Serious Adverse Event Report

Southern District Health Board

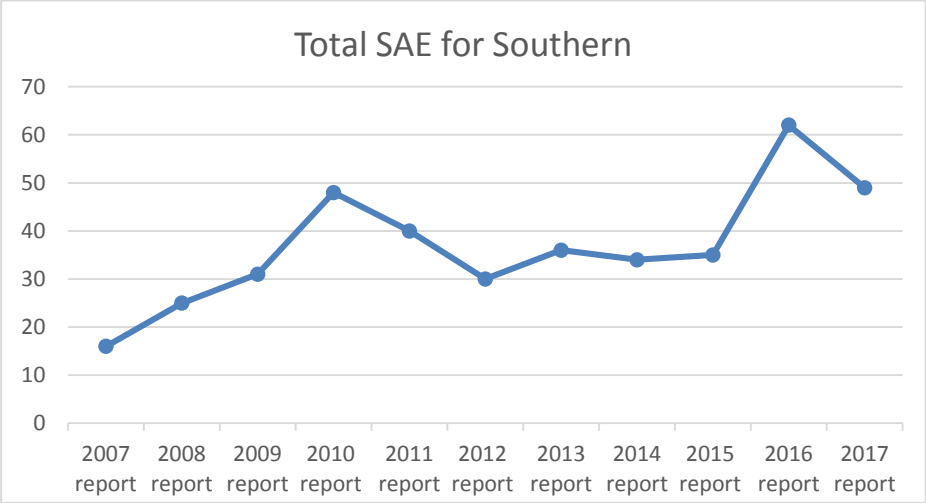
2016-2017

Serious Adverse Events 2016 - 2017

Welcome to the serious adverse event release from Southern District Health Board for the period of 1 July 2016 - 30 June 2017.

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 Southern District Health Board (Southern DHB), the recommendations to make the care safer and our progress with implementing these safety measures. You may notice that some events have not had their investigation completed at the time of release of this report. This means that the event is still under investigation or that the recommendations are in the process of being implemented.

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report *"Learning from adverse events – adverse events reported to the Health Quality & Safety Commission"*; available on-line at http://www.hqsc.govt.nz



Graph A

Graph A - In the 2016/17 year Southern DHB reported 50 events.

Southern DHB Annual Report: Quality and Performance Account provides analysis of the main groups of events and the district-wide improvement work being undertaken. A Quality Account summary will also be communicated to the wider public through community newspapers. Both publications are available on our website at http://www.southerndhb.govt.nz

What is a serious adverse event?

Serious adverse events are events (incidents) 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 using the Severity Assessment Code (SAC). The two major SAC classifications, SAC1 and SAC2 are called serious adverse events.

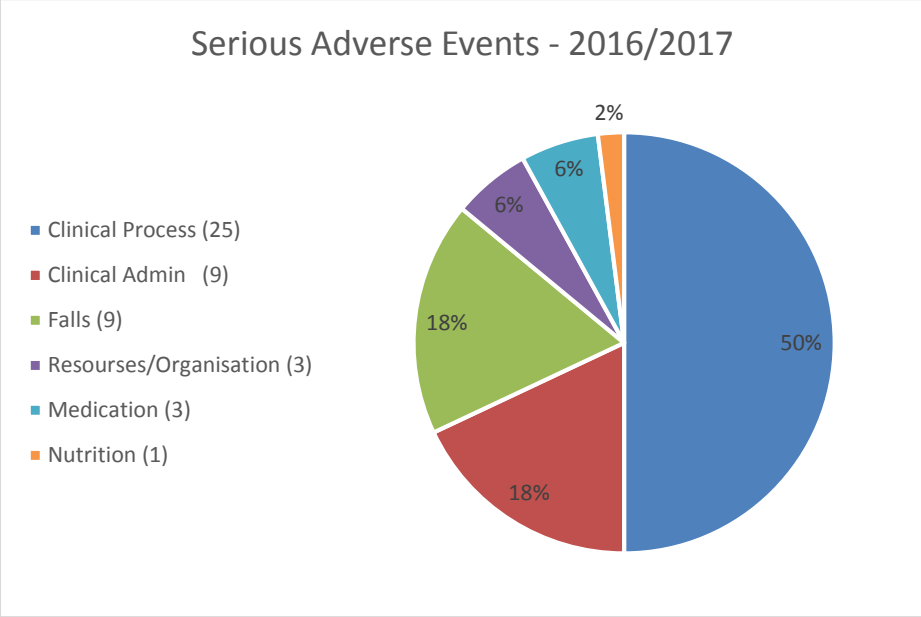
As a provider of health services we are required to report serious adverse events to the Health Quality and Safety Commission.

