Waitemata District Health Board
Best Care for Everyone

Serious & Sentinel Events Report FY 2013/2014

Falls

#	Died ?	SAC	RE Code	Date of Event	Summary of Reportable Event (as per brief descriptor on REB)	Key Investigation Findings	Recommendations
1	N	2	12	14/07/2013	A patient sustained a head injury as the result of a fall. The patient was discharged home after rehabilitation.	• A falls risk assessment was not completed on admission (within eight hours of admission). The risk assessment was completed later on admission to the ward (moderate falls risk). • An individualised falls prevention care plan was not in place.	A falls prevention programme is in place focusing on a number of key activities, including: • Ward case and data reviews – the Heads of Division Nursing meet with all wards and falls champions to discuss ward falls data, particular ward issues and the importance of preventing falls with serious harm. • Falls Champions – falls champions have been identified on every ward and education and training days are held regularly. Topics discussed include falls data, themes identified from serious and sentinel event investigations, events, the use of cot sides, observation of patients, handover from ward to ward, the importance of minimising clutter and timely and complete risk assessment and care planning. • Improving investigations – the role of the charge nurse manager in the initial stage of investigating a fall has been reinforced and a new falls investigation template report has been developed to ensure investigations identify recommendations that will help prevent harm from falls . • A schedule of weekly auditing of falls risk assessments and care planning commenced in August 2013. There has been significant improvement in the national Health Quality and Safety Falls Markers (the per cent of at-risk patients assessed for risk of falls; and the per cent of patients medium or high-risk for falling with an individualised care plan) since the introduction of this weekly audit. The audit results are now available in real time for senior nurses to monitor and report to ward staff - and to patients and their families - via ward quality boards.
2	N	2	12	21/07/2013	A patient sustained a fractured arm as the result of a fall. The patient was managed conservatively with a collar & cuff and was discharged home with support.	• The patient was accurately assessed as a low falls risk on admission. • All appropriate low falls risk care plan interventions/measures were in place.	
3	N	2	12	26/07/2013	A patient sustained a fractured vertebra as the result of a fall. The patient did not require rehabilitation and was discharged home.	• A falls risk assessment was completed on admission to the Assessment & Diagnostic Unit (ADU) and the patient was correctly assessed as a high falls risk. • A high falls risk care plan was not documented. • The patient was referred to physiotherapy for review. The fall occurred before the review could be completed. • Confusion and an unfamiliar environment were factors that likely contributed to the patient's fall.	
4	N	2	12	28/07/2013	A patient sustained a fractured hip as the result of a fall. The patient was discharged home after rehabilitation.	• A falls risk assessment was completed 12 days after admission. The patient was scored as a high falls risk. • The falls risk assessment should have been updated following a change in the patient's mobility status. • The patient had difficulty with balance and severe osteoporosis which were factors that likely contributed to the fall.	
5	Y	2	12	31/07/2013	A terminally-ill patient sustained a fractured hip as the result of a fall. The patient died a day after the fall. The fall was not the cause of death.	• The patient was accurately assessed as a medium falls risk on admission. • The patient was-assessed as a high falls risk when medical condition deteriorated. • There was no documented individualised falls prevention care plan with interventions/measures in place. • End-of-life care was in place for the patient's terminal medical condition, which included morphine pain relief. It is likely the morphine contributed to the patient's fall.	
6	Y	2	12	31/07/2013	A patient sustained a fractured hip as the result of a fall. The patient died a month after the fall. The fall was not the cause of death.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place with the exception of a low line bed, which was deemed unsuitable for the patient. • The patient was assessed as safe to walk without assistance.	

