Serious and Sentinel Event Report
01 July 2013 – 30 June 2014

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

Category	Brief description	Main findings
12 (Falls)	Unwitnessed patient fall, patient found non-responsive and died the next day.	All relevant and appropriate systems were in place. As a result of the review there are a number of recommendations for improvement.

Recommendations	Progress on Implementation
The Clinical Nurse Managers are made aware of the requirements following a serious and sentinel event for debriefing and counsel to staff.	Implementation underway
Evaluation of sensor mat use be evaluated by Allied Health.	Implementation underway
Additional personal patient alarms be purchased.	Procurement of additional personal patient alarms has been approved.
Education on restraint and bedrail use be provided.	Education has taken place within the Grey Base Hospital. It is intended to extend this across all services and sites.
Education to all West Coast DHB staff on "the correlation between falls and psychotropic medication".	Education has taken place within the falls coalition group. It is intended to extend this across all services and sites.
Analysis of all falls within the West Coast DHB.	A falls coalition group has been established with a mandate to review falls and prevention of falls for the West Coast DHB.

Category	Brief description	Main findings
12 (Falls)	Patient fall resulting in fractured femur.	A cognitive assessment was completed which indicated the patient was often confused or impulsive. No Falls Risk Assessment was completed at time of admission and not addressed in the care plan. The falls risk assessment was completed after the fall.

Recommendations	Progress on Implementation
Introduce a formal training programme for falls risk assessment and provide to all new clinical staff.	Nursing staff can now access the Canterbury DHB Falls Assessment 'E Learning' module and work is underway for a South Island regional training programme.
Regular audit of clinical notes is undertaken to determine that minimum documentation requirements are met. Results of these audits are communicated to all staff and education designed for improvement.	An audit work-stream has been formed to review and develop an audit schedule. The WCDHB has a mandatory Clinical documentation education session, where this is reinforced.
Ensure that follow up plans and referrals are actioned when noted in the clinical file. An audit on a random selection of files quarterly to be undertaken.	An audit work-stream has been formed to review and develop an audit schedule. The WCDHB has a mandatory Clinical documentation education session, where this is reinforced.

Category	Brief description	Main findings
2 (Clinical Process)	Bowel perforation of patient following routine ovary removal.	The team found that there were a number of factors contributing to the event.
Recommendations		**Progress on Implementation**
Abnormal blood results require a review and plan for management by the Resident Medical Officer (RMO) in a timely manner. That education about identification and management of sepsis needs to be incorporated into the regular RMO teaching schedule.		Implementation underway
There is early identification of one point of contact for patients and their family / whanau as soon as a significant complication is recognised.		Interim system now in place, to be formalised on appointment of Patient Safety Officer.
Develop an ACC treatment injury folder to contain all necessary documentation That clinical staff be provided with education on timely and accurate completion of ACC documentation.		Implementation underway
Resident Medical Officer (RMO) orientation process to ensure RMO's are aware of the requirement and responsibility in reviewing and notifying all inpatient histology test results to the consultant.		Implementation underway
All patients who are commenced on narcotic analgesia have laxatives charted to commence as soon as the patient is able to take oral medication Consideration is given to the use of standardised stickers for administration of narcotic analgesia and appropriate laxatives similar to those used in obstetrics.		Implementation underway
Regular audit of clinical notes is undertaken to determine that minimum documentation requirements are met, with feedback to the clinical staff with ongoing education as required.		An audit work-stream has been formed to review and develop an audit schedule. A mandatory Clinical documentation education session is currently in place.
Category	**Brief description**	**Main findings: These will be posted on completion**
12 (Falls)	Patient suffered a Fractured Neck of Femur in unwitnessed fall.	The patient had been identified as a high falls risk; however, this was not transposed onto the clinical documentation. The patient's physical presentation could have been contributed to the fall.
Recommendations		**Progress on Implementation**
All patients/residents in aged care have a current falls risk assessment, appropriate strategies are in place to prevent falls. Compliance is tested through regular audit activity.		A falls coalition group has been established with a mandate to review falls and prevention of falls for the West Coast DHB.
Introduce a formal training programme for falls risk assessment and strategies to reduce risk and provide to all new clinical staff.		Nursing staff can now access the Canterbury DHB Falls Assessment 'E Learning' module and work is underway for a South Island regional training programme.
Additional personal patient alarms be purchased.		Procurement of additional personal patient alarms has been approved.
Education to all WCDHB staff on the correlation between falls and delirium/confusion, including genitourinary/bowel symptoms		Implementation underway