Using Serious Adverse Events to promote Patient Safety & Prevent Harm

All serious adverse events are investigated (reviewed) to try to determine the major cause(s) 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 events 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 rather than blame those individuals who are involved in the event.

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

Southern DHB is committed to improving patient safety in line with the HQSC programme of work; this forms part of the transparent process of identifying harm and working to learn from incidents and improve our patient safety. Information available at http://www.hqsc.govt.nz



Graph B **Reporting Categories for 2014-2015 – total and percentage**

Graph B indicates the number and type (as per the Health Quality & Safety Commission definitions) of reported serious adverse events for the period. As indicated by graph B, the largest group of serious adverse events relate to Clinical Processes 50% (assessment, diagnosis, treatment, general care), followed by clinical administration 18% (handover, referral, discharge), falls 18% (serious harm from falls e.g. broken hip), Resources/organisation 6%, medication error 6% (dispensing, prescribing or administration of medications) and Nutrition 2%.

Report provided by:

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Falls

	Description	Main Findings	Recommendations	Progress on Implementation
1	Fall resulting in fracture. Neck of humerus.	Unclear if fall/trip or medical event that resulted in fall.		
		Toilet call bell difficult to reach.	Refit of call bell to enable improved access to be added to capital plan 2016/17.	Completed.
		Shower lip present trip/fall hazard and limited space for turning patients who use walking sticks.	Removal of shower lip to make wet room, enabling better access to be added to capital plan 2016/17.	Completed.
		Time lag for electronic Trendcare system (to be available at admission).	Policy for the care plan to be completed within 8 hours of admission. Time lag to be reduced.	Completed.
2	Fall resulting in fracture. Neck of femur.	Reduced level of patient supervision.	Regular intentional nurse rounding to assist with toileting. Allocation of another staff member to oversee patients when the allocated nurse is not on the ward. Implement team-based model of care in the ward.	Completed
		There were times when the patient was confused and agitated without an absolute cause identified.	Delirium screening for patients who are in a state of confusion.	Completed.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
3	Fall resulting in dislocated shoulder.	Document for the safe use of bedrails introduced in February 2017.	The new document introduced in February 2017 is implemented and adhered to.	Completed.
			Daily audits of bedrail use by the Associate Charge Nurse Manager to be reported and recorded at the daily huddle.	Completed.
		Training sessions for the team required.	Training sessions for the team over the following weeks with further training for any staff who are not covered.	Completed.
4	Fall resulting in fracture. Neck of femur.	Patient flow through the Emergency Department (ED) to be improved. Need a more proactive approach to getting elderly patients to the ward earlier in the shift so families can be involved in the admission and patients can be appropriately assessed and orientated to the ward.	Implementation of intentional rounding.	Recommendation in progress.
			As part of the Releasing Time to Care (RTC) programme and patient flow it is recommended that the Emergency Department and medical ward Charge Nurse Managers work together to identify high risk patients and facilitate earlier transfer to the ward.	Recommendation in progress.
			Review current admission documentation that follows the patient to the ward. Link in with the RTC and Dunedin work.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Develop a process where patients are either not handed over at shift change over time or where transfers cannot be avoided, the oncoming nurse would receive the patient handover.	Improve the handover processes between Emergency Department and the ward so essential patient information is handed over.	Recommendation in progress.
		Where late transfers are unavoidable, wards need to implement appropriate measures to ensure patient safety overnight. This may include locating patients closer to the nurses' station and use of falls alarm.	Wards to implement appropriate measures to ensure patient's safety overnight when they are being transferred from Emergency Department in the evening and overnight.	Recommendation in progress.
5	Fall resulting in fractured thumb.	Appropriate care and action implemented. All policies, falls prevention and risk screens were in place.	No recommendations.	Completed.
6	Fall resulting in fracture. Neck of femur.	The ward has not had recent delirium management training.	Complete 3x training sessions over 6 weeks. Add more if 90% staff members have not attended at least one.	Recommendation in progress.
		The ward has not implemented Confusion Assessment Method (CAM) screening due to staff vacancy.	Implement newly created Delirium Screening and Management on the ward.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
7	Fall resulting in fracture. Neck of femur.			Investigation initiated.
8	Fall resulting in fracture. Neck of femur.	Individualised level of falls risk management strategies appears to have been insufficient for someone with an extensive falls history, at high risk of fracturing with falls, on treatment for a urinary tract infection (UTI), with a known cognitive deficit.	Education of clinical staff to include: Falls Interventions: so it is not rote form filling and the plan is truly individualised. Prioritise the location of these patients closer to the nurses' station where they will be more visible to a higher volume of staff. Ensuring staff awareness, that, as symptoms are treated, the patient may become more impulsive with mobilising. Highlighting to staff, with use of current falls data, the most frequent times of falling within the organisation, the types of injuries that are sustained, and the impact on the person's life post fall via case study examples.	Recommendation in progress.
		Identification of high-risk fallers on admission.	Identification of high-risk fallers to include: Flagging this cohort of high-risk patients on admission and throughout the hospital stay.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
			Ensuring adequate verbal and written handovers between wards, highlighting any patients at high risk of falls and fractures and the potential requirement for higher levels of staffing input.	
9	Fall resulting in fracture. Neck of femur.			Investigation report in draft.

