

MidCentral District Health Board Summary 1 July 2008 to 30 June 2009 Serious and Sentinel Events

Event code* (see codes below)	SAC 1/SAC 2/ N/C(not classified)	Description of Event	Patient Outcome	Review Findings	Recommendations / Actions	Follow up
4B	2	Patient not receiving tertiary intervention in an appropriate timeframe	Stroke with significant hemi paresis	Failure of referral mechanisms to tertiary hospital. Referral not followed up on when patient not reviewed within a reasonable timeframe. DHB found in breach of its obligations under the Health and Disability Code.	Implementation of a system to ensure inter-DHB referrals are received and actioned.	A system was implemented to ensure inter-DHB referrals are tracked and actioned.
4B	2	A woman was transferred to secondary facility with complications following a normal delivery.	Emergency surgery and admission to ICU	Inability to replace fluid loss in transit and lack of clarity as to receiving service at secondary hospital in the acute situation.	All relevant teams and Ambulance service agree to appropriate communication and transfer arrangements for women being transferred from a primary maternity unit to the secondary services with extreme complications.	Recommendations are currently being implemented.
11	2	Young person was admitted to inpatient unit and sustained injury.	Fracture of the humerus.	Injury occurred during the restraint procedure where both the coordination and the technique used were contributing factors to the injury. It appeared that the restraint procedures used by the two organisations differed and the roles and responsibilities of the employees of the two organisations need clarifying.	<ul style="list-style-type: none"> Calming and restraint should be undertaken by trained health staff only. When a young person requires admission immediate referral to tertiary provider should be actioned. Admission to an adult secondary health unit should be for the shortest time necessary. 	<p>Improved communication between secondary and tertiary health providers for timely and efficient transfer of young people.</p> <p>Staff appropriately trained.</p>
4B	SAC1	Shoulder dystocia.	Neonatal death.	Baby transferred to tertiary hospital and subsequently died. Possible deficiencies in fetal monitoring.	Root Cause Analysis (RCA) commenced.	RCA commenced
4A	SAC 1	Patient discharged without full investigations.	Unexpected death following accident.	Patient presented via ambulance as a result of a car accident. Upon arrival patient was assessed and was discharged home. Patient died five days later. A subsequent post mortem found that patient died as a direct result of injuries that were received in the motor vehicle accident.	<ul style="list-style-type: none"> SMO lead patient handover. 3 definitive shift start times to assist with handover. 	<p>Improvements and changes to shift handover embedded.</p> <p>Improved number of senior medical staff in post.</p>

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6G	SAC2	Fall whilst an inpatient.	Displacement of existing fractured tibia/fibula.	Patient on bed rest and aware of the requirement for bed rest. Leaned to locker and fell out of bed. Patient assessed and found to have displaced the previous relocation of tibia/fibia. Taken back to theatre for another relocation.	<ul style="list-style-type: none"> To ensure those patients on bed rest have equipment placed within a safe reaching distance, and have access to their call bell. 	Reminders to nursing staff and care assistants.
6C	SAC2	Fall whilst an inpatient.	Fractured left tibia.	Patient admitted after stroke. Increased confusion and history of alzheimers. On falls prevention programme as assessed as at risk of falls. Patient room was away from nursing station. Identified as requiring level 2 observation (15 minute) but not completed at every interval. Patient placed on toileting plan (every 2 hrs) but also not completed at required times.	<ul style="list-style-type: none"> Consistent documentation to be completed by all staff when patients on falls/observation programmes. Ongoing assessment and evaluation of risk factors around the patients falls risks. Assessment and evaluation of urinary elimination with toileting plan if applicable implemented. Use of Invisabeam monitoring in lieu of having an environment where patients can be continuously observed by staff. 	In progress
6G	2	Fall whilst an inpatient.	Fractured left neck of femur.	Patient with dementia, confused and dis-orientated. Plan in place to discharge. Hip protectors in place as constant observation was discontinued as per discharge plan. Patient mobilising with frame and assistance from staff.	<ul style="list-style-type: none"> Gradual discontinuation of specialling of dementia patients rather than an immediate stop to allow for ongoing assessment of needs of patients. 	In progress

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Event Codes:

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| 1 | Wrong patient, site or procedure | | |
| 2 | Suicide of an inpatient | | |
| 3 | Retained Instruments or swabs | | |
| 4 | Clinical management problem | - plus sub-code: | |
| 5 | Medication Error | A | Diagnosis (including delayed and misdiagnosis) |
| 6 | Falls | B | Treatment (including delayed and inadequate) |
| 7 | Blood transfusion reaction | C | Monitoring/observations (not performed and/or actioned) |
| 8 | AWOL patient | D | Procedure associated incident or complication |
| 9 | Physical assault on patient | E | Investigation (delayed, not ordered or actioned) |
| 10 | Delays in transfer | F | Discharge and transfer |
| 11 | Other | G | Other |