

MidCentral District Health Board Summary 1 July 2007 to 30 June 2008 Serious and Sentinel Events

Serious or Sentinel	Event code* (see codes below)	SAC 1/SAC 2/ N/C(not classified)	Description of Event	Patient Outcome	Review Findings	Recommendations/ Actions	Follow up
2008-125 Sentinel	Medication error Event Code 5	Prior to SAC introduction (Not classified)	Unintended overdose of an antibiotic eye injection due to an incorrect dilution from a formulation error.	The patient has lost vision in the eye and may lose the eye.	Workload prioritisation: No system exists for Pharmacy to prioritise their work in line with staffing resources available Pharmacy environment cramped No system for answering phone calls. No electronic check for calculations	1. Develop a process for Pharmacy staff to undertake to prioritise their work 2. Undertake an Occupational Health and Safety audit and a clinical risk review of the pharmacy environment to identify areas of risk to the individuals and to the department. 3. Review of the phone system and the practise of answering phones 4. Enhance the existing double check processes	1. Recommendations have been implemented. A whiteboard has been installed in a prominent area of the pharmacy. This has been ruled up to provide a daily overview of the dispensing and compounding tasks to be achieved in the pharmacy. Progress during the day is noted on the board. A formal prioritization of workloads plan has been drafted. 2. Substantial progress is underway. A clinical risk assessment has been conducted and risks have been assessed and treatments identified. Pharmacist/Pharmacy Technician ratios are reviewed daily and services that are offered are modified accordingly. Stock imprest for consumables is in place. 3. Recommendations have been implemented. A telephone system for call direction has been installed. 4. Recommendations have been implemented. Three pharmacists independently check all calculations. An audit trail of these calculations is recorded, signed by each pharmacist and filed with the Master batch document. A complete review of the compounding master documents has been undertaken.

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2008:124 Sentinel	Event Code 4D	Prior to SAC introduction (Not classified)	Information withheld due to patient confidentiality				

Event Codes:

- 1 Wrong patient, site or procedure
- 2 Suicide of an inpatient
- 3 Retained Instruments or swabs
- 4 Clinical management problem - **plus sub-code:**

- A** Diagnosis (including delayed and misdiagnosis)
- B** Treatment (including delayed and inadequate)
- C** Monitoring/observations (not performed and/or actioned)
- D** Procedure associated incident or complication
- E** Investigation (delayed, not ordered or actioned)
- F** Discharge and transfer
- G** Other

- 5 Medication Error
- 6 Falls
- 7 Blood transfusion reaction
- 8 AWOL patient
- 9 Physical assault on patient
- 10 Delays in transfer
- 11 Other