LTR8

Queensland Government
Queensland Health

Bundaberg Health Service District

COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: 0603 02
Office Use Only

Type of Complaint: ☒ Written ☐ Verbal ☐ Telephone

Name of person handling complaint: DM/Peter Lock
Name and Designation of Staff handling the complaint

Facility:	Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint	☒ Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify – MP		

Complainant Details	Name: Pisi	UR:
	Election Status:	Admission Status:
	Gender: M	DOB: Post Code:
	Complainant Name If different to above	

Complaint referred by: If from an external source	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed	Complaint submitted: 11/06/03	Complaint registered: 24/06/03
	Acknowledgment: 16/06/03	First progress report:
	Date of Resolution/Closure: 17/06/03	

Complaint Issue See Complaint Categories and Description	**Category**	**Description**
	1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	
Service Type	Location of Incident:	
Staff Category	Staff involved in the complaint: Dr Patel	

Severity of Complaint	☐	Level One: Trivial, misconceived, subject matter not warranting acceptance for investigation
	☐	Level Two: Complainant could have resolved complaint easily with support from staff involved
	☐	Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	☐	Level Four: Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
	☐	Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

Complainant Objective What does the complainant want to happen?	☒ Register concern	☐ Receive explanation	☐ Obtain apology
	☐ Obtain refund	☐ Access service	☐ Change procedure
	☐ Change policy	☐ Compensation	☐ Disciplinary action
	Please provide details:		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	☒ Concern registered	☐ Explanation given	☐ Apology provided
	☐ Costs refunded	☐ Services provided	☐ Procedure/practice change
	☐ Policy change	☐ Compensation received	☐ Disciplinary action taken
	☐ No action taken		
	Please provide details:		

Recommendation/ Action taken What action has been taken as a result of this complaint?	☐ Staff member/contractor counselled	☐ Training/education of staff provided
	☐ Duties changed	☐ Dismissal/ termination of contract
	☐ Quality improvement activity initiated	☒ No action taken
	Please provide details: Peter spoke with P151	

Adverse Outcome	

Narrative	Please provide a brief summary of the complaint P151 complained that a procedure to his ear had been done in the wrong place

Office Use Only Performance indicators	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
	Date		
Reported in trends analysis			

Queensland Government
Queensland Health

Bundaberg Health Service District

COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: 0503.15 .
Office Use Only

Type of Complaint: ☒ Written ☐ Verbal ☐ Telephone

Name of person handling complaint: DM Peter Leck
Name and Designation of Staff handling the complaint

Facility:	Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint			
	☒ Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify – MP		

Complainant Details		
	Name: P53	UR:
	Election Status:	Admission Status:
	Gender:	DOB: Post Code:
	Complainant Name If different to above	

Complaint referred by: If from an external source			
	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed		
	Complaint submitted: 26.05.03	Complaint registered: 24.06.03
	Acknowledgment: 18.06.03	First progress report:
	Date of Resolution/Closure: 18.06.03	

Complaint Issue See Complaint Categories and Description	**Category**	**Description**
	1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	
Service Type	Location of Incident: Theatre	
Staff Category	Staff involved in the complaint: Dr Patel	

Severity of Complaint		
	☐	Level One: Trivial, misconceived, subject matter not warranting acceptance for investigation
	☐	Level Two: Complainant could have resolved complaint easily with support from staff involved
	☐	Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	☐	Level Four: Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
	☐	Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

Complainant Objective What does the complainant want to happen?	☒ Register concern	☐ Receive explanation	☐ Obtain apology
	☐ Obtain refund	☐ Access service	☐ Change procedure
	☐ Change policy	☐ Compensation	☐ Disciplinary action
	Please provide details:		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	☒ Concern registered	☒ Explanation given	☐ Apology provided
	☐ Costs refunded	☐ Services provided	☐ Procedure/practice change
	☐ Policy change	☐ Compensation received	☐ Disciplinary action taken
	☐ No action taken		
	Please provide details:		

Recommendation/ Action taken What action has been taken as a result of this complaint?	☐ Staff member/contractor counselled	☐ Training/education of staff provided
	☐ Duties changed	☐ Dismissal/ termination of contract
	☐ Quality improvement activity initiated	☒ No action taken
	Please provide details: Peter wrote to P53 explaining an investigation of the incident was undertaken by senior staff and to apologise.	

Adverse Outcome	

Narrative	Please provide a brief summary of the complaint P53 wrote very upset and distressed that the catheter had been inserted into her carotid artery and she had to be flown to Brisbane to have it repaired. As well as the treatment by the Anaesthetist and that her Husband was not notified.

Office Use Only Performance Indicators	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
Reported in trends analysis	Date		

Queensland Government
Queensland Health

Bundaberg Health Service District

COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: 02/04-03
Office Use Only

Type of Complaint: ☐ Written X Verbal ☐ Telephone

Name of person handling complaint: Dr Darren Keating
Name and Designation of Staff handling the complaint

Facility:	☑ Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint	x Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify		

Complainant Details	Name: P131	UR:
	Election Status:	Admission Status:
	Gender: F	Post Code: 4670
	Complainant Name If different to above:	

Complaint referred by: If from an external source	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed	Complaint submitted: 02.07.04	Complaint registered: 27.07.04
	Acknowledgment:	First progress report:
	Date of Resolution/Closure: 20/08/04	

Complaint Issue See Complaint Categories and Description	**Category** 1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	**Description** **9 – believes she should have had a biopsy on breast instead of cream given to her by Dr Patel. She has since had surgery and believes that this may have been prevented if she had had the biopsy.**
Service Type	Location of Incident:	
Staff Category	Staff involved in the complaint: Dr Patel	

