Taranaki District Health Board
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Serious or Sentinel	Event Code	Description of Event	Review Findings	Recommendations/ Actions	Follow up
Serious	06	Inpatient given incorrect blood	• Two similar patients with like surgeries in bed spaces next to each other. • The incorrect patient label was placed on the blood/blood product transfusion record form. • The patient had pain and nausea immediately prior to starting the infusion. • The procedure of checking blood/blood product transfusion record form against the patient's identification band was not followed by the staff involved. • Doctors and nurses were aware of their responsibilities in regard to prescribing and giving blood. • The nursing shift was considered busy and the doctor may have been fatigued due to only having three hours sleep overnight. • Patient clinical notes, including medication charts were randomly left on the nurses' station bench. • Clear Blood Transfusion Therapy procedures in place.	• Review and updating of the Blood and Blood Product Protocol and related information and update if required. • Raise awareness re ensuring the correct patient label is placed on the blood/blood product transfusion record request form and that the DHB's procedure when checking a blood product for transfusion be followed. • Education sessions to all department nursing staff on the Administration of Blood/Blood Products protocol to occur. • New Zealand Blood Services Clinical Nurse Specialist has spoken to department staff. • The staff concerned with the event have been followed up individually by the Director of Nursing and Chief Medical Officer. • Explore the option of adding a 'check box' process to the blood/blood product transfusion sheet that requires the administrator to check the blood against the form, check the labelled form and the blood against the patient's identification band. • Purchase trolleys to be used for blood collection and transfusions in the unit. Each trolley will have a laminated copy of the transfusion flow chart attached. • Individual slots for patient charts to be made with staff required to return the chart to the appropriate slot. • Recommendations reported to the DHB's Blood Transfusion Committee who will ensure implementation and monitoring (audit) activity occurs as well as reporting progress to the New Zealand Blood Service.	Completed Completed Completed Completed Completed Discussed with decision not to implement made Completed Completed Completed and Ongoing

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				• Key learning points from this event to be compiled and shared across the organisation.	Completed
Serious	01	Delay in diagnosis and treatment of tuberculosis resulting in the transmission of tuberculosis to others living and working with the patient.	• Patient presented with atypical pneumonia and while tuberculosis was considered and a tuberculosis (mantoux) test ordered, the suspicion was not reported to Public Health staff. • An urgent respiratory outpatient appointment was made but the patient did not attend. The administrator is unable to recall whether attempts to contact the patient were made or inadvertently missed. • A letter advising that the patient did not attend their urgent appointment, as per our procedure, was not sent to the patient's GP. • As the patient's condition had improved significantly, the patient believed follow up was not necessary. • Four months later, the patient's GP ordered a chest x-ray however the result (possibility of an atypical pneumonia or tuberculosis) was not followed up. • Over the next six months, the patient presented to hospital with infections and abscesses that required surgical treatment, inpatient stays and ongoing dressing changes. Swabs of the wounds over this period were negative until a scraping of a sinus at the time of the last surgery showed tuberculosis infection.	• Education of staff in relation to notifying Public Health of any patient suspicious of tuberculosis infection. • Education of staff in relation to the importance of following procedure and ensuring the patient's GP is notified that their patient has not attended their appointment. • Review of the case occurred within the Department of Surgery.	Completed Completed Completed
Sentinel	02	Failure to diagnose a bowel torsion and infarction.	• Issues identified with the way in which the early warning score observation chart limits for the patient were set and communication with the medical staff, when these limits were exceeded. • An abdominal x-ray should have been performed earlier and the diagnosis of bowel torsion or infarction considered. • Referred and investigated by the Coroner	• Review of the case by the multidisciplinary morbidity and mortality review staff meeting to enable learning from the event. • Refresher training for nursing staff in relation to early warning score and for medical staff who set limits on when to take further action.	Completed Completed

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Serious	01	Semi-urgent colonoscopy referral not processed.	• An administration error occurred resulting in the referral being received and filed but not actually placed on the waiting list.
			• Unable to determine the exact reason for the error however, likely contributing factors identified were:
			  ○ Large influx of referrals received that day
			  ○ Busy office where other functions, along side actioning referrals, occur resulting in numerous disruptions.
			  ○ No checking process in place.
			• Once the DHB was aware of the delay, the patient was scheduled urgently for a colonoscopy where a bowel tumour was found.
				• All referrals received on that day were checked to ensure they were all wait listed correctly.
				• Event discussed by the Endoscopy User Group.
				• Prior to this occurrence, several improvements to the efficiency and safety of the endoscopy (including colonoscopy) referral process had been identified and were about to be implemented. These included:
				  ○ Eliminating disruptive activity in the referral office where possible.
				  ○ Replacing several waiting lists with a combined semi-urgent waiting list and a combined surveillance waiting list.
				  ○ Separate folders to store the printed semi-urgent and surveillance referral forms.
				  ○ Colonoscopy clinic appointments are made using the electronic waiting list and checking against the printed referral forms to ensure a match.
				• The DHB now belongs to the National Endoscopy Quality Improvement Programme that looks at quality, productivity and efficiency. This programme includes the regular review of referral processes for endoscopy, including that for colonoscopy.
					Completed
					Completed
					Completed
					Completed
					Completed and Ongoing
					Ongoing

Serious	12	Inpatient fall resulting in a fractured hip.	• Falls risk assessment not completed prior to fall. • Patient has mobility issues – uses a walking frame with minimal assistance. • Patient lost balance. • There were no environmental hazards identified.	• Reiterated to staff the importance of completing falls risk assessments for patients who fit the criteria. • Patient advised to seek assistance/be supervised when mobilising.	Completed Completed