21/11/2012

# Serious and Sentinel Events 2011/12

This is the first time that we (along with all other District Health Boards) have published our own information regarding **serious** and **sentinel adverse events** on our website. Our report will coincide with the national release of pooled data from the Health Quality and Safety Commission involving serious and sentinel events from across all District Health Boards www.hqsc.govt.nz

District Health Boards classify the severity of adverse events or incidents using the Severity Assessment Code (SAC). All incidents are assigned a SAC score of 1- 4 and this report covers only SAC1 and SAC2 incidents. For the purpose of this report the two major SAC classifications, SAC1 and SAC2 are broadly comparable to a **serious adverse event** which is one *that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function* – and therefore is ***SAC 2*** and a **sentinel adverse event** which is *life threatening or has led to an unexpected death or major loss of function* – and therefore is ***SAC 1***.

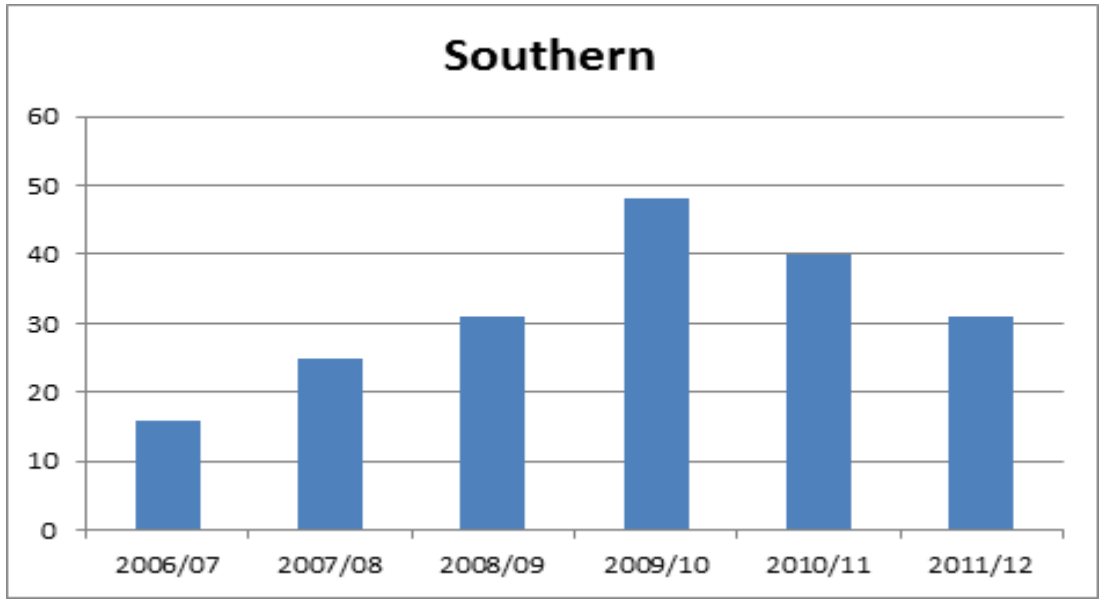
You may notice that some incidents have not had their investigation completed at the time of release of this report. This means that the incident is still under investigation or that the recommendations are in the process of being finalised.

We have provided graphs to summarise the incidents that have occurred in the Southern DHB. The rise and fall in the number of incidents can indicate a number of factors including better reporting as well as actual frequency of incidents.

The Southern DHB is committed to providing safe and quality care, putting the patient at the centre of everything we do. Whilst we acknowledge that adverse events can take place within our facilities we are always looking at new strategies to prevent them.