Severity of Complaint		**Level One:** Trivial, misconceived, subject matter not warranting acceptance for investigation
		Level Two: Complainant could have resolved complaint easily with support from staff involved
		Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	X	**Level Four:** Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
		Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

Complainant Objective What does the complainant want to happen?	☐ Register concern	x Receive explanation	☐ Obtain apology
	☐ Obtain refund	☐ Access service	☐ Change procedure
	☐ Change policy	☐ Compensation	☐ Disciplinary action
	Please provide details: DMS to investigate		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	☐ Concern registered	☑ Explanation given	☐ Apology provided
	☐ Costs refunded	☐ Services provided	☐ Procedure/practice change
	☐ Policy change	☐ Compensation received	☐ Disciplinary action taken
	☐ No action taken		
	Please provide details: Letter from DMS to P131 explaining procedures		

Recommendation/ Action taken What action has been taken as a result of this complaint?	☐ Staff member/contractor counselled	☐ Training/education of staff provided
	☐ Duties changed	☐ Dismissal/ termination of contract
	☐ Quality improvement activity initiated	☑ No action taken
	Please provide details:	

Adverse Outcome	

Narrative	Please provide a brief summary of the complaint

Office Use Only Performance indicators	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
Reported in trends analysis	Date		

Queensland Government
Queensland Health

Bundaberg Health Service District

COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: 0704-03
Office Use Only

Type of Complaint: ☐ Written X Verbal ☐ Telephone

Name of person handling complaint: Dr Darren Keating
Name and Designation of Staff handling the complaint

Facility:	☑ Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint			
	x Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify		

Complainant Details		
	Name: P131	
	Election Status:	Admission Status:
	Gender: F	Post Code:
	Complainant Name If different to above:	

Complaint referred by: If from an external source			
	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed		
	Complaint submitted: 02.07.04	Complaint registered: 27.07.04
	Acknowledgment:	First progress report:
	Date of Resolution/Closure:	

Complaint Issue See Complaint Categories and Description	**Category**	**Description**
	1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	**9 – believes she should have had a biopsy on breast instead of cream given to her by Dr Patel. She has since had surgery and believes that this may have been prevented if she had had the biopsy.**
Service Type	Location of Incident:	
Staff Category	Staff involved in the complaint: Dr Patel	

Severity of Complaint		
		Level One: Trivial, misconceived, subject matter not warranting acceptance for investigation
		Level Two: Complainant could have resolved complaint easily with support from staff involved
		Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	x	**Level Four:** Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
		Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

Complainant Objective What does the complainant want to happen?	☐ Register concern	x Receive explanation	☐ Obtain apology
	☐ Obtain refund	☐ Access service	☐ Change procedure
	☐ Change policy	☐ Compensation	☐ Disciplinary action
	Please provide details: DMS to investigate		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	☐ Concern registered	☐ Explanation given	☐ Apology provided
	☐ Costs refunded	☐ Services provided	☐ Procedure/practice change
	☐ Policy change	☐ Compensation received	☐ Disciplinary action taken
	☐ No action taken		
	Please provide details:		

Recommendation/ Action taken What action has been taken as a result of this complaint?	☐ Staff member/contractor counselled	☐ Training/education of staff provided
	☐ Duties changed	☐ Dismissal/ termination of contract
	☐ Quality improvement activity initiated	☐ No action taken
	Please provide details:	

Adverse Outcome	

Narrative	Please provide a brief summary of the complaint

Office Use Only Performance Indicators	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
Reported in trends analysis	Date		

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Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and tr this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No	P0334	Date Registered	3/8/04	Date Received
Risk Assessment	Consequence: Major	Likelihood: Possible	Risk Rating: Very High	RECEIVED 02 AUG 2004 DQDSU
Risk Level				
Assessed by	JT Russell			
Action required	Fwd to DUM, DNMS, DON 2/8/04			

Please print clearly using a black pen (Attach extra sheets if required)

Site ☑ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Patient/Visitor Adverse Event

Bundaberg Hospital
BRAMICH
DESMOND

SEX: M
UR NO: 086644

PLANT OPERATOR

Department	ICU.		
Sex of subject	(Male)	Female	Not stated
Subject is	(Patient)	Visitor	Other
IMHS Client	Involuntary	Voluntary	Unknown
Reporters details	Name: Karen Fox		
	Contact No.: Ext 2310		
Reporters classification	Please specify: RN.		
1st Witness	Name & Contact No.: D. Aitken, Ext 2310		
2nd Witness	Name & Contact No.:		
Place of Adverse event	ICU.		
Date of Adverse event	27/7/04	Time:	
Current patient diagnosis/problems	Ventilated #ribs		
Adverse Event Type	ICC drain, no water in underwater seal section.		
Next of Kin notified?	Yes (No) N/A	Name:	
Medical officer notified?	(Yes) No N/A	Name: DR PATEL.	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event	Time:			
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:				Date & Time:	
Duty of Disclosure process initiated?	Yes	No	N/A	Name:	

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

On doing checks - noted no water in underwater seal drain section of ICC drain.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Busy, unstable bed.
From previous shift

Treatment/Investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Put water into appropriate section.

Impact or Outcome - What has been the outcome of this adverse event?

Unknown -

Minimisation of Outcomes - What factors minimised the outcome or if this was a near miss, what stopped the event from occurring?

Rectifying the situation

Prevention - How could this adverse event have been prevented?

More time, checking.

Signature		Date	28/7/04.

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor/Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Awareness of need for H_2O in underwater sealed drainage, unsure of who set up unit. Emergency situation.

Has the adverse event been documented in the medical record?	Yes	No	If not, why not?
Name: Terri Brown	Signature: Terri Brown		

Please forward this form to the District Quality and Decision Support Unit

Directors Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

Queensland Government
Queensland Health

Bundaberg Health Se

Sentinel Event F

Already forwarded ✓ to DM, DMS, DON

Can you make sure they get a form for AE follow up. Thx J.

