Serious & Sentinel Event Report

Counties Manukau District Health Board

2011-2012

Counties Manukau District Health Board (CMDHB)
Serious & Sentinel Event Report 2011-2012

Introduction

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious and Sentinel Events.
http://www.hqsc.govt.nz/our-programmes/reportable-events/serious-and-sentinel-event-reports/

For the 2011-2012 financial year, CMDHB has reported twenty five events that have caused serious harm or death.

What is a Serious or Sentinel event?

'A serious or sentinel event has resulted in, serious lasting disability or death, not related to the natural course of the patient's illness or underlying condition

As part of Counties Manukau DHB's commitment to providing safer care for patients, we have in place a process for investigating serious and sentinel patient safety incidents that occur in our organisation. The purpose of investigating serious and sentinel events is to determine the underlying causes of the event so that improvements can be made to the systems of care to reduce the likelihood of such events occurring again.

Serious and sentinel event reviews at CMDHB are undertaken according to the following principles:

- Establish the facts: what happened, to whom, when, where, how and why
- To look for improvements in the system of care rather than apportion blame to individuals
- To establish how recurrence may be reduced or eliminated
- To formulate recommendations and an action plan
- To provide a report as a record of the investigation process
- To provide a means of sharing learning from the incident

Guide to Event Categories

Code	Description
1	Wrong patient, site or procedure
2	Suspected suicide of an inpatient, including suspected suicide of patient: • while on approved leave from an inpatient unit, or • having absconded from inpatient unit, or • having absconded from assessment unit/ED while awaiting admission to inpatient unit.
3	Retained instruments or swabs
4	Clinical management issues – use subcategories below
4a	Diagnosis (including delayed diagnosis or incorrect diagnosis)
4b	Treatment (including delayed treatment or incorrect treatment)
4c	Monitoring/observations (including delayed, incorrect or omitted monitoring)
4d	Procedure associated incident
4e	Investigation (including delayed or omitted investigations)
4f	Discharge/transfer
4g	Other clinical management issue, or combination of clinical issues
5	Medication incident
6	Fall
7	Blood transfusion reaction
8	Missing/absconded/AWOL from inpatient unit
9	Physical assault on patient
10	[Intentionally blank]
11	Other
12	Hospital acquired infection
OPS	Suspected suicide of a mental health service user within seven days of contact with the service

Serious or sentinel	Event Category	Description of event	Review findings	Recommendations/actions	Follow-up
Sentinel	2	Death of an Mental Health inpatient due to suicide	No consistent process in place to ensure that assessment and oversight of care of a patient in the inpatient unit is done by a Consultant Psychiatrist. No systematic process in place to comprehensively review longitudinal history and factor this into clinical decision making following transfer of care to service.	Commission independent external review of care provided Continue with planned urgent review of medical cover requirements to ascertain a standard level of Psychiatrist cover for acute inpatient unit Implement development of contingency plan to identify coverage of gaps when the minimum medical staffing levels cannot be met. Development of a standardised process for a summary of a patient's longitudinal history to be presented at Multi-disciplinary team meetings and for allocation to a key worker in the Community.	External review has been undertaken and report submitted to the senior leadership team to action recommendations. Urgent review of medical cover has been undertaken and contingency plans are in place. Development of process underway
Serious	3	This patient required wider than normal surgical tubing to hold the bowel aside during an operation. The patient was readmitted four days post-operatively and was found to have retained surgical tubing. Further surgery was required to retrieve tubing.	Wider surgical tubing was not available in theatre and therefore a different type of tubing was used. Because this was unusual, it was not added to the theatre count sheet and was retained inside the patient at the end of the procedure.	Theatre Charge Nurse to review stock levels and include wider surgical tubing. The use of any consumable for any reason other than which the item was originally intended needs to be identified and added to the surgical count. Discuss in the nurses theatre education day to raise awareness of the risk of retained items For discussion and review at the General Surgery Morbidity and Mortality meeting to raise awareness of retained items.	All actions have been completed.