Category	Brief description	Main findings:
2 (Clinical Process)	Full term baby delivered by emergency caesarean section unable to be resuscitated.	The WCDHB guideline for induction of labour requires a full review. There was a lack of clarity regarding what is considered an adequate monitoring period pre and post administration of prostin. There were a number of issues around equipment and documentation in theatre. The use of the ISBAR tool in handover could have been more effectively used.

Recommendations	Progress on Implementation
The Induction of Labour Guidelines for Induction of labour i.e. Monday-Friday if non-urgent be applied and clearly define: a. What a full antenatal assessment requires. b. What the appropriate amount of time for CTG monitoring pre and post That women being induced using Prostin, that are on the ward having CTG monitoring, be checked every hour by the Midwifery Co-ordinator/Senior midwife and documented by CTG sticker form, which must be filled in with every CTG assessment administration of Prostin. That the Cervical Ripening Guidelines and the Electronic foetal monitoring (EFM) Guidelines be reviewed and they clearly state the minimum amount of time for CTG monitoring pre and post administration of Prostin.	The Canterbury DHB guideline was reviewed in April 2014. These guidelines are in the process of being reviewed by the Maternity Safety and Quality review group to replace the current West Coast DHB guideline.
All maternity/obstetric staff have Electronic foetal monitoring (EFM) training, minimum every 3 years. All senior staff have up to date EFM training before commencing employment. All new staff attend/complete Electric foetal monitoring (EFM) within 3 months of commencing employment. For inductions the service should use Partograms that have sufficient space to record all required clinical data.	All staff will be attending an educational workshop the first week in November. This is a recognised expectation. The Maternity Safety and Quality review group will consider how this is monitored. As above These are in every maternity delivery pack. The Maternity Safety and Quality review group to consider how these could be improved to ensure sufficient space to record all the information required.
A hands free phone is installed in Operating Theatre, with laminated contact details for the West Coast DHB/Canterbury DHB Maternity personnel in close proximity.	Implementation underway
Consideration be given to the purchase of a Lactometer or improved utilisation of the i-Stat for neonatal Ph and Lactate testing. Maternity staff be trained to use the i-Stat.	Implementation underway As above

All Senior Medical Officer's covering paediatrics have regular skills refreshment around resuscitation equipment. A standardised Neonatal Clinical Emergency Proforma is developed, and that it is available on every paediatric Resuscitaire. A review of neonatal resuscitation equipment in WCDHB is undertaken. Consideration should be given to including an oxygen blender on each paediatric resuscitaire within the WCDHB. Consideration is given for theatre to purchase a pulse oximeter with neonatal capability and have permanent placement of this on their paediatric resuscitaire. Staff utilise the CDHB neonatal handbook that is accessible on the intranet. Neonatal Resuscitation Guidelines are reviewed with the national guidelines regarding the removal of lines and tubes following neonatal death. Theatre has a copy of the same laminated flow charts that Maternity wards special care nursery has in regards to neonatal resuscitation. Equipment in theatre remains in the same position.	This recommendation has been provided to the Maternity Safety and Quality review group for Implementation. Completed, there is now a standard proforma with every paediatric resuscitaire. Identified between both Canterbury DHB and West Coast DHB's a standard arrangement for all paediatric resuscitation equipment. The Neonatal resuscitaire now has the inclusion of an oxygen blender. The provision of oxygen blenders to the Birthing Suites resuscitaire will be addressed within the hospital new build programme. Implementation underway This recommendation has been provided to the Maternity Safety and Quality review group for Implementation. Completed The resuscitaire is stored in Theatre 3 and is returned there after use. This recommendation will be further considered by the Theatre Manager.
The request for paediatric support should come directly from the LMC or Obstetrician. Handover using the ISBAR tool. A Communications document is developed to record all phone consultations, based on the ISBAR tool. Further training and education is undertaken regarding use of the ISBAR tool for all patient handovers. On-line training be made available.	This recommendation has been provided to the Maternity Safety and Quality review group for Implementation. Completed Completed As above

Category	Brief description	Main findings:
2 (Clinical Process)	Patient found to have bowel perforation following colonoscopy.	Doctor to doctor handover was not optimal. The management of the patient on recognition of the perforated bowel, may have been more appropriate to the Critical Care Unit. The Medical Early Warning System (MEWS) should have been used more effectively with closer monitoring.

