Wairarapa District Health Board
Serious and Sentinel Events Report: 2016-2017

There were eight serious adverse events reported by the Wairarapa District Health Board (WrDHB) during the period of 1 July, 2016 to 30 June, 2017. The following report outlines the summary and findings from reviewing those events, and the changes that have been recommended and implemented with the aim of preventing such events happening again in the future.

The events reported sit within the categories of:

- Medication /IV fluids
- Clinical Process
- Documentation

Any serious adverse event identified is investigated by relevant clinicians and the quality team. The reports are reviewed by the Clinical Event Review Group and learning is the key focus. The recommendations from the reports are shared back to the relevant people within the organisation and added to the organisation's Corrective Action Plan which is overseen by the Clinical Board to ensure implementation. Regular review and audit is routine as part of the follow up to ensure recommendations have been actioned and are effective, and that changes have become part of normal practice.

WrDHB encourages an open and honest patient-centred culture where we communicate openly with patients and their whanau/family at all times. When an adverse event occurs we practise open disclosure, listen to the concerns of the patient, answer any questions transparently and provide support. WrDHB wishes to sincerely apologise to the patients and their whanau/family involved in these events and acknowledges the distress that occurs when things go wrong in healthcare. We thank them for allowing us to share their stories.

What happened	What we found	What we are doing to prevent this happening again
Adverse reaction to IV Flecainide causing cardiac arrest	Previous limited echocardiogram showing poor left ventricular contractility, possibility of thyrotoxic cardiomyopathy. No record in the inpatient notes or evidence that a full cardiovascular exam was undertaken. No record that these findings were noted or of any action that was subsequently taken (although noted on the discharge summary). No record of a formal echocardiogram being arranged. Patient re-presented with a fast tachycardia, discussion was held about whether this represented an SVT or rapid atrial fibrillation. A trial of Flecainide agreed. No mention in the record of any assessment that this patient had cardiac failure, nor any evidence or recollection that Dr was informed of the previous echocardiogram or the details of the patient history when discussing whether to give Flecainide. Patient suffered an asystolic cardiac arrest following administration of Flecainide from which the patient was successfully resuscitated with no long term sequelae.	Reminder to medical staff that a focused clinical assessment/examination is required and significant clinical findings need to be emphasised in the clinical record. Medical staffs have been made aware of the importance of reviewing previous notes and results. Training in clear phone communication skills to be provided for RMOs. Contraindications to use of IV flecainide to be relayed to all medical staff.

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Delay in the diagnosis and treatment of cancer	Patient presented to the emergency department having suffered a fall. As part of the patient's assessment in the emergency department an urgent CT scan was organised. The urgent provisional report on the scan revealed a variety of injuries. The patient was treated with pain relief and admitted to the hospital for on-going care. Subsequent full formal reporting of the CT scan was entered into the IT system the following day where the senior radiologist, noted in addition to the injuries already recorded on the preliminary report that there were numerous enlarged mesorectal lymph nodes. The report suggested endoscopic examination to rule out a rectal tumour. This final report and its contents were not noted nor acted upon and the patient was subsequently discharged. A copy of the final CT report was sent to the patients GP practice. A review of the audit of the final CT report of 16th March confirmed that this report was not sighted until November 2016 some 8 months later. The DHB had no further contact with the patient until he presented 8 months later in November with pain and discomfort in the rectal area. At that time a rectal carcinoma was diagnosed and the patient is subsequently undergoing a course of treatment. There was a failure to read and therefore act upon the final CT report. The reasons for this failure were investigated and the	The DHB is currently in the middle of a major upgrade of its patient administration system scheduled for implementation due end of January 2018. The new system will allow the process of electronic sign off for radiology results. Medical Staff were reminded of the need to follow up and review reports of investigations they order particularly during this period until electronic sign off is available. The management of unexpected results and the policy and procedure related to unexpected results has been reviewed by Radiology.

