Unposted Incident - Edit 11

ACT Health

Incident ID: [redacted]　　1a

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Street:
Suburb/City:
Postcode:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:

Medical Record #:
Age:
Country:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:

Incident Time: 07:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 2 - Ante Natal Ward
Program / Aggregate Area: Womens and Childrens Health

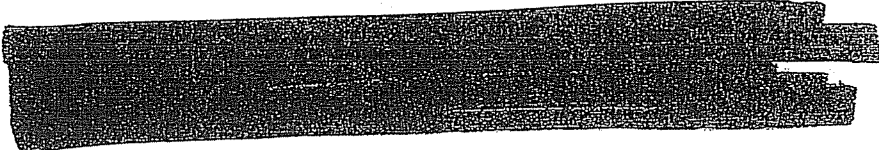
What happened in the incident?

Summary: Ureter cut during surgery
Details:
SI Details:

Origin of Incident Report: Notification from Clinician
Reporter's Name: Perkins, Helen
Contact Phone:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:

Reporter's Position: Registered Nurse / Midwife
Reviewed By Name:

Investigations/Findings:



Investigated By:
Controls Implemented:
Transfer Required: Other Interstate / Major Hospital
Deceased: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Date of Notification to Insurer:

Coroner Notified: No
Autopsy performed: No

Insurer Notif Mode: Batched Report

Personnel Involved

Person #1:
Person #2:
Admitting Specialist:
Primary Care Team: Gynaecology
Code Blue/MET?: No
Outcome: Moderate
Significant Incident Level: Not a Significant Incident

Person #1 Position:
Person #2 Position:
VMO: No
Secondary Care Team:

Significant Incident Type: Not a Significant Incident

Contributing Factors

Classification		
Treatment	Complications	Damaged - Vascular / Tubular Structure
Treatment	Complications	Genito-Urinary Trauma
Treatment	Complications	Intra-Operative / Intra-Procedural
Treatment	Complications	Unplanned return to OT
Treatment	Surgery / Procedural Related	Injury During

Risk Rating:

Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Debriefing Date (Pt/Client):
Debriefing Time (Pt/Client):
Pt/Client Debriefed By:
Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):
Open Disclosure Date (Pt/Client):
Open Disclosure Time (Pt/Client):
Disclosure completed by (Pt/Client):

Follow-Up Status (NOK): Offered and Accepted
Debriefing Date (NOK):
Debriefing Time (NOK):
Next Of Kin Debriefed By:
Open Disclosure Comments (NOK):

Open Disclosure Status (NOK): Conducted
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):

Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Follow-Up Status (Family):
Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Incident ID:

Refer to Clinical Review Committee

1 c

Date referred to CRC: [redacted]0

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry	Reference	Cost

Action Taken

Created By: [redacted]

O'Donnell, Rosemary
This case wil also be reviewed through the Gynaecology M&M Meeting and then forwarded for review by CRC
Follow Up Allocated To: O'Donnell, Rosemary
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

General Comments

Created By: [redacted]

Incident Classifier, PSQU
Incident outcome amended to Moderate in line with Significant Incident Reporting Policy and to be raised as a high risk incident pending patient outcome and outcome of CRC review.

High risk incident submitted after approval by GM, TCH. Clinical Risk Coordinator.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Swain, Sharon
For Clinical Reviewer: Day 45 SIB update due by [redacted] Clinical Risk Coordinator
Follow Up Allocated To: [redacted]
Actioned: Yes
Linked Document Path:
Follow Up By Date: [redacted]
Mail Sent On:

Created By: [redacted]

Swain, Sharon
For Clinical Reviewer: Day 100 SIB report due by [redacted] Clinical Risk Coordinator
Follow Up Allocated To: [redacted]
Actioned: Yes
Linked Document Path:
Follow Up By Date: [redacted]
Mail Sent On:

Documents

No Attached Documents.

1d – 1at

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

ACT Health

Comprehensive Custom Report

Incident ID: [redacted] 1au

Who did the incident happen to?

Medical Record #: [redacted]

Incident Involved: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Gender: [redacted]
Country: [redacted]
Age: [redacted]
Diagnosis/Presenting Problems:
Transferred From:

When did the incident occur?

Admission Date: [redacted]
Incident Date: [redacted]
Notification Date: [redacted]
Date Closed: [redacted]
Incident Time: 07:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 2 - Ante Natal Ward
Program / Aggregate Area: Womens and Childrens Health

What happened in the incident?

Summary: Ureter cut during surgery
Details: [redacted]

Reporter's Name: Perkins, Helen
Reporter's Position: Registered Nurse / Midwife
Contact Phone:
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings:
Investigated By:
Controls Implemented:
Transfer Required: Other Interstate / Major Hospital
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Insurer Notif Mode:
Date of Notification to Insurer:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position:
Admitting Specialist: [redacted]
Primary Care Team: Gynaecology
Secondary Care Team:
Code Blue/MET?: No
Outcome: Moderate
Significant Incident Type:
Significant Incident Level:

Classification

Treatment	Complications	Genito-Urinary Trauma
Treatment	Complications	Unplanned return to OT
Treatment	Complications	Intra-Operative / Intra-Procedural
1. Patient Assessment	1a. Physical	Nursing assessment - incomplete
2. Staff Factors	2b. Knowledge/Skills/Competency	
Treatment	Complications	Damaged - Vascular / Tubular Structure
Treatment	Surgery / Procedural Related	Injury During

What Follow-Up Occurred?

