Auckland District Health Board Summary
1 July 2011 to 30 June 2012
Serious and Sentinel Events

There were 60 serious and sentinel events reported by ADHB in the July 2011 to June 2012 year.

Events identified as serious and sentinel received an in-depth investigation by a team of clinicians and quality department staff who were independent from the event. The report was reviewed by a committee of senior management and senior clinical staff for robustness and for issues which may need to be addressed at an organisational level. The recommendations from the reports are tracked to ensure that follow-up and implementation occurs.

The table and report below outlines a summary of events, findings and recommendations of the events which have occurred. The events have been classified into nine themes:

- Delay in escalation of treatment
- Wrong procedure
- Patient mis-identification
- Procedural injury
- Medication error
- Delay/failure in follow up or treatment
- Failure to monitor
- Self harm
- Falls

Severity Code (SAC)	Description of Event	Review Findings	Recommendations/Actions	Completed
		Delay in escalation of treatment		
1	Delay in diagnosis of postoperative intra-abdominal complications with fatal outcome	Communication between clinicians Delay in recognising critical illness	Standardised handover (ISOBAR) Wider implementation of physiologic Early Warning Score Education to improve staff skills in recognition of critical illness	Complete Complete Complete
2	Delay in assessment and treatment following acute admission for postoperative complications. Subsequent cardiac arrest possibly preventable. Survived	Referral / handover issues – delay in being seen by appropriate staff Delay in detecting deterioration	Increase medical staff availability through roster re-design Improved registration and tracking of expected referrals	Complete Complete
2	Delay in diagnosis and treatment of organ failure caused by severe gastroenteritis. Patient died, preventability uncertain.	Delay in recognising critical illness	Wider implementation of physiologic Early Warning Score Education to improve staff skills in recognition of critical illness Expand medical high dependency services	Complete Complete In progress
1	Delay in identifying abnormal heart rhythm due to electrical interference, delaying resuscitation. Patient died, preventability uncertain.	Inability of staff to identify if artefacts real Lack of escalation of persistent presumed artefacts	Education package to be provided to address issues related to persistent artefacts, and escalation process.	In progress

		Wrong procedure		
1	Wrong intra-ocular lens used due to an ambiguous order for a special lens	Standardised lens ordering system	Revised lens ordering form	Complete
1	Intra-ocular injection into wrong eye. No harm to patient	No process for independent checks of correct side prior to procedure No handover and multiple distractions in procedure room	Implement "time-out" in the procedure rooms Limit access to procedure rooms to reduce distraction	Complete Complete
2	Incorrect bowel surgery performed causing bowel obstruction. Another operation required to correct error.	Complex case with other surgical issues causing distraction	Double check key operative steps during surgery Assessment of daytime workload Provide coaching to staff	Complete Complete Complete
1	Incorrect CT scan with contrast performed on patient	Two consecutive similar patients. No identification check of patient prior to radiological procedure	Review in progress	
		Patient mis-identification		
1	Due to patient mis-identification at a preoperative test, the wrong intra-ocular lens was implanted after cataract extraction	Failure to correctly identify patient prior to eye test Inconsistent test results not validated	Process for checking clinic patient name and address reviewed and improved Purpose built clinic addresses issue of patient queues which contributed to event	Complete Complete

1	Platelet transfusion given to wrong patient due to incomplete check process	Failure to check patient identity correctly	Enforce and audit 2-person check of patient identity Two-person check to be performed in area with minimal distraction	Complete Complete
		Procedural injury		
1	Accidental displacement of breathing tube in unstable patient during CT scan for trauma. Fatal additional brain injury due to lack of oxygen.	Combination of mechanical problems with position and security of breathing tube. Limited equipment available for alternative ventilation.	Transport checklist to include formal breathing tube security checks Change to longer breathing monitoring cables Increase range of breathing support equipment available during transport	Complete Complete Complete
2	Severe high pressure gas injury to lungs causing cardiac arrest during anaesthesia for complex airway surgery. Not fatal	New airway management technique with limited education of staff Limited options due to complexity of patient and constraints of the technique Patient factors increased risk of complication	Additional education of staff in new airway management system Purchase of new ventilator with enhanced safety features Multi-disciplinary briefings prior to all airway surgery introduced	Complete Complete Complete
2	Cardiac arrest due to blood vessel injury during treatment for life threatening heart rhythm irregularity	Unrecognised trauma to artery during procedure Difficult heart catheter access in complex patient with previous scarring of heart tissue Uncommonly performed procedure	Event reviewed with national colleagues and discussion of risks with use of recommended equipment in complex patients Consultation on ways to reduce risk of injury during procedure sought from overseas experts	Complete Complete

1	Bowel injury during gynaecological surgery requiring multiple re-operations for infection with eventual fatal outcome.	Awaiting formal review	Awaiting formal review	N/A
		Medication errors		
2	Incorrect medication given resulting in significant temporary deterioration. Patient died later of underlying condition.	Incomplete medication checking and documentation procedures	Improved drug labelling and clinical form to improve prescribing and documentation of medication administration Independent checking of medication Education of staff concerning safe medication practice and formation of medication safety group in the service	Complete Complete Complete
2	Overdose of local anaesthetic to airway resulting in cardiac arrest and significant brain injury (not fatal)	Total local anaesthetic dose not well appreciated High absorption sites of administration Limited monitoring to detect early signs of toxicity	Changes to the outpatient form to check for early signs of toxicity Increase monitoring of the patients' vital signs and purchase of new monitoring equipment Development of formal protocol for outpatient airway local anaesthesia	Complete Complete Complete

