Serious Adverse Event Report

Southern District Health Board

2012-2013

Serious Adverse Events 2012- 2013

Welcome to the serious adverse events release for 1 July 2012 - 30 June 2013 from the Southern District Health Board.
It is recognised worldwide that health care is a complex process, has associated risks and that patients may become harmed when receiving care intended to help them. This report provides details of the serious adverse events that have occurred within the Southern District Health Board (SDHB), the recommendations to make improvements to the care we provide and our progress.

The report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious Adverse Events
http://www.hqsc.govt.nz

For the 2012-2013 financial year, SDHB has reported 33 events that have caused serious harm or death and 2 events that nearly caused serious harm; with a total of 35 events.

What is a serious adverse event?

Serious adverse events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

District Health Boards classify the severity of adverse events or incidents using the Severity Assessment Code (SAC). The two major SAC classifications, SAC1 and SAC2 are called **serious adverse events** which is one that is *life threatening or has led to an unexpected death or major loss of function* – and is classified as a ***SAC 1*** and one *that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function* – and is classified as a ***SAC 2***.

As a provider of health services we are required to review these events and report them to the Health Quality and Safety Commission.

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.

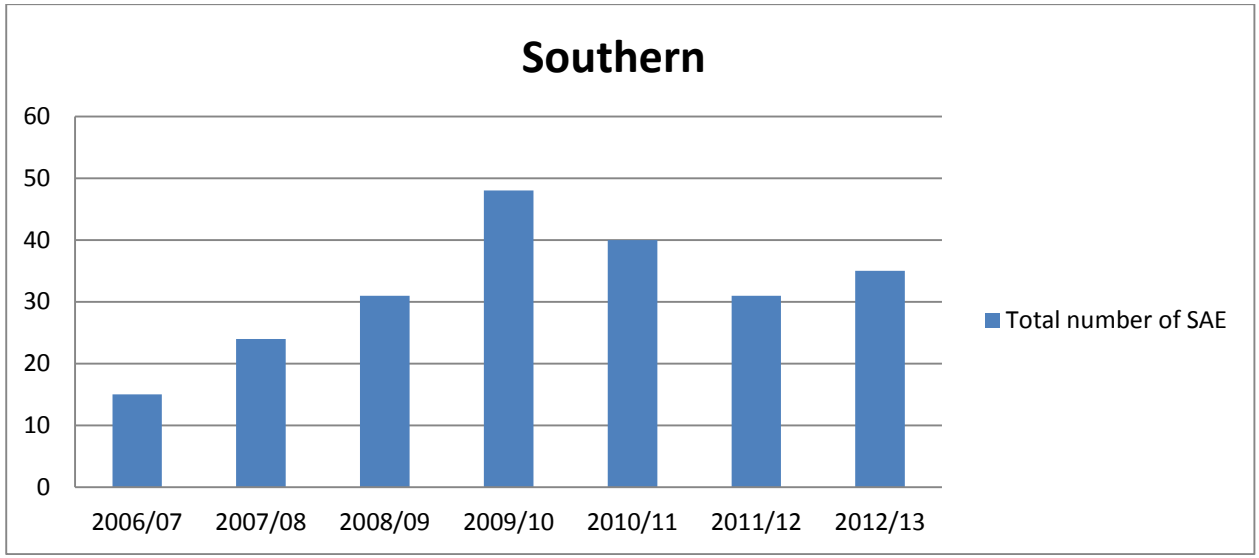
Using Serious Adverse Events to promote Patient Safety & Prevent Harm

All serious adverse 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 or similar adverse event in the future. The aim is therefore to enhance patient safety by learning from adverse events and near misses that occur in health and disability services and not to blame individuals who are involved in the event.

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

The Southern DHB is committed to the Open For Better Care campaign developed through HQSC; this forms part of the transparent process of identifying harm and working to learn and improve our patient safety.

In the July 1, 2012 to June 30, 2013 year, 35 serious adverse events took place in the Southern District Health Board (see Graph A).

