Serious and Sentinel Events 2011/12

New Zealand has an excellent health care system which provides safe and efficient care to the vast majority of people using its services. However, adverse incidents still occur due to failures in the system. It's important these events are reported so we can learn from them and improve the way we do things.

Over the last few years Serious and Sentinel event reports have been released by the Health Quality and Safety Commission (HQSC), formerly the Quality Improvement Committee (QIC). This year DHBs will instead release their own reports directly to their communities, published on their websites.

The population in the lower North Island uses many health services that are shared across hospital sites, so we have published the reports for Wairarapa, Capital and Coast and Hutt Valley DHB together

Serious and sentinel events are events which have resulted in some harm to patients. A serious event is one which has led to significant additional treatment and a sentinel event is life threatening or has led to an unexpected death or major loss of function.

The HQSC requires DHBs to review events and report them using a standardised form, the Reportable Event Brief. This is the basis for both reporting events and advising the HQSC of review outcomes.

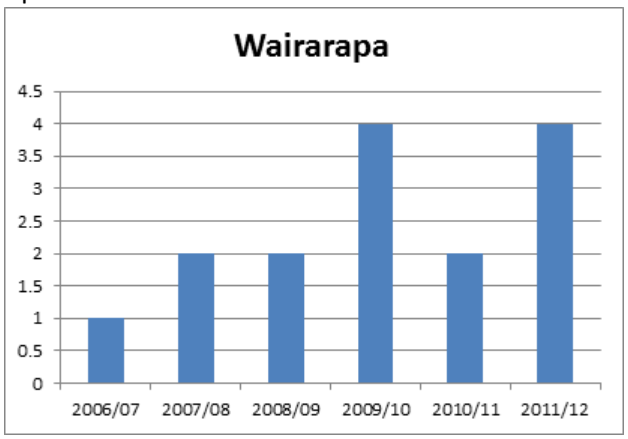
The reports for Wairarapa and Hutt Valley DHB are on page 2. The Capital and Coast DHB starts on page 5.

Events are graded in terms of severity from one to four on the Severity Assessment Code (SAC) scale. SAC 1 events are the most severe.

Wairarapa District Health Board

The table below outlines events Wairarapa DHB have reported to the Commission over the last year. The graph shows the reporting trend for Wairarapa DHB. This equates to 3 inpatient events for every 8,530 discharges and 1 community event per 37,224 community contacts for the 2011/12 period.

Event Category	Died	SAC	Event summary
5	Y	1	Over the counter medication left with patient contrary to care plan. Patient took unintentional overdose and subsequently died.
5	Y	1	Incorrect thrombolytic medication prescribed and administered. Patient subsequently died.
4 d	Y	2	Patient died during operation as a consequence of a pulmonary embolus (clot in lung).
1	N	2	CT scan performed on wrong patient.



Hutt Valley District Health Board

The following is a summary of the Serious and Sentinel events that occurred between 1 July 2011 and 30 June 2012 at Hutt Valley DHB. There are 10 events, which have been reviewed, reported and are categorised as follows:

Date of Event	Description of Event	Review Findings	Recommendations/Actions
July 2011	Patient fall resulting in fracture to nose	Patient fainted when standing up for chest x-ray.	Review completed. Recommendation that nurse stays with patient whilst undergoing radiology procedure
September 2011	Patient fall resulting in fracture to pelvis	Patient fell whilst moving from commode to bed unassisted.	Review completed. Patient assessed as high falls risk and monitored closely. Patient managed conservatively and discharged home within 48 hours
September 2011	Patient acquired pressure ulcer during hospital stay	Patient immobile longer than expected following orthopaedic surgery.	Review completed and causative factors identified. Staff attended pressure ulcer study day to expand assessment knowledge and action plan when deviation from the norm.