Medication and Intravenous Fluids				
10	Respiratory arrest following administration of multiple doses of analgesia (opioid and other).	Accidental overdose of morphine.	Education programme on pain management. The development of a pain management pathway.	Completed.
		Lack of understanding regarding accumulative effect of intravenous morphine.	Education programme on analgesia, usage, dosage and the different types.	Completed.
		Poor patient positioning.	Education programme on the baseline observations and their recording, including the recording of pain scores.	Completed.
11	Near miss serious harm. Incorrect medication route.			Investigation to be initiated.

	Description	Main Findings	Recommendations	Progress on Implementation
12	Incorrect medication dose.			Investigation report in draft.

Clinical Administration				
13	Failure to follow-up. Surgical procedure.	Lost or mislaid booking form for surgery.	Electronic booking from to be considered.	Recommendation in progress.
		No checks and balances from outpatient plan to the surgery treatment proposed.	The clinic outcome "Waiting List - In-patient (IP) Elective" is entered onto Patient Management System (PMS) from the outpatient clinic not later in the process.	Recommendation in progress.
		Lack of initiation of booking process.	Outpatient clerk to email the booking administrator the Day Clinic List with the outcome showing the patients with the outcome "Waiting List - IP elective" so booking forms can be checked.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
			Encourage patients and GPs to be aware of the expected treatment timeframe and to make contact with service where it has not been provided. Encourage staff to feel empowered to inititate process where there appears to be a breach and ensure it is clearly brought to the attention of the provider.	Recommendation in progress. Recommendation in progress.
14	Delay in follow-up. Loss in visual function.	This event was included in the external review commissioned for the service. Findings and recommendations can be accessed HERE.		Completed.
15	Delay in follow-up. Loss in visual function.			Investigation to be initiated.
16	Delay in follow-up. Cancer.			Investigation initiated.
17	Delay in follow-up. Cancer.			Investigation initiated.

