Serious and Sentinel Event Report
01 July 2012 – 30 June 2013

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

Category	Brief description	Main findings
2 (Clinical Process)	Cervical Ectopic Pregnancy	The misdiagnosis of a probable cervical pregnancy (a rare event) appears to be the significant factor.
Recommendations		**Progress on Implementation**
Develop robust protocols to exclude cervical ectopic pregnancy prior to further intervention.		Scan reporting now will consider possibility of cervical ectopic pregnancy.
Protocols developed for Medical Management of 1st Trimester Miscarriage formalised.		Protocols developed for Medical Management of 1st Trimester Miscarriage have been formalised.
Provision of enhanced information for patients post D&C for miscarriage.		Patients are informed of the www.Healthinfo.org.nz site which contains information regarding miscarriage and many other medical issues.
Review orientation package for locum Obstetrics and Gynaecology consultants to ensure they are fully aware of the limited facilities available in smaller centres.		The orientation package now includes informing locum Obstetrics and Gynaecology consultants of the limited facilities available in smaller centres.
Health literacy workshops provided locally to assist clinicians to consider effective communication.		Clinicians have access to patient communication and risk prevention workshops held nationally. Options for delivering workshops locally are still being explored.

Category	Brief description	Main findings
2 (Clinical Process)	Baby found to have cerebral damage as a result of reduced oxygen flow during birth	The review found that there were a number of factors contributing to the event. These have resulted in the recommendations for improvement.
Recommendations		**Progress on Implementation**
Ensure protocols for emergency caesarean sections include the requirement to call the on duty Paediatrician.		Protocols for emergency caesarean sections now include the requirement to call the on duty Paediatrician.
Guidelines developed to assist maternity staff to identify high risk pregnancies and appropriate care and delivery options.		Guidelines have been updated. They are readily available on the web site and they link to the Christchurch Women's Hospital guidelines.
Review timelines recommendations for emergency obstetric procedures.		Work is underway at a national and local level.
ISBAR Handover tool becomes the standard handover framework.		The tool is being rolled out throughout WCDHB.

Paediatricians' duty roster made widely available.	The Senior Medical Officer's Roster is now available on the intranet.
Initial and on-going STABLE (infant resuscitation) training provided.	Training has been provided.
Patient transfer guidelines to be developed with appropriate patient information.	Guidelines being developed.
Written information given to maternity patients is reviewed to ensure the use of clear language and avoidance of the use of medical jargon.	As patient information is being updated it is being checked to ensure the language is clear and medical jargon is not used.
Increased availability and staff education in the use of interpreters	Interpreter services now co-ordinated throughout the West Coast DHB.
Ensure information regarding entitlement to travel and accommodation assistance is known to staff and appropriately offered.	The role of National Travel Assistance Administrator within the DHB who co-ordinates access to travel and accommodation for patients has been publicised.

Category	**Brief description**	**Main findings**
2 (Clinical Process)	Patient death following a routine appendectomy	The review found that there were a number of factors contributing to the event. These have resulted in the recommendations for improvement.

Recommendations	**Progress on Implementation**
PACU (Post Anaesthesia Care Unit) documentation reviewed to ensure clarity around oxygen delivery required to maintain oxygen saturation.	The PACU documentation has been reviewed.
Develop clear discharge criteria and management guidelines for the post-operative care on discharge from PACU.	Discharge Criteria document has been modified from the Canterbury DHB PACU policy, to be WCDHB specific. Additional medical handover information and documentation has been implemented.
Formal and comprehensive programme for upskilling nurses to work in PACU.	Training has been provided. The nursing team are working across services. All theatre staff (nursing and anaesthetic technicians) attend the New Zealand Resuscitation Council "CORE Resuscitation Course."
Base for solo nurse in the paediatric unit be the nursing station as this is the point that provides the best observation of patients.	Base for solo nurse in paediatric unit is now the nursing station.
Clear documentation and communication around location of defibrillators made available.	Staff made aware of location of defibrillators.
Protocol developed for resuscitation to ensure that emergency trolleys are staffed by the team member with greatest familiarity of the clinical specialty and trolley in use.	Emergency trolleys have been standardised throughout the organisation.
Emergency trolleys and equipment throughout the organisation reviewed to ensure appropriate stock of paediatric equipment and drugs.	All clinical leads and relevant staff have met and agreed on appropriate stock of paediatric equipment and drugs for emergency trolleys.
Cardiac monitoring leads removed from general use defibrillators so that Paediatric defibrillator pads are the only option.	Cardiac monitoring leads have been removed so that Paediatric defibrillator pads are the only option.
Pulse oximeter monitors have default alarm volume increased to louder setting.	Pulse oximeter monitors have had their default alarm volume set to maximum

		setting.
Clinical deterioration scenarios practiced within teams to aid in establishing team roles and familiarisation with emergency equipment used during resuscitation.		Scenarios are being practiced. Currently awaiting enhancement of practice with the purchase of a Junior Manikin simulation package.
Following a serious incident equipment to be quarantined for data analysis and equipment safety checks.		The Serious and Sentinel Event Policy has been updated and now requires equipment involved in a serious event to be quarantined for analysis and checks.
Category	**Brief description**	**Main findings: These will be posted on completion**
12 (Falls)	Patient fall ~ fracture Neck of Femur	Review underway
2 (Clinical Process)	Baby born and later found to have brain injury	Completion of review expected end of November 2013.
2 (Clinical Process)	Stillborn full term baby	Completion of review expected end of November 2013.
2 (Clinical Process)	Complication following colonoscopy	Review underway.
2 (Clinical Process)	Patient had myocardial infarction following elective surgery	Review underway.
12 (Falls)	Patient fall ~ fracture to pelvis	Review underway.
2 (Clinical Process)	Unplanned homebirth of baby requiring resuscitation on arrival to hospital	Completion of review expected end of November 2013.