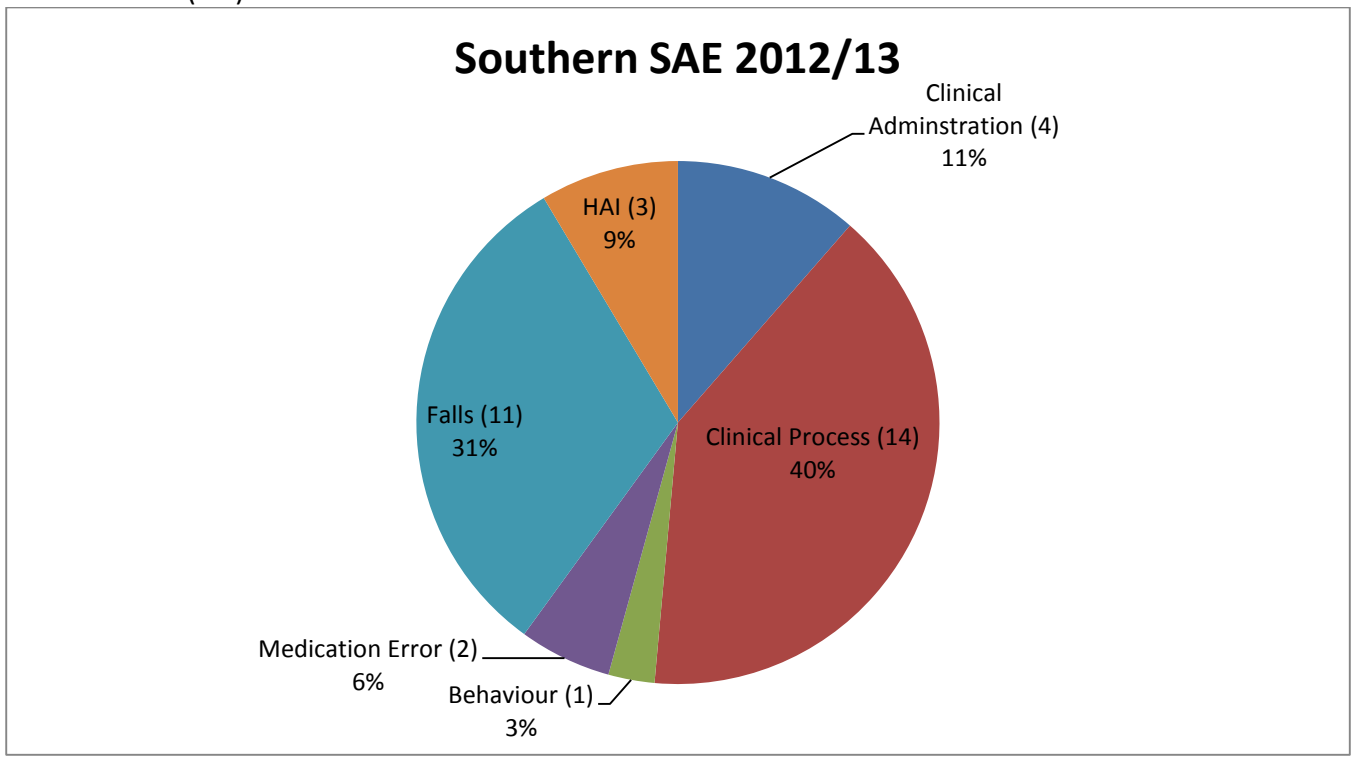


Graph A Total number of Serious Adverse Events for the Southern DHB per year.

*Please note that the 2012-2013 report excludes mental health events as they were reported in a separate report.

Graph B indicates the number and type of reported serious adverse events for the period.

Clinical process (eg assessment, diagnosis, treatment, general care) accounted for 40% (14) of all error and patient falls 31% (11). *Clinical administration* incidents (e.g. handover, referral, discharge) account for 11% (4); and *medication events* (e.g., giving a patient the wrong medicine, or an incorrect dosage) was 6 percent (2). There were three cases of *healthcare acquired infection* (HAI) (9%), and one case of *absence without leave* (3%).



Graph B Reporting Categories for 2012-2013 – actual number and percentage

Details	Description	Main Findings	Recommendations	Progress
SAC2	A chest x-ray recommended a CT scan which was not followed up in a timely manner.	1. Missed early diagnosis of a potentially curable squamous carcinoma of the bronchus.	1. That a high suspicion of cancer flag be applied to such abnormal x-rays by the radiologist. The Cancer Nurse Co-coordinator monitors the fast track screen and can actively follow up patients where delays are occurring.	1. Department to complete.
		2. Of note the abnormality was not detected by the clinician who ordered the x-ray. The lesion is visible in retrospect. Radiological lesions can be missed especially if viewed in sub optimal conditions, such as poor quality monitors.	2. The process of sign off for x-rays within the electronic medical record needs to be reviewed.	2. Under discussion.
		3. There is no evidence that the x-ray was acknowledged by any of the clinical team. It is not clear what process is undertaken to identify and review radiology reports from the clinical record.	3. The service involved to review its systems for the acknowledgment of radiological reporting.	3. Complete.
		4. Currently in Dunedin	4. Review of current system.	4. Under review.

