Wairarapa District Health Board
Serious and Sentinel Events Report: 2015-2016

There were 3 serious adverse events reported by the Wairarapa DHB during the period of 1 July, 2015 to 30 June, 2016. The table below outlines a summary of events, findings and recommendations of the events which have occurred.

The events reported sit within the categories of:

- Medical Device / Equipment
- Patient Fall
- Wrong Patient

Adverse events identified as serious receive an in-depth investigation by a team of relevant clinicians and quality staff. The reports are reviewed by the patient safety committee and learning is the key focus. The recommendations from the reports are shared back to the relevant people within the organisation to be integrated into normal practice and then reviewed regularly to ensure changes have been implemented to try to minimise the chance of similar events happening again.

Our practice is to communicate openly with patients and whanau/family at all times when adverse events occur and listen to concerns, provide support and involve patients and whanau/family in the review to the degree they prefer and where possible answer their questions and address any concerns that they have.

We sincerely apologise to the patients and whanau/family involved in these cases and acknowledge the distress and grief that occurs when things go wrong in healthcare.

1.	12543

Event Category: Medical Device/Equipment **Deceased?:** N **SAC Rating: 2**

Event Summary: Piece of orthopaedic equipment left in patient

REVIEW

Key findings:

- Review undertaken which identified the device is not part of surgical count
- Patient returned to theatre to have piece removed under local anaesthetic

Recommendations:

- Policy change to new orthopaedic specific count sheet to reflect the need for orthopaedic equipment to be counted
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Recommendations progress (i.e. action plan):

- Relevant theatre staff informed of change to policy
- Regular audit of safe surgery practices

2.	12601

Event Category: Patient Fall **Deceased?:** N **SAC Rating: 2**

EVENT SUMMARY: Patient fell following elective total knee joint replacement, sustaining a dislocation requiring surgery.

REVIEW

Key findings:

- Prior to fall, the patient was in visible room on the ward
- Patient was assessed by physiotherapy following initial operation and trained for elbow crutches with supervision
- Patient slipped when using crutches in toilet

Recommendations:

- Review care plan
- Patient education to call for assistance when needing to mobilise

Recommendations progress (i.e. action plan):

- Full falls analysis template completed
- CNM has established process regarding purposeful rounding (regular rounds by staff to check on patients and their need to move) to reduce falls risk
- Patient reassessed by physiotherapy, to use high frame rather than crutches with assistance and regular reviews

3. 12031

Event Category: Clinical Process **Deceased?:** N **SAC Rating: 2**

EVENT SUMMARY: Wrong patient was taken to operating theatre with notes of another patient, correct procedure actually undertaken

REVIEW

Key findings:

- Verbal confirmation of name occurred as opposed to physical check of wristband
- Patient actually got correct procedure
- Safe theatre practice guidelines implementation will reduce the risk of this happening again

Recommendations:

- Regular and repeated audit of safe theatre practices, including physical check of wristband required
- Education for clinicians around SAC rating and importance of thorough review following such events

Recommendations progress (i.e. action plan):

- Regular audit of surgical procedures (150 per quarter) using Safe Surgery Audit