Date of Event	Description of Event	Review Findings	Recommendations/Actions
			Patient discharged home with district nursing care – pressure ulcer resolved.
October 2011	Retained swab following surgery. Swab removed by GP two weeks later.	Correct swab procedure not followed.	Action plan developed and recommendations implemented and communicated to all staff.
October 2011	Patient fall resulting in fracture to elbow.	Patient fell whilst independently getting into bed	Review completed. Patient assessed as high falls risk and monitored closely. Falls prevention strategies implemented. Fracture surgically repaired.
October 2011	Patient had respiratory arrest following use of PCA (Patient Controlled Analgesia)	Complex patient with chronic pain issues	PCA management reviewed Case study used for staff education
November 2011	Patient sustained pressure ulcer	Patient independently mobilising – no specific recommendations for specific pressure cares in patient care plan, documentation sporadic Pressure relieving mattress in situ Braden score re-assessment not completed as per protocol Patient discharged to home with follow up from community nursing, ACC form completed	Day 1 and day 5 audit process reviewed: 1. A sticker is now placed directly in the patient's progress notes on the day of audit. Where care shortfalls are apparent this highlights the care or process to be followed for the patient post audit. It has been amended to include a wound chart section. Care that is required is discussed with the allocated nurse. 2. A document of care tasks or processes not completed determined by the patient documentation audit, is placed on a notice board in the central office. The Associate Clinical Nurse Manager and Coordinators on each of the following shifts are responsible for ensuring that any nursing care highlighted as not being completed is carried out. 3. The senior team review these summary sheets on a monthly basis. Delivery of education based on the findings is carried out by the Clinical Nurse Educator. Patterns are discussed with individual nurses. Feedback is also given at ward meetings. 4. Day 5 audits continue every 5 days until discharge of patient. 5. All patients who have a risk of developing pressure areas are supplied an alternation air pressure mattress. 6. Care plans to be formalized

Date of Event	Description of Event	Review Findings	Recommendations/Actions
November 2011	Patient presented to ED, fracture not identified	Fracture identified 10 days later and reset in theatre	Clinician to undertake communication and listening skills training. Event discussed at staff education for learnings
Mar 2012	Patient fall resulting in fracture	Patient mobilizing independently – fell in bathroom Fracture treated conservatively and patient discharged home	No identified cause for fall
April 2012	Patient fall resulting in fracture	Patient with multiple co-morbidities sustained a fracture to hip Fracture repaired surgically	All assessments of the patient during admission identified the patient as a falls risk. All strategies in place to minimise the risk, including a high/low bed, red flag outside the room, risk clearly identified on nursing handover sheets and 15 minute checks in place when the family were not present. The hospital falls group are looking at these types of issues, where the patient is identified as a risk and, despite strategies being put in place, the patient still falls. There are plans to include “falls risk “sticky labels in the drug chart and observation chart to further highlight to the medical teams the risks for the patient.

Capital and Coast DHB

Capital and Coast District Health Board (CCDHB) has reported 19 Serious and Sentinel events to the Health Quality and Safety Commission during the period 1 July 2011 to 30 June 2012.

Figure 1: CCDHB Serious and Sentinel Events reported by financial year period

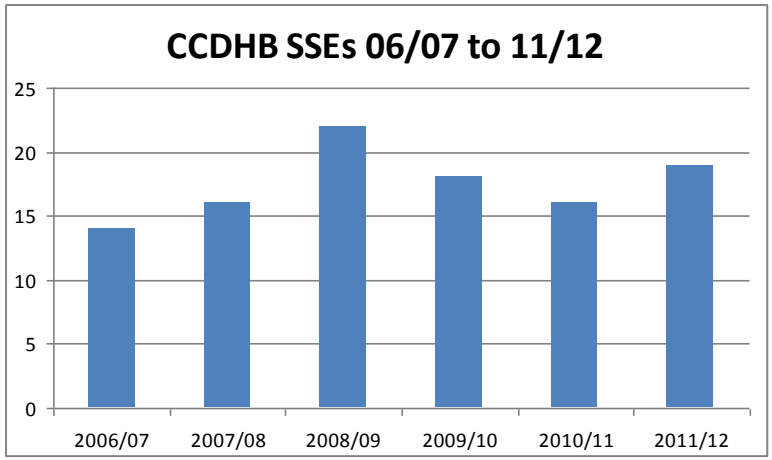


Figure 2:

CCDHB Serious and Sentinel Events 11-12 by category

The number of events reported is shown above the percentage of overall events for each category.