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						• The patient's fractured hip contributed to but was not the cause of the patient's death.	
7	N	2	12	01/08/2013	A patient sustained a fractured arm as the result of a fall. The patient was discharged back to a residential aged care facility.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
8	N	2	12	02/08/2013	A patient sustained a fractured hip as the result of a fall. The patient was discharged home after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • The patient's confusion contributed to the patient's fall.	
9	N	2	12	04/08/2013	A patient fractured a vertebra as the result of a fall. The patient was discharged home after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • The patient's confusion/disorientation and medical condition contributed to the patient's fall.	
10	N	2	12	05/08/2013	A patient sustained a fractured pelvis and facial fracture as the result of a fall. The patient was discharged to a residential aged care facility after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • The patient had mild cognitive impairment which may have contributed to the fall. • The patient's medication may have contributed to the fall.	
11	N	2	12	06/08/2013	A patient sustained fractures to the pelvis and hip as the result of a fall. The patient was discharged home after rehabilitation.	• A falls risk assessment was not completed on admission. • There was no individualised falls prevention care plan with interventions/measures in place. • The patient's medication likely contributed to the patient's fall.	
12	Y	2	12	17/09/2013	A patient sustained a head injury as the result of a fall. The patient died a day after the fall. The patient's death was unrelated to the fall.	• A falls risk assessment was not completed as the patient was immobile. • Cots sides were used and were appropriate for this patient. • One cot-side was down at time of the patient's fall due to the patient eating a meal. • The patient lost balance while trying to re-position in the bed. • The patient's confusion contributed to the patient's fall.	
13	N	2	12	25/09/2013	A patient sustained a fractured hip as the result of a fall. The patient was discharged home after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	

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						• The patient's acute confusion contributed to the fall.	
14	N	2	12	01/10/2013	A patient sustained a fractured hip and dislocated finger as the result of a fall. The patient was discharged to a residential aged care facility after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • The patient's acute confusion contributed to the fall.	
15	N	2	12	03/10/2013	A patient sustained a fractured pelvis and hip as the result of a fall. The patient was discharged home after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
16	N	2	12	09/10/2013	A patient sustained a fractured leg as the result of a fall. The patient was discharged home after rehabilitation.	• The falls risk assessment on admission was not accurate. Therefore, the falls care plan interventions/measures in place did not accurately reflect the care required.	
17	N	2	12	12/10/2013	A patient sustained a fractured hip as the result of a fall. The patient was discharged to a residential aged care facility after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
18	N	2	12	15/10/2013	A patient sustained a fractured elbow as the result of a fall. The patient was discharged home the day after surgery.	• A falls risk assessment was not completed as the patient was attending an outpatient appointment. • The patient was noted to be fully independent with no cognitive impairment.	
19	N	2	12	15/10/2013	A patient sustained a fractured leg as the result of a fall. The patient was discharged home.	• The patient was assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place but non-slip socks had not been replaced at the time of the fall.	
20	Y	1	12	29/10/2013	A patient sustained a fractured hip as the result of a fall. The patient subsequently died. The fall was not the cause of death.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
21	Y	2	12	05/11/2013	A patient sustained a fractured elbow as the result of a fall. The patient died a month after the fall. The fall was not the cause of death.	• The patient was accurately assessed as a high falls risk on admission • Not all appropriate high falls risk interventions/measures were in place e.g. no low line bed; no toileting plan in place; no evidence of hourly rounding being completed. • Bed rails were used but were contraindicated. The patient climbed over the bed rails. A low line be would have been more appropriate. • The addition of 10-minute checks would have been appropriate for	