Serious or sentinel	Event Category	Description of event	Review findings	Recommendations/actions	Follow-up
Serious	4a	The patient had a total of four visits to the Emergency Department over nine weeks during which time her condition was not diagnosed. This resulted in a delayed diagnosis of a spinal tumour and a greater than anticipated loss of function. Such a tumour is rare in this age group.	Staff wrongly attributed the symptoms to stress. On the second visit, the patient was not assessed by a Senior Medical Officer On the last visit to the Emergency Department, the patient left without being assessed by a doctor at all because the Emergency Department was busy and there was an anticipated wait of more than 2 hours.	Education for front-line staff should emphasise the concept that an organic cause for symptoms should be sought and positively excluded. A Senior Medical Officer should review all patients who re-present to the Emergency Department with a persisting complaint within a 4-week period. A new procedure has been instituted in the Emergency Department under which all patients who self-discharge will be telephoned next working day by a senior nurse to determine that the problem that brought them to the department has been dealt with.	All actions have been completed
Sentinel	4a	Ruptured uterus in a woman with a previous caesarean section leading to a still birth and loss of her uterus.	There was a delay recognising and treating the patient's ruptured uterus.	Education for all staff about the risks and symptoms of ruptured uterus in women attempting a vaginal birth after a caesarean section. Education to include the Registrar monthly teaching programme, Obstetric emergency care programme and all ward staff through the Midwife Educators	A ruptured uterus scenario will be included in the simulation training as part of the multidisciplinary obstetric training course for obstetric emergencies.

Serious or sentinel	Event Category	Description of event	Review findings	Recommendations/actions	Follow-up
Sentinel	11	Exsanguination and subsequent death in a patient following haemodialysis undertaken at a community dialysis house.	The change in the risk factor status of the patient didn't flag a multidisciplinary team review to re-assess his suitability for continuing with the home haemodialysis programme. Patients are trained to manage post-dialysis bleeds appropriately; however the severity of the consequences that can occur as a result of a significant post-dialysis bleed may not have been explicitly communicated to patients. There was only one telephone line at the community dialysis house. This meant that when any phone was being used, the St Johns alarm system could not be activated.	Renal team to review criteria for selection for home haemodialysis and to review the 'flags' for prompting an urgent case review to re-assess suitability for continuation for patients already on home haemodialysis. Nurse Manager Home Haemodialysis Unit to work with Learning & Development team to revise the training processes and manual and ensure processes are explicit, clear and standardised for all patients. Put two lines into the Kidney House so that all St Johns Alarm activations have a dedicated line.	To be addressed at the next Senior Medical Officer's Meeting The review of the training manuals is about to be initiated. This is a 3-6 month process and will be undertaken by staff in conjunction with the Learning & Development team. Completed Completed.

Summary of Falls causing patient harm

In the 2011-2012 year CMDHB had a total of twenty falls resulting in serious harm or death.

- There were 7 fractures of the hip and one fracture involving the lower end of the femur.
- There were 5 fractures involving the upper limb and one involving the sternum.
- Six patients suffered a head injury, and in three of these cases, this may have contributed to the patient's death.

Patient falls prevention is a key focus area of the CMDHB Aiming for Zero Patient Harm initiative. A multidisciplinary group led by the Professional Leader for Physiotherapy and supported by the Centre for Quality Improvement was formed in June 2010, to identify, oversee and coordinate the work required to help prevent patients suffering serious harm from falls at CMDHB.

Current Strategies in place to mitigate the risk of serious harm from a fall.

- All patients to have a falls risk assessment completed within 6 hours of admission to the ward.
- Ensuring appropriate interventions are put in place according to the assessed risk, including:
  - Provision of non-slip socks
  - Falls alert on room door
  - Frequent nurse rounds (up to hourly)
  - Nursed on low bed
  - Walking frames and other stability supports
  - Medication review to decrease use of medications likely to increase risk of falling
  - Hip-protectors
- Ensuring every patient is reassessed regularly or when their condition changes
- Developing an organisational clinical equipment management system that allows wards to quickly and efficiently access falls prevention equipment (example alarms, Invisibeams, high low beds as required by patients)

Plans for future strategies (September 2012 – March 2013)

- Investigate the use of impact resistant flooring mats in areas with high risk patients
- Initiation of staff engagement survey predominantly looking at accuracy of risk assessment, implementation of appropriate interventions and the barriers to achieving this.