**Serious and sentinel events 2011/12**

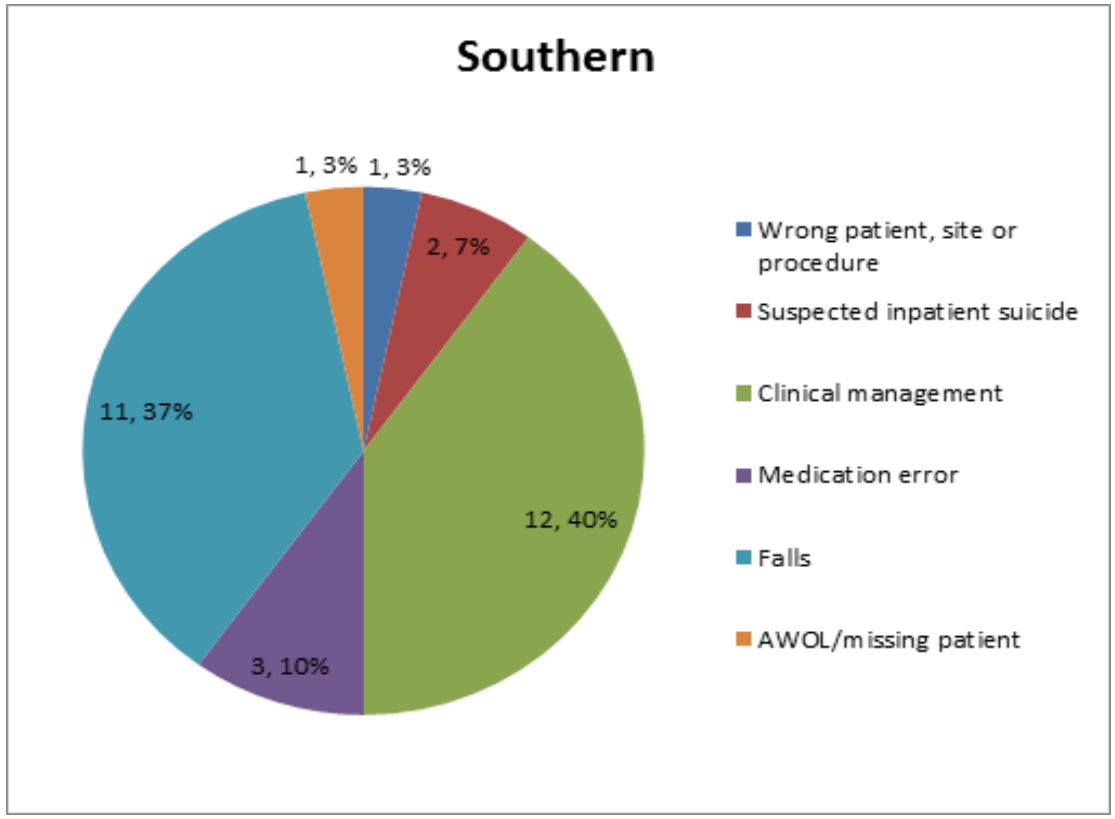
In the July 1, 2011 to June 30, 2012 year, 30 serious and sentinel events took place in the Southern District Health Board (see Graph A).




**Graph A: Number of serious and sentinel event for the Southern DHB per year**

## Summary of events

Graph B indicates the number and type of reported serious and sentinel events for the period as reported to the Health Quality and Safety Commission. *Clinical management* incidents (e.g., errors of diagnosis and treatment) account for 40% of these events (12 Incidents), and *Patient Falls* accounted for 37 percent of all serious and sentinel events reported in 2011/12 (11 incidents). *Medication events* (e.g., giving a patient the wrong medicine, or an incorrect dosage) is the third largest category at 10 percent (3 incidents). There were two cases of *inpatient suicide* (7%), and one case each of *absence without leave* (AWOL) and *wrong patient site or procedure* that were serious or sentinel events.




**Graph B: reporting categories – 2011-2012 – actual number and percentage.**

## Using Serious and Sentinel events to promote Patient Safety & Prevent Harm

All serious and sentinel events are investigated to try to determine the major cause, or causes, that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same adverse event in the future. The aim is therefore to enhance patient safety by learning from adverse events and near misses that occur in the health and disability services and not to blame individuals who may be involved in the event.

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### TABLE 1: SAC 1 and 2 Events in SDHB 1 July 2011–30 June 2012

SAC1 – Unexpected death resulting in the process of health care or inpatient suicide, Wrong patient, wrong site or wrong procedure etc.