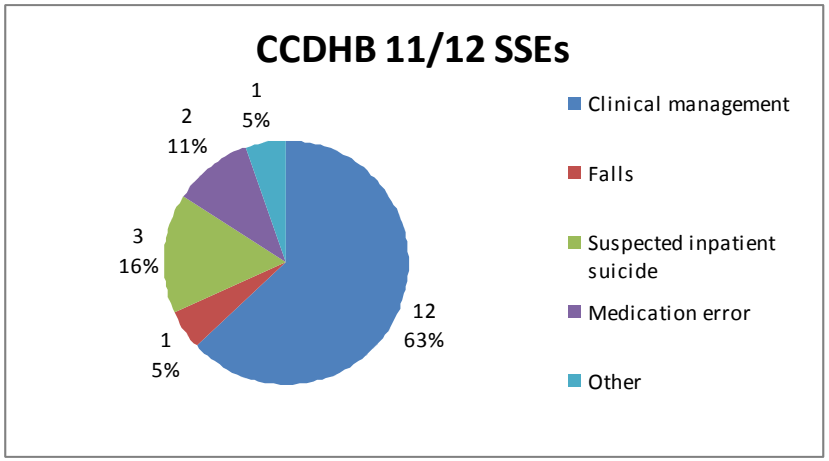


Figure 3: Event categories

Figure 3: CCDHB Serious and Sentinel Events involving falls reported by financial year period

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Suspected suicide of inpatient	Y	1	Suspected suicide of inpatient	The review found: -evidence of practice variance and mixed understanding of expectations when undertaking observations -variable understanding and appreciation by the inpatient team regarding client's treatment goals and level of clinical risk despite clear documentation of diagnosis, risk and indications of treatment approach	Recommendations related to: -review and clarification of nursing observations policy to specify minimum levels of observation and documentation and subsequent education and inclusion in staff orientation -development and implementation of single care plan document to ensure treatment goals and care planning are clear	A formal apology was made to the family at the time of the incident. Regular communication and meetings have been held with the client's family and these continue. A full copy of the review report has been provided. • Single acute inpatient 24 hour care planning document has been developed and implemented • Observation policy has been reviewed and updated and is currently being piloted on the unit - staff education completed. • Wider review of clients transferring from adolescent services to adult service and communication with non-DHB clinical staff has been being formulated and commenced In addition the DHB has commissioned independent review of inpatient suicide incidents, this independent review is in progress.
Suspected suicide of inpatient	Y	1	Suspected suicide of mental health client while on approved leave from inpatient unit	The review found: -issues regarding documentation and communication of both hard copy and electronic information -staffing patterns that contributed to the inefficiencies in communication between clinicians	Recommendations related to: -management of clinical information -review of current policy and procedures in relation to the report findings -access to computer work stations -increase in psychiatrist and psychologist staffing establishment -improvements in communication with and provision of information to families	A formal apology was made to the family at the time of the incident. Regular communication and meetings have been held with the client's family and these continue. A full copy of the review report has been provided. Further information requested by the family has been provided. • Workstation access has been addressed. • Policies and procedures all reviewed and updated. • Reconfiguration of Psychiatrist and Psychologist staffing establishment completed. • Work continuing in improving communication and information provision to families. In addition the DHB has commissioned independent review of inpatient suicide incidents, this independent review is in progress.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Suspected suicide of inpatient	Y	1	Suspected suicide of inpatient	Combined review in progress with referring DHB		Note: A formal apology was made to the family at the time of the incident. Initial communication and meetings have been held with the client's family. A full copy of the review report with offer to meet as desired will be provided when the review is complete. In addition the DHB has commissioned independent review of inpatient suicide incidents, this independent review is in progress and will also consider this incident review when the incident review is complete.
Clinical management -monitoring/ observations	Y	2	Concern re care, treatment and location of stroke patient. Patient subsequently deceased.	Review in progress		Note: Family advised of review, report and offer of meeting as desired will be provided when review is complete.
Fall	N	2	Fall resulting in fractured hip	Review in progress		Note: Family advised of incident. Review report and offer of meeting as desired will be provided when review is complete.
Other	N	2	Patient with known allergy - anaphylactic allergic reaction to chlorhexidine impregnated equipment (catheter)	The review team extended a formal apology on behalf of the DHB to the patient and family. Review found: -the patient's allergy was known and staff took careful measures to reduce the risk of exposure to chlorhexidine -the multiple lumen line selected and used did not have a warning on the outer packaging although another line considered did have such a warning and was not used -none of the staff involved were aware that registered trademarks on the outer packaging that did not use the word	Recommendations related to: -providing an alert to all staff regarding the trademark significance -development of a policy for management of chlorhexidine allergy and list of all products used at the DHB that contain chlorhexidine -review of communication methodologies in the department of anaesthesia Immediate risk mitigations taken included: -withdrawal of the product from the DHB, meeting with manufacturer and subsequent labelling of all products to ensure it is clear on the outer packaging -stocking non chlorhexidine impregnated lines	The patient and family have been provided with a formal apology, a copy of the report and a meeting to discuss was held. Alert circulated to staff. Case will be presented at scheduled Grand Round. Policy development awaiting project leader allocation. Department of Anaesthesia review of communication methodologies completed.

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				chlorhexidine were intended to convey that the line did contain chlorhexidine	and storing those impregnated with chlorhexidine in one area only -the DHB notified the manufacturer, Medsafe, HQSC and all NZ DHBs	
Clinical management -diagnosis	N	2	Delay in diagnosis and treatment of lung cancer due to failure to follow up results of investigations	The review identified that there was no system to alert Emergency Department clinicians or the reporting Radiologist to additional imaging completed as per Radiology protocol. As a result a chest x-ray was not reported or reviewed leading to a 5 month delay in diagnosis of lung cancer.	The review noted that Radiology had already implemented process changes to mitigate this risk as a result of the incident and ahead of the completion of the review. The referring clinician is now informed of all additional imaging, and the new process ensures this is transparent to all clinicians. Induction of Radiologists now incorporates workflow image review processes.	The patient and family have been provided with a formal apology, a copy of the report and the offer of a meeting as desired. Process documentation is being finalised and then all actions will be complete.
Clinical management -diagnosis	N	2	Delay in diagnosis and treatment of breast cancer due to delay in follow up results of investigations	The review found that the delay in follow up of the result was due to the Breast Clinic not having a formal process in place to correlate investigations requested with reports received (to ensure all reports of requested investigations were received).	The review noted that the patient had been sent a formal apology. Recommendations related to: -Consideration by Strategic Clinical Governance of the need for set processes to correlate reports received with investigations ordered across all outpatient services, to reduce potential risk -Breast Clinic; changes to clinic processes including weekly review of the clinic Biopsy Book, regular meetings between Surgeons and Cytopathology Service, changes to laboratory report addresses -Laboratory review of the minimum requirements for information on Request Forms	The patient has been provided with a formal apology, a copy of the report and the offer of a meeting as desired. Planned implementation of the DHB electronic results sign off project is March 2013. A formal risk is recorded on the DHB risk register regarding lack of an overall system and consistent processes to ensure results of all requested investigations are reviewed and signed off. As part of the risk mitigation plan Directors were asked to review and report on current systems and processes in place in each service for results review and sign off and to identify and address any risks noted. This has resulted in some further process changes being implemented and/or commencing. The Breast Clinic process including the laboratory report address have been changed. Weekly review of the clinic biopsy book has been instigated. The Laboratory have completed the review of minimum requirements for information on Request Forms and implementation of this is underway by the clinic.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -diagnosis	N	2	Delay in diagnosis of intracranial haemorrhage (bleed in brain).	The review found that the presentation was atypical and a diagnosis of migraine was reasonable given the presenting signs, symptoms and history. The review team considered that appropriate care was given, to the patient who responded to treatment for migraine. Review noted written discharge instructions were not comprehensive.	The review noted that the Emergency Department had commenced developing guidelines for headache subsequent to identifying that this incident had occurred. Recommendations related to: -formal apology and provision of the report to the patient with offer of a meeting to discuss if desired -completion and implementation of Emergency Department headache guideline with associated education -Emergency Department process improvement project in relation to written discharge instructions -Emergency Department consideration of feasibility of developing a list of "trigger presentations" that require Senior Medical Officer review	The patient has been provided with a formal apology, a copy of the report and a meeting is scheduled. Emergency Department headache guideline is in progress. Other actions commencing.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -diagnosis	N	2	Delay in diagnosis and treatment of rectal cancer due to significant delay in referral process	The review found that the root cause of the delay in diagnosis was that at the time of the incident Gastroenterology Services did not have a system in place to effectively monitor and manage wait lists where patients were exceeding nationally recommended waiting timeframes.	The review noted that in April 2012 it was identified that Gastroenterology Services was not able to deliver investigations within guideline timeframes. As a result a number of risk mitigations were implemented including; monitoring and reporting the waiting list and wait times, clinical assessment and review of all patients waiting over 5 months, a plan to reduce the wait list including additional sessions and matching resources to workload. The review team considered the above plan provided sufficient risk mitigation to prevent a similar incident. Recommendations related to: -formal apology and provision of the report to the patient with offer of a meeting to discuss if desired -clinical review of the waiting list and communication as required with the patient should the clinical review identify that the delay has affected the outcome -development of an agreed process to inform patients of options including private options for investigations and treatment.	The patient has been provided with a formal apology, a copy of the report and offer of a meeting as desired. A formal risk is recorded on the DHB risk register regarding lack of an overall system and consistent processes to ensure results of all requested investigations are reviewed and signed off. As part of the risk mitigation plan Directors were asked to review and report on systems and processes in place for each service for results review and sign off and to identify and address any risks noted. This has resulted in some further process changes being implemented and/or commencing. Gastroenterology Services risk mitigation plan and resource planning continue to ensure the waiting time continues to reduce and is sustained. Clinical review in progress. Development of an agreed process for informing patients of their options (including private options) is commencing. Gastroenterology and Laboratory have commenced meetings to progress the action to improve the communication of and processes for results of investigations.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -diagnosis	N	2	Delay in diagnosis and treatment of lung cancer due to failure of planned follow up results of investigations	The review found that follow up ordered for a patient referred to Respiratory Services did not occur due to a failure in the process for booking follow up appointments and a lack of audit to ensure all requested follow up appointments are booked. As a result there was a four year delay in the initiation of treatment for the patient's lung cancer. The review noted that since the Respiratory Services moved together with other services within the Clinical Measurement Unit (CMU) the booking system had changed including audit which mitigated future risk. However during the course of the review it was identified that the new CMU booking and follow up process had been subsequently altered which created the potential for a similar incident to occur. The formal CMU process was immediately re-instigated when this was identified during the review therefore managing the risk going forward.	Recommendations related to: -formal apology and provision of the report to the patient with offer of a meeting to discuss if desired -noting the risk of a similar incident was considered sufficiently mitigated by actions implemented during the review, and that further improvement of booking and audit processes was in progress.	The patient has been provided with a formal apology, a copy of the report and offer of a meeting as desired. A formal risk is recorded on the DHB risk register regarding lack of an overall system and consistent processes to ensure results of all requested investigations are reviewed and signed off. As part of the risk mitigation plan Directors were asked to review and report on systems and processes in place for each service for results review and sign off and to identify and address any risks noted. This has resulted in some further process changes being implemented and/or commencing. The new audit process is in place for all services now based in the Clinical Measurement Unit (CMU) including Respiratory Services, with ongoing work to further improve the CMU booking and audit process.
Clinical management -diagnosis	Y	2	Delay in diagnosis and treatment of lung cancer due to failure to follow up results of investigations	The review found that the patient's surgical care and recovery 2 years previously was unremarkable, and that an incidental finding detected during the admission was not picked up on or actively managed at that time. As a result the patient was not informed of the finding, and no decisions regarding further investigation, diagnosis and treatment were initiated. The review noted that subsequent to a previous incident, the	The review noted the risk mitigations that the DHB had implemented as detailed in the review findings section and noted that the risk mitigations implemented were considered sufficient mitigation to reduce the risk of a similar incident occurring. The review team recommended formal apology and provision of the report to the patient's family with offer of a meeting to discuss if desired.	The patient's family have been provided with a formal apology, a copy of the report and a meeting to discuss was held. A formal risk is recorded on the DHB risk register regarding lack of an overall system and consistent processes to ensure results of all requested investigations are reviewed and signed off. As part of the risk mitigation plan Directors were asked to review and report on the systems and processes in place for each service for results review and sign off and to identify and address any risks noted. This has resulted in some further process changes being implemented and/or

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				DHB had implemented a number of mitigations to reduce the risk of this type of incident occurring. These included; a guideline for communication of Radiology results and an electronic Radiology system which improved report times and visibility of images to the ordering clinician. When this incident was identified, and before the review was completed, the DHB implemented further risk mitigations including: routine copying of Radiology reports to general practitioners (GPs) and the Respiratory Service, staff then cross check that the patient is being followed up. The Intensive Care Unit (ICU) changed processes so that incidental findings are now included routinely in both the hospital discharge summary and the ICU internal transfer summary. ICU also now requires both verbal and written handovers to the clinical team responsible for the patient to be completed prior to patient transfer to the ward.		commencing.
Clinical management -diagnosis	Y	2	Pulmonary embolus (blood clot in lung) not diagnosed on CT scan. Patient subsequently deceased.	Review in progress		Note: Meeting with family held at commencement of review to advise of incident, apologise and inform of review. A full copy of the report and offer of meeting as desired will be provided when review is complete.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -treatment	N	2	Delay in diagnosis and treatment of bowel cancer due to delayed follow up of results of procedure.	The review found that there was a two month delay in follow up of a patient's colonoscopy findings due to the lack of a process to ensure that reports were actioned during periods of gastroenterologist leave. The review found that there is no formalised process to monitor histology reports on a day to day basis. The review acknowledged that the DHB Electronic Results Sign Off project is due for implementation March 2013 and will mitigate much risk of such an incident occurring in the future.	Recommendations related to: -formal apology and provision of the report to the patient and family with offer of a meeting to discuss if desired -Gastroenterology Services implement a system to monitor histology results day to day and to ensure reports are actioned during staff leave.	The patient and family will be provided with a formal apology, a copy of the report and an offer to meet as desired. A formal risk is recorded on the DHB risk register regarding lack of an overall system and consistent processes to ensure results of all requested investigations are reviewed and signed off. As part of the risk mitigation plan the Directors were asked to review and report on current systems and processes within each service for results review and sign off and to identify and address any risks noted, this has resulted in some further process changes being implemented and/or commencing. Gastroenterology Services have commenced developing systems for monitoring day to day histology results and ensuring reports are actioned during staff leave. Gastroenterology Services will now request "Copy to Gastroenterology Services" on all Inpatient Request Forms (this is already addressed for outpatients) to ensure all results requested by individual gastroenterologists are received by the service. Gastroenterology and Laboratory have commenced meetings to improve the communication of and processes for reporting and reviewing results of investigations.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -treatment	Y	2	Delay in diagnosis and treatment of sepsis. Patient subsequently deceased.	The review found: -the treatment plan and care in Emergency Department and the ward was appropriate -communication and decision making between specialties in relation to investigations was appropriate -the lack of any documentation of the specialty plan or medical handover for the patient was not desirable Review noted that the following actions had subsequently been implemented: -Rapid medical rounds -Structured medical handover on weekends -Medicines reconciliation -Early warning score	Recommendations related to: -Sepsis recognition education -Sepsis pathway development -Shared information with general practitioners	Communication with the patient's family has been managed in accordance with the Health and Disability Commissioner's complaints process. Ongoing sepsis recognition education continues. A sepsis pathway for the Medical Assessment and Planning Unit has been developed and implemented. The Internal Medicine service is leading the DHB wide generic sepsis pathway project. "Manage my health" - a DHB project is in progress this will enable visibility of primary/General Practitioner records to hospital clinicians.
Clinical management -treatment	Y	2	Unexpected death of patient following attendance at clinic	Review in progress		Note: Family advised of review, report and offer of meeting as desired will be provided when review is complete.
Medication	N	2	Concern re discharge medications. Patient required readmission for 11 days.	Review in progress		Note: Patient advised of review, report and offer of meeting as desired will be provided when review is complete.

Event Category	Died?	SAC Rating	Event summary	REVIEW Key findings	REVIEW Recommendations	REVIEW Recommendations progress i.e. action plan
Clinical management -treatment	Y	2	Post dates induction of labour, foetal distress. Emergency caesarean section. Infant subsequently deceased.	Review in progress		Note: Woman and family advised of review, meeting to discuss held. Report and offer of meeting as desired will be provided when review is complete.
Medication	Y	2	Concern re discharge medications. Patient required readmission. Patient subsequently deceased.	Review in progress		Note: Family advised of review, report and offer of meeting as desired will be provided when review is complete.