Waitemata District Health Board
Te Wai Awhina

Waitemata District Health Board
Serious & Sentinel Events Report FY 2011/2012

Falls					
SAC	**RE Code**	**Summary of Reportable Event**	**Investigation Findings**	**Recommendations**	**Follow up**
1	6	84 year old patient fell resulting in a fractured hip Falls prevention measures in place Fall occurred while mobilising independently Patient died post operatively	1. At the time of the incident falls risk assessment not in place in the Assessment Diagnostic Unit (ADU). 2. High operative risk due to medical history.	1. Falls Risk Assessment now in place in ADU 2. Falls Prevention Programme and Falls Audit	A Falls Prevention Programme has been implemented as a DHB quality improvement project and in collaboration with the Northern Region DHBs as part of the First Do No Harm programme. A multidisciplinary falls prevention steering group has been established to oversee the programme. All serious falls are investigated to identify contributing factors and are referred to the steering group to inform the falls prevention programme. Multiple targeted interventions have been implemented over the past 12 months, and continue to be implemented, to prevent falls and mitigate harm from falls. These include: – Hourly rounding of patients – Ward-based multi-disciplinary team review of all falls – In-depth investigation and analysis of falls resulting in fracture – Falls sticker added to patient chart (to alert staff of patient fall) – Non slip red socks – Fall alert magnets for nursing station whiteboards – A revised falls risk assessment tool – Automatic alert on patient information management system
2	6	77 year old patient fell resulting in a fractured hip. Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls risk assessment accurately completed. Falls care plan implemented on admission and reassessed after fall.	1. Falls Prevention Programme and Falls Audit.	
2	6	83 year old patient fell resulting in a fractured hip Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently Patient had a further fall which resulted in a fractured elbow	1. Falls risk assessment accurately completed. Falls care plan implemented on admission and reassessed. 2. Right side residual weakness contributed to fall	1. Falls Prevention Programme and Falls Audit	
2	6	76 year old patient fell resulting in fractured hip Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls risk assessment accurately completed. Falls care plan implemented on admission (high risk) and reassessed. 2. Possible contribution of medications oxynorm and fentanyl to the patient's fall. 3. Usually rang the bell for assistance but did not on this occasion.	1. Falls Prevention Programme and Falls Audit	
2	6	75 year old patient fell resulting in a fractured ankle. Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls risk assessment accurately completed. Falls care plan implemented on admission and reassessed (low risk). 2. Syncopal (fainting) episode contributed to fall	1. Falls Prevention Programme and Falls Audit	
2	6	54 year old patient fell resulting in a fractured hip Falls risk assessment and falls care plan	1. Falls risk assessment and falls care plan not completed 2. Severe osteoporosis not known on	1. Education and training in relation to falls risk assessment being completed on all patients 2. Falls Prevention Programme and Falls Audit	

		not implemented Fall occurred while mobilising independently with crutches after surgical repair of other fractured hip (sustained in a fall at home)	admission		
2	6	89 year old patient fell resulting in a fractured hip Falls risk assessment and falls care plan not completed Fall occurred while mobilising independently	1. Fall risk assessment and falls care plan not completed despite deterioration in patient's condition 2. Patient should not have been left unattended in the bathroom 3. Delay in response to call bell	1. Education and training in relation to: – falls risk assessment being completed on all patients – ensuring call bells are answered promptly 2. Falls Prevention Programme and Falls Audit	
2	6	67 year old patient fell resulting in a fractured hip Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls risk assessment completed. Falls care plan implemented on admission (medium risk) and reassessed 2. Delay in response to call bell 3. Possible contribution of usual night sedation medication	1. Falls Prevention Programme and Falls Audit	
2	6	79 year old patient fell resulting in a fractured hip Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls Risk Assessment completed. Falls care plan implemented on admission (able to mobilise independently) and reassessed and amended after fall. 2. High operative risk due to medical history	1. Falls Prevention Programme and Falls Audit	
2	6	88 year old patient fell resulting in a fractured hip Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently	1. Falls Risk Assessment completed. Falls care plan implemented on admission (high risk) and reassessed with the exception of a continence assessment and plan which may have prevented the fall	1. Education for staff to ensure that continence assessments and plans are completed for all patients as a part of the falls risk assessment 2. Falls Prevention Programme and Falls Audit	
1	6	86 year old patient fell hitting their head and sustaining a laceration Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently Delay in diagnosis of bilateral subdural haemorrhages. Patient subsequently died Referred to the Coroner	1. Falls risk assessment accurately completed. Falls care plan implemented on admission (high risk) and reassessed 2. Increased risk of sub-dural haemorrhage with dementia 3. CT head not undertaken in context of fluctuating behaviour and history of multiple recent falls and most recent fall resulting in head injury (laceration) – leading to delay in diagnosis of sub-dural haemorrhages 4. High operative risk due to medical history	1. Education with regard to ensuring information from multiple sources (e.g. speaking with relatives) is sought when staff are unfamiliar with dementia patient's baseline (usual) behaviour This will assist with recognising changes in patient behaviour in a more timely manner 2. Morbidity and mortality reviews by medical staff to highlight risks of subdural haemorrhage with dementia, and the need for vigilance in patients with unexplained and rapid deterioration in mental state or fluctuating behaviour	