Sentinel events are rare and serious events that require p
Sentinel events must be reported verbally to the District Manager
Nursing and other relevant Director wi
This written report forwarded to DQDSU

Please print clearly using a black pen

Site	☒ Bundaberg	☐ Childers	[

Details of the subject of the sentinel event (fill in applicable details)

Last Name:	Or affix Patient Label: BRAMICH	Sex of Patient:	☒ Male ☐ Female ☐ Not stated
First Name:	DESMOND	IMHS Clients:	☐ Voluntary ☐ Involuntary ☐ Unknown
UR Number:	086644	Unit	Inpatient Unit ICU
DOB/Age:			Unit where event occurred ICU
Reporters Details	Name: Toni Workman	Signature	Toni Workman
	Contact No. 41503310	Date	2.8.04
Reporters Classification:	☒ Nurse ☐ Medical Officer ☐ Allied Health Professional ☐ Other - specify		

Sentinel Event

Please indicate which Sentinel Event has occurred:

- ☐ Procedures involving the wrong patient or the wrong body part
- ☐ Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- ☐ Haemolytic blood transfusion reaction resulting from ABO incompatibility
- ☐ Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs
- ☐ Infant discharge to wrong family
- ☐ Maternal death or serious morbidity associated with labour or delivery
- ☐ Intravascular gas embolism resulting in death or neurological damage
- ☐ Suicide of a patient in an in-patient unit
- ☒ Any serious and rare event

Date of Event	27.7.04			Time of Event	1300 onwards	hours
Reported to:	☐ DM	☐ DMS	☐ DON	Time reported		hours
...lso reported to:	☐ DCAHS	☐ DCS	☐ Service Director IMHS	Time reported		hours

Narrative Provide details of how this event occurred, including people involved, outcomes etc Attach additional sheets if insufficient space

Pt readmitted in extremis, Anaesthetist & pt, trying to stabilise pt, insert lines, give blood, surgeons with pt, pt had period of ventricular standstill. during central line insertion. DIW surgeons need to TF pt to Brisbane were facilities. Dr Gaffed pts attending surgeon. Dr Rated informed staff pt did not require Thoracic Surgeons & transfer. See attached notes and sequence of events. Initial attempt to obtain vsd @ PCH then PAH resulted in a vsd being available & booked in 1430 hrs. Delay due to subsequent events & demise of pt.

ICU ISSUES WITH VENTILATED PATIENTS;

BBH ICU is a
Designated level one unit, capable of ventilation for short periods of time 24-48hrs. Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit made clear to surgeons and this has appeared to distress one of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would "not practice medicine like this and would resign". He stated that he "would not transfer his patients to other hospitals". He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamicin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM. Dr Patel has attempted to cause conflict with the staff in ICU, By stating the NUM is unsupportive of her staff.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses, every time we have a patient of Dr Patels's the staff anticipate an argument. When Dr Patel's ventilated Patients require ongoing care or have been ventilated for longer than 24-48 hrs ,it needs to be reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs. He has done this when a bed has already been obtained. This has, on several occasions placed the patient in jeopardy as they have further deteriorated

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went

into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit, repeatedly when the limitations of the unit are well known.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU continues.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient). This delay may have contributed to the outcome of this patient.

My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.

L/R/U

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and trea this person and to prevent injury to others. Ensure medical records are factual and up to date.

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DQDSU Use Only

Registration No	P0392	Date Registered	31/8/04	Date Received
Risk Assessment	Consequence: Moderate	Likelihood: Possible	Risk Rating: High	RECEIVED 20 AUG 2004 DQDSU
Risk Level	High			
Assessed by	Dave DMS.			
Action required				

Please print clearly using a **black** pen (Attach extra sheets if required)

Site ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

BUNDABERG HOSPITAL SEX UR NO
P127

Department	SURG		
Sex of subject	(Male)	Female	Not stated
Subject is	(Patient)	Visitor	Other
MHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name: D JENKIN		
	Contact No.: 2336		
Reporters Classification	Please specify: NURSING.		
1st Witness	Name & Contact No.: J NICHOLS		
2nd Witness	Name & Contact No.		
Place of Adverse event	SURGICAL		
Date of Adverse event	8/8/04 Time: AM SHIFT		
Current patient diagnosis/problems	? Alzheimers		
Adverse Event Type	KNOW INT RESECT/DYHIS		
Next of kin notified?	Yes No N/A	Name:	
Medical officer notified?	Yes No N/A	Name:	

Staff Adverse Event — Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of event	Time			
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

See attached Discharge Summary

Medical Officer's Signature:			Date & Time:	
Open Disclosure process initiated?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

Low Anterior Resection 5/8/04.
Dehiscence (full) 8/8/04
Return to OT for Repair of dehiscence + reduction of omentum. 8/8/04

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

dry retching during attempt at N/G tube insertion

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Return to OT same day for repair + reduction of omentum. Delay in recovery. Prolonged stay 14 day Extra Path, XRAY. Swab wound - green exudate 7/8.

Impact or Outcome - What has been the outcome of this adverse event?

delay in recovery. Return to OT. ? wound infection
↑ Length of stay

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Quick action to pack wound c̄ saline gauze until return to OT

Prevention - How could this adverse event have been prevented?

Clinical technique.

Signature	[signature]	Date	19/8/04.