	Description	Main Findings	Recommendations	Progress on Implementation
18	Lost referral. Maternity.			Investigation to be initiated.
19	Delay in follow-up. Loss in visual function.			Investigation initiated.
20	Delay in referral. Cancer.	Wrongly triaged colposcopy referral.	Ensure colposcopy nurse has sufficient orientation to standards.	Completed.
			Ensure nurse has access to consultant to advise when unsure or unclear of triaging code.	Completed.
		Staff education.	Ensure all staff understand legal requirements around date stamping, signing forms/documents.	Completed.
		Review colposcopy triage form.	Review district triage form and ensure in alignment with National Cervical Screening Programme standards.	Completed.
			Remove all other triage documents.	Completed.
			Review colposcopy documents to ensure district consistency.	Completed.
		Review specific computer drive (U:Drive) folder for Colposcopy.	Colposcopy team to review all documents currently on U:Drive in the colposcopy folder to rationalise and place appropriately for all staff to access.	Completed.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Review colposcopy practice around paper heavy process, mitigating confusion and reducing errors.	Colposcopy audit recommendation that paper-light process be introduced and available IT systems are utilised maximally, ensuring inconsistencies are kept to a minimum.	Completed.
		Audit of referral triaging.	Implement district-wide 3 monthly audit of 10 referrals by lead colposcopist to ensure triaging standards are being met.	Completed.
21	Delay in follow-up. Loss in visual function.	Until this point the patient's fields had been yearly and shown deterioration however were still delayed a further 5 months at clinical request that then became 8 months with delays inherent in the service at the time.	Establish a clinic format for locum medical staff that allows for sufficient time or process to full assess and plan care for complex patients as well as the non-complex patients.	Completed.
		No phone log in place until June 2016 and when in place not used to monitor for frequency of phone contact with individual patients. No procedure for reviewing these frequent caller's cases.	Develop a system to proactively manage frequency of individual patient phone calls. Produce a plan for dealing with these frequent callers.	Completed.
		Delay in having urgent patient receive visual field test even when it was planned for (3 month delay).	Undertake work aimed specifically at improving patient flow through the system to alleviate the delays in all and in particular identified urgent patients receiving their appointment	Completed.

	Description	Main Findings	Recommendations	Progress on Implementation
Nutrition				
22	Allergic reaction to known allergen.	Orange alert sticker on the patient file did not raise flags to any frontline staff to check the notification was on the patient management system (PMS). Failure to put the allergy on Patient Management System (PMS) as per protocol.	Global reminder to all appropriate staff about the responsibility to clearly check/update/document alerts in patient notes as per protocol. Follow-up at Charge Nurse Managers' meeting following reminder email to ensure this information is disseminated down to all teams. Reinforce to all staff the role and responsibilities of the food service associate role and how the electronic menu ordering system works with Patient Management System (PMS), Trendcare and special diet requirements.	Completed. Completed. Completed.
Clinical Process				
23	Pressure injury. Inpatient			Investigation to be initiated.