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		Hospital there is a system by which newly abnormal x-rays are sent directly to the Respiratory Department to ensure adequate follow-up. It is not clear however, that this system worked in this case.		
SAC2	Delay in treatment of cancer due to delayed referral.	This review has revealed a failure of a referral to be transferred in a timely fashion between one department and another. 1. When a fax is sent from one department to another, there is no way of knowing that it has arrived. 2. There is no acknowledgement or receipt of a referral and therefore no mechanism to determine whether the referral has been acted upon.	1 and 2. A system should be developed whereby there is a check list of all referrals sent off at the point of referral so that as acknowledgement of receipt of each referral is received, these are checked off and if no receipt is received within a reasonable period of time then that should be chased up by the referrer.	1 and 2. The South Island e-Referral system is currently being rolled out to primary care across the region. Southern DHB is due to commence Phase One of this rollout in November 2013. However, at this time we have no information as to when this system will be available for internal referrals. The service involved is investigating an interim process of relaying internal patient referrals that does not involve fax until the

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				South Island e-Referrals system can be implemented.
SAC2	Delay in response to abnormal blood test results leading to delay in referral.	Investigation not complete at time of report.		
SAC2	Outpatient appointment not arranged after surgery for bladder cancer.	Investigation not complete at time of report.		
SAC1	Retained swab Intraoperatively.	A surgical swab from an anaesthetic line insertion pack was introduced into the surgical swab count due to the Rampley's forceps used initially coming from the surgical field. This resulted in compromise of the check as the extra swab gave appearance of all swabs having been removed from the surgical cavity prior to commencement of closure.		

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		1. Two accountable items counts signed by nursing staff in patient's care pathway. Organ/Cavity closure not signed and documented in patient notes.	1. Review accountable items policy district wide, standardise and implement on all SDHB sites.	1. District-wide policies for Side marking, Count and WHO checklist have been completed and implemented.
		2. An accountable items count documented as correct when extra swab was introduced.	2. Standardise peri-operative documentation incorporating World Health Organisation (WHO), Association of Perioperative Registered Nurses (AORN), Australian College of Operating Room Nurses (ACORN) recommendations.	2. Complete.
		3. Nursing staff identified multiple interruptions during counts procedure with no specific time allocated for accountable item counting.	3. Accountable items count to be documented fully and accurately.	3. Complete and also a Cavity Swab count policy that will require 3 signatures.
		4. Swab on Rampley's forceps not opened and separated as part of count procedure.	4. Accountable item count to be undertaken uninterrupted.	4. Complete
		5. No documentation of	5. Document in patient notes	5.Complete

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		instrument being handed off away from surgical field.	when instruments were utilised outside of surgical field	
		6. No WHO 'time out' documentation in patient notes.	6. Implement WHO "time out" strategy in all theatres and invasive procedures.	6. Complete
		7. Consultant not in theatre for final part/end of surgery 'Time Out'	7. Provide WHO documentation for all patient notes.	7. Complete
		8. Plain anaesthetic swabs without a radio opaque identifier were used in cardiac theatre for anaesthetic intervention.	8. Swabs used in invasive operative procedure separated and opened to view radio opaque identifier as part of count (ACORN standard 7.2)	8. A procurement process is occurring to purchase different coloured swabs for different procedures (e.g. – line insertion or cavity packing).
		9. Swabs for surgical and anaesthetic interventions were similar in size and both coloured white.	9. Review sundries in theatre. Swab colour and radio opaque identification	9. As above.
		10. No standardisation of practice for intervention of central venous line insertion.	10. Standardise protocol for district Main Operating Theatres.	10. Complete.

Details	Description	Main Findings	Recommendations	Progress
			11. Discuss and debrief with team and wider team to identify key learning's for all hospital sites. 12. Arrange educational sessions to ensure staff are aware of role obligations. 13. Apply knowledge, skills framework and competency for mandatory annual assessment of implementation of quality standardised accountable item counts for all peri-operative staff.	11. Complete. 12. To be completed. 13. To be completed.
SAC2	Inadequate monitoring leading to cardio pulmonary arrest.	This event is most likely related to accumulation of medication. A saturation probe being in situ may not have stopped this event occurring but would have alerted nursing staff before it occured. 1. Nurse's looking after scoliosis patients should have training and education in the use of the	1. Training of nursing staff for the specific care of scoliosis patients needs to be	1. Several nurses have recently been trained by rostering them supernumerary and using an