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	following areas of concern defined. The final report arrived at least one day after the patient's admission from the emergency department. The emergency department team noted that they would have had no direct visibility of the final report unless they specifically sighted it in the patient case notes. The ward team note that they acted upon the provisional CT report as provided to them by the ED Department. This report made no mention of the rectal lymph nodes. From this discussion the current weakness in the IT system that exists at present was highlighted. Best practice has been identified as being that all such reports are signed off by the referring doctor as having been seen. Laboratory and radiology reports are received in this DHB electronically. Unfortunately due to the age of the patient administration system within the DHB an automatic process of electronic sign off for all doctors is not possible. This lack of an electronic sign off is identified as the primary cause of this adverse event.	
Thrombophlebitis requiring surgical intervention	IV cannula inserted during ambulance transfer, was documented on arrival but not handed over to ward staff. Poor documentation of regular assessment of IV cannula site.	Education to ward staff regarding assessment and documentation of IV cannulas. Review of the responsibilities for nursing staff around patient refusal of medication and escalation to medical staff.

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	Lack of written documentation in patient notes from the time IV cannula was removed and when area marked. It was noted that patient had been advised to elevate arm with little compliance and it was therefore difficult to get arm above the heart despite multiple instructions. It was also difficult for staff to ascertain pain level from patient. Patient's refusal of Clexane was not recorded on nursing notes or reported to medical staff. Surgery was required to remove ante cubital fossa septic vein. Patient's discharge was delayed due to the thrombophlebitis and resulting surgery.	Review of documentation forms for IV assessment. Compulsory framework for integrated notes. Use of this patient story as a learning tool at IV training days to illustrate why it is important to document progress within notes Auditing of documentation in relation to IV assessment scoring on charts has taken place to ensure change of practice.
Delay in diagnosis of PET in a 26/40 pregnant woman and her subsequent emergency transfer and delivery of a 26 week baby.	Review of the case found that the patient was hypertensive throughout her antenatal care from when she first presented at 8/40 gestation. There was a failure in the patient being transferred to specialised care at numerous points during her antenatal care despite an uncontrolled and elevated BP and a lack of a managed plan to control her elevated BP, including close monitoring and serial growth scanning of the foetus. There was failure at 25/40 to diagnose PET (as opposed to essential hypertension) despite a clear clinical presentation of such.	Development and implementation of an escalation plan for midwifery staff to enable escalation of concerns related to patient wellbeing, including hypertension. Including informing and escalating Obstetric and Gynaecology (O & G) response, with confirmation from CMO that midwives can call him directly if they are gravely concerned for a woman. The maternity service is working on a project to ensure clear guidelines and documentation for when a client is transferred from primary to secondary care and vice versa. Each handover requires appropriate information and consultation and clear documentation within the case record. In-house education has commenced in maternity to ensure all midwives feel confident

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	At the time of admission there was a lack of a clear and documented handover from primary to secondary care to ensure clear accountability of care. Throughout the antenatal period there was poor documentation by obstetricians and Lead Maternity Carer (LMC). There was delayed action in the transfer of the patient on the, despite core midwives being concerned about the condition of the patient. Antenatal steroids were not given despite indications that the infant may be delivered prematurely. The transfer of the unstable patient by ambulance was unsafe and did not follow procedural guidelines. There are clear guidelines and protocols at WrDHB in place to manage all aspects of the care of a patient presenting as this patient did, however these were not followed.	with secondary level care and around the use of the Maternity Early Warning System (MEWS) observation chart and the escalation tool. O& G Senior Medical Officers (SMOs) have been briefed on the importance of informing LMC when secondary care level women are officially under obstetric care and no longer meet primary LMC care criteria and the requirements of how hand over (transfer of care/ clinical responsibility) will occur. A review of the transfer policy and procedure and reorientation of policy for all staff and the content that states that the transfer out of seriously ill clients requires close co-ordination by the Duty Nurse manager (DNM) with the receiving hospital, that during the transfer the client must be accompanied by suitably qualified, trained and equipped health professionals who are able to supply suitable treatment en route. Obstetric locum doctors' orientation reviewed and ratified by Clinical Board ensuring clear guidance about where WrDHB guidelines and policies are to be found. Accessibility of guidelines improved. Clear guidelines about the foetal assessment during premature labour or illness and the administration of medication including steroids, are to be reviewed and emphasised to all maternity staff. 'Care during the transfer of care' project is being led by Quality Facilitator and the Charge Midwifery Manager is doing a thesis