				3. Falls Prevention Programme and Falls Audit	
2	6	60 year old patient fell resulting in a fractured hip. Falls risk assessment completed and falls care plan implemented Fall occurred while mobilising independently Patient died post operatively.	1. Falls risk assessment accurately completed. Falls care plan implemented on admission (high risk) and reassessed -this included nursing the patient on a high/low bed 2. Patient had cognitive impairment (from past brain injury) with residual weakness and impulsive behaviour which contributed to the fall 3. Difficulty moving patient back into bed from floor 4. 15 minute checks were in place as part of the falls care plan but these were not documented. Fall occurred in between these checks 5. High operative risk due to medical history	1. Case reviewed with ward staff regarding the preventability of the fall 2. Education and training about the importance of completing and documenting observations 3. Education and training on the safe moving and handling of patients after a fall 4. Education and training on the standards of documentation in clinical records when events occur	
2	6	84 year old patient fell resulting in a fractured hip Falls risk assessment not completed on admission Patient died post operatively	1. Falls risk assessment not completed 2. Patient had known dementia 3. High operative risk due to medical history	1. Education and training in relation to falls risk assessment being completed on all patients 2. Falls Prevention Programme and Falls Audit	

Clinical Management					
SAC	RE Code	Summary of Reportable Event	Investigation Findings	Recommendations	Follow up
2	4b	17 year old patient with crush injury to finger. Incorrect splint resulted in a necrotic fingertip requiring amputation	1. Crush injury managed using mallet splint which impeded blood supply leading to necrosis of the fingertip 2. Injury not appropriately assessed and monitored after initial review 3. Incomplete instructions given to primary care providers about requirements for follow up and review	1. Review clinical management of crush injuries with orthopaedic staff 2. Education to staff about appropriate treatment, follow up and monitoring of crush injuries	Completed
1	12	83 year old patient developed a Staphylococcus aureus bacteraemia 15 days after admission. Intravenous (IV) leur site likely cause of infection Patient subsequently died	1. Lack of compliance with IV Leur management policy – no documentation of date of insertion and daily condition of leur site 2. Lack of reporting of infected IV leur sites	1. Education to reinforce importance of compliance to the IV Leur Management Policy 2. Audit compliance with IV Leur Management policy	Completed