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		Scoliosis Pathway plus have knowledge, awareness and comprehension of the complex analgesic requirements of these patients. Nursing staff must have training and understanding of the actions and effect of 'routine' scoliosis patients, particularly in the paediatric patient group.	implemented. A clinical audit of the pathway needs to be implemented to monitor compliance with the pathway.	"apprentice" system whereby they are mentored by an experienced nurse. Staff have attended the Acute Pain Service education sessions. The ward educator will be teaching specific sessions around scoliosis and is waiting input from the Scoliosis Coordinator.
		2. Medications that cannot be swallowed in tablet form should ideally be made in elixir. This must be documented in the patient pathway to assist in individualised care planning.	2. Documentation of the patient's preferences to ensure that individual care needs are noted and planned in care such as this patient's inability to swallow tablets would improve care.	2. We have extended the nurse "specialing" period by a full 24 hours which includes the Transition Day. Therefore the nurses become very familiar with the patients and their needs. Only RNs experienced in scoliosis care may relieve the specialing nurse for meal breaks.
		3. The scoliosis pathway must be used correctly, maintaining ongoing assessment and appropriate care management.	3. Nurses at the bedside are expected to attend ward rounds of their patients to have input into ongoing care planning.	3. The nurses are always present at ward rounds.
		4. Encouragement of open communication with other members of the wider team,	4. Strengthening of the clinical team relationships to ensure optimum communication	4. The anaesthetist now rings in the morning if not in the hospital and speaks directly to the nurse

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		especially the anaesthetists involved in the scoliosis corrective surgery, consultant surgeon, scoliosis coordinator and other nurses within the team. Use the Acute Pain Service for advice especially around use of pain medication equipment.	between all members of the health care team. This will also lead to seeking guidance and advice from appropriate multidisciplinary team.	involved in the patients care. The Scoliosis Coordinator liaises regularly with nursing staff, medical staff, and allied health staff.
SAC1	Retained Swab; not intraoperative	1. Failure for wound care management to be recorded in a consistent manner on one form resulting in all care events not being reviewed by all the team members. 2. Gauze swab not best practice to pack a wound. 3. Referral to the wound care specialist was late in the patients care and early involvement may have prevented a delay in diagnosis.	1. Use of a standardised documented wound assessment and care planning form for entire wound healing journey. An education plan and roll-out will need to be developed to maximise buy in and use. 2. Education on best practice of packing wounds to all team members. 3. Education role out to all stake holders including consultants, junior medical and nursing staff in the wards, emergency department and district nursing with a view in the future to continuing into the secondary and primary care setting.	1. Draft of district standardised wound document to be available end of November. Consultation has commenced. 2. Risk alert under consultation. 3. Complete.

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		4. Vac dressing not best practice for purulent wounds.	4. A clinical guideline needs to be developed to activate wound care specialist input at the most appropriate time in the patient journey. 5. Wound care planning needs to reflect a full wound assessment, a plan of what's been done at each care event and the ongoing plan with review date.	4. Complete. 5. Reminder to be tabled at the next senior nurse meeting and educator groups regarding completion of documentation and referrals.
SAC2 Near Miss	Breast milk almost given to the wrong baby.	1. Inadequate barriers in place to reduce risk of expressed breast milk (EBM) cross-feed error. 2. The Neonatal Intensive Care Unit (NICU) Feeding Guideline is not always adhered too. 3. Storage of EBM potentially contributes to incorrect bottle selection.	1. Installation of barcode scanners in NICU. 2. Consider introducing an audit of EBM administration practices and associated guidelines to reinforce correct checking practices. 3. EMB storage and labelling needs to be reviewed and a uniform standard process instigated immediately e.g.	1. Complete. 2. Complete. 3. Complete.

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			Barcode labels with NHI and Surnames.	
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SAC2	Breast milk given to the wrong baby	1. Inadequate barriers in place to reduce risk of expressed breast milk (EBM) cross-feed error. 2. The Neonatal Intensive Care Unit (NICU) Feeding Guideline is not always adhered too.	1. Installation of barcode scanners in NICU. 2. Consider introducing an audit of EBM administration practices and associated guidelines to reinforce correct checking	1. Complete. 2. Complete.

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		3. Storage of EBM potentially contributes to incorrect bottle selection	practices. 3. EMB storage and labelling needs to be reviewed and a uniform standard process instigated immediately e.g. barcode labels with national health index (NHI) and surnames.	3. Complete.
SAC2	Misidentification of specimen in theatre.	Prior to patient coming into theatre paperwork for previous patient was not cleared from theatre work station. When specimen container and request form were labelled, previous patient's labels were used. The World Health Organisation (WHO) Surgical Checklist procedure was not adhered to, missing an opportunity to correct wrongly labelled specimen container and request form.	Patient Safety Bulletin issued as risk alert and learning points highlighted as below: 1. Ensure complete set of notes and all labels of previous patient have been removed from theatre prior to next patient being brought in. 2. Utilise WHO checklist at end of procedure to ensure specimen details match to patient. Case review at staff meeting to highlight risk and mitigations.	Completed.