SAC2 – Major permanent disability or loss of function unrelated to the natural course of illness and differing from expected outcome

| Details | Description | Main Findings | Recommendations | Progress |
|---|---|---|---|---|
| SAC2 | Mental health service user overdose requiring significant medical care. | Investigation not complete at time of report. | | |
| SAC 2 | Fall resulting in fractured wrist | The patient had a Falls Risk Assessment carried out twice prior to the fall. They did not have a Falls Risk Assessment carried out when they became acutely agitated. | Falls champion to provide refresher education to staff around falls reassessment when the patient's condition changes. This will be reviewed during the next fall's audit. | All recommendations have been discussed with staff and implemented. |
| SAC 2 | Fall resulting in fractured femur (leg) | Review of environment identified no risks. | No recommendations. | Fall in public area investigated by Health and Safety Advisor and incident notified to Department of Labour who informed that no further investigation was required. |
| SAC 2 | Patient administered chemotherapy when contraindicated by laboratory result not identified in the | 1. Three autonomous laboratory systems used within a regional service with multiple locations heightens the risk of laboratory results being missed.<br><br>2. Restrictive access to one of these systems. | 1. Review procedures requiring access to laboratory results.<br><br>2. Investigate concerns regarding accessing and undertake a test of | 1. Department to complete.<br><br>2. The number of people able to access this system has been |