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						the patient.	
22	N	2	12	18/11/2013	A patient sustained a fractured arm and lacerations to scalp as the result of a fall. The patient was discharged to an aged residential care facility after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
23	Y	2	12	20/11/2013	A patient sustained a fractured hip as the result of a fall. The patient died six weeks after the fall. The fall was not the cause of death.	• The patient was accurately assessed as a high falls risk on admission. • Not all appropriate high falls risk interventions/measures were in place e.g. 15-minute checks were not completed and a personal alarm was not in place.	
24	N	2	12	12/12/2013	A patient sustained a fractured hip as the result of a fall. The patient was discharged home after rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
25	N	2	12	12/01/2014	A patient sustained a fractured hand as the result of a fall. The patient was discharged home after rehabilitation.	• A falls risk assessment was not completed on admission. • There were no individualised falls prevention care plan interventions/measures in place. • The patient was known to be a high falls risk from multiple previous admissions.	
26	N	2	12	29/01/2014	A patient sustained a fractured clavicle (collar bone) as a result of a fall. The patient was discharged home with support.	• A falls risk assessment was not completed on admission. • There was no individualised falls prevention care plan with interventions/measures in place. • The patient's low blood pressure likely contributed to the patient's fall. • The patient was transferred late at night and was unfamiliar with the environment.	
27	N	2	12	11/02/2014	A patient sustained a fractured wrist as a result of a fall. The patient was discharged to an aged residential care facility.	• A falls risk assessment was not completed on admission. • There was no individualised falls prevention care plan with interventions/measures in place. • There was no continence assessment or plan in place. • The patient's confusion contributed to the patient's fall.	
28	N	2	12	21/02/2014	A patient sustained a fractured hip as a result of a fall. The patient was discharged to an aged residential care facility after a period of rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
29	N	2	12	20/02/2014	A patient sustained a head injury as a result of a fall. The patient was discharged to an aged residential care facility	• The patient was accurately assessed as a high falls risk on admission.	

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					after a period of rehabilitation.	• All appropriate high falls risk interventions/measures were in place. • There was no continence assessment or plan in place.	
30	N	2	12	27/02/2014	A patient sustained a fractured wrist as a result of a fall. The patient was discharged to an aged residential care facility after a period of rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • Not all appropriate high falls risk interventions/measures were in place e.g. no low-line bed, 15minute checks were not completed and a personal alarm was not in place.	
31	Y	1	12	03/03/2014	A patient sustained a head injury (haemorrhage) as a result of a fall. The patient subsequently died.	• The patient was accurately assessed as a high falls risk on admission. • The falls risk care plan interventions/measures in place did not accurately reflect the care required. The patient should have been on continual observation due to the patient's confusion. • The patient's confusion contributed to the fall. • The patient's fall contributed to the patient's death.	
32	N	2	12	20/03/2014	A patient sustained a fractured hip as a result of a fall. The patient was discharged to an aged residential care facility after a period of rehabilitation.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • There was no continence assessment or plan in place.	
33	N	2	12	02/04/2014	A patient sustained a fractured nose as a result of a fall. The patient was discharged back to an aged residential care facility.	• A falls risk assessment was not accurate on admission. Therefore, the falls risk care plan interventions/measures did not accurately reflect the care required.	
34	Y	1	12	18/04/2014	A patient sustained a fractured leg as a result of a fall. The patient subsequently died. The fall was not the cause of death.	• The patient was accurately assessed as a high falls risk on admission. • Not all appropriate high falls risk interventions/measures were in place - a personal alarm could have been considered.	
35	N	2	12	28/04/2014	A patient sustained facial injuries including a fractured nose as a result of a fall. The patient was discharged to a residential aged care facility.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place. • The patient's confusion and medications contributed to the fall. • The use of cot sides contributed to the patient's fall.	
36	Y	1	12	09/05/2014	A patient sustained a fractured pelvis and hip as the result of a fall. The patient subsequently died. The fall was not the cause of death.	• A falls risk assessment was not accurate on admission. • The falls risk care plan interventions/measures in place did not accurately reflect care required. • The patient's delirium contributed to the fall.	
37	N	2	12	13/05/2014	A patient sustained a fractured leg as a result of a fall.	• The falls risk assessment was inaccurate on admission. Therefore, the	

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						falls risk care plan measures in place did not accurately reflect care required. • The patient's walking stick was not placed where the patient could easily access it.	
38	N	2	12	20/05/2014	A patient sustained a fractured rib as a result of a fall. The patient was discharged back to a residential aged care facility.	• The patient was accurately assessed as a high falls risk on admission. • All appropriate high falls risk interventions/measures were in place.	
39	N	2	12	01/06/2014	A patient sustained a fractured hip as a result of a fall. The patient was discharged to a private hospital as the patient was not able to complete rehabilitation.	• A falls risk assessment was incomplete on admission. • The falls risk care plan interventions/measures in place did not accurately reflect the care required - the patient required one to one observation, not 10 minute checks. • Hourly rounding was not documented in the patient's clinical records	