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SAC2	Failure to follow treatment plan and therefore chemotherapy not stopped on acute presentation.	1. Lack of early specialist oncology input	1. Oncology and emergency department (ED) to consider developing a process whereby all patients presenting acutely are notified early.	1. Process change has occurred so that all oncology patients must be discussed with the on call oncology consultant. The Oncology Clinical Nurse Specialist will carry out education sessions for the ED staff.
		2. Lack of oncology notification that a patient under active treatment had presented acutely.	2. Consider iPM alerts for patients under active cancer treatment.	2. Under discussion.
		3. Emphasis on neutropenic sepsis potentially reduces the significance of other complications of cancer treatment.	3. Oncology/Haematology services to review current "Green Card" information.	3. Under discussion.
		4. Patient and family/whanau deviation from recommended contact information.	4. The current policy relating to the patient enquiries should be reviewed with communications staff and updated if necessary.	4. Under discussion.

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SAC2	Air embolism causing shock.	1. No training provided for the management of a swan ganz sheath to the nurse looking after the patient during intensive care unit (ICU) nurse orientation training. 1a. Unclamped swan ganz sheath at the time of removing IV line from the swan ganz IV arm, most likely allowing air entrainment into the swan ganz sheath. 1b. The swan ganz sheath is a specialised device and the structure of the wide bore line and anatomical placement means there is increased risk of harm to the patient and nursing staff require specialised training to care for these safely. 2. The absence of non-return valves on the manifold taps increases the risk of air entry into the line.	1a,b. ICU to develop specific swan ganz training that is supplementary to the central venous access device (CVAD) certification. • ICU to update the current orientation with Swan Ganz sheath management. • Level 2 CVAD certification to be updated during nursing orientation to the ICU. • Remind senior nursing staff to make sure they are aware of the skill level of nursing staff on a shift and provide supervision if needed. 2. ICU trialling systems that include non-return valves on manifolds connected to swan ganz sheaths.	The recommendations of this report have recently been released. The recommendations are expected to be actioned and implemented as soon as possible.

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		3. The patient was sitting up in a chair which may have contributed to air entry into the line. It is recognised that patients undergoing cardiac surgery are unable to lie flat. However the patient is able to be semi reclined in bed for the removal of CVAD'S.	3. Swan ganz management training for all staff and supervision from senior nurses for inexperienced staff.	
SAC2	Missed diagnosis of ectopic pregnancy which subsequently ruptured requiring emergency treatment.	No one main cause 1. Improved communication regarding referrals versus request for advice is essential. 2. Improve communication within team.	1. Process change for communication of referrals and/or advice. 2. Provide medical staff of specialist clinical services access to the electronic patient management information system in the emergency department.	1. A process change is in progress. 2. Department to complete in consultation with information technology services.
SAC2	Misinterpretation of x-ray.	X- Ray plain films are not viewed in a timely fashion commensurate with the time frames for an acute admission. In this case there was a failure		The recommendations of this report have recently been released. The recommendations are expected to be actioned and

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		to recognize and act upon the findings on chest x-ray in a timely manner. An urgent CT and surgical review was warranted. 1. Acute X-rays were not reviewed on and reported in a time frame consistent with making decisions about those reports.	1. Plain film X-rays to be reviewed within 24 hours of being taken, and the report become available rapidly. a. Radiology to move to reporting all of the urgent films from the past 24 hours first thing in the morning. b. The new Radiology Information System (RIS) should be rolled out as soon as possible. The current system does not include voice recognition dictation facilities, meaning that dictated reports must be typed, then verified and corrected prior to being issued, thus delaying reporting. c. The new RIS is (at time of writing) awaiting approval from	implemented as soon as possible. a. Partially complete.

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			the executive and board. recommendation was also included in a previous SAC 1 report. d. Clinicians to be enabled to view radiology images from home.	
		2. Bedside clinicians had a lack of certainty about who and how to ask for a review of a plain film.	2. Publicize the numbers to call for plain film advice.	
		3. The combination of electronic and paper charting produced at least one significant drug error with no harm. Hybrid electronic and paper systems are known to have increased risk.	3. The DHB to a complete uptake of Medchart as soon as possible. a. IT recognizes that certain areas (notably intensive care, emergency department and operating theatre) require use of complex infusions. However this is unable to be facilitated by Medchart as the module of Medchart that is required is not	3. Electronic prescribing and administration (ePA) has planned roll out dates of: Dunedin Hospital – April 2014 Southland Hospital – August 2014 Wakari Hospital – November 2014.