	Description	Main Findings	Recommendations	Progress on Implementation
24	Delay in follow-up. Cancer.	The patient's first specialist assessment (FSA) waiting list was closed due to an acute presentation for another reason therefore his pending consult was overlooked and the medical staff were unaware of the referral.	FSA waiting list should not be closed due to acute presentation to the department. If acute presentation when awaiting a FSA then referral and notes should be reviewed by either the Urology Nurse Specialist or a consultant to decide the appropriate course of management.	Completed.
		No way to confirm that the administrator receives the photocopy of pathology log book containing patient histologies and plan for follow-up. Therefore it is unclear if the administrator received the list.	Send pathology log book (not photocopy) so it can be documented that a follow-up has been made.	Completed.
		FSA appointments are made from the waiting list and then the original referral pulled from the filing cabinet.	Manual checks/audits of the filing cabinet to ensure the waiting list report matches the hardcopy.	Completed.
25	Delay in diagnosis. Failed metalware, right hip.	Difficult surgical repair of fractured neck of femur with suboptimal placement of metal fixation.	Consider an early X-ray soon after weight bearing if there is increased risk of failure of the metal fixation with a weight bearing fracture.	Completed.
		Poor communication between surgical service and rehabilitation service regarding the suboptimal metal fixation.	Enhance communication between the orthopaedic service and the rehabilitation service with regard to shared patients. This will be achieved by dedicated time during the weekly orthopaedic radiology meetings for the Geriatrician to attend and discuss shared care patients. It is scheduled to commence in November 2016.	Completed.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Lack of recognition by the rehabilitation service of the significance of a number of gait abnormalities which should have raised suspicion for the need to X-ray the hip.	Clinicians on the Rehabilitation Service involved in this patient's care give an education session on recognising the signs of hip dislocation/failed hip fixation.	Completed.
		Good handover is dependent upon information that could signify a departure from normal/routine post-operative care being identified and clearly documented. There should be a process, or processes, that ensures such information, at handover, is sent and acknowledged.	Orthopaedic team to review handover/referral process and documentation to Assessment Treatment and Rehabilitation for post-operative care (ATR) 87807.	Completed.
26	Delay in surgical wound packing removal.	Inconsistencies in recording operation notes as noted by surgical Charge Nurse Manager (CNM).	Review operation note form, looking to ensure that a clear description of what has occurred in the operation is documented. This is to be typed in real time to ensure clear documentation.	Recommendation in progress.
		No clear ongoing wound care instructions for post-operative care.	Woundcare chart is commenced in theatre which includes description of operation, current state of wound including current dressing regime, an accurate decription of what is currently packed within the wound and clear post-operative dressing instructions.	Recommendation in progress.
		Lack of verbal nurse-to-nurse handover from theatre to Post Anaesthetic Care Unit (PACU) handover to the ward.	Review processes regarding transfer of information from theatre to PACU and to the receiving ward.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Lack of guidance within Negative Pressure Wound Therapy policies regarding accurate recording pertaining to number of pieces of packing removed and inserted.	Review Negative Pressure Wound Therapy policies to be updated to include recording type and number of packing pieces.	Recommendation in progress.
27	Pressure injury. Acquired in hospital.			Investigation report in draft.
28	Perforation Gastric tube.	Clearer and more accurate documentation of intubations and OGT/NGT (Orogastric Tube/Nasogastric Tube) placement in babies especially those less than 28 weeks gestation is needed.	Intubation record to be adopted for use. Record for tube insertion to be developed. Use of peer approach to OGT/NGT insertion for babies less than 28 weeks gestation in the first few days of life - includes review of clinical picture, ventilation, number of tube placement attempts and number of OGT/NGT insertions. Measurement check with two nurses, insert with second nurse observing, use of lubricant for insertion.	Completed.
		X-ray review need not clear if it included all nursing staff and placement of all lines and tubes.	Review of X-rays by nursing staff, findings documented at time of review, placement of all tubes.	Completed.
		Use of PVC feeding tubes review needed.	PVC feeding tubes have been removed from the MICU supply and changed to opaque polyurethane feeding tubes.	Completed.

	Description	Main Findings	Recommendations	Progress on Implementation
		Documentation in clinical notes review needed. Was not chronological or clear record of events and action taken especially in relation to the timing of emergency responses.	Development of a form for clinical records to provide clearer documentation of number of intubation attempts, OGT/NGT insertions.	Completed.
		Review of ETTs (Endotracheal) and central lines required manipulation to lengthen or shorten tubes/lines required to the correct length resulting in disruption of taping or securing devices, potential trauma and repeat placement of OGT/NGT emergency responses.	Review of national and international guidelines and policies for OGT/NGT insertion and methods of measuring for correct length of placement.	Completed.
29	Delay in diagnosis. Sarcoma.	Initial surgery delayed due to insufficient urologists over Christmas period.	Surgical operating time and urology resources be reassessed particularly over the holiday period.	Recommendation in progress.
		Follow-up clinic appointments not made at 3 weeks post-operatively and subsequently 2-3 monthly as requested.	Follow-up guidelines to be developed for junior staff to follow.	Recommendation in progress.
			Discharge summary to include outpatient follow-up instructions.	Recommendation in progress.
			Discharge check list must be completed by nursing and medical staff which must include outpatient follow-up.	Recommendation in progress.
			Appointments must be booked at requested time intervals in advance and independent of radiology investigations; with a request for these to be completed by appointment date.	Recommendation in progress.

	Description	Main Findings	Recommendations	Progress on Implementation
			Cancer follow-up database is to be resourced and kept updated and monitored.	Recommendation in progress.
		CT scan not acknowledged due to reliance on paper copies of abnormal radiology results being followed up in the urology radiology meeting (with an outpatient appointment after requested CT scan performed which showed recurrence).	Electronic reports are to be acknowledged in set timeframe and escalation process is made to be robust and timely.	Ongoing.
			Radiology meeting review of positive radiological investigations are placed on meeting agenda by both radiologist and urologists and outcomes are to be documented and acted on.	Recommendation in progress.
		Communication with the patient was unclear.	Patients are communicated with effectively on discharge plan without the use of abbreviations.	Recommendation in progress.
		Urology resources appear inadequate particularly time for administration, theatre capacity and clinical nurse specialist support.	The Urology Service will be reviewed - (including staffing, the staff mix, administrative processes and value stream mapping with activity follow).	Recommendation in progress.
30	Contaminated surgery item.	Unable to definitively prove source of fibres but likely derived from the current theatre packs or Theatre Sterile Service Unit (TSSU) practice.	Ensure the Check Fives and Weck cells are changed in the current propack before propack reintroduced, or alternatively hand-off current Check Fives and Weck cells and open appropriate replacements.	Completed.
			Remove the cotton buds from the 'intraocular tray' and open sterile alternative.	Completed.

	Description	Main Findings	Recommendations	Progress on Implementation
			Notify current pack provider of incident.	Completed.
			Review to practice and policy of cloth use in TSSU to remove the chance of eye instrument contamination.	Completed.
			Ensure no cloths in TSSU are used in the eye instruments or crates.	Completed.
		The drawing up of solution could have provided a point of entry.	Drawing up of Balanced Salt Solution Bottles either directly from Phaco machine or directly into syringe forgoing drawing up from pottle.	Completed.
		Surgical technique may have contributed to a mode of delivery of the fibres and as such should be assessed against best practice.	Review surgical technique of surgical instruments passing directly to scrub nurse.	Completed.
			Education required for nurses on the importance of the 'tracking form' and need to complete it accordingly - especially of the consumables and the importance of being able to track 'reference' and 'lot' numbers.	Completed.
31	Tracheostomy management issue.	There were no additional Intensive Care Unit (ICU) resources to support Outreach Services.	Investigate the development of a dedicated Outreach Service.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Due to the demand exceeding the capacity in ICU, the patient was prematurely discharged to the ward. Adequate ward staffing and resources therefore could not be organised.	Strict adherence to recent Variance Response Management Action Plan.	Recommendation in progress.
		There was a lack of resource for dedicated daily review by ICU staff of recent ICU discharges.	Daily planned review of tracheostomy patients recently discharged from ICU.	Recommendation in progress.
		There were no clear guidelines for early escalation of care for a patient with tracheostomy problems.	Refinement of Tracheostomy Response Team documents and education materials.	Recommendation in progress.
32	Delay in diagnosis. Vestibular schwannoma.			Investigation initiated.
33	Delay in treatment. Neutropenic sepsis.	Protocol/policy or procedure not being followed which led to a patient being put at risk of serious harm or potential serious harm.	Review of policies and protocols and the "Green Card" for use in the community setting.	Completed.

	Description	Main Findings	Recommendations	Progress on Implementation
		The reason given for not following the protocol was the practice did not have tazobactam in stock.	General Practices to stock tazobactam 4.5g or have access to stock for use in emergencies.	Completed.
		Contributing factors for not following the correct procedure were lack of education and knowledge of the seriousness of neutropenic sepsis and lack of supervision.	Improved education for registered nurses, general practitioners, and ward staff on febrile neutropenia. Raising awareness of the risk or potential risk to a patient.	Completed.
		The advice given from the oncology nurse responding to the 0800 call could have been clearer in advising of the urgency and severity of patients presenting febrile and neutropenic.	Fully implement the use of UKON's telephone triage tool (a 24 hour triage, rapid assessment access tool kit) into the ward with some specific instructions about specific community support.	Completed.
34	Retained surgical item. Maternal.	No formal count in delivery suites.	That a system of formally counting and accounting for all "swabs" in the delivery suites be established. This should be non-negotiable.	Recommendation in progress.
		Birthing packs do not contain swabs with tails.	That the current Combines in the delivery and suture packs be replaced with swabs with tails.	Recommendation in progress.
		There was a handover of clinical care and nursing staff during the patient's case.	That clear protocols be established: for swab counting when paitents start their delivery in the delivery suite and are then transferred to Theatre, in particular identifying who is responsible for the total swab count.	Recommendation in progress.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
35	Retained surgical item. Maternal.	No formal count in delivery suites.	That a system of formally counting and accounting for all "swabs" in the delivery suites be established. This should be non-negotiable.	Recommendation in progress.
		Birthing packs do not contain swabs with tails.	That the current Combines in the delivery and suture packs be replaced with swabs with tails.	Recommendation in progress.
		There was a handover of clinical care and nursing staff during the patient's case.	That clear protocols be established: for swab counting when patients start their delivery in the delivery suite and are then transferred to Theatre, in particular identifying who is responsible for the total swab count.	Recommendation in progress.
36	Pressure injury. Inpatient.			Investigation report in draft.
37	Failure to follow up with additional procedure.			Investigation report in draft.

	Description	Main Findings	Recommendations	Progress on Implementation
38	Complication of labour. Medication error.	The clinical impression of imminent delivery following spontaneous rupture of membranes with meconium liquor and an associated fetal heart deceleration was not confirmed with a comprehensive vaginal examination to assess cervical dilation. This resulted in a delayed diagnosis of obstructed labour.	Review requirements for regular refresher education topics for all professional groups and document when these have occurred.	Recommendation in progress.
		Inadequate monitoring of fetal wellbeing resulting in an incorrect assessment of fetal distress.		
		Administration processes could be improved for documentation of clinical findings and classification of incidents.	Remind staff about timely and comprehensive documentation of clinical information.	Recommendation in progress.
			Investigate providing staff with a personal click stamp with registration authority number next to signatures in clinical notes.	Recommendation in progress.
			Review training for staff on classification of incidents.	Recommendation in progress.
		The anaesthetics service was not informed of the baby's death and caused distress to the family when they phoned to ask for feedback on their service.	Review processes undertaken following the death of a baby to ensure all relevant parties have been informed.	Recommendation in progress.
		The death was not discussed with the coroner despite the baby being born in poor condition and a drug error.	Seek advice from the coroner - confirmation she will take jurisdiction.	Completed.

	Description	**Main Findings**	**Recommendations**	**Progress on Implementation**
		Drug administration error following failure of medical and nursing staff to adequately check preparation of IV midazolam. The drug protocol referred to two concentrations of IV midazolam even though only one was stocked.	Review NICU drug management and charting; consider pharmacy audits. Review resident medical staff orientation to Hospital Policies on medication. Administration and medication prescribing.	Recommendation in progress. Recommendation in progress. Recommendation in progress.
39	Retained item. Delayed removal. Wound packing.			Investigation report in draft.
40	Retained item. Stent.			Investigation report in draft.
41	Delay in diagnosis. Lung cancer.			Investigation initiated.

	Description	Main Findings	Recommendations	Progress on Implementation
42	Delay with transfer. Maternity.			Investigation report in draft.
43	Failure to follow-up. Cancer.			Investigation report in draft.
44	Failure to follow up. Intracranial lesion.			Investigation to be initiated.
45	Delay in diagnosis. Patient deceased.			Investigation report in draft.
46	Pressure injury. Residential care acquired.	The patient should have been reviewed in the community sooner as she required a higher level of care than was provided due to her deterioration in mental health and sepsis. Braden scores were not recorded daily and they should be for patients with pressure injuries. Accurate reporting may have impacted on the deterioration.	Inform planning and funding of the outcome of the review so they can provide feedback to the residential centre where the patient resides. Improve compliance with Braden score, daily for complex patients.	Completed. Recommendation in progress.

	Description	Main Findings	Recommendations	Progress on Implementation
		The pressure injury was not recorded in the electronic incident system on admission.	Report all pressure injuries accurately on admission within the electronic incident system.	Recommendation in progress.
47	Arterial line snapped during removal.			Investigation report in draft.

Resources / Organisation / Management				
48	Delay in follow-up. Loss in visual function			Investigation to be initiated.
49	Delay in follow-up. Loss in visual function			Investigation to be initiated.
50	Delay in follow-up. Loss in visual function			Investigation to be initiated.