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1	N	0	02	21/10/2013	A patient required further surgery to remove a retained specimen.	There were a number of issues during the patient's surgery that resulted in the usual specimen collection process and the Surgical Safety Checklist process not being followed.	• Breaks will not be scheduled during short surgeries to ensure consistency of staff in theatres. • Labelling of the specimen pot and entry into the specimen tracking book will not occur until the specimen has been received by the circulating nurse. • The Surgical Safety Checklist should be modified to clearly define who is responsible for completing each step.	Open disclosure was completed by the anaesthetic and surgical teams. Audit of the Surgical Safety Checklist following the incident shows consistent compliance with >98% compliance in completing of all three parts of the checklist.
2	Y	1	02	01/10/2013	A patient died after suffering a severe postpartum haemorrhage at home following a birth.	• Patient not able to be resuscitated. • There was limited briefing of maternity unit staff prior to patient's arrival. • The appropriate emergency call pathway was not followed but this did not contribute to the outcome.	• Reinforce ISBAR (Identify, Situation, Background, Assessment and Request) communication tool to Waitemata DHB maternity services staff. • Review maternity emergency external transfer protocols. • Reinforce maternity emergency call pathways and educate/update staff.	
3	N	2	02	02/10/2013	A baby suffered neonatal meconium aspiration syndrome complicated by a pneumothorax (air in space around lung) and neonatal stroke intrapartum.	• The current guidelines for CTG monitoring did not include duration required of monitoring for reduced fetal movements.	• Update the guideline regarding management of reduced fetal movements that includes recommended length of CTG trace recording.	

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4	N	2	02	10/12/2013	A baby sustained a skull fracture and brain haemorrhage during a difficult birthing process. Baby discharged home.	• The procedures used were consistent with standard practice and were used with reasonable caution. • The caesarean section was complicated because of a long second-stage labour • The skull fracture and sub-galeal haematoma (blood clot) could have resulted from the ventouse/forceps/traction assisted caesarean delivery; or could have occurred spontaneously and not be related to techniques or procedure used in this case.	Nil recommendations.	
5	Y	1	02	07/03/2014	A neonatal death associated with a water birth.	• The water birth was appropriate - Waitemata DHB's inclusion criteria of water for labour and birth were met. • There was a normal progression of labour i.e. no adverse factors noted in fetal or maternal wellbeing during labour.	• The death is being investigated by the Coroner.	
6	N	2	02	29/04/2014	A neonate sustained a head injury (subdural (brain haemorrhage) in the mother's pelvis during labour.	An investigation is underway.		
7	Y	1	02	17/04/2014	A patient sustained a cardiac tamponade following the insertion of a central venous catheter. The patient deteriorated and subsequently died.	An investigation is underway.	• The death is being investigated by the Coroner.	
8	N	2	02	18/10/2013	There was a delay in the timely assessment of a patient referred with skin cancer.	• The patient's referral was logged and appropriately prioritised for specialist assessment. • The patient's referral waited 150 days from receipt to the first specialist assessment appointment. • There was no alert system that identified and flagged that there was a delay between the referral being received and logged and the referral being wait-listed.	• A Patient Service Centre (booking and scheduling) improvement project is underway; regular reporting and monitoring of referrals is underway. An electronic flag now highlights cases where there is a delay between logging and wait-listing a referral.	
9	N	2	02	18/06/2014	A patient experienced a delay in diagnosis and treatment for cancer.	• The patient waited 55 days after a biopsy showed residual cancer for a follow-up appointment.	• A new electronic system will provide alerts for pathology and other laboratory reports. • Until a new system is in place, regular monitoring will occur to ensure results are checked and signed off by	

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						• The priority grading for patients with a histology that confirms cancer does not generally change which can result in delays in follow-up.	clinicians. • Any patient that returns a positive histology result for cancer should be upgraded to a priority 1 (urgent) referral.	

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

SAC	Severity Assessment Code - (Severity of outcome to patient)
1	Serious or Death
2	Major