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			available yet. b. The development and use of a separate sheet for fluid and infusion administration (not the old drug chart) may lessen risk and be cheaper. c. An assessment of hardware requirements required for introduction of Medchart to the above areas to be conducted urgently.	
		4. There are a growing number of places where patient information can be recorded.	4. The DHB develop an overarching policy with regard to electronic patient note taking. a. All electronic notes should be printed out prior to transfer between environments where there is a transition between computerized and paper systems or between computerized systems E.g. ED to ward and ICU to ward. This requirement should be included as part of the nursing handover.	

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			b. Formulation of a coordinated structure and policy for an electronic notes system be created for the entire DHB and to begin in the near future.	
		5. Tests are often requested in the Emergency Department on behalf of other teams. Due to the 24/7 nature of the service, it is not always possible for the individual who orders the test to review the test.	5. Emergency senior staff to convene and create a position on the ordering of tests by ED staff on behalf of other teams.	
SAC2	Tension pneumothorax not recognised on x-ray leading to emergency intervention.	The patient's clinical course has not been adversely affected by this event. 1. Non compliance with existing intensive care unit (ICU) policies. 2. Detailed x-ray review was not done in a timely manner.	1. That this case is presented in a clinical audit meeting held by clinical staff including nurses and to include review of existing safety practices related to this event. 2. Address the responsibilities of the clinician for obtaining the results of an ordered	The recommendations of this report have recently been released. The recommendations are expected to be actioned and implemented as soon as possible.

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			investigation.	
		3. New medical staff to area.	3. Review and formalise registrar orientation in ICU.	
		4. Communication in handing over duties to oncoming medical staff.	4. Reminder to junior medical staff to be vigilant at handover times. Review the processes around communications on changed observations.	
SAC2	Wrong side surgery.	1. Side not marked pre-operatively.	1. Marking the side and site of surgical procedure is an important aspect of patient safety and should be routinely adopted in all settings where surgical procedures occur.	1. District-wide policies for Site marking, Count and World health Organisation (WHO) checklist have been completed and implemented.
		2. Time Out Check not optimally timed.	2. All theatre team members to be involved in a final check / time-out check. This should occur immediately before skin incision.	2. Complete.
		3. Human factors.	3. The Open Disclosure which occurred should attract positive attention as an example of good practice.	3. Complete.

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		4. Environmental factors.	4. DHB staff should be reminded that the use of cell phones or Personal Digital Assistant (PDA) to obtain clinical images can be used to transfer information, with patient consent, but must be deleted as soon as practical after. 5. A review of wall mounted items should occur in theatres. Non essential items should be removed. Wipe-Boards should be installed to ensure greater visibility of surgical case details.	4. Areas involved have purchased a camera for use if needed. 5. Complete.
SAC2	Possible delay in diagnosis and transfer to higher level care.	Investigation not complete at time of report.		
SAC2 x3	Wound infection following pacemaker insertion for three patients.	No singular cause identified for this cluster of events. Microbial results were identified as different organisms in all three cases.		

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		1. Theatre environment inadequate and policy needs review.	1a. All staff working in the Cardiac Catheterisation Laboratory (CCL) to wear appropriate theatre attire. 1b. Once skin has been breached no entry of any staff is to take place until patients procedure has completed and dressing in place. The only exception being emergencies. 1c.Lead apron cleaning to be done regularly. 1d. Doors to the theatre are to be kept closed during procedures and non-theatre attired staff may utilise the viewing workstation in the reporting area attached to the CCL. 1e. Team consent to commencement of procedure: Time out. 1f. Cleaning of theatre to occur once patient has left the theatre	1. Complete. 1b. Complete. 1c. Complete. 1d.Complete. 1e. Complete. 1f. Complete.

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			and not before.	
			2a. Instructions on Solunet® package to be changed to reflect the need that the patient must use sponge till solution is all gone.	2a. Complete.
		2. Pacemaker Insertion Clinical Care Pathway (Otago) (PICCP) needs review	2b.Instructions on package sent to patients to be updated.	2b. Complete.
			2c. If patient shows no proof of showering on presentation to the CCL, patient to be returned to the ward for this to take place.	2c. Under discussion. Currently nurses clean the site with chlorhexidine soaked gauze on the ward instead of patient showering with and Solunet® sponge.
			2d. Facilitation of stock of Solunet® for outlying hospitals needed.	2d. Under discussion.
			2e. Documentation to be updated to reflect changes recommended.	2e. This is currently being developed.
		3. Patient Communication	3. Cardiac physiologists to review discharge guidelines given to patient.	3. Compete.

