day as a recheck. • The event has been raised and discussed with staff. • Staff have now widened the 'next day follow up telephone check' process to include any case that is viewed as being at risk of deteriorating after discharge and is based on clinical findings and risk factors such as age.	In place In place Completed In place

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	02	Brittle asthmatic child suffered a respiratory arrest, successfully resuscitated, transferred to Starship but has significant neural deficit.	• Paediatric team might not be informed about ED visits of paediatric patients with frequent or concerning presentations which do not result in admission to the children's ward for ongoing care. • Paediatric team might not be notified about paediatric patients who have "Direct" or "Open" access to the paediatric team on call in timely manner at the time of their ED presentation. • Standard ED management of asthma in children is with nebulisers. • Letters generated after patient misses clinic appointments might send wrong message. • In patients with frequent or long term steroids, adrenal suppression should be considered. • Patients with severe asthma, e.g. those receiving IV bronchodilators, should have intensive monitoring and access to intensive treatment facilities.	• Agreement that ED will notify paediatric team by phone call or email of ED visit of an individual patient who has frequent or concerning presentations which do not result in admission to the children's ward. • Agreement that ED will notify paediatric team on call about paediatric patients who have "Direct" or "Open" access to the paediatric team on call at the time of their ED presentation. • Education of ED staff regarding the best practice for the use of metered-dose inhalers and spacer in all except severe and life threatening asthma attacks. • Alterations implemented to the "Do Not Attend" process including formal communication to patient's family and GP as appropriate. • Education of paediatric staff of the importance of considering adrenal suppression in patients on frequent short term courses of steroids or long term steroids. • Agreement that paediatric patients with clinical concerns should be considered for early transfer to adult High Dependency Unit/Intensive Care Unit. • Paediatric assessment unit resuscitation bay has been modified to facilitate practical resuscitation. • ED and Paediatric clinicians will participate in paediatric airway management and training sessions and regular paediatric resuscitation scenarios. • Medical alert on hospital information system and personalised asthma action plan for the patient has been implemented.	Completed Completed Ongoing Completed Ongoing Completed Completed Ongoing Completed

Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
				• All children with asthma who have had previous presentations with cardio-respiratory arrest or admission to Intensive Care Unit for asthma management will have a personalised acute hospital management plan.	Ongoing
Sentinel	02	Patient presented to ED following a fall and discharged. Patient later deteriorated and required emergency treatment for a brain bleed that the patient did not survive.	• At the time of presentation the patient did not exhibit any head injury symptoms, however the mechanism of injury included a fall onto head and required assessment. • During the ED stay, the patient did not display any head injury symptoms. • Specific head injury information (verbal and written) was not given to the patient on discharge. • Patient unable to identify all medications so recent clinical records were utilised to obtain this information. • Patient did not identify that he was on Ticagrelor when asked about blood thinning medication. • The most recent GP referral containing the patient's medication list did not include Ticagrelor. • While Ticagrelor was documented in some patient related documents available on the patient management system, it is not normal practice for ED staff to look through all linked documents as these can be significant in number. • It is not normal practice for ED staff to contact the GP or Pharmacy as part of medicine reconciliation unless specific concerns/questions are identified. At the time of this event, the usual Pharmacy and GP would not have been available.	• Ensure specific head injury advice (verbal and written) is given to patients presenting with an accident resulting in a fall and a hit head. • Assess feasibility of an alert on the patient management system for patients on un-monitored antiplatelet/ anticoagulant medication. • Implementation of the SHER (shared electronic record between ED and GP practices) to be explored as part of the Acute Demand Project.. • Assess feasibility of a shared repository for medications between primary, secondary and pharmacy services. • An independent review, via the Health and Disability Commissioner, is planned.	Ongoing Being considered Being considered Being considered