1a✓

Follow-Up Status (Pt/Client):
Debriefing Date (Pt/Client):
Debriefing Time (Pt/Client):
Pt/Client Debriefed By:
Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK): Offered and Accepted
Debriefing Date (NOK):
Debriefing Time (NOK):
Next Of Kin Debriefed By:
Open Disclosure Comments (NOK):
Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):
Follow-Up Status (Family):
Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Pt/Client):
Open Disclosure Date (Pt/Client):
Open Disclosure Time (Pt/Client):
Disclosure completed by (Pt/Client):
Open Disclosure Status (NOK):
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):
Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):
Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Clinical Review

Reviewer: [redacted]

Level Of Review: Level 2 - Multi-Disciplinary/Program Review

Review Dates

Date to Secretariat: [redacted]
Date to Executive: [redacted]
Date to Clinical Review Committee:
Date to ACT Health Clinical Audit Committee:

FLAGS

Specific Referral: No
Specific Referral:
Incident Reports: Yes
Inpatient Deaths: No
Diagnosis at Admission:
Diagnosis at Death:
Inpatient Death Post Mortem: No
Inpatient Deaths Coroners: No
Unplanned Re-admissions: No

Admission 1

Admission1 Date:
Admission1 Specialty:
Admission1 Diagnosis:
Admission1 Discharge Date:

Admission2

Admission2 Date:
Admission2 Specialty:
Admission2 Diagnosis:
Admission2 Discharge Date:
Re-admission Outcome:
Unplanned Return to OT: No
Return to OT Specialty:
First Surgeon Level:
First Surgeon Name:
First Surgery Date:
First Surgery Description:
Date of Second Surgery:

Second Surgery Type/Related to previous:
Second Surgeon Level:
Second Surgeon Name:
Date of Third Surgery:
Third Surgery Type/Related to previous:
Third Surgeon Level:
Third Surgeon Name:
Unplanned Transfer: No
Unplanned Transfer Date:
Unplanned Transfer Reason:

Refer to Clinical Review Committee

Date referred to CRC:

Journal Entries

Date/Time | Journal Entry | Reference | Cost

CRC-Exec M'ting Outcomes

Created By:

Case presented at CRCE today. Letter to be drafted to Director of Urology re: why an open procedure was not attempted when an endoscopic procedure abandoned. Case to also be presented to CRC as cluster re: lack of Interventional Radiologist.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

General Comments

Created By:

PSQU Incident Classifier
Incident outcome amended to Moderate in line with Significant Incident Reporting Policy and to be raised as a high risk incident pending patient outcome and outcome of CRC review.

High risk incident submitted after approval by GM, TCH. Clinical Risk Coordinator.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Letter sent to urology Director Await response
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Perintatl minutes received and tabled at CRCE Letter to be replying that case has also been referred to Urology Department for review.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

CB report and exec summary given to BA yesterday and email to Clinical Board secretariat today. Case closed
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Documents

9 Documents Attached.
Referral.pdf ( ) (by
perinatal M&M.pdf ( ) (by
Letter to Urol.pdf ( ) (by
FW Angio Vascular cases.rtf ( ) (b
Letter to perinatal.pdf ( ) (by
CRC CB Report .doc ( ) (
CRC CB Exec Summary .doc ( ) (
CRC Interventional Radiology.pp
Case review summary.doc ( ) (b

1ax – 1ay

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

Unposted Incident - Edit 18

Incident ID: 2a

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Street:
Suburb/City:
Postcode:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:

Medical Record #:
Age:
Country:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:

Incident Time: 12:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Pharmacy
Program / Aggregate Area: Pharmacy

What happened in the incident?

Summary: Patient received 5 times the dose of a chemotherapeutic agent resulting in low blood counts and treatment delay as a result of cytoxic drug manufacturing error.

Details:

SI Details:

Origin of Incident Report:
Reporter's Name: Whitby, Fiona
Contact Phone: 62442221
Reviewed By: Consultant
Treatment Given:

Reporter's Position: Pharmacist

Steps Taken By:
Steps Taken:
Investigations/Findings:
Investigated By:
Controls Implemented:

Transfer Required:
Deceased: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer: [redacted]

Coroner Notified: No
Autopsy performed: No

Insurer Notif Mode: Batched Report

Personnel Involved

Person #1:
Person #2:
Admitting Specialist: [redacted]
Primary Care Team: Haematology
Code Blue/MET?: No
Outcome: Minor
Significant Incident Level: High Risk

Person #1 Position:
Person #2 Position:
VMO: No
Secondary Care Team:

Significant Incident Type: Near Miss situation that if not detected would have lead to a Sentinel or Significant Incident

Contributing Factors

Classification		
Medication	Medication Continuum	During Stay
Medication	Medication Involved	Cytotoxic
Medication	Medication Management	

Risk Rating:

Potential Risk Rating:

Significant Incident Details

Significant Incident Category: Clinical
Person Responsible for SI Report: Sharon Swain
Initial SI Report: Yes
Media Interest: No
Complaint by Family/Carer: No
Circumstances Likely to evoke service sensitivities : No
Initial SI Comments:
Initial Report Submitted: Yes
Initial Report Submitted By: McKeowen, Liz (Liz McKeowen)
Date Initial Report Submitted: [redacted]
Interim SI Report: No
Interim Status Update:
Interim Investigation Type:
Interim Clinical Review/Investigation Status:
Interim ongoing action still required: No
Interim SI Comments:
Interim Report Submitted: No
Date Interim Report Submitted:
Interim Report Submitted By:
Final SI Report: Yes
Final Status Update: Case presented to CRC Exec [redacted] No recommendations made. Pharmacy are implementing a new electronic prescribing system that should decrease the occurrence of manufacuring errors.
Final Investigation Type: Clinical Review
Final Clinical Review/Investigation Status: Investigation concluded
Final ongoing action still required: No
Final SI Comments:
Final Report Submitted: Yes
Final Report Submitted By: Swain, Sharon (Sharon Swain)
Date Final Report Submitted: [redacted]

What Follow-Up Occurred?

Follow-Up Status (Pt/Client): Offered and Accepted
Debriefing Date (Pt/Client):
Debriefing Time (Pt/Client):
Pt/Client Debriefed By:
Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client): Conducted
Open Disclosure Date (Pt/Client):
Open Disclosure Time (Pt/Client):
Disclosure completed by (Pt/Client):

Follow-Up Status (NOK): Offered and Accepted
Debriefing Date (NOK):

Open Disclosure Status (NOK): Conducted
Open Disclosure Date (NOK):

2c

Debriefing Time (NOK):	Open Disclosure Time (NOK):
Next Of Kin Debriefed By:	Disclosure completed by (NOK):
Open Disclosure Comments (NOK):	
Follow-Up Status (Carer):	Open Disclosure Status (Carer):
Debriefing Date (Carer):	Open Disclosure Date (Carer):
Debriefing Time (Carer):	Open Disclosure Time (Carer):
Carer Debriefed By:	Disclosure completed by (Carer):
Open Disclosure Comments (Carer):	
Follow-Up Status (Family):	Open Disclosure Status (Family):
Debriefing Date (Family):	Open Disclosure Date (Family):
Debriefing Time (Family):	Debriefing Time (Family):
Family Debriefed By:	Disclosure completed by (Family):
Open Disclosure Comments (Family):	

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC: [redacted]

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry	Reference	Cost

General Comments

Created By: [redacted]	McKeowen, Liz Day 1 high risk incident submitted with approval from Ag General Manager, TCH. Clinical Risk Coordinator. Follow Up Allocated To: Actioned: No Linked Document Path:	Follow Up By Date: Mail Sent On:
Created By: [redacted]	Swain, Sharon Day 100 high risk incident report submitted with approval from TCH GM. Clinical Risk Coordinator Follow Up Allocated To: Actioned: No Linked Document Path:	Follow Up By Date: Mail Sent On:

Documents

No Attached Documents.

2d – 2g

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

Comprehensive Custom Report

Incident ID: [redacted]

2h

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Country:
Diagnosis/Presenting Problems:
Transferred From:

Medical Record #:
Age:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:
Date Closed:

Incident Time: 12:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Pharmacy
Program / Aggregate Area: Pharmacy

What happened in the incident?

Summary: Manufacturing error resulted in patient receiving 4 x 800mg doses of cytarabine instead of 4 x 160mg doses. Patient experienced low blood counts and treatment delay as a result.

Details:

Reporter's Position: Pharmacist
Reporter's Name: Whitby, Fiona
Contact Phone: 62442221
Reviewed By: Consultant
Treatment Given:

Steps Taken By:
Steps Taken:
Investigations/Findings:
Investigated By:
Controls Implemented:
Transfer Required:
Deceased: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer:

Coroner Notified: No
Autopsy performed: No
Insurer Notif Mode:

Personnel Involved

Person #1:
Person #2:
Admitting Specialist:
Primary Care Team: Haematology
Code Blue/MET?: No
Outcome: Minor
Significant Incident Level:

Person #1 Position:
Person #2 Position:
Secondary Care Team:
Significant Incident Type:

Classification

Medication	Medication Continuum	During Stay
Medication	Medication Involved	Cytotoxic
Medication	Medication Management	

What Follow-Up Occurred?

Follow-Up Status (Pt/Client): Offered and Accepted

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Follow-Up Status (NOK): Offered and Accepted

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Clinical Review

Reviewer: [redacted]

Level Of Review: CRC - Executive Review

Review Dates

Date to Secretariat: [redacted]

Date to Executive: [redacted]

Date to Clinical Review Committee:

Date to ACT Health Clinical Audit Committee:

FLAGS

Specific Referral: No

Specific Referral:

Incident Reports: Yes

Inpatient Deaths: No

Diagnosis at Admission:

Diagnosis at Death:

Inpatient Death Post Mortem: No

Inpatient Deaths Coroners: No

Unplanned Re-admissions: No

Admission 1

Admission1 Date:

Admission1 Specialty:

Admission1 Diagnosis:

Admission1 Discharge Date:

Admission2

Admission2 Date:

Admission2 Specialty:

Admission2 Diagnosis:

Admission2 Discharge Date:

Re-admission Outcome:

Unplanned Return to OT: No

Return to OT Specialty:

First Surgeon Level:

First Surgeon Name:

First Surgery Date:

First Surgery Description:
Date of Second Surgery:
Second Surgery Type/Related to previous:
Second Surgeon Level:
Second Surgeon Name:
Date of Third Surgery:
Third Surgery Type/Related to previous:
Third Surgeon Level:
Third Surgeon Name:
Unplanned Transfer: No
Unplanned Transfer Date:
Unplanned Transfer Reason:

Refer to Clinical Review Committee

Date referred to CRC:

Journal Entries

Date/Time | Journal Entry | Reference | Cost

CRC - Communication Out

Created By: [redacted]

[redacted]
Letter of findings sent to Director of Pharmacy. Nil systems issues identified. Case closed
Sent To:
Follow Up Allocated To:
Actioned: No
Linked Document Path

Sent Date:
Follow Up By Date:
Mail Sent On:

CRC-Exec M'ting Outcomes

Created By: [redacted]

[redacted]
Discuss findings with Director of Pharmacy.
Follow Up Allocated To:
Actioned: No
Linked Document Path

Follow Up By Date:
Mail Sent On:

General Comments

Created By: [redacted]

Liz McKeowen
Day 1 high risk incident submitted with approval from Ag General Manager, TCH. Clinical Risk Coordinator.
Follow Up Allocated To:
Actioned: No
Linked Document Path

Follow Up By Date:
Mail Sent On:

Documents

3 Documents Attached.
[redacted]-Case review summary.doc ( ) [redacted]
[redacted]-File Note Proforma.doc ( ) (b[redacted]
[redacted]-CRCE letter.pdf ( ) (by [redacted]

Unposted Incident - Edit 18

Incident ID: 39

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Street:
Suburb/City:
Postcode:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:

Medical Record #:
Age:
Country:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:

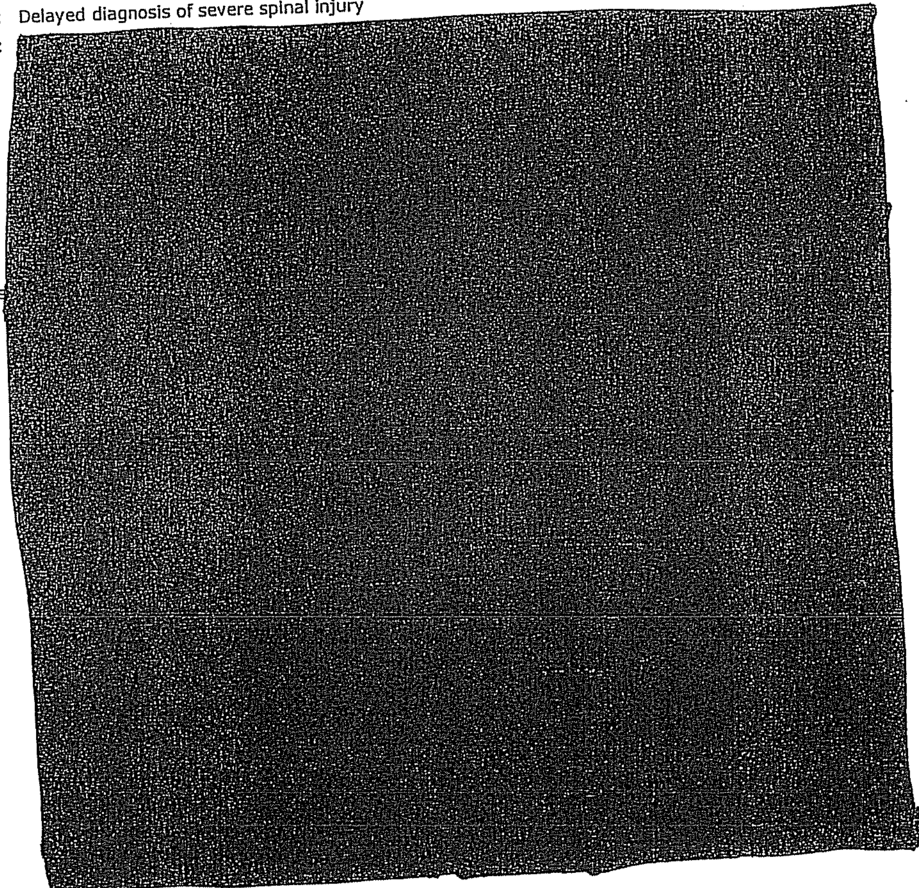
Incident Time: 06:30

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 6 - Ward 6A
Program / Aggregate Area: Medical Services

What happened in the incident?

Summary: Delayed diagnosis of severe spinal injury
Details:



SI Details:

Origin of Incident Report: Notification from Clinician
Reporter's Name: McDowell David
Contact Phone: 62444080
Reviewed By:

Reporter's Position: Staff Specialist
Reviewed By Name: David McDowell

Treatment Given: Rescusitated post acute neurological decline. Intubated/ventilated/inotropic support. Urgent decompressive spinal surgery. Transfusions of blood and platelets. Transferred to spinal unit RNSH (NSW)

Steps Taken By: David McDowell

3b

Steps Taken: Urgent decompressive surgery
Investigations/Findings: Patient transferred to ICU. Needs review by medical teams involved and refer to clinical review committee.
Investigated By:
Controls Implemented:
Transfer Required: Other Interstate / Major Hospital
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Insurer Notif Mode: Batched Report
Date of Notification to Insurer: [redacted]

Personnel Involved
Person #1: ED, Rheumatology, ICU, anaesthetics, Neurosurgery
Person #1 Position:
Person #2: Radiology
Person #2 Position:
VMO: No
Admitting Specialist: Rheumatology
Secondary Care Team:
Primary Care Team: Rheumatology
Code Blue/MET?: No
Outcome: Major
Significant Incident Type: Major/permanent loss of function (sensory, motor, physiological or intellectual); disfigurement
Significant Incident Level: Major

Contributing Factors		
Coordination	Coordination of Care	
Patient Assessment	Physical	

Classification		
Diagnostic Events	Missed	Neurological - Spinal
Treatment	Complications	Damaged - Neural Structure
Treatment	Complications	Haematoma
Treatment	Complications	Haemorrhage
Treatment	Complications	Hypo / Hypertension
Treatment	Complications	Neurological
Treatment	Complications	Unplanned transfer to ICU
Treatment	Emergency Management and MET	Internal - Onsite
Treatment	Emergency Management and MET	Involving Patient / Client
Treatment	Emergency Management and MET	Unplanned Transfer to ICU/CCU
Treatment	Emergency Management and MET	Unplanned Transfer to Theatre

Risk Rating:
Potential Risk Rating:

Significant Incident Details

Significant Incident Category: Clinical
Person Responsible for SI Report: Narelle Aldridge
Initial SI Report: Yes
Media Interest: No
Complaint by Family/Carer: No
Circumstances Likely to evoke service sensitivities : No
Initial SI Comments: Referred to TCH CRC and Medico-legal for notification to ACTIA. Not aware of any discussion regarding open disclosure due to patient transfer to Sydney.
Initial Report Submitted: Yes
Date Initial Report Submitted: [redacted]
Initial Report Submitted By: Swain, Sharon (Sharon Swain)
Interim SI Report: Yes
Interim Status Update: CRC extended review in progress. Patient remains an inpatient in Sydney Hospital
Interim Investigation Type: Clinical Review RCA
Interim Clinical Review/Investigation Status: Investigation in progress
Interim ongoing action still required: Yes
Interim SI Comments:
Interim Report Submitted: Yes
Date Interim Report Submitted: [redacted]
Interim Report Submitted By: McKeowen, Liz (Liz McKeowen)
Final SI Report: Yes
Final Status Update: Patient was recently discharged from hospital walking. He has ongoing neurogenic bladder and bowels issues that are being followed up in the community.
Final Investigation Type: Clinical Review RCA

3c

Final Clinical Review/Investigation Status: Investigation ongoing
Final ongoing action still required: No
Final SI Comments:
Final Report Submitted: Yes
Final Report Submitted By: Coordinator, QSU Risk (QSU Risk Coordinator)
Date Final Report Submitted: [redacted]

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Debriefing Date (Pt/Client):
Debriefing Time (Pt/Client):
Pt/Client Debriefed By:
Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):
Open Disclosure Date (Pt/Client):
Open Disclosure Time (Pt/Client):
Disclosure completed by (Pt/Client):

Follow-Up Status (NOK): Offered and Accepted
Debriefing Date (NOK): [redacted]
Debriefing Time (NOK):
Next Of Kin Debriefed By: Treating Doctor
Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):

Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Follow-Up Status (Family): Offered and Accepted
Debriefing Date (Family): [redacted]
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC: [redacted]

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry	Reference	Cost

32

General Comments

Created By: [redacted]

McKeowen, Liz
Incident amended to Major in line with Significant Incident Reporting Policy.
Clinical Risk Coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

ADON, TCH Medical Services
There is another riskman related to this same incident. Reported to CRC.
Sent onto ED Director, ED DON and ED of AMS
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Duggan, Tracey
pt received on ward early hours of morning reviewed several times overnight at request of nursing staff met activated for drop in b/p and paraplegia
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Swain, Sharon
Day 1 SIB submitted with approval by GM TCH. Clinical Risk Coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Coordinator, QSU Risk
Extended review closed. Recommendations forwarded from CRC to relevant governance committee. QSU Risk Coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Documents

No Attached Documents.

3e – 3u

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

Comprehensive Custom Report

Incident ID:

3V

Who did the incident happen to?

Medical Record #:

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Country:
Diagnosis/Presenting Problems:

Age:

Transferred From:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:
Date Closed:

Incident Time: 06:30

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 6 - Ward 6A
Program / Aggregate Area: Medical Services

What happened in the incident?

Summary: Delayed diagnosis of severe spinal injury
Details:

Reporter's Name: McDowell David
Reporter's Position: Staff Specialist
Contact Phone: 62444080
Reviewed By Name: David McDowell
Reviewed By:
Treatment Given: Rescusitated post acute neurological decline. Intubated/ventilated/inotropic support. Urgent decompressive spinal surgery. Transfusions of blood and platelets. Transferred to spinal unit RNSH (NSW)
Steps Taken By: David McDowell
Steps Taken: Urgent decompressive surgery
Investigations/Findings: Patient transferred to ICU. Needs review by medical teams involved and refer to clinical review committee
Investigated By:
Controls Implemented:
Transfer Required: Other Interstate / Major Hospital
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Insurer Notif Mode:
Date of Notification to Insurer:

Personnel Involved

Person #1: ED, Rheumatology, ICU, anaesthetics, Neurosurgery
Person #1 Position:
Person #2: Radiology
Person #2 Position:
Admitting Specialist: Rheumatology
Secondary Care Team:
Primary Care Team: Rheumatology
Code Blue/MET?: No
Outcome: Major
Significant Incident Type:
Significant Incident Level:

Classification

1. Patient Assessment 1a. Physical

2. Staff Factors	2a. Training	Staff not trained / inadequate training
2. Staff Factors	2a. Training	Inability to access training (rostering)
2. Staff Factors	2a. Training	Inadequate training resources available
2. Staff Factors	2b. Knowledge/Skills/Competency	
2. Staff Factors	2c. Supervision	Inadequate Staffing
2. Staff Factors	2c. Supervision	Lack of medical consultant supervision
2. Staff Factors	2d. Staff Allocation/Scheduling/Availabilit y	Medical staff working excessive hours
4. Equipment	4a. Failure	
6. Information	6c. Quality of Information	
7. Communication	7a. Staff - Staff	Clinical handover - medical
7. Communication	7b. Staff - Patient	
8. Policies and Procedures	8b. Failure to follow Procedures / Guidelines	
8. Policies and Procedures	8d. Site Identification	Wrong site - surgical procedure
Treatment	Complications	Damaged - Neural Structure
Treatment	Complications	Haematoma
Treatment	Complications	Hypo / Hypertension
Treatment	Complications	Haemorrhage
Treatment	Complications	Neurological
Treatment	Complications	Unplanned transfer to ICU
Treatment	Emergency Management and MET	Internal - Onsite
Treatment	Emergency Management and MET	Involving Patient / Client
Treatment	Emergency Management and MET	Unplanned Transfer to ICU/CCU
Treatment	Emergency Management and MET	Unplanned Transfer to Theatre
Diagnostic Events	Missed	Neurological - Spinal

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Follow-Up Status (NOK): Offered and Accepted

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By: Treating Doctor

Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Follow-Up Status (Family): Offered and Accepted

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Clinical Review

Level Of Review: Level 3 - Extended Review

Reviewer:

Review Dates

Date to Secretariat:

Date to Executive:

Date to Clinical Review Committee:

Date to ACT Health Clinical Audit Committee:

Incident ID:

3x

FLAGS

Specific Referral: Yes
Specific Referral: ADON Medical services
Incident Reports: No
Inpatient Deaths: No
Diagnosis at Admission:
Diagnosis at Death:
Inpatient Death Post Mortem: No
Inpatient Deaths Coroners: No
Unplanned Re-admissions: No

Admission 1

Admission1 Date:
Admission1 Specialty:
Admission1 Diagnosis:
Admission1 Discharge Date:

Admission2

Admission2 Date:
Admission2 Specialty:
Admission2 Diagnosis:
Admission2 Discharge Date:
Re-admission Outcome:
Unplanned Return to OT: No
Return to OT Specialty:
First Surgeon Level:
First Surgeon Name:
First Surgery Date:
First Surgery Description:
Date of Second Surgery:
Second Surgery Type/Related to previous:
Second Surgeon Level:
Second Surgeon Name:
Date of Third Surgery:
Third Surgery Type/Related to previous:
Third Surgeon Level:
Third Surgeon Name:
Unplanned Transfer: No
Unplanned Transfer Date:
Unplanned Transfer Reason:

Refer to Clinical Review Committee

Date referred to CRC:

Journal Entries

Date/Time | Journal Entry | Reference | Cost

34

CRC-Exec M'ting Outcomes

Created By:

Case presented to CRCE on [redacted] and decision made for Extended Review. Identified who CRCE would like to have as team members & same advised.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

General Comments

Created By:

Liz McKeowen
Incident amended to Major in line with Significant Incident Reporting Policy.
Clinical Risk Coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Updated CRCE on case and that only one more interview is remaining until next team meeting where findings and recommendations will be formulated.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Feedback from a CRC member regarding recommendation "All Trauma Alerts to be admitted under the Trauma Service". They felt that it should be withheld. ER team emailed today for feedback re whether to submit recommendations as they stand. Bronwyn Avard is away until [redacted] Feedback received from Shayne Brown as agrees to go ahead with current recs (see Q drive attachment). await feedback from Rebekah and Bryan
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Responses received from all members re: whether changes to recommendations be made. All members agreed that the recommendation stay as agreed and not to change/withhold recommendations that the ER team agreed upon. The final report was given to the CRC Chair and forwarded to Clinical Board secretariat yesterday. Case closed.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Email sent to all interviewees thanking them for their contribution and informing them that the case has been closed. The CRC presentation was seen by the Radiologist and Neurosurgeon involved in the case.
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Documents

10 Documents Attached.
-Memo TCH CRC (incorp ACRS & CRCS) re Extended Review.doc ( ) (
-Meeting 11 Feb 2011.doc ( )
-Team meetings.doc ( ) (
-Case review summary.doc ( ) (by
-ER 045 RCA spinal cord compression FINAL.doc ( )
-ER 045 RCA wrong siteFINAL.doc ( ) (b
-ED QAC review.pdf ( ) (by
-ER 045 Chain of Events.doc ( )
-Final Report to CB.pdf ( )
-Clinical Review Committee May Ver3.ppt ( ) (by

3z – 3ao

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

ACT Health

Unposted Incident - Edit 15

Incident ID:

4a

Who did the incident happen to?

Medical Record #: 20098841

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Street:
Suburb/City:
Postcode:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:

Age:
Country:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:

Incident Time: 11:20

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 3 - Post Anaesthetic Care Unit (PACU)
Program / Aggregate Area: Womens and Childrens Health

What happened in the incident?

Summary: Overdose of IV paracetamol
Details:

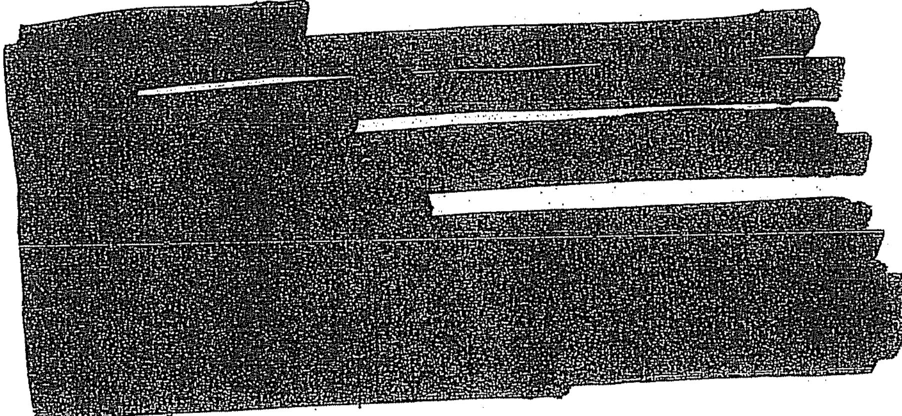
SI Details:

Origin of Incident Report: Notification from Clinician
Reporter's Name: Dobson, Jacky
Contact Phone:
Reviewed By: Registrar
Treatment Given: Paracetamol level at 4 hours with baseline LFT's
Level high however did not require further treatment.

Reporter's Position: Pharmacist
Reviewed By Name:

Steps Taken By:
Steps Taken:

4b

Investigations/Findings: 

Investigated By: K Dunn

Controls Implemented: Urgent review of paracetamol guidelines across TCH - commenced.
Follow -up with peri-operative services ensuring education re use of Paediatric guardrails.

Transfer Required:

Coroner Notified: No

Deceased: No

Autopsy performed: No

Date of Death:

Time Of Death:

Next Of Kin Notified: Yes

Police Notified?: No

Insurer Notif Mode: Batched Report

Date of Notification to Insurer:

Personnel Involved

Person #1:

Person #1 Position:

Person #2:

Person #2 Position:

VMO: No

Admitting Specialist:

Secondary Care Team:

Primary Care Team: Paediatric Surgery

Code Blue/MET?: No

Outcome: Minor

Significant Incident Type: Near Miss situation that if not detected would have lead to a Sentinel or Significant incident

Significant Incident Level: High Risk

Contributing Factors

Staff Factors	Knowledge / Skills / Competency

Classification

Medication	Administration Related	Incorrect Dose
Medication	Administration Related	Pump Management
Medication	Medication Continuum	During Stay
Medication	Medication Involved	Analgesia
Medication	Prescribing Related	

Risk Rating:

Potential Risk Rating:

Significant Incident Details

Significant Incident Category: Clinical

Person Responsible for SI Report: Sharon Swain

Initial SI Report: Yes

Media Interest: No

Complaint by Family/Carer: No

Circumstances Likely to evoke service sensitivities : No

Initial SI Comments: This incident will be reviewed by the TCH CRC and has been referred to the medico-legal coordinator for referral to ACTIA

Initial Report Submitted: Yes

Date Initial Report Submitted:

Initial Report Submitted By: Swain, Sharon (Sharon Swain)

Interim SI Report: No

Interim Status Update:

Interim Investigation Type:

Interim Clinical Review/Investigation Status:

Interim ongoing action still required: No

Interim SI Comments:

Interim Report Submitted: No

Date Interim Report Submitted:

Interim Report Submitted By:

Final SI Report: Yes

4c

Final Status Update: R/V by TCH CRC Exec [redacted] Refer to Anaesthetics QAC & OT ADON. CRC awaiting response re: local investigation. Panadol alert developed by Medication Safety Work Group & sent to local areas.

Final Investigation Type: Clinical Review

Final Clinical Review/Investigation Status: Investigation in progress

Final ongoing action still required: Yes

Final SI Comments: Awaiting findings from Anaesthetics QAC & OT ADON. CRC to follow up further with these areas.

Final Report Submitted: Yes

Date Final Report Submitted: [redacted]

Final Report Submitted By: Swain, Sharon (Sharon Swain)

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client): Not relevant

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Follow-Up Status (NOK):

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Open Disclosure Status (NOK): Conducted

Open Disclosure Date (NOK): [redacted]

Open Disclosure Time (NOK):

Disclosure completed by (NOK): Medical team

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC: [redacted]

Associated Risks

No Associated Risk.

Journal Entries

Date/Time | Journal Entry

Action Taken

Created By: [redacted]

DON, TCH Paediatrics
further analysis of this matter needs to occur. Will discuss further with relevant CNC's/clinicians
Follow Up Allocated To:
Actioned: Yes
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

CNC, TCH PACU
I spoke with the staff involved they did misintrepret the r in PR as a 2.I informed them of the corect dose of paracetamol per kg for a child. This information has been documented in the communication book. I spoke with the consultant today and advised him of the the error he will speak to the registrar involved.
Follow Up Allocated To:
Actioned: Yes
Linked Document Path:
Follow Up By Date:
Mail Sent On:

General Comments

Created By: [redacted]

Incident Classifier, PSQU
Following discussion with the clinical risk coordinator, the incident outcome is amended to moderate pending additional information from the 4B CNC.
Incident Classifier
Follow Up Allocated To: Dunn, Kim
Actioned: Yes
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Swain, Sharon
Day 1 SIB submitted with approval on behalf of TCH Exec. Clinical Risk Coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By: [redacted]

Swain, Sharon
Day 100 report submitted. clinical Risk coordinator
Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Documents

No Attached Documents.

4e – 4y

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

Unposted Incident - Edit 21

Incident ID:

59

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Street:
Suburb/City:
Postcode:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:

Medical Record #:

Age:

Country:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:

Incident Time: 13:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 3 - Operating Theatres
Program / Aggregate Area: Surgical Services

What happened in the incident?

Summary: Wrong side surgery. Operation subsequently performed on the right side.
Details:

SI Details:

Origin of Incident Report:

Reporter's Position: Clinical Nurse Consultant (CNC)

5. b

Reporter's Name: Boyd, Helen
Contact Phone:
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: Correct nursing procedures have been completed at this point and hospital Executive contacted
Investigated By:
Controls Implemented:
Transfer Required:
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Insurer Notif Mode: Batched Report
Date of Notification to Insurer:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position: Career Medical Officer
VMO: No
Admitting Specialist:
Secondary Care Team:
Primary Care Team: Orthopaedics
Code Blue/MET?: No
Outcome: Extreme
Significant Incident Type: Procedures involving the wrong patient or body part resulting in death or major permanent loss of function
Significant Incident Level: Catastrophic

Contributing Factors

Classification

Diagnostic Events	Radiology Investigation	Incorrect Labelling Of Film / Report
Treatment	Surgery / Procedural Related	Wrong Side / Site

Risk Rating:
Potential Risk Rating:

Significant Incident Details

Significant Incident Category: Clinical - Sentinel
Person Responsible for SI Report: Narelle Aldridge
Initial SI Report: Yes
Media Interest: No
Complaint by Family/Carer: No
Circumstances Likely to evoke service sensitivities : No
Initial SI Comments: Referred to ACTIA and CRC. Investigation commenced.
Initial Report Submitted: Yes
Date Initial Report Submitted:
Initial Report Submitted By: Swain, Sharon (Sharon Swain)
Interim SI Report: Yes
Interim Status Update: An extended review of this incident is underway. No further contact from Coroners Office at this time.
Interim Investigation Type: Clinical Review RCA
Interim Clinical Review/Investigation Status: Investigation in progress
Interim ongoing action still required: No
Interim SI Comments:
Interim Report Submitted: Yes
Date Interim Report Submitted:
Interim Report Submitted By: Coordinator, QSU Risk (QSU Risk Coordinator)
Final SI Report: Yes
Final Status Update: Extended review complete. Awaiting presentation at CRC.
Final Investigation Type: Clinical Review RCA
Final Clinical Review/Investigation Status: Investigation concluded
Final ongoing action still required: No
Final SI Comments:
Final Report Submitted: Yes
Date Final Report Submitted:
Final Report Submitted By: Coordinator, QSU Risk (QSU Risk Coordinator)

What Follow-Up Occurred?

Open Disclosure Status (Pt/Client):
Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Follow-Up Status (NOK):

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

Journal Entries

Date/Time | Journal Entry

Action Taken

Created By:

Family meeting held on 835-1920 hrs with and and Sonia Hogan (facilitator, PSQU). Daughter in attendance. husband Discussed clinical facts and offered apology for the event. Talked about the internal (clinical review, briefings to executive) and external processes that this event (referral to national reporting if client's condition deteriorates/does not meet pre morbid status). Stated that we will meet again once the extended review (12 weeks) has been undertaken to discussed recommendations and learnings. Family happy to be contacted by letter/e mail. Assurred the family that they can ask further questions at any time and we can be contacted on our mobile numbers (provided).

Follow Up Allocated To: Hogan, Sonia
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Hogan, Sonia
Contacted family of follow up meeting arrranged fr

Follow Up Allocated To: Hogan, Sonia
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Hogan, Sonia
Meeting with family on to talk about what actions had been taken since the wrong site surgery post clnical review. Attendeees from Health Directorate-

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

General Comments

Created By:

McKeowen, Liz
Consideration will be given to reviewing the sentinel event classification should this lady return to a level of physical and neurological functioningsimilar to her pre-morbid state.

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Incident Coordinator, PSQU
Incident referred to the Clinical Review team as meets screening criteria around wrong site surgery
Incident Classifier

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Swain, Sharon
Approval received from Ag GM TCH for submission. Clinical Risk Coordinator.

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Incident Coordinator, PSQU
This notification is the master of 2 grouped incidents.
The other notification no. is
Incident Coordinator

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Swain, Sharon
For Clinical Reviewer:
Day 45 SIB update due by . Clinical Risk Coordinator

Follow Up Allocated To:
Actioned: No
Linked Document Path:
Follow Up By Date:
Mail Sent On:

Created By:

Swain, Sharon
For Clinical Reviewer:
Day 100 SIB update due by . Clinical Risk Coordinator

Follow Up Allocated To:
Follow Up By Date: 19 May 11

Actioned: No

Linked Document Path:

Mail Sent On: 19 May 11

Se

Created By: [redacted]

Incident Classifier, PSQU

Patient deceased [redacted] matter has been referred to coroner.

Clinical Risk Coordinator.

Follow Up Allocated To:

Actioned: No

Linked Document Path:

Follow Up By Date:

Mail Sent On:

Created By: [redacted]

Coordinator, QSU Risk

Submission of 45 day report approved by Executive Director of Surgery and Oral Health

Follow Up Allocated To:

Actioned: No

Linked Document Path:

Follow Up By Date:

Mail Sent On:

Created By: [redacted]

Coordinator, QSU Risk

Day 100 SIB update approved for submission by ED Surgery and Oral Health. QSU Risk Coordinator

Follow Up Allocated To:

Actioned: No

Linked Document Path:

Follow Up By Date:

Mail Sent On:

Documents

No Attached Documents.

5f – 5ax

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions

Comprehensive Custom Report

Incident ID: [redacted]

5 a)

Who did the incident happen to?

Incident Involved:
First Name:
Surname:
Date of Birth:
Gender:
Country:
Diagnosis/Presenting Problems:
Transferred From:

Medical Record #:
Age:

When did the incident occur?

Admission Date:
Incident Date:
Notification Date:
Date Closed:

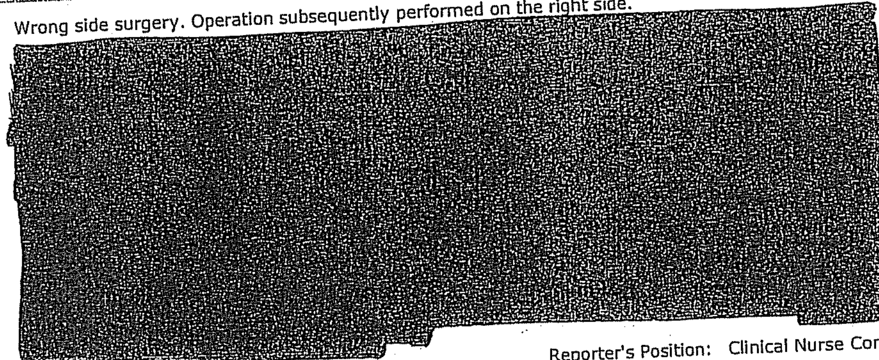
Incident Time: 13:00

Where did the incident occur?

ACT Health Site: TCH
Physical Location: Level 3 - Operating Theatres
Program / Aggregate Area: Surgical Services

What happened in the incident?

Summary: Wrong side surgery. Operation subsequently performed on the right side.
Details:



Reporter's Name: Boyd, Helen
Reporter's Position: Clinical Nurse Consultant (CNC)
Contact Phone:
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: Correct nursing procedures have been completed at this point and hospital Executive contacted
Investigated By:
Controls Implemented:
Transfer Required:
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: Yes
Police Notified?: No
Insurer Notif Mode:
Date of Notification to Insurer:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position: Career Medical Officer
Admitting Specialist:
Secondary Care Team:
Primary Care Team: Orthopaedics
Code Blue/MET?: No
Outcome: Extreme
Significant Incident Type:
Significant Incident Level:

Classification

1. Patient Assessment — 1a. Physical
3. Patient Factors — 3a. Co-Morbidity
6. Information — 6c. Quality of Information

6. Information	6d. Completeness of Information	
7. Communication	7a. Staff - Staff	Clinical handover - nursing
Treatment	Surgery / Procedural Related	Wrong Side / Site
Diagnostic Events	Radiology Investigation	Incorrect Labelling Of Film / Report
7. Communication	7d. Patient Consent Issues	Unable to consent due to poor cognition
8. Policies and Procedures	8b. Failure to follow Procedures / Guidelines	

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Follow-Up Status (NOK):

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Clinical Review

Reviewer:

Level Of Review: Level 3 - Extended Review

Review Dates

Date to Secretariat:

Date to Executive:

Date to Clinical Review Committee:

Date to ACT Health Clinical Audit Committee:

FLAGS

Specific Referral: No

Specific Referral:

Incident Reports: Yes

Inpatient Deaths: No

Diagnosis at Admission:

Diagnosis at Death:

Inpatient Death Post Mortem: No

Inpatient Deaths Coroners: No

Unplanned Re-admissions: No

Admission 1

Admission1 Date:

Admission1 Specialty:

Admission1 Diagnosis:

Admission1 Discharge Date:

Admission2

Admission2 Date:

Admission2 Specialty:

Admission2 Diagnosis:

Admission2 Discharge Date:

Re-admission Outcome:

Unplanned Return to OT: No
Return to OT Specialty:
First Surgeon Level:
First Surgeon Name:
First Surgery Date:
First Surgery Description:
Date of Second Surgery:
Second Surgery Type/Related to previous:
Second Surgeon Level:
Second Surgeon Name:
Date of Third Surgery:
Third Surgery Type/Related to previous:
Third Surgeon Level:
Third Surgeon Name:
Unplanned Transfer: No
Unplanned Transfer Date:
Unplanned Transfer Reason:

Refer to Clinical Review Committee

Date referred to CRC:

Journal Entries

Reference 5 bb Cost

Date/Time Journal Entry

CRC-Exec M'ting Outcomes

Created By:

Case discussed today at CRCE. Multiple systems issues identified. Case to be an Extended Review.
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

General Comments

Created By:

Liz McKeowen
Consideration will be given to reviewing the sentinel event classification should this lady return to a level of physical and neurological functioningsimilar to her pre-morbid state.
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

PSQU Incident Coordinator
Incident referred to the Clinical Review team as meets screening criteria around wrong site surgery
Incident Classifier
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

ER team finalised and memo sent to Executives advising of commencement of Extended review
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

First team meeting held on Chain of events discussed and staff identified for interview. Interview questions formulated.
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

Documentation of Extended Review thus far forwarded to CAR TL on 30/3/11 for a quality check. Quality check done on ER process so far.
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

Second team meeting held on CA comleted and draft recommendations formulated. Both to be emailed out to team members when typed up.
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

Murrells, Tami
Hi this patient died on Are you able to review her death (Coroners) as part of your review and add comments to Death Reviews spreadsheet?
Thank you, Tami
Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Created By:

ER Final Report forwarded to Lesley Dickens (secretariat for Clinical Board) this morning. Email sent to OT TL requesting they inform nursing staff involved that the review has been finalised and staff can contact me for feedback. Case closed

Follow Up Allocated To:
Actioned: No
Linked Document Path:

Follow Up By Date:
Mail Sent On:

Documents

6 Documents Attached.

- Case review summary .doc ( ) (
- Chain of Events.doc ( ) (
- -ER047 RCA V2.doc ( ) (
- ER Final Report.pdf (
- Meeting 1.doc ( ) (by
- Memo TCH CRC (incorp ACRS & CRCS) re Extended Review.doc ( ) (

5bd – 5bs

Documents exempt in accordance with **Section 38 of the FOI Act**

Secrecy provisions