West Coast DHB Serious and Sentinel Event Report
01 July 2011 – 30 June 2012

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Category	Brief description	Main findings	Recommendations	Progress on implementation
4g (clinical management)	Resuscitation of baby performed in maternity ward	Medical and nursing staff congratulated on successful outcome. <u>Issue identified:</u> Need one location for resuscitation equipment, that minimises risk of infection and ensures equipment and skilled staff resources are on hand with immediacy	The most suitable location for resuscitation of neonates/infants is the Emergency Department A full range of age appropriate resuscitation equipment with the exception of a 'resuscitaire' be maintained at this location That the 'resuscitaire' be transported with immediacy to the Emergency Department when required	• Resuscitation Service Leader established providing clinical leadership, mentoring, and education • Resuscitation of infants presenting to Grey Hospital now occurs at ED • A full review of appropriate equipment, training needs, and maintenance requirements has occurred • Protocols to guide staff are being developed.
11 (other)	Patient threatened staff member	The patient's underlying mental state coupled with an unwanted referral to mental health services, and previous complaints about services, resulted in the threat.	The system for referral between services be reviewed A streamlined system for dealing with complaints is established Guidance for staff be developed around appropriate support for patients wishing to take complaints further	• Complaints system being streamlined for timely response
4d (procedure associated)	Burns to patient during surgery	Investigation still underway		

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4g (clinical management)	Attempted assault on staff and subsequent delay in transport	Links between the patient's underlying condition and reported subsequent behaviour were not fully recognised or addressed. The patient's anxiety exacerbated by outings contributed to agitation and ultimately an attempted assault. Lack of clarity in process led to a delay in Police escorted transfer of patient to high needs facility	Documented assessment of mental state, before and after leave become incorporated as standard practice in the inpatient unit	• Risk assessment and treatment planning documentation modified and adopted across region • Education package being developed for same, to be delivered in line with electronic clinical documentation system changes
			Risk Assessment process be modified to include recognition of risk patterns, and documentation linking management of assessed risks to the treatment plan.	
			Treatment planning process be modified to ensure regular updating of links between assessment and intervention in the context of changing presentation	
			Education for relevant staff regarding assessment and treatment planning process changes	
			Risk guidelines be developed regarding appropriate escorting for leave, and this be incorporated into Limits of Movement documentation	
			Clear guidelines be developed for transfer of high risk service users to Canterbury to include • communications with CDHB • the role and responsibilities of Police • the process for arranging transport and escort	