| Details | Description | Main Findings | Recommendations | Progress |
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| | local computer system. | | access to the system. | increased. |
| | | 3. The patient management systems show a mix of preliminary and completed results. | 3. Review the possibility that an alert or dashboard system could be developed.<br><br>3b. Review options to merge the two DHB patient information systems or look to integrate results into a district or regional wide clinical system. | 3. Under review.<br><br>4. Under discussion. |
| SAC2 | Fall resulting in fractured wrist. | Patient fainted or lost their balance going down some stairs. | No recommendations. | |
| SAC2 | Fall resulting in fractured femur (leg). | Investigation not complete at time of report. | | |
| SAC2 | Death in community of a mental health service user. | This death was attributed to therapeutic prescribing and administration of medication. | 1. Further notification to the Centre for Adverse Reactions Monitoring (CARM) to include the unexplained postmortem medication level.<br><br>2. Case to be discussed by the Dunedin Division of Psychiatry and that local practices for monitoring this medication are reviewed. | 1. Completed.<br><br>2. Completed. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | | 3. Southern DHB change their monitoring practices for this medication.<br><br>4. Reminder to all Dunedin psychiatrists and psychiatric registrars about the potential for doses of medication to increase over time, and the importance of critically reviewing the clinical. | 3. Prescribing guidelines have been redeveloped to reflect best practice.<br><br>4. Discussed at the division of Psychiatry. There is a recent paper in the College journal so medical staff will be looking at this closely to see if the guidelines require amending. |
| SAC 2 | Tumour identified as an incidental finding on scan and not followed up. | 1. Forecasted Out-Patient appointment for the patient, but this did not eventuate. Patient lost to follow up.<br><br>2. Abnormality on initial CT scans not observed by radiologists and surgical registrars.<br><br>3. Abnormality on third CT scan | 1. The Team involved are to review their internal processes for the making and confirmation of Out-Patient Clinic appointments.<br><br>2. That the relevant staff be made aware of the findings in this case, and that the case be used as the basis of a joint education session for staff in Radiology and services, possibly as part of on-going quality assurance activity. | The recommendations of this report have recently been released.<br><br>The recommendations are expected to be actioned and implemented as soon as possible |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | reported urgently by radiologist, but not seen or actioned by clinical team.<br><br>4. There are insufficient feedback loops between IT systems to ensure that reports are seen, acknowledged and actioned.<br><br>5. Incidental radiological findings were missed by the clinical team. | 4. That the electronic request system be completed as a matter of urgency.<br><br>5. That the Team involved review the process for reviewing follow-up imaging results. Consideration should be given to requiring all imaging results in the clinical intranet to be acknowledged. | |
| SAC2 | Delayed treatment resulting in patient requiring resuscitation. | 1. Early warning scoring (EWS) chart requires review<br><br>2. There was a delay in specialist referral<br><br>3. Monitoring and communication/elevation of care not completed as per MEWS (Maternity Early Warning Score) | 1. Progress a maternity specific early warning score tool to be used whenever patients are required to stay on delivery suite for whatever reason.<br><br>2. If post partum haemorrhage (PPH) suspected or confirmed, referral to specialist medical staff is required.<br><br>3. Ongoing monitoring of women and clear communication in cases where observations are outside expected parameters, with early | 1. This is currently being developed<br><br>2. Education is delivered through the midwifery educators relevant courses available to all staff.<br><br>An audit of perineal trauma has also been presented<br><br>3. Education has been provided. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | | involvement of senior medical staff | |
| | | 4. Management of collapse was not completely adhered to as per guidelines. | 4. Ongoing "drills and skills" education for all staff in management of maternal collapse. | 4. Related services have joined an audit process to discuss the risks of simultaneous needs from different cases and disciplines. |
| | | 5. No accurate estimation of blood loss. | | 5. Education has been provided |
| | | 6. Management of haemorrhage while awaiting theatre needs review. | 6. Review medical supplies. | 6. Medical supplies are now available in all specialist areas. |
| | | 7. Prompt sheet required for Post Partum Haemorrhage (PPH) situations. | 7. Clear documentation and check list as per national guidelines. | 7. Completed and in use. |
| SAC2 | Fall resulting in fractured hip. | 1. Strategies were documented in the falls care plan but not evaluated. | 1. This fall to be utilised as a case study teaching tool for nursing staff. | 1. Clinical Nurse Educator, Charge Nurse Manager & Falls co-ordinator to facilitate this. |
| | | 2. There were no documented strategies in place to manage the clinical setting and thus the increased risk of falling. | 2. Ensure all staff are provided with a refresher in the falls prevention programme. | 2. Ensure all staff attend at least one of these in-services. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | 3. Post fall care plan could have been more detailed. There were no strategies documented to manage new risk factors identified. | 3. Ongoing audits occur to ensure that the Falls Prevention Programme is being utilised correctly. | 3. Feedback to ward staff results of audits and engage staff to formulate action plans. |
| SAC2 | Significant medical treatment of the patient required following intentional overdose after absconding from an inpatient unit. | Investigation not complete at time of report. | | |
| SAC2 | Patient fall resulting in fractured femur (leg). | 1. Strategies could be more individualised to the patient based on their fall assessment.<br><br>2. Other strategies could have been documented to mitigate identified risk factors on the care plan.<br><br>3. There were no documented strategies in place to manage the patient's care in the clinical | 1. Ensure all staff are provided with a refresher course in the falls prevention programme.<br><br>2. Audits occur to ensure that the Falls Prevention Program is being utilised correctly.<br><br>3. No recommendation. | 1. Patient falls prevention updates are at least six monthly. All staff attend at least one of these in-services.<br><br>2. Feedback to ward staff results of audits and to engage staff to formulate action plans.<br><br>3. Ongoing education to staff regarding clear documentation. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | setting and thus the increased risk of falling. | | |
| SAC 2 | Missed diagnosis of cancer due to abnormality being missed on an earlier xray. | Investigation not complete at time of report. | | |
| SAC2 | Medication error | 1. Nursing handover currently occurs in the medication room.<br>2. Difficulty in accessing patient records<br>3. Concern regarding monitoring of blood glucose and treatment of | 1. Review of handover location in the ward.<br>2. Review availability of patient records in the ward for staff caring for patients<br>3. Review high potassium and low blood sugar protocols. | 1. The ward handover has been moved from the medication room to the charge nurse mangers office.<br>2. Three chart trolleys have been purchased to display and hold observation charts so that bedside handover is more effective and observation charts are separated from the notes.<br>3. Not yet completed |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | low blood sugar.<br><br>4. Prescribing was not consistent with hospital Formulary guidelines.<br><br>5. Documentation was not up to the standards required for legibility and identification of author. | 4. Identify whether e-prescribing (electronic) will be implemented – this would ensure that the incorrect prescribing would not occur without prompting and having to override the system.<br><br>5. Organisational communication reminding all clinical staff about their responsibilities in legibility of signatures, designation and time of entry. | 4. e- prescribing is expected to be in place in the ward by the end of 2012.<br><br>5. Completed . |
| SAC2 | Fall resulting in fractured humerous (arm) | 1. The patient remained at significant risk of future falls due to their complex health problems.<br><br>2. The flooring was assessed as being non slip however it was found that there was a residue of soap on the shower room floor | 1. Encourage the patient to use the showering chair.<br><br>2. The cleaning staff were reminded of the need to ensure all soap residue was removed from the floor when the shower | 1. The patient is regularly encouraged to use the showering chair by staff.<br><br>2. Increased cleaning of the shower has improved the surface of the shower. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | which was not being thoroughly scrubbed and removed each day and may have contributed to the patients fall and subsequent fractured arm. | rooms are cleaned. | |
| SAC 2 | Antibiotic prescribed in error for a patient with a documented allergy to that drug, resulting in serious allergic response. | Investigation not complete at time of report. | | |
| SAC 2 | Fall resulting in fractured hip and humerous (arm). | 1. Patient fall occurred when staff on their meal break, meaning less staff to attend to patients.<br><br>2. Patient had been given a purging medication which resulted in more frequent toilet requirement. | 1. When the nursing staff levels in the ward are at four or less per shift, the shift Coordinator should stagger meal breaks so there is only one staff member off the ward at any time, to ensure there is adequate staff to attend to patients' needs.<br><br>2. To ensure that the nursing handovers follow a prescribed template and include mention of purging medicines given, if their effect is causing a change in the patient's usual condition. | 1. Completed.<br><br>2.Completed. |