		Delay/Failure in follow-up or treatment		
1	Administrative error delayed follow up resulting in patient becoming blind in only seeing eye.	"Clinic Outcome" form lost preventing follow-up appointment being made	Change document handling process to ensure matching of clinical outcome form & clinic attendees	Complete
2	Failure to arrange for follow-up after ED discharge on the basis of abnormal blood tests resulted in delayed diagnosis of appendicitis	Blood tests not followed up and incorrect interpretation of blood results	Review post-discharge blood test result system	Complete
2	Administrative failure to ensure follow-up for abdominal aneurysm. Required emergency surgery after rupture.	Internal referral 'lost' in system	Use barcoded internal referral form for all internal referrals made by the service. Service internal referrals be logged at the central referral office Education and reminders to medical staff of the correct referral process	Complete Complete Complete
1	False negative lab result due to technical issues. Subsequent intrauterine fetal death. Preventability uncertain.	Technical (IT) failure No checklist to ensure correct setup of laboratory instrument	Technical (IT) issue resolved immediately. Develop checklists for instrument preparation and result authorisation	Complete In progress
2	Delay in identification of abnormal histology showing cancer, resulting in delay in treatment.	Laboratory specimen/request for additional testing not correctly tracked Delayed report was not escalated	System for reliable linkage of multiple laboratory tests Implement escalation process for overdue reports	In progress In progress

2	Unplanned pregnancy in high-risk patient following procedure for tubal ligation	No systematic process for following up and accepting obstetric pathology results	Work in progress to streamline accountability process for accepting and closing off laboratory results Implement escalation process for overdue reports Staff reminded of responsibilities re accepting results	In progress In progress Completed
		Failure to monitor		
2	Missed opportunities to prevent injury due to failure to screen for family violence over multiple hospital contacts.	Ongoing barriers to screening in the acute setting	Widespread education/reminders to staff regarding need for screening. Project group in place to understand and reduce barriers to screening.	Complete In progress
1	Delay/failure to escalate monitoring and treatment. Patient died, preventability uncertain.	Poor communication between clinical staff Limited patient observations	Staff communication workshops Expanded medical high dependency services	Complete In progress
1	Failure to monitor high risk patient in shower. Fatal cardiac arrest, preventability uncertain.	Failure to recognise severity of patients underlying condition	Risk assessment system for all patients on remote heart rhythm monitoring requiring shower Provide ward staff with experience in the high dependency cardiac care	Complete In progress

		Self harm		
2	Multiple injuries after intentionally falling 4 levels within hospital building. Not fatal.	Security guard and psychiatric watch roles not well defined or communicated	Full implementation of revised policy for management of patients at risk of self-harm, including skill levels and supervision required, communication and handover processes.	In progress
2	Non-English speaking patient left hospital and attempted suicide by drowning. Not fatal	Undiagnosed mental health issue Trained interpreters not utilised	Increase range and capability of translation / interpreter options	In progress
1	Suicide while on approved half-day leave from mental health unit	No direct causal factors were identified by the review team	Recommendations related to general service delivery issues are: Revision of transfer of care policy /processes. Integration of care planning between services	In progress
1	Suicide while on approved day leave from mental health unit	No direct causal factors were identified by the review team	Recommendations related to general service delivery issues are: Development of multidisciplinary care planning approach Collaborative discharge planning improvement	In progress

Inpatient Falls

Thirty-three patients had falls with major harm recorded in 2011-2012. Two patients' falls occurred in the 2010-2011 year, but were found in a retrospective review for falls with major harm. Therefore the number of falls with major harm in 2011-2012 was 31, compared to 34 in 2010-2011 (when the extra two falls are added). Only the falls that occurred in 2011-2012 are considered in the review findings here.

Twenty-one patients who fell sustained fractures (about half were hip fractures), two falls resulted in bleeding inside the patient's head, seven patients sustained lacerations that needed suturing, and one patient had a serious knee injury after a fall. The total number of patients with fractures after a fall in 2011-2012 is the same as the number in 2010-2011.

One patient died as a consequence of falling. In a second patient the fall was considered a significant condition contributing to the death, although not related to the condition causing the patient to die. Three other patients died after being injured from falling, but the injury from falling was not the cause or contributing factor to their death.

The majority of patients (17) fell on their way to or from the toilet, but the time of day was not a factor in the fall. Wearing socks was a factor in three falls. One patient fell climbing over bedrails.

Case review of all the falls found falls risk assessment was not always undertaken and different areas were either not using risk assessment tools or using different tools. No area was using one of the more accurate tools. Individualised falls care planning was variable. No comprehensive falls policy or guideline had been developed for use across the ADHB.

A multidisciplinary group including senior leadership was tasked with improvement specialist support to address falls with harm:

- Falls with major are now accurately categorised, quarterly checking through coding databases to ensure ADHB identifies all inpatients that fall and have major harm from the fall. Case review by the charge nurse and the clinical effectiveness advisor addressing the patient, environment and staff factors. Individualised recommendations to address these factors are developed.

- Standardised risk assessment with an intervention package has been agreed and forms are being printed with implementation across all adults areas in ADHB. The MORSE risk assessment tool has been incorporated into the tool.

- A falls policy has been developed and is being consulted on.

- Intentional rounding is being piloted in two wards. Intentional rounding involves patients being asked every hour if there is anything the staff member can do for the patient (in addition to normal clinical contact). Such an approach helps address comfort and toileting needs.

Falls with major harm have reduced since January 2012. From July to Dec 2011 there were 25 falls with major harm, but from January to June 2012 there have been 6 falls.