Recommendations	Progress on Implementation
Protocol reviewed for the handover of patients to ensure the following is included: • Patient diagnosis, or in absence of diagnosis – investigations ordered / underway and management plan. • Any potential issues highlighted to receiving surgeon.	Implementation underway
Policies and Procedures reviewed to indicate that when a major complication of surgery is recognised, the patient is transferred to the Critical Care Unit for closer observation and management.	Implementation underway
Utilisation of the MEWS tool as an expected standard of care to ensure that the tool is used to alert staff to a patient's changing health status at the earliest opportunity. There is ongoing education on the use of the MEWS tool and audit of its applicability.	Implementation underway

Category	Brief description	Main findings:
2 (Clinical Process)	Accident victim with multi-trauma went into subsequent cardiac arrest and died.	Patient had a significant cardiac history, the patient presented with multiple physical injuries. The patient was cardiac monitored, however there was a significant delay in time for the 12-lead ECG to be performed. There was a lack of documentation of vital sign recordings in the clinical notes. Interdisciplinary communication was poor. No clearly defined policy/procedure for arranging inter-hospital transfer for patients.

Recommendations	Progress on Implementation
Completion of a 12-lead ECG procedure is performed on all trauma patients within ED, particularly those with a known cardiac history Audit to ensure staff compliance with WCDHB documentation policy/procedures ISBAR handover to staff called in after hours with appropriate history of patient Improved communication between agencies and departments using an agreed communication tool e.g. ISBAR Develop a regional inter-hospital policy and procedure	Implementation underway

Category	Brief description	Main findings:

12 (Falls)	Fractured shoulder blade following fall	The patient was identified as a high falls risk. The most successful strategy used to mitigate the risk of falls while in hospital was one to one supervision and personalised diversional therapy. The patient was alone at the time of the fall. Medication was not identified as a factor. Actions taken following the fall were timely and appropriate, however, despite attempts to reduce the risk level, the patient continued to have further falls.
Recommendations		**Progress on Implementation**
a.) A copy of current Assessments and Care Plans / Pathways is included in transfer documentation to be used to inform interim care until the receiving ward is able to complete a comprehensive assessment and care plan. b.) Consideration is given to staggering staff meal breaks so that a wider area of the unit is under observation at all times.		The ward where the fall occurred, have initiated a patient transfer flow chart. Implementation of this flow chart is currently underway. The Nurse Manager of the ward is currently reviewing this recommendation.
Patient transfers are pre arranged for a time that is convenient for the patient and for both wards, to enable a safe and complete handover of information with minimal chance of distraction. The Ward where the fall occurred has an identified and designated admission nurse for all admissions on each shift.		Implementation underway Completed
A documentation audit is carried out to assess compliance with the WCDHB Clinical Documentation Procedure and corrective actions are implemented according to results.		An audit work-stream has been formed to review and develop an audit schedule The West Coast DHB has a mandatory Clinical documentation education session, where this is reinforced.
The Falls Prevention Coalition considers how the group's expertise can best be used to support individual care planning within secondary care.		The West Coast DHB has initiated 'Falls Champions' across the DHB. The ward where the fall occurred is using this expertise.

Category	**Brief description**	**Main findings: These will be posted on completion**
12 (Falls)	Fractured neck of femur following fall	Completion of review expected middle of November 2014.
2 (Clinical Process)	Misinterpretation of CT scan potentially leading to ischaemic bowel	Completion of review expected middle of November 2014
2 (Clinical Process)	Full term baby, resuscitated and ventilated and subsequently died 24 hours later	Completion of review expected end of November 2014
12 (Falls)	Fractured neck of femur following fall.	Completion of review expected middle of November 2014