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			3b. Two week follow-up checks of wound & device site at Invercargill hospital for those patients from Lakes District.	3b. Complete.
		4. Surveillance management	4a. A nationally defined Surgical Site Infection definition to be utilised for all cardiac procedures so as to ensure consistency. 4b. Trending needs to be carried out to ensure issues are noted as soon as possible, and therefore reported earlier. 4c. Reporting of all SSI's requires an incident form to be completed.	4a. A pacemaker audit is part of ANZACS-QI (All New Zealand acute coronary syndrome - Quality Improvement) to be rolled out 2014. 4b. Accepted. 4c. Accepted.
SAC1	Medication error. An extra dose of anticoagulants was given.	The drug chart was not checked by staff at handover. 1. Not scrutinising the drug chart was the principal error in this case.	1. All clinical staff involved in this event to be reminded that the patient's drug chart should always be sought out and referred to when questions are	The recommendations of this report have recently been released. The recommendations are expected to be actioned and implemented as soon as possible.

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			raised about medications having been given.	
		2. Two systems for recording medications given to the patient are used. The white board in Emergency Department resuscitation area and the paper medication chart.	2. That a single drug chart for a patient be adhered to. In an emergency if drugs are given and not recorded on the drug chart they should be recorded as soon as practical on the patient drug chart.	
		3. This was a difficult, dynamic, high risk clinical situation, which in general in these kind of situations resulted in confusion, incomplete communication and understanding, and inaccurate record keeping.	3. That in an urgent clinical situation, all medications orders be made in a clearly audible voice, confirmed verbally as having been given, and verbally as having been recorded.	
		4. It is customary for heparin to be drawn up and placed in the kidney dish with the lignocaine before the procedure starts. Thus, it is readily to hand during Percutaneous Coronary Intervention when heparin would normally be given.	4. In a primary angioplasty situation, heparin is not routinely drawn up and presented to the operator in a routine fashion in a kidney dish near the access site.	
		5. Handover incomplete.	5. Staff members remember to	

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			take a full and precise handover when the patient changes clinical circumstances, such as moving from one part of the hospital to another. As a general rule, there should be independent medical and nursing handovers.	
		6. CCL staff unaware that a check list is done in Emergency Department for Emergency Percutaneous Coronary Intervention.	6. The Emergency Department document "Checklist for Patients Undergoing Emergency Percutaneous Coronary Intervention" should be made prominent to CCL staff and its use should be reviewed.	
		7. Team communication in an emergency situation.	7. All staff involved in these clinical situations would benefit from the cautionary lesson of this case.	
SAC2	Inappropriately prescribed medication.	Patient with history of chronic glomerulonephritis causing end stage renal failure was admitted for treatment of pneumonia.	1. Clinical Director to facilitate relationship with the renal physicians and what their expectations around these patients are.	1. In-house education complete for medical staff on drug interactions.
		2. Nephrologists not consulted	2. All renal patient admissions	2. Complete.

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		for a number of days. Not noted that antibiotic may interact with chronic anticoagulation therapy. Discharged on oral antibiotic to perform home dialysis. Anticoagulation monitoring test (INR) not requested when returned the following day for blood tests.	will be notified to Nephrologists.	
SAC2	Absence with out leave (AWOL) of a high risk youth.	Adolescent was residing in the Children's Ward until a suitable placement could be found. **Contributory Factors:** Poorly controlled insulin dependent diabetic. Behavioural issues and inability to be discharged home. Staff involved attended to the situation as per hospital policy and procedures.	CYFS Multi-agency Safety Plan to be updated following incident.	Complete.

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SAC2	Fall resulting in fractured wrist.	1. The patient was moved shortly before their fall from the side room directly in front of the nurses' station. Although this move was unavoidable it may have contributed to their fall. 2. Strategies in the falls care plan could be more individualized to the patient based on their assessment.	1. Minimize moves around the ward and hospital for patients with dementia 2. That falls refreshers for all Internal Medicine nursing staff continue to be scheduled regularly. 3. Audits occur to ensure that the Falls Prevention Program is being utilized correctly.	1. Complete. 2. Complete. 3. Results of audits fed back to ward staff allowing engagement of staff to formulate action plans.
SAC2	Fall resulting in fractured neck of femur.	1. Patient had cognitive impairment and was impulsive. 2. All falls risk assessments and documentation were completed pre and post fall. 3. All appropriate actions were taken post fall.	No recommendations due to all reasonable falls prevention measures taken.	Complete.

Details	Description	Main Findings	Recommendations	Progress
SAC2	Fall resulting in fractured neck of femur.	1. The patient had both visual and hearing impairments which probably made using the lower ground car park problematic for them in terms of accessing the building itself. 2. The car park is quite poorly lit making the kerbs that delineate the centre parking spaces hazardous for people with visual impairment.	1. Investigate the function of the raised kerbs in the centre portion of the car park especially those close to the walk-through to the building entrance. Could the kerbs be removed? 2. Identify whether the lighting could be improved.	1. Kerbs cannot be removed but have been repainted in highly visible paint. 2. Under discussion.
SAC2	Fall resulting in fractured neck of femur.	Patient was admitted with acute confusion on background of progressive dementia. Strategies to prevent falls could have been more individualized to the patient.	1. Falls refreshers for nursing staff continue to be scheduled regularly. 2. Audits occur to ensure that the Falls Prevention Program is being utilized correctly.	1. Complete. 2. Complete.
SAC2	Fall resulting in fractured neck of femur.	Extensive investigation in directorate. No formal report.	1. Falls assessment to be completed within 6 hours of admission to ward. 2. Weekly audit of falls documentation and random spot audit on another day.	1. Complete. 2. Complete.

Details	Description	Main Findings	Recommendations	Progress
			3. Introduce "Use of bedrails" flow chart.	3. Complete.
SAC2	Fall resulting in fractured neck of femur.	1. Although the patient did not appear to require a Falls alarm attached, it could have been considered. 2. No Falls Risk assessment carried out following the fall. Environmental issues: 3. Layout of bathrooms not appropriate in size for immobile patients. 4. Bath room too small. 5. Not enough Hand Rails in bathroom. 6. There is a large lip to get over when wheeling. patients on commodes etc into the shower. 7. Bath rooms need to made into wet areas. 8. No room for rubbish bag.	1. Charge Nurse Manager (CNM) to follow up with ward staff as to when Falls Risk Assessment should be reviewed again. 2. CNM to discuss with ward staff regarding the equipment that is available and should be used to assist with falls prevention. 3. CNM to follow up with Service Manager and Nurse Director.	1. Complete. 2. Complete. 3. Bathrooms to be renovated in the year 2013/14. 3-8. Occupational Therapy assessment requested for an assessment of interim measures.

Details	Description	Main Findings	Recommendations	Progress
SAC2	Fall resulting in fractured neck of femur	The patient's transient confusion and impaired judgement appears to be the root cause of the fall. 1. There seems to be long delays in the needs assessment and discharge planning process from referral to assessment. 2. The patient did not have close family and their support network involved close friends. These friends were not involved in the initial discharge and placement assessment discussions.	There was unfortunately probably no way of improving the patient's transient confusion. 1. Discuss with needs assessment manger if there is a way to improvement to discharge planning and whether these delays could have been avoided. 2. Discuss with needs assessment team that consideration be given to a more holistic assessment involving family/ friends/patient representative during the assessment. 3. Assess time to discharge with audit.	1. Complete. 2. Complete. 3. Complete.
SAC2	Fall resulting in open reduction of left hip	Investigation not complete at time of report.		

Details	Description	Main Findings	Recommendations	Progress
	dislocation.			
SAC2	Patient fell off the operating table during neck of femur repair	Investigation not complete at time of report.		
SAC2	Fall resulting in fractured cervical vertebra.	1. Administration of sedative medication in a vulnerable environment (patient alone in the TV lounge). 2. Patient mobilised without nursing assistance. 3. There is a new falls prevention programme which did not appear to have been implemented in its entirety. 4. Placing a post surgical patient who had been operated on at tertiary hospital, on a secondary hospital ward, under	1. Review of the procedure for the administration of medication with sedating effects. 2. Review of the nurse call/alarm system in the lounge and patient recreation areas, with a trial of various options to improve the ability for patients to alert nursing staff. 3. Review of the falls prevention programme and policy, with recommended audit of the new policy. 4. Review of the transfer policy for patients between Dunedin and Invercargill hospitals, and of transfer of acute patients into	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
		the care of the acute medical team without an assessment on acute or surgical ward.	ward.	
SAC2	Fall resulting in fractured neck of femur and a cervical vertebra.	Triage of the event has occurred. Similar events are currently under review and prevention strategies identified are to be applied.	Pending review.	Action pending review of similar events.