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		on referral guidelines and transfer of care, both of which will be implemented.
Post partum haemorrhage requiring large blood transfusion	Referral guidelines based on BMI were not followed by LMC, resulting in subsequent delivery at primary health care facility as opposed to recommended secondary. The referral guidelines if had been followed by the LMC midwife would identify that the patient met the criteria for obstetric and anaesthetic referral based on her BMI. Patient suffered heavy blood loss as a result of vaginal wall tear that was not noted during post birth examination requiring surgical intervention and large blood transfusion and subsequent transfer to High Dependency Unit (HDU). Emergency anaesthesia was difficult due to patient's Body mass Index (BMI). Locum anaesthetist was challenged by difficulty with spinal insertion and patient was a high risk for general anaesthesia due to BMI and unsuitable equipment. Patient noted to have had 4 previous well pregnancies that progressed to full term with quick labours of 1-2 hours with birth weights ranging from 3090g to 4451g. The obstetrician was consulted via telephone when the pregnancy reached 40 weeks with a suspected Small for Dates LFD baby. Decision for induction of labour occurred following	External review was performed. Multi disciplinary team review has identified improvements to be made in antenatal referral to anaesthetics and obstetrics based on MOH and local guidelines. Matter has been referred to and is under review by the Midwifery Council and has also been referred to the Health and Disability Commissioner.

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	an Ultrasound confirm foetal size. Obstetrician had not physically seen or reviewed the patient and was working from LMC advice. Infant delivered via water birth weighing 3640g with Apgars of 9 and 10. Patient had an estimated blood loss of 300mls (physiological third stage management), perineum was documented as being intact. Water birth and physiological management were noted during review as questionable choices with the known risk factors in a grand multip that laboured quickly.	
Patient died during surgical procedure of Laparoscopic Cholecystectomy	Sudden unexpected death occurred on table during previously uneventful laparoscopic cholecystectomy, despite resuscitation attempts Post mortem suggested cause of death was haemorrhage, although surgeon's inspection at the time of did not reveal this volume of blood at the time of surgery and when laparoscope was withdrawn. Review noted that a clear leader of resuscitation was not defined.	Event reviewed by independent external anaesthetist, report received and reviewed and recommendations noted Surgeon and anaesthetist to attend next available ACSL training as recommendation to improve resuscitation skills. Coroner's office to be contacted to discuss whether clinicians can attend post mortem in situations such as this.
Colonoscopy referral misfiled resulting in	Following an audit after finding a previous referral had been misfiled it was found that a referral for a colonoscopy had	Installation of WebPas (new electronic patient administration system) and development of new system for referral letter

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delayed diagnosis of cancer.	been misfiled, resulting in referral time for treatment outside targets for referral type (3 months later). Subsequent urgent colonoscopy found a malignant tumour requiring surgery and treatment. Referral system allows potential for referrals to be misfiled due to process. Inherent weakness in outdated IT system means that electronic referrals received have to be printed out then transferred to the endoscopy unit. Printed referral was misplaced due to use of paper clips. Current process will have to continue until the IT system upgrade is completed and operational-scheduled late January 2018	management is being undertaken as part of WebPas, implementation due end of January 2018. REM lite referrals are now matched to the WebPas booking system to ensure each referral has been processed into a procedure booking. A review of all electronic referrals from the last year to check that each referral has been entered into endoscopy system. Weekly audit checks that all referrals received electronically into the DHB have been transferred to the endoscopy unit and entered into that system will continue until the IT system upgrade to WebPas.
Urgent referral for Colonoscopy misfiled resulting in delayed treatment (2)	Following an audit after finding a previous referral had been misfiled it was found that a referral for a colonoscopy had been misfiled, resulting in referral time for treatment outside targets for referral type. Subsequent diagnosis of malignant tumour requiring surgery. Referral system allows potential for referrals to be misfiled	Installation of WebPas (new electronic patient administration system) and development of new system for referral letter management is being undertaken as part of WebPas, implementation due end of January 2018. REM lite referrals are now matched to the WebPas booking system to ensure each referral has been processed into a procedure booking.

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	due to process. Inherent weakness in out-dated IT system means that electronic referrals received have to be printed out then transferred to the endoscopy unit. Process will continue until the IT system upgrade is completed and operational-scheduled for late January 2018.	A review of all electronic referrals from the last year to check that each referral has been entered into endoscopy system. Weekly audit checks that all referrals received electronically into the DHB have been transferred to the endoscopy unit and entered into that system will continue until the IT system upgrade to WebPas.