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Referred to Errormed. - Surgeon present at meeting

Has the adverse event been documented in the medical record?	(Yes)	No	If not, why not?
Name: DJ PNKL	Signature: [signature]		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

Noted.
Recent study of dehiscence rates showed reduced incidence in last yr of previous years.
[initials] DMS 27/8/04

HSO Comment (Staff Adverse Event Only)

DQDSU Comment

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No	P0392	Date Registered	31/8/04	Date Received
Risk Assessment	Consequence: Moderate	Likelihood: Possible	Risk Rating: High	RECEIVED 20 AUG 2004 DQDSU
Risk Level	High			
Assessed by	[signature]			
Action required by	DMS.			

Please print clearly using a **black** pen (Attach extra sheets if required)

Site ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

BUNDABERG HOSPITAL SEX UR NO

Pin

1

Department	SURG		
Sex of subject	(Male)	Female	Not stated
Subject is	(Patient)	Visitor	Other
IMHS client	Involuntary	Voluntary	Unknown
Reporters Details	Name: D JENKIN		
	Contact No.: 2336		
Reporters Classification	Please specify: NURSING.		
1st Witness	Name & Contact No.: J NICHOLS		
2nd Witness	Name & Contact No.		
Place of Adverse Event	SURGICAL		
Date of Adverse Event	8/8/04 Time: AM SHIFT		
Current patient diagnosis/problems	Alzheimers		
Adverse Event Type	LOW INT RESECT/DYHIS		
Next of kin notified?	Yes No N/A	Name:	
Medical officer notified?	Yes No N/A	Name:	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

See attached Discharge Summary

Medical Officer's Signature:			Date & Time:	
Open Disclosure process initiated?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

Low Anterior Resection 5/8/04.
Dehiscence (full) 8/8/04
Return to OT for Repair of dehiscence + reduction of omentum. 8/8/04

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Pt vomiting during attempt at N/G tube insertion

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Return to OT same day for repair + reduction of omentum. Delay in recovery. Prolonged stay. 14 day Extra Path, XR04. Swab ordered. - green exudate 0/8.

Impact or Outcome - What has been the outcome of this adverse event?

Delay in recovery. Return to OT. ? wound infection
+ Length of stay

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Quick action to pack wound i Saline gauze until return to OT

Prevention - How could this adverse event have been prevented?

Clinical technique.

Signature		Date	19/8/04.

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor/Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Referred to Errormed. — Surgeon present at meeting

Is the adverse event been documented in the medical record?	(Yes)	No	If not, why not?
Name: D J PINKER	Signature:		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

DSO Comment (Staff Adverse Event Only)

DSU Comment

BUNDABERG HEALTH SERVICE DISTRICT

CLINICAL SUMMARY

BUNDABERG HOSPITAL SEX UR NO

P127

J. CHAPMAN

Usual GP: BURNETT MED CNTR

Address: PO BOX 812

BUNDABERG Q 4670

PENSIONER

Admission Date: 03/08	Discharge Date: 17/08	Follow up Clinic:	Referral:

Principal Diagnosis: (one only) The condition which after study was found to be the main reason for the patient's admission

Recto-sigmoid Tumour

Secondary Conditions:

Principal Procedure: Low anterior resection

Type of anaesthetic - ☐ Local ☐ Sedation ☑ General ☐ Spinal ☑ Epidural

Secondary Procedure/s and or Significant Non-Surgical Procedures:

- Colonoscopy
- Wound repair

Complications: ☐ Wound infection (include organism) ☐ Urinary tract infection (include organism)

- Wound dehescence.

External Cause of Injury/Poisoning:

Clinical Course and Significant Results:

- IV Abx's -
- DVT Prophylaxis -

(P) Wound/Ostomy Daily R/V Prn Cline 4 daily R/V Sng Cline

Falls Risk Assessment: ☐ High ☐ Med ☐ Low

Interventions that need addressing following discharge: Pt needs

Remove Sutures/Clips: ___/___/___ LMO ☐ Hospital Doctor ☐

Enclosed by Mail
Abnormal results
☐ ECG
☐ Radiology Reports
☐ Haematology
☐ Histopathology
☐ MBA2
☐ Other

DISCHARGE MEDICATION - DOSAGE & FREQUENCY	DISCHARGE MEDICATION - DOSAGE & FREQUENCY
Nil PD's	

MO Signature: [signature] Print Name: Dr Aslam

Designation: Date: 23/8/4

Consultant: Dr Patel

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person Involved is safe and that all necessary steps have been taken to support and trea[t] this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No		Date Registered		Date Received
Risk Assessment	Consequence: Moderate	Likelihood: Possible	Risk Rating: High	RECEIVED 29 OCT 2004 DQDSU
Risk Level	High			
Assessed by	[signature]			
Action required	DMS/DDONS.			

Please print clearly using a black pen (Attach extra sheets if required)

Site	☐ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Patient/Visitor Adverse Event — Enter details in this column

BUNDABERG HOSPITAL SEX UR NO

P 15

Department			
Sex of subject	(Male)	Female	Not stated
Subject is	Patient	Visitor	Other
IMHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name: D Jenkin		
	Contact No. 2336		
Reporters Classification	Please specify		
1st Witness	Name & Contact No.		
2nd Witness	Name & Contact No.		
Place of Adverse event	SURGICAL		
Date of Adverse event	26/10/04	Time	AM.
Current patient diagnosis/problems	Lap Chole followed by bleeding haematoma DAY 1		
Adverse Event Type	& Patient Injury		
Next of kin notified?	(Yes) No N/A	Name:	
Medical officer notified?	(Yes) No N/A	Name: PATEL	

Staff Adverse Event — Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From		To	
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

[M]edical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

[If r]elevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

[M]edical Officer's Signature:		Date & Time:	
[Open Dis]closure [Pro]cess initiated?	Yes / No / N/A	Name:	

Please complete all sections on page 2 for all adverse events (Patient or Staff)

escription of Adverse Event - Please describe exactly what happened, including who was involved

Patient underwent Lap Chole 25/10
Became tachycardic pyrexic - Abdo
distended. Painful Abdomen.

REVISED

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

ontributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Procedure

for management of [illegible]

reatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Transfer back to OT → ICU for 1 DAY. Was
Multiple tests, Xrays.

mpact or Outcome - What has been the outcome of this adverse event?

Stay in ICU then back to Surgical for
> 3 DAY

inimisation of Outcomes - What factors minimised the outcome or if this was a near miss, what stopped the event from occurring?

Nurses close observations when
condition deteriorated

evention - How could this adverse event have been prevented?

? Surgical technique

Signature		Date	29/10/06.

Thankyou for completing this form. Please give this form to your Shift Supervisor

hift Supervisor / Management Report

mment on action taken or action needed to be taken to prevent recurrence

No Errors.

s the adverse event been documented in the medical record?	Yes	No	If not, why not?
me:	Signature:		

Please forward this form to the District Quality and Decision Support Unit

ector's Comment (Where required)

SO Comment (Staff Adverse Event Only)

DSU Comment

LTK 11

5 - NOV 2004

Bundaberg Health Service District

Adverse Event Report Form

Queensland Government
Queensland Health

Ensure that any person involved is safe and that all necessary steps have been taken to support and tr this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use only

Registration No	P0540	Date Registered	9/11/04.	Date Received
Risk Assessment	Consequence: Moderate	Likelihood: Possible	Risk Rating: High	RECEIVED 29 OCT 2004 DQDSU
Risk Level	High			
Assessed by	YK			
Action required	DMS/DDONS.			

Please print clearly using a black pen (Attach extra sheets if required)

Site: ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Patient/Visitor Adverse Event
Enter details in this column

BUNDABERG HOSPITAL SEX UR NO

P15

Department			
Sex of subject	(Male)	Female	Not stated
Subject is	Patient	Visitor	Other
TMHS Client	Involuntary	Voluntary	Unknown
Reporters details	Name: D STANKO		
	Contact No.: 2336		
Reporters Classification	Please specify		
1st Witness	Name & Contact No.		
2nd Witness	Name & Contact No.		
Place of Adverse Event	SURGICAL		
Date of Adverse Event	26/10/04 Time: AM.		
Current patient diagnosis/problems	Lap Chole followed by		
Adverse Event Type	& Patient Injury		
Next of Kin notified?	(Yes) No N/A	Name:	
Medical officer notified?	(Yes) No N/A	Name: PATEL	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift type	Fixed	Standard	Rotating	Other
Date of Event		Time:		
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment involved	Including Asset Number: Laparotomy Kit Diathermy			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's signature:			Date & Time:	
Was Disclosure discussed?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

Patient underwent Lap Chole 25/10
Became Tachycardic sweaty - Abdo
distended. Painful abdomen.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Practice

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

for evacuation of leak [illegible]
Transfer back to OT → ICU for 1 DAY.
multiple tests, Xrays.

Impact of Outcome - What has been the outcome of this adverse event?

Stay in ICU then back to Surgical for
> 3DAY

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring

Nurses close observation when
condition deteriorated

Prevention - How could this adverse event have been prevented?

? Surgical technique

Signature	[signature]	Date	29/10/04

Thankyou for completing this form. Please give this form to your Shift Supervisor.

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

5/11/04 → Note this is a medical issue in relation to ? surgical technique. DMS has received not appropriate for D[illegible] at this time
To Erromed.

Has the adverse event been documented in the medical record?	(Yes)	No	If not, why not?
Name: D. J. [illegible]	Signature: [signature]		

Please forward this form to the District Quality and Decision Support Unit

Directors Comment (Where required)

[illegible] DON

DQSU Comment (Staff Adverse Event Only)

DQSU Comment

LIKIL

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No.	P0552	Date Registered	10/11/04	Date Received: RECEIVED - 8 NOV 2004 DQDSU
Risk Assessment	Consequence: Minor	Likelihood: Unlikely	Risk Rating: Med	
Risk Level	Med			
Assessed by	VF			
Action required by				

Please print clearly using a **black** pen (Attach extra sheets if required)

Site ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Patient/Visitor Adverse Event
Enter details in this column

Full Name	Or affix Patient Label: MARILYN DAISY		
Number	005225.		
Visitor Contact Details			
DOB/Age			
Department	SURG/Comm.		
Sex of subject	Male	(Female)	Not stated
Subject is	(Patient)	Visitor	Other
IMHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name: D J Tonkin		
	Contact No: 41502336		
Reporters Classification	Please specify		
1st Witness	Name & Contact No. DR.		
2nd Witness	Name & Contact No.		
Place of Adverse event	SURG / RENAL		
Date of Adverse event	DURING Time MONTH OCTOBER		
Current patient diagnosis/problems	BKA / Renal Failure		
Adverse Event Type	Patient Care.		
Next of kin notified?	Yes No N/A	Name:	
Medical officer notified?	Yes No N/A	Name:	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Type of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:			Date & Time:	
Open Disclosure process initiated?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved.

Patient had amputation of leg 29/9. Self discharged, at own risk 6/10. Had had 9 visits to Renal Unit since discharge for dialysis. Renal Physician advised me on 4/11 that he has been advised by Vascular Surgeon in Brisbane that

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

sutures had been left in stump. Should be removed after 6 weeks post op — Patient stated he would go to local hospital for dressing. Plan not [illegible] discharge ~~practice~~ / holistic care not attended Renal dialysis

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Nil.

Impact or Outcome - What has been the outcome of this adverse event?

Wound has healed.

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

No factors identified

Prevention - How could this adverse event have been prevented?

Signature	[signature]	**Date**	8/11/04

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Discharging nurses ~~counselled re need to direct patient to seek medical help for removal of sutures~~. Counselled re need to fax or send a plan for wound care to other hospital or give patient. (Renal NUM advised)

Has the adverse event been documented in the medical record? Yes / No (circled: No) If not, why not? Several weeks post discharge

Name: / NUM SURGICAL UNIT MANAGE[illegible] Signature: [signature]

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

MARILYN J

005225

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
6/10/04 1430hr	Nursing: pt admitted to unit for 4 hrs dialysis, UF 1000ml Total during treatment continuous overflow of faeces today c/o abdo pain Shaws coctail ✓ Albumin given IV as ordered CVC dressing attended °wound ooze °swelling at entry site of same hygiene needs attended x 3. problem free dialysis but became hypertensive @ end of treatment Dr Ben informed of same. Tf back to ward @ 1430hr
	Albumex® 20 (B)3470550128 EXP 16 SEP 05 Peel
6/10/04	1515hrs — Pt. given Endone 5mg oral and 1gram Panadol oral at 0900hrs prior to Dialysis. Pt. R.T.W. from Renal dialysis at approx. 1430hrs. Stump dressing attended as per MR91. Dr. Waterson stated pt. was going home today against Medical advice. Discharge at own risk form was signed by pt. D/C Meds sent to Pharmacy at 1445hrs. — A. Alexander RN (ALEXANDER)
6/10/04	1600hrs pt discharged 1600hrs. Care as per path. left with daughter Picking up meds from pharmacy as leaves. Aware of dx at local hosp. to return for dialysis late in week [illegible]
6/10/04	1605hrs, Dressing on Ⓛ neck changed, cannula removed, Pad changed, Pt incont of faeces, Wheelchair to car — [illegible] RN

INPATIENT PROGRESS NOTES

LTKLS

Queensland Government
Queensland Health

Bundaberg Health Service District

Incident Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and trea this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No:	P0700	Date Registered	7/2/05	Date Received	RECEIVED 07 JAN 2005 DQDSU
Risk Rating	Low	(Medium)	High	Very High	Extreme
DQDSU Action	file				
Forward to:					
Action required					

Please print clearly using a black pen (Attach extra sheets if required)

Site	☑ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry
Incident type	☑ Actual	☐ Potential		

Patient Incident

Bundaberg Hospital
HALTER
TREVOR J

SEX: M
UR NO: 035261

Department:	SURG		
Sex of subject:	(Male)	Female	Not stated
Subject is:	(Patient)	Visitor	Other
MHS Clients:	Involuntary	Voluntary	Unknown
Reporters Details:	Name: M. MULLINS		
	Contact No.: 41502332		
	Classification: RN		
1st Witness:	Name & Contact No.: D. Littlefield 41502330		
2nd Witness:	Name & Contact No.: DRS. BOYD.		
Place of Incident:	Room 30 / SURG WD		
Date of Incident:	25/12/04 Time: 1320hR		
Current patient diagnosis/problem:	Post Lap chole: T/F from RBH		
	VRE ISOLATION.		
Next of kin notified?	Yes No (N/A)	Name:	
Medical officer notified?	(Yes) No N/A	Name: DRS. BOYD.	

Staff Incident

Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Shift time	From	To		
Date		Time		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the Incident?			
Experience in this task	years			
Place of Incident				
Cause of Injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff incident where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Drain had staple removed with it at the time. This was mutually

Medical Officer's Signature: [signature] Date & Time: 25/12/04 1400hR

Please complete all sections on page 2 for all Incidents (Patient or Staff)

See Guidelines for assistance with completing this section

Description of Incident - Please describe exactly what happened, including who was involved

Bellavac removed as per Dr Patels orders written in pts chart. Noted difficulty trying to remove Bellavac tubing + discomfort caused to pt in procedure. D. Littlefield was asked by myself to comfort pt due to him not being able to relax long enough to remove tube. When tubing removed a foreign object was lodged in a port hole of tubing sticking out as it was removed. Tip intact no bleeding to site noted Dr Boyd R/N tip + object

If this incident is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form, attach & forward to DQDSU
If this is a security incident, ensure Security Officer completes Security form and forwards to Operational Services Manager Sent to path

Contributing factors - Identify causes that contributed to the incident

foreign body attached to drain

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Sent tip of tubing + foreign object to pathology for SWAB / M/C/S

Outcome - What has been the outcome of this incident?

Pain on removal of Bellavac

Minimisation or Prevention - What factors minimised the outcome, or what could have prevented this event from occurring?

Procedures in theatre checking regarding stapling + drain insertion

Has the incident been documented in the medical record?	Yes (circled)	No	If not, why not?
Signature	M Mullins (MULLINS)	Date	25/12/04

Incident Category and Sub Category - Please refer to guidelines

Category: Peri Operative Procedure Subcategory: Peri Operative Complication

Cost Centre Manager's Report

Comment on action taken or action needed to be taken to prevent recurrence

Object looked like a remnant skin staple. Bellovac insertion on 28/11/04 following drainage cholephrine closed.
Referred to surgeon Dr Patel + OT NUM

CCM Risk Assessment	Consequence – Please Circle					Likelihood – Please circle				
	Negligible	Minor (circled)	Moderate	Major	Extreme	Rare	Unlikely	Possible	Likely	Almost certain
Risk Rating	Low (marked)		Medium		High		Very High		Extreme	

Name: JENKIN NUT MANAGER Signature: [signature]

Please forward this form to the District Quality and Decision Support Unit

Comment (Director, WHSO) where required

L/K/14

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No	P0429	Date Registered	9/9/04	Date Received
Risk Assessment	Consequence: Minor	Likelihood: Possible	Risk Rating: Medium	
Risk Level	Medium			
Assessed by	[signature]			
Action required				

RECEIVED
- 6 SEP 2004
DQDSU

Please print clearly using a **black** pen (Attach extra sheets if required)

Site ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

BUNDABERG HOSPITAL SEX UR NO
HILLIER F 002378
DORIS J

UR Num

Vis

Department	SURG		
Sex of subject	Male	(Female)	Not stated
Subject is	(Patient)	Visitor	Other
MHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name: D Thanks		
	Contact No.: 2336		
Reporters Classification	Please specify		
1st Witness	Name & Contact No.		
2nd Witness	Name & Contact No.		
Place of Adverse Event	SURG/OT		
Date of Adverse Event	4/6/04	Time: AM.	
Current patient diagnosis/problems	NECROTISING FASCITIS POST LAPAROTOMY		
Adverse Event Type	PATIENT / INJURY / COMPLICATION		
Next of kin notified?	(Yes)	No	N/A — Name:
Medical officer notified?	(Yes)	No	N/A — Name:

Staff Adverse Event Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event	Time			
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
2nd Witness				
Medical officer notified?	Yes	No	N/A	Name:

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:			Date & Time:	
Open Disclosure process initiated?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened including who was involved

Patient had lap chole 28/8. Developed cellulitis post op worsening until 4/9. Taken to OT for exploration & regime 3x fascicotomy for necrotising fasciitis.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

? cause

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Return to OT
Ambulation therapy

Impact or Outcome - What has been the outcome of this adverse event?

Prolonged stay. Return to OT
Prolonged AB therapy. Wound x 3.

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Ambulation therapy for period prior to return to theatre.

Prevention - How could the adverse event have been prevented?

?

Signature		Date	16/9/04

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor/Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Dr Ermonet
Infection Control Nurse Hospital

Has the adverse event been documented in the medical record?	Yes	No	If not, why not?
Name: P J Tenkin	Signature:		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

HSO Comment (Staff Adverse Event Only)

DSU Comment

LTR15

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No.

BUNDABERG BASE Hospital / ~~Service~~ THEATRE Ward / Department

Date and Time of incident 15 / 8 / 03 0900 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P132	Birth Date: / / . UR Number
Ward/Department/Area: THEATRE	Medical Officer: DR J PATEL.
Location of Incident: OR4	Time and Date Medical Officer Notified: hours/15/8/03
Illness/Disability: Lap Cholecystectomy	Patient Mental State before Incident: ☒ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS
Has the patient any Debility: ☐ YES ☒ ~~No~~ Specify:	Does the patient use supportive aids: ☐ YES ☐ No N/A ✓ Specify:

Patient injury:	Yes	No		Yes	No	OTHER (SPECIFY)
Due to patient Fall / Slip	☐	☐	Rails Up	☐	☐	
from bed	☐	☐	Safety Restraints in use	☐	☐	
from chair	☐	☐	Staff in attendance	☐	☐	
in shower / bath	☐	☐	Staff in Attendance	☐	☐	
in toilet	☐	☐	Staff in attendance	☐	☐	
in corridor	☐	☐	Staff in attendance	☐	☐	
on wet floor	☐	☐	Signs displayed	☐	☐	

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *.....
Feet & Toes *.....
Internal Organs *.....
Multiple Locations *.....
Ot & Unspecified location
* Specify location

Nature of Injury: (CIRCLE)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other ~~Accident~~ Actual Longer
Nature of Disease: Anaesthetic time
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other .....

What happened: (CIRCLE)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other
Equipment not working
What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other Faulty equipment
Asset number of equipment .....

Medical Attention Received
First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☐ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long .....

How did the incident occur:
I was scrubbed for Lap Cholecystectomy and could not get the multifire Ligaclipper to work. I got assistance from RN C Dobson + CN G. Doherty but was still unable to get equipment to work.

Name of Witness/s: (1) ~~Patel~~ C Dobson Contact No.: 41502484

(2) G Doherty Contact No.: 41502484

Reporting Person: M GOATHAM (PRINT) SIGNATURE M Goatham Date: 15/8/03

Forward to Area Supervisor

(Please turn page)

QH22bis

Area Supervisor Investigation Report

This incident was reported to me on 15/8/03 at 1000 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

- Difficult instrument to assemble.

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☑ Occasional ☐ Rare ☐

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☑	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Need to train new staff re. this instrument. Inservice — 21/8/03

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: DAVID LEVINGS **Designation:** ANUM

Signature ..... Date: 15/8/03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: Inservice ✓

Name: Kennedy Signature: Kleeney Date: 8/9/03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: ..... Signature: ..... Date: ...../...../.....

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

BUNDABERG BASE Hospital / Service

Cost Centre No. [ ]

THEATRE Ward / Department

Date and Time of incident 15 / 8 / 03 [ ][ ] hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P133	Birth Date: / / .	UR Number
Ward/Department/Area: THEATRE	Medical Officer: J PATEL	
Location of Incident: OR4	Time and Date Medical Officer Notified: hours 15/8/03	
Illness/Disability: Exploratory Laparotomy	Patient Mental State before Incident: ☒ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS	
Has the patient any Debility: ☐ YES ☒ NO Specify:	Does the patient use supportive aids: ☐ YES ☒ NO Specify:	

Patient injury:	Yes	No		Yes	No
The patient Fall / Slip	☐	☐	Rails Up	☐	☐
from bed	☐	☐	Safety Restraints in use	☐	☐
from chair	☐	☐	Staff in attendance	☐	☐
in shower / bath	☐	☐	Staff in Attendance	☐	☐
in toilet	☐	☐	Staff in attendance	☐	☐
in corridor	☐	☐	Staff in attendance	☐	☐
on wet floor	☐	☐	Signs displayed	☐	☐

OTHER (SPECIFY) Potential

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes *
Internal Organs *
Multiple Locations *
& Unspecified location
* Specify location

Nature of Injury: (CIRCLE)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (CIRCLE)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other
Equipment Failure

What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other
Asset number of equipment

Medical Attention Received

First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☐ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long

How did the incident occur:

I was scrubbing for Exploratory Laparotomy and sucker stopped working. Found that Blue Sucker bottle liner had faulty valve and had to be replaced.

Name of Witness/s: (1) D GADDES Contact No.: 4502484

(2) D LEWIS Contact No.: 4502484

Reporting Person: M GOATHAM (PRINT) SIGNATURE [signature] Date: 15/8/03

Forward to Area Supervisor

(Please turn page)

QH22bis

1 of 1

Area Supervisor Investigation Report

This incident was reported to me on 15 / 8 / 07 at 1700 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☑

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

notify Steve to notify company

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: DAVID LEVINGS **Designation:** ANUM

Signature ..... Date: 15 / 8 / 07

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☑ No ☐

Further Comments: Normal procedure followed. Awaiting T/C OT re outcome

Name: Kennedy Signature: ..... Date: 20 / 8 / 07

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: ..... Signature: ..... Date: ..... / ..... / .....

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No.

BUNDABERG BASE Hospital / Service THEATRE Ward / Department

Date and Time of incident 15 / 8 / 03 0900 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P132	Birth Date: / / .	UR Number
Ward/Department/Area: THEATRE	Medical Officer: DR J PATEL	
Location of Incident: ORY	Time and Date Medical Officer Notified: hours 15803	
Illness/Disability: Lap Cholecystectomy	Patient Mental State before Incident: ☐ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS	
Has the patient any Debility: ☐ YES ☐ No Specify:	Does the patient use supportive aids: ☐ YES ☐ No Specify: N/A ✓	

Patient injury:	Yes	No		Yes	No	OTHER (SPECIFY)
the patient Fall / Slip	☐	☐	Rails Up	☐	☐	
from bed	☐	☐	Safety Restraints in use	☐	☐	
from chair	☐	☐	Staff in attendance	☐	☐	
in shower / bath	☐	☐	Staff in Attendance	☐	☐	
in toilet	☐	☐	Staff in attendance	☐	☐	
in corridor	☐	☐	Staff in attendance	☐	☐	
on wet floor	☐	☐	Signs displayed	☐	☐	

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *.....
Feet & Toes *.....
Internal Organs *.....
Multiple Locations *.....
Other & Unspecified location
* Specify location

Nature of Injury: (CIRCLE)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other Retrial — Longer Anaesthetic Time
Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other .....

What happened: (CIRCLE)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other Inappropriately packaged Faulty Equipment
What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other Faulty Equipment
Asset number of equipment failure

Medical Attention Received
First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☐ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long .....

How did the incident occur:
I was scrubbed for Lap Cholecystectomy and Co was given Right angle forceps with inappropriately wrapped with ratchet handle instead of plain. It was very difficult to assemble as inner sheath would not hold together

Name of Witness/s: (1) G Doherty Contact No.: 41502484
(2) C Dobson Contact No.: 41502484

Reporting Person: M Goatham (PRINT) SIGNATURE M Goatham Date: 15803

Forward to Area Supervisor *(Please turn page)*

QH22bis

WIVI

Area Supervisor Investigation Report

This incident was reported to me on 15/8/03 at 1100 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☒

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Notify CSSD.

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: DAVID LEVINGS **Designation:** ANUM

Signature ..... Date: 15 / 8 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: ? CSSD notify. Chief Comp re Acting APC. — Yes. CK

Name: Kennedy Signature: [signature] Date: 20 / 8 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: ..... Signature: ..... Date: ..... / ..... / .....

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

BUNDABERG BASE Hospital / Service

Cost Centre No.

Theatre Ward / Department

Date and Time of incident 15/8/03 0900 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P132	Birth Date: / / .	UR Number
Ward/Department/Area: THEATRE	Medical Officer: DR J PATEL	
Location of Incident: OR4	Time and Date Medical Officer Notified: 0900 hours 15/8/03.	
Illness/Disability: Lap Cholecystectomy	Patient Mental State before Incident: ☐ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS	
Has the patient any Debility: ☐ YES ☒ No Specify:	Does the patient use supportive aids: ☐ YES ☐ No Specify: N/A	

Patient injury:	Yes	No		Yes	No	OTHER (SPECIFY)
the patient Fall / Slip	☐	☐	Rails Up	☐	☐	
from bed	☐	☐	Safety Restraints in use	☐	☐	
from chair	☐	☐	Staff in attendance	☐	☐	
in shower / bath	☐	☐	Staff in Attendance	☐	☐	
in toilet	☐	☐	Staff in attendance	☐	☐	
in corridor	☐	☐	Staff in attendance	☐	☐	
on wet floor	☐	☐	Signs displayed	☐	☐	

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes *
Internal Organs *
Multiple Locations *
& Unspecified location
* specify location

Nature of Injury: (CIRCLE)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other Potential Anal - longer anaesthetic time - ?

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (CIRCLE)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other Faulty Equipment / Failure

What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other Faulty equipment
Asset number of equipment

Medical Attention Received

First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☐ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long .....

How did the incident occur:

I was ambobed for Lap Cholecystectomy and needed 10mm lap Sucker to get gall stones out of abdominal cavity that had spilled from gallbladder - Noted screw missing from sucker so could not suck properly. No other large sucker available to use

Name of Witness/s: (1) G Doherty Contact No.: 41502484

(2) C Dobson Contact No: 41502484

Reporting Person: M Goatham (PRINT) SIGNATURE ..... Date: 15/8/03

Forward to Area Supervisor

(Please turn page)

Area Supