Bermuda Hospitals Board
Sentinel & Serious Events: 2011 - 2015

	Event type	Follow up/process improvement
	2011	
1	**CASE MANAGEMENT EVENT: Delay in diagnosis & treatment:** **2011** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **Patient outcome: Temporary harm**	• Extended period from admission → intervention potentially contributing to adverse patient outcome • Protocols for enhanced timing of test ordered until completion with review of results, and appropriate intervention • Clinical pathway developed
2	**UNANTICIPATED DEATH:** **2011**	• High risk patient • Patient had cardiac arrest post procedure • Due to high mortality risk for Anaesthesia and surgery, patient had been cancelled several weeks prior • Risks vs benefit evaluated pre-procedure • Unfortunately patient did not survive necessary procedure
3	**CASE MANAGEMENT EVENT: Fall:** *Patient death or serious disability associated with a fall* **2011** **Severe Harm event**	• Found on floor having fallen • Sustained a fracture requiring surgical intervention • Patient was on the Falls Prevention protocol when fall occurred • Increased monitoring implemented post-fall
4	**UNANTICIPATED DEATH:** **2011**	• Patient who was being monitored had a cardiac arrest on the ward and CPR was unsuccessful • The event was reviewed related to inability to retrieve electronic documentation from monitor • Review with Chief of service derived process improvements related to ensuring the documentation is saved before equipment “times out” and information cannot be retrieved, policy updated

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	2012	
5	**CASE MANAGEMENT EVENT: Fall:** *Patient death or serious disability associated with a fall* **2012** **Severe harm event**	• Elderly patient had a syncope/fainting episode • Sustained a fracture requiring surgery • Patient was on the falls prevention protocol when fall occurred
6	**CASE MANAGEMENT EVENT: Delay in diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results* **2012** **Temporary harm (strong potential for severe harm)**	• Diagnosis of patient was not known at time of report • This was due to results not followed up in a timely manner • Protocols for enhanced timing of tests from when ordered to completion, and communication and review of results
7	**CASE MANAGEMENT EVENT: Delay in diagnosis & treatment:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2012** **Death event**	• Admitted to ward pending transfer overseas for procedure that is not available in Bermuda • Patient fell on ward • RCA: Appears that there was a change in patient condition which caused the fall • Patient had a life threatening condition secondary to therapy prescribed, a recognized complication of the specific treatment • Delay in transfer overseas • Continuous monitoring was not ordered prior to transfer • Opportunities for earlier recognition and communication
8	**CASE MANAGEMENT EVENT: Fall:** *Patient death or serious disability associated with a fall*	• Patient fell when getting out of chair to return to bed • Sustained a fracture • Was on falls prevention protocol at the time of fall

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	2012 **Severe harm event**	
	2013	
9	**CASE MANAGEMENT EVENT:** **Medication related:** *Medication error leading to the death or serious disability of patient due to incorrect administration of drugs (e.g. Omission, dosage error, dose preparation, wrong time, wrong rate of administration, wrong administrative technique, wrong patient)* **2013** **Severe harm event**	• Adverse medication reaction due to incorrect dose ordered • RCA • Main issue: miscommunication re appropriate dosage during emergency situation • Improved communication skills at each transition of care between multi-disciplinary team • Full disclosure & apology to the patient when patient recovered • Process improvement re communication within the team
10	**UNANTICIPATED DEATH:** *Death just over 24 hours post admission* **2013** **Death event**	• This elderly patient had acute condition, confirmed on diagnostic testing • The patient and family reported the symptoms had persisted over a period of several months and that the GP had reviewed the patient 2 months earlier • Patient condition deteriorated over the next several hours • The patient had a cardiac arrest and was resuscitated • Discussion with the family with the attending physician, led to withdrawal of any further life supporting efforts and the patient expired 25 ½ hours after admission
11	**UNANTICIPATED DEATH:** **2013** **Death event**	• Patient was admitted in critical condition, then suffered a cardiac arrest • Patient was resuscitated but later had further deterioration, resuscitation unsuccessful and patient expired
12	**CASE MANAGEMENT EVENT:** **Fall:** *Patient death or serious disability associated with a fall* **2013** **Severe harm event**	• Patient fell and sustained a fracture • Patient was assessed for falls risk on admission • Patient was not identified as being at risk for falling prior to fall
13	**UNANTICIPATED DEATH:**	• Patient had cardiac arrest in OR after procedure • Resuscitation efforts were unsuccessful

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	2013 **Death event**	• Patient had extensive co-morbidities • It was identified pre-op that the patient was high risk for Anaesthesia, • Procedure was deemed to be necessary
14	**UNANTICIPATED DEATH:** **2013** **Death event**	• Intrauterine fetal demise of one twin • Admitted from Dr. office with suspected demise of one fetus • One fetus delivered and other infant deceased • Five days prior a Biophysical Ultrasound was reported as normal for both fetus's
15	**UNANTICIPATED DEATH:** **2013** **Severe harm event → Death**	• Patient was assessed to be a moderate risk for Anaesthesia for major surgical procedure • Had cardiac arrest post induction prior to surgery • Resuscitated and transferred to ICU but later expired due to co-morbidities • RCA: Patient had expressed a strong desire to have surgery due to limited mobility and chronic pain despite being apprised of the risks
16	**UNANTICIPATED DEATH:** **2013** **Death event**	• Patient had a cardiac arrest when going to OR for emergency surgery • Anaesthetist was there, resuscitation was unsuccessful
17	**CASE MANAGEMENT EVENT:** **Delay in treatment:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2013** **Severe harm event**	• Patient required transfer to overseas facility • Transfer time/ETA of medi-vac was unavoidably delayed by team and patient's condition deteriorated further in the interim • Follow up did not find that this was a preventable delay with the medi-vac transfer, out of BHB control
18	**CASE MANAGEMENT EVENT:** **Delay in diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test*	• Patient was admitted and died 3 days later secondary to complications of admitting diagnosis • Results were not followed up/acted on in timely • Unclear if outcome would have changed

	results **2013** **Death event**	
19	**CASE MANAGEMENT EVENT:** **Delay in diagnosis & treatment:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results* **2013** **Death event**	• Patient, admitted with exacerbation of a chronic illness and died • Patient's condition had deteriorated and certain indicators were at a critical level • Patient did not have a new treatment which at that time was very new to BHB and all criteria and processes related to it were "evolving" • RCA: Based on the review it was not "proven" that the newer treatment modality/ therapy would have prevented the outcome • Other standard, well recognized, therapies were utilized • Unfortunately due to additional medical conditions at that time the patient deteriorated and resuscitation was unsuccessful • Process improvements discussed around enhanced communication with specialist services, timing of treatment, and monitoring record opportunities
20	**CASE MANAGEMENT EVENT:** **Delay in Diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2013** **Death event**	• Patient deteriorated and died after receiving treatment • RCA : A diagnosis was made that was correct and treated; a second diagnosis was not detected • Process improvements: Communication among team at various points of care to be strengthened • Alerts for specific conditions/treatment to be highlighted in written and verbal communication
21	**ENVIRONMENTAL EVENT:** **Fall:** *Patient death or serious disability associated with a fall.* **2013** **Severe harm event**	• Partially sighted patient on medical ward left ward in a wheelchair and fell down steps and was paralyzed. • RCA found "system" opportunities related to patients who are non-compliant • Staff perceptions re chronic patient's, i.e. possible complacency when patients "do as they please". • Access available was unintentional, viewed on CCTV • Process for patient's authorization to leave clinical unit reviewed • Strengthened communication within team.
22	**CASE MANAGEMENT EVENT:** **Monitoring event:** *Patient death or serious*	• Patient was not connected to a monitor, later found dead • RCA: Review and re-education of patient monitoring criteria and documentation.

	disability associated with an avoidable delay in treatment or response to abnormal test results **2013** **Death event**	• Alarm education/protocols: criteria for monitor application, and preventing alarm fatigue. • Full communication of process improvements throughout department
	2014	
23	**CASE MANAGEMENT EVENT:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results* **2014** **Death event**	• Missed/delay in diagnosis: • RCA • Delay potentially contributed to adverse outcome • All past history and potential diagnoses must be considered during assessment despite appearance of patient
24	**CASE MANAGEMENT EVENT:** *Patient death or serious disability associated with a fall* **2014** **Death event**	• Fell when being transferred with standing hoist, sustained a sustained a fracture. • Preventable fall • Review of policy and re-education of staff re safe operating procedures using this piece of equipment.
25	**CASE MANAGEMENT EVENT:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results* **2014** **Severe harm event**	• Post-op patient had a respiratory arrest, discovered the oxygen tubing was connected to air and not oxygen • RCA • It was determined that there was a degree of "over-sedation" which contributed to this event and the patient responded to a reversal agent and the teams swift resuscitative efforts including the application of oxygen which increased the patients saturation levels to normal, there was no long term impact to the patient.
26	**CASE MANAGEMENT EVENT:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test*	• Patient had a test repeated 13 months after the initial test and was found to have a serious condition which "should have" been detected on the original test • RCA • Process improvements related to seeking 2nd opinion • "No sign off" to finalize report before obtaining a 2nd opinion if results

	results **2014** **Severe harm event**	are not definitive
27	**CASE MANAGEMENT EVENT:** **Delay in diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2014** **Death event**	• Family member had asked for feedback related to a test report "discrepancy". • The death of patient with terminal illness was not related to the test report
28	**CASE MANAGEMENT EVENT:** **Delay in diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results* **2014** **Death event**	• Death was not expected • RCA • Enhanced communication between disciplines • Timely documentation in medical record • Patient had pre-existing condition which was unknown and directly contributed to the outcome
	2015	
29	**CASE MANAGEMENT EVENT:** **Delay in diagnosis:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2015** **Severe harm event**	• Patient had a sudden deterioration in clinical status • This followed an invasive treatment • ICU transfer was required • RCA • Handover communication enhancements opportunities identified between departments
30	**CASE MANAGEMENT EVENT:** *Patient death or serious disability associated with a fall* **2015**	• Fall with injury, patient sustained a fracture • Was not at risk for falls per e assessment on admission • Had been advised to call for assistance, fell when trying to complete a task independently • Patient admitted to being non-compliant with instructions

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	Severe harm event	
31	**ENVIRONMENTAL EVENT: Surgical site infection:** Hospital associated post-operative surgical site infection contributed to patient morbidity **2015** **Severe harm event**	• RCA • Intensive review to identify cause did not identify a definitive cause • General review of all processes involved • Small changes made to prevent future recurrences
32	**MEDICATION EVENT: Medication error: Increased dose**. *Medication error leading to the death or serious disability of patient due to incorrect administration of drugs (e.g. Omission, dosage error, dose preparation, wrong time, wrong rate of administration, wrong administrative technique, wrong patient)* **2015** **Severe harm event**	• Patient had serious complication related to treatment • RCA • Review of medication related tests inadequate, • Improved monitoring procedures developed/clinical pathway enhancement
33	**CASE MANAGEMENT EVENT: Mis-interpretation of test result:** *Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.* **2015** **Death event**	• Test result mis-interpreted • RCA • Full review and process improvements made for specific procedures related to event • Widespread re-education and communication
34	**CASE MANAGEMENT EVENT: Fall:** *Patient death or serious disability associated with a fall* **2015** **Death event**	• Patient fell likely due to acute change in clinical status • RCA • Review of management: satisfactory, likely unpreventable event and fall related to medical diagnosis • Death related to change in clinical condition