			3. Patient had a significant and complex medical history		
2	4c	81 year old patient with post-operative PCA (patient controlled analgesia) had an opiate-induced respiratory arrest and subsequent cardiac arrest Patient fully recovered	1. Patient deterioration not recognised 2. Patient controlled analgesia policy not followed	1. Education to reinforce importance of : – following NEWS (Early Warning Score) Policy – ensuring pre-operative observations are noted on the NEWS Chart – recording patient controlled analgesia (PCA) observations – opiate induced respiratory depression	A multidisciplinary team is investigating measures to improve knowledge and practise in relation to opiate prescribing and administration. Measures being considered include: – Development of an oxycodone e-learning module (completed) – Development of a pain management e-learning module – A pain management workshop for medical and nursing staff – House surgeon rounding with the pain team and palliative care team as part of house surgeon training and education
1	4a 4b	Caesarean section for foetal distress. Baby died at birth.	Currently under investigation	Currently under investigation	
1	3	73 year old patient returned to theatre (within hours) for removal of retained swab	1. Count protocol not followed	1. Education of staff involved in relation to following correct count procedures 2. Reinforcement of use of surgical checklist	Completed
1	4g	83 year old patient collapsed and died one day post discharge Patient had bowel surgery eight days prior Referred to the Coroner	Currently under investigation	Currently under investigation	
2	12	75 year old patient developed a central line associated blood stream infection (methicillin resistant Staphlococcus aureus (MRSA))	1. Early advice from infectious disease physician when patient first isolated MRSA in sputum not requested.	1. Education and training sessions to highlight importance of timely request for input/advice from infectious diseases physicians for this group of patients	Completed
1	4g	31 year old patient had a cardiac arrest while receiving haemodialysis at a satellite unit Patient subsequently died. Discussed with Coroner but not for inquest	1. St John Ambulance called to emergency situation in satellite unit	1. Review of current satellite unit emergency response policy as part of an organisation-wide patient transport quality improvement project. Project is reviewing transportation of critically ill patients	Phase 1 of a transportation of critically ill patients quality improvement project commenced in September 2012
2	5 4g	42 year old patient inappropriately prescribed opiate medication, and inadequately monitored following opiate administration Patient suffered respiratory depression resulting in transfer to intensive care for airway management	1. Patient with complex medical history not appropriate for elective surgery admission at Waitakere Hospital 2. Admission to discharge planner (A-D planner) not completed – patient's background history not clearly documented 3. Inconsistency between requirements for frequency and documentation of observations for patients receiving intravenous opiates and regular oral opiates	1. Review pre-operative assessment processes for elective surgery patients at Waitakere Hospital 2. Review requirements for completion of A-D planner, and education and training of staff about requirements 3. Review and amend opiate management and observation policies so that observations for those receiving regular oral opiates is the same as for those receiving PCA analgesia	1. Completed 2. Review completed and education and training underway 3. Amendment of policies underway
2	3	36 year old required removal of a vaginal swab 3 weeks after birth	1. Count protocol not followed	1. Education and training in relation to completing a swab count when suturing, and documentation of count on labour and delivery form	Completed

2	4d	34 year old sustained a bladder perforation during laparoscopic surgery requiring transfer to a tertiary facility for urological repair	Under investigation	Under investigation	
2	4b	44 year old patient received an unnecessary operation: booked for removal of a portacath (port with catheter inserted beneath the skin); procedure under local anaesthetic; no portacath insitu; procedure abandoned	Under investigation	Under investigation	

Medication Events					
SAC	**RE Code**	**Summary of Reportable Event**	**Investigation Findings**	**1. Recommendations**	**Follow up**
2	5	79 year old patient readmitted after adverse response to medication. Patient discharged with unclear monitoring instructions Fully recovered	1. Decision to prescribe medication (sotalol) made after careful consideration and trialling of the medication prior to discharge 2. Post discharge instructions not well detailed	1. Discuss at Medication Safety Group Meeting to align renal dose protocols with regional DHBs 2. Educate medical staff on the safe prescribing of sotalol in patients with renal impairment, and documenting and communicating clear post discharge instructions	Completed
2	5	89 year old patient incorrectly prescribed medication. Fully recovered	1. Appropriate admission medication history not completed. Previous discharge summary used to document medications. 2. GP and Test Safe information to clarify medications and dosages not reviewed 3. Correct timing of medication not checked 4. Unclear date of prescription 5. Error identified via Pharmacist Medicine Reconciliation	1. Clinicians to complete e-Learning prescribing modules 2. Education of staff regarding using multiple sources for medicine reconciliation 3. Implementation of the electronic e-medicines reconciliation (eMR) programme	Electronic medicine reconciliation pilot underway.
2	5	83 year old patient deteriorated after a prescribing and administration error. Fully recovered	1. Appropriate admission medication history not completed. Previous discharge summary used to document medications 2. GP and Test Safe information to clarify medications and dosages not reviewed 3. Unclear prescribing date and time for medication administration 4. Correct timing of medication not checked 5. Error identified via pharmacist medicine reconciliation	1. Clinicians to complete e-Learning prescribing modules 2. Education of staff regarding using multiple sources for eMR 3. Implementation of eMR Programme	Electronic medicine reconciliation pilot underway.

Inpatient Suicide					
SAC	RE Code	Summary of Reportable Event	Investigation Findings	2. Recommendations	Follow up
1	2	Completed suicide of an 83 year old patient who left a medical inpatient unit and was found deceased at home Referred to the Coroner	1. No indication the patient had any suicidal ideation; no previous mental health history	1. Hourly rounding of patients	Completed