| Details | Description | Main Findings | Recommendations | Progress |
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| SAC 2 | Fall resulting in fractured hip | Falls risk assessment not completed for the patient on admission. | 1. Staff be made aware of the requirement for a Falls Risk Assessment to be completed for all new admissions.<br><br>2. Facility to adopt and implement the Falls risk project which includes comprehensive documentation, training and an updated falls risk assessment form.<br><br>3. That the use of the out of date Falls Risk Assessment form be phased out across Southern DHB as soon as possible, in conjunction with the implementation of the Falls Project .<br><br>4. That the current fall risk policies and documentation be updated to ensure documents referred to are current. | 1. Implemented and reinforced.<br><br>2. Completed.<br><br>3. Partially completed as the Falls Project is rolled out over various wards.<br><br>4. Completed. |
| SAC 2 | Fall resulting in serious head injury | 1. The non completion of the Falls Risk paperwork. | 1. Have a plan in place to ensure staff complete required falls risk paperwork on admission. | 1. Completed. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | 2. There are some issues with lack of staff education and knowledge that might contribute to an increased risk of patient falls, which may be compounded on night shift when staff are not exposed to day shift practices, culture and regular in-service education.<br><br>3. Southern DHB policies on indwelling urinary catheters (IDC) give no guidance for the timing of removing catheters particularly for falls risk patients. | 2. Ensure all staff, including permanent night shift staff, receive ongoing education.<br><br>2a. Review with Human Resources (HR) the risk for patients, staff and the DHB when employment contracts are in place which do not require an annual update of practice in a day time setting for those on permanent night shift.<br><br>3. Review with clinical staff best practice for timing of indwelling catheter removal and implement changes to practice and related policy.<br><br>4. When patients are transferred between units a formalized handover summary is provided. The use of the framework for the information could be utilized. | 2. The ward now have a coordinator with designated days for falls in-service with scheduled 6 monthly presentations and 3 monthly formal audits.<br>2a. To be reviewed with HR.<br><br>3. Areas have reviewed practice and now implemented 0600 hours as designated removal time for IDC .<br><br>4. Utilising a referral template as a guide for minimum standard for verbal handover content. |
| SAC 2 | Fall resulting in fractured patella (knee cap) | Patient mobilised independently. | Falls prevention programme being introduced to ward. | |

| Details | Description | Main Findings | Recommendations | Progress |
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| SAC 2 | Missed diagnosis of pulmonary embolus (blood clot in lungs) | Original reporting of radiology results was reviewed and deemed to be within the normal range of reporting error rates. | No recommendations. | |
| SAC 2 | Delay in diagnosis due to a failure in process | 1. The incorrect doctor was selected on the Radiology Information System (RIS) as the referrer was not listed for selection. | 1. A policy is developed that requests for diagnostic medical imaging must be entered on RIS using only the doctor identified on the request form, with contingency for where the clinician is not listed. | 1. Draft policy out for final consultation. |
| | | 2. The doctor incorrectly entered as the referrer did not receive a copy of the test result, so no follow up was made following the reporting of the ultrasound. | 2. A clear and quick process is to be developed for the addition of doctors on RIS which can then be distributed to all relevant staff. | 2. New Information Technology (IT) process whereby new or changed information is identified, implemented and forwarded to application specialists for updating in their systems. |
| | | 3. The actual referrer did not follow up on the missing results. | 3. A procedure to be written for when test results are received in an area in which the clinician does not work. This should include the distribution on, of results to the | 3. Document reviewed. Changes to be incorporated. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | | identified clinician, plus feedback to Medical Imaging to indicate the misdirection and allow investigation and correction of the system.<br><br>3a. Investigate the possibility of an electronic request system, whereby a request for a scan can be tracked from request to report and a physician see outstanding requests made vs. reports received over a pre-defined time period.<br><br>3b.Investigate the possibility of a flagging or escalation system for abnormal imaging results where further action is being recommended.<br><br>3c. To re-visit the decision to have Dunedin and Southland patient information systems on different databases. | 3a. Not supported by Senior Management Group as not able to be implemented with our current systems.<br><br>3b. Memo sent to all radiologists to reinforce practice of phone notification to referrer for abnormal results. Rules for engagement for Locum Radiologists.<br><br>3c. Reviewed. Planning underway to move to another patient information system rather than merging current systems. |
| SAC 2 | Delay in | Referral for one condition | Medical staff are reminded of the | Alert bulletin sent by Chief Medical |

| Details | Description | Main Findings | Recommendations | Progress |
|---|---|---|---|---|
| | treatment for cancer due to failure of referral process. | contained comment regarding suspicion of an unrelated cancer in another organ system which needed investigation.<br><br>The primary receiving department followed correct process, but the second abnormality was overlooked. | need for separate referrals for more than one condition. | Officer to all Southern DHB medical and nursing staff and Southland GPs highlighting the need for separate referrals.<br><br>For the receiving doctor to follow up if a second condition is noted. |
| SAC 2 | Subtherapeutic medication levels at time of cardiac procedure, possibly leading to stroke | 1. Some components of blood tests may not be reported unless specifically requested.<br><br>2. Inconsistent directives to staff regarding what is to be requested on the laboratory form.<br><br>3. No direction or protocols regarding care of patients who are on the medication Dabigatran.<br><br>4. There are no site specific protocols for this procedure which are up to date.<br><br>5. A resident medical officer checked the blood results and did | 1. In the case of this specific test both components should be reported.<br><br>2. A checklist to be written.<br><br>3. Review, adapt and implement the Otago policy procedure and pathway for Southland.<br><br>4. Implement policy and procedure for Southland site.<br><br>4a. Ideally have one central administration staff member booking these tests.<br><br>5. Standardise laboratory requests. | The recommendations of this report have recently been released. The recommendations are expected to be actioned and implemented as soon as possible |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | not recognise the significance of them.<br><br>6. Delayed letter to GP who was responsible for the monitoring of therapeutic medication levels, advising of procedure.<br><br>7. This procedure is usually treated as acute and not semi elective and therefore do not have scheduled time slots. | 6. Clinic letters with significant change of medications/ treatment need to be prioritised by the consultant as urgent & sent within two working days of patient being seen, communicated verbally to the GP on the clinic day & documented in the clinical record.<br><br>6a. All patients to have blood test day prior to procedure and results checked preferably the evening before procedure to prevent the patient presenting for procedure if therapeutic medication levels not achieved.<br><br>7. Audit to be undertaken .<br><br>7a. Provide education regarding procedure to both medical and nursing staff.<br><br>7b. If possible treat procedure as semi elective rather than acute and have a scheduled time on a designated day of the week. | |

| Details | Description | Main Findings | Recommendations | Progress |
|---|---|---|---|---|
| SAC 1 | Inpatient death in Mental Health Services | The care provided by Southern DHB to this complex individual, included a therapeutic alliance based on recovery, trust, autonomy and independence. | 1. Risk Assessment<br>• Consider defining what Low, Medium, High mean in relation to risk and whether this is universally understood within the service<br>• Consider providing further training around risk assessment. Consider the appropriateness of non-regulated staff assessing and documenting risk.<br><br>2.Direction and Delegation<br>• Consider revisiting the Registered Nursing staff understanding of the *Direction and Delegation Guidelines* especially in terms of countersigning non-regulated staff documentation.<br><br>3.Talking Therapies<br>• Consider further training and development of staff in relation to therapies | A working group was formed in 2011<br><br>1. Review the service's approach to clinical risk assessment and management<br>• Review how the service teaches risk assessment and management<br>• Review the Clinical Risk Management system<br>The outcome of that working party was changes in:<br><br>• Documentation Processes<br>• Teaching Risk Assessment and Management<br>• 'Clinical Risk Management System'<br><br>2. Clinical Nurse Specialist is providing in-services to staff on Direction and Delegation.<br>These will be completed by the end of the year.<br><br>3. The department is planning a team day in December to cover Talking Therapies. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | | such as Cognitive behavioural development.<br><br>4. Staff Support<br>• Review current policy in debriefing and de-escalation.<br><br>5.Police Liaison<br>• Whilst it is acknowledged that the police will conduct their own investigations into sudden unexpected deaths the DHB may wish to consider its position with the police in terms of reaching an understanding of interviewing employees, both in terms of initial contact and support through the process. | <br><br>4. Underway<br><br>5. Not complete |
| SAC1 | Unnecessary surgery due to an error with biopsy specimens | Usual protocol was not followed with the handling of two specimens. | 1. Changes in process recommended.<br><br>2. A copy of the patient note and radiology report should be attached to the request form for | 1. Complete.<br><br>2. A new biopsy request form has been developed which provides all the information needed. |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | | all biopsies.<br><br>3. Laboratory Service to introduce a routine 3 day turnaround time.<br><br>4. Streamline Multidisciplinary meetings to allow for completeness of discussion. | <br><br>3. The Laboratory will process specimens in a timely manner so they are available to medical staff when needed.<br><br>4. The format and procedure of this meeting is under review and this will be ongoing as the Southland component of the Breast Service is incorporated. |
| SAC1 | Misdiagnosis | Investigation not complete at time of report. | | Case notified to the Heath Quality and Safety Commission. |
| SAC1 | Death of the patient in hospital following intentional overdose after absconding from a inpatient unit | The patient took a fatal overdose whilst on leave from the ward. The patient was a voluntary patient.<br><br>1. Leave was arranged by the patient and was collected by a friend (who remains unidentified).<br><br>2. The patient was placed on 'Unauthorised leave' that evening | <br><br>1. Routinely obtain contact details of person picking up a patient from the ward setting and discuss the responsibility with the individual/s who accept to support inpatients on-leave from the ward.<br><br>2.Check that the 'Unauthorised Leave' documentation is | <br><br>1. Contact details are now routinely obtained.<br><br>2. The unauthorised leave policy, processes and documentation have |

| Details | Description | Main Findings | Recommendations | Progress |
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| | | and police contacted. | completed | been reviewed with the Police and we now have clearer processes around responsibilities and pathways. |
| | | | 3. Routinely ask patients to hand in unused medication on admission to the ward whether they are voluntary or not. | 3. Not yet completed |
| SAC 1 | Cardio Pulmonary Resuscitation (CPR) not performed when patient collapsed, as assumed patient had a "Not for resuscitation" order. | 1. Inaction by nursing staff to follow the Resuscitation Policy | 1. An education & performance management plan to be developed for the nursing staff involved in incident, including resuscitation simulation training. | 1. Training facilitated |
| | | 2. Lack of defined Not For Resuscitation (NFR) process in this ward | 2a. Develop a handover sheet with up to date information noted for each patient. | 2a. Completed |
| | | | 2b. Formalize a "Resuscitation Status" process for ward. | 2b. In progress. |
| | | | 2c. Resuscitation Status process to be included in the Ward orientation programme. | 2c. in progress. |
| | | 3. Lack of identified senior registered nurse on shift | 3. Each shift ward to have the senior registered nurse identified on roster & white board. | 3. Complete. |

| Details | Description | Main Findings | Recommendations | Progress |
|---|---|---|---|---|
| SAC 1 | Delayed diagnosis | 1. Delay in making the initial diagnosis<br><br>2. Delay in recognising a possible cause for acute deterioration of the patient's condition | 1. Clinicians should be supported to access results from home should they wish to do so<br><br>2. Clinicians are reminded that they have a duty to review the results of tests that they request.<br><br>3. Intensive Care Unit (ICU) charts to be redesigned to include a 'plain film checked by doctor" tick box.<br><br>4. ICU to instigate a "radiology review" memo pad or similar so that clinicians can sign films off.<br><br>5. Routine team handovers take place in areas appropriate for this purpose with adequate facilities for reviewing diagnostic imaging.<br><br>6. Other mechanisms for alerting the clinical team that a film is available for review should be explored.<br><br>7. The SDHB should commit to providing:<br>1) A timely urgent/soon/routine CT service within an agreed timeframe | The recommendations of this report have recently been released. The recommendations are expected to be actioned and implemented as soon as possible<br><br>4. A bedside 'flag' system is under development and the introduction of the Southern Intensive Care software system and whiteboard monitor is expected to be of benefit. |

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| | | | 2) Support for the radiology reporting targets as described in the report. | |