MidCentral District Health Board Summary
1 July 2012 to 30 June 2013
Serious Adverse Events

Event code*	SAC	Description	Review Findings	Recommendations	Follow up
2	**1**	Undiagnosed condition that has resulted in patient being paralyzed from chest down.	There was a significant delay in the diagnosis and referral to specialist services of a fracture of the mid spine.	• An algorithm for the management of back pain is developed. • Review the guidelines for use of diagnostic test such as MRI.	In progress
2	**1**	Arrest call not made .There was no indication that the patient was not for cardio pulmonary resuscitation.	Policy regarding arrest calls was not followed.	• Review the Not for Cardio Pulmonary Resuscitation Policy. • Update all staff on the policy. • All patients/families are aware of resuscitation options at time of admission.	Recommendations in progress
2	**1**	Possible delay in making arrest call. There was no indication that the patient was not for cardio pulmonary resuscitation.	Policy regarding escalating information regarding unexpected deterioration of patient was not followed.	• Deliver education programme regarding managing deteriorating patients. • Monthly audits of early warning score and actions implemented. • Strengthen policy regarding escalation.	Recommendations in progress
2	**1**	Reporting of x-ray, taken in June 2011, not completed. Diagnosis made in April 2013 when further x–ray taken.	Delayed diagnosis of pulmonary lesion resulted in poorer outcome for patient.	• Locum staff receive adequate orientation to MidCentral Health processes. • The software is reviewed to determine where improvements can be made to ensure that no film can be overlooked as part of reporting. • Audits to determine the rate of un-reported films are implemented.	Recommendations in progress

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2	**2**	Undiagnosed condition on x-ray resulting in delayed treatment.	Radiologist report on positive bone scan not sought.	• All positive bone scans with relevant prior history to be reported by Radiologist. • Regular meetings with lead medical staff to be scheduled. • Reduce interruptions and work demands for those reporting CT scans.	Recommendations in progress
2	**2**	Missed diagnosis of thoracic spine fracture.	Review in progress		
2	**2**	Missed diagnosis of cervical spine fracture.	Review in progress		
10	**2**	Impulsive patient behavior led to injury.	Review in progress		
2	**2**	Prolonged admission as a result of care and treatment delivered.	Limitations in care and treatment, related to clinical team decision making and inappropriate care setting.	• Clear clinical responsibility is established. • Robust treatment plan developed.	In progress
2	**1**	Incomplete assessment may have lead to medication contributing to death.	Review in progress		
12	**2**	Fall resulted in fracture of elbow.	Fracture not diagnosed for four days following fall.	• Implement routine clinical checks following falls. • Strengthen documentation.	Completed
12	**2**	Fall resulting in a fractured hip.	On day of discharge patient was waiting to go home and fell.	• No recommendations	Completed
12	**2**	Fall resulting in fractured hip	Identified as falls risk and regularly reassessed. Appropriate strategies in place.	• Falls risk is specifically identified on handover notes. • Invisabeam use is identified and recorded on nursing care plan.	Completed

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Te Pae Hauora o Ruahine o Tararua

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12	**2**	Fall resulting in fractured hip	Assessed as at risk and falls prevention strategies in place. Patient fell and sustained a fractured hip.	• Nursing care plan reflects the fall prevention plan more comprehensively. • Further education on the falls prevention programme in particular post fall requirements in relation to neurological observations if a head injury is reported.	Completed
12	**2**	Fall resulting in fractured left hip	Falls risk was recorded but no plan was put in place initially and patient fell 12 hours after admission.	• Risk assessment is given priority at admission with early implementation of preventative strategies.	Completed
12	**2**	Fall resulting in fractured hip	Patient had three falls in early morning prior to the final fall in which he sustained a fracture. Issues around toileting were noted as being a common thread.	• All nursing staff undergo falls assessment and intervention training in this unit. • Streamline the recording of assessment and interventions in care plans. • Develop a case study for staff for educational purposes.	Completed
12	**2**	Fall resulting in fractured hip	No history of falls. Appropriate falls assessments were completed on admission.	• Raise staff awareness regarding bed level settings.	Completed
12	**2**	Fall resulting in fractured hip	Noted as falls risk with appropriate assessment and interventions in place. Went to help another patient, fell and sustained fracture of hip.	No recommendations.	Completed
12	**2**	Fall resulting in fractured hip	Review in progress	No recommendations.	Completed
12	**2**	Fall resulting in fractured hip	Falls risk assessment noted as not at risk. Following the fall, falls prevention plan	• Falls assessment and prevention	Completed

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			was not put in place.	training for all staff in this unit. • Ensure all staff in higher falls risk areas have a falls prevention ID card. • Develop a case study for educational purposes.	
12	**2**	Fall resulting in fractured hip	Review in progress		
					The following relates to all falls events. The Falls Action Group continues to work on developing falls injury prevention strategies. We are participating in the Open for Better Care campaign that has as its first focus area falls injury prevention

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Event Codes:

General classification of event	Event code
Clinical administration (eg handover, referral, discharge)	01
Clinical process (eg assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (eg, wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)	10
Patient accidents (not falls) (eg, burns, wounds not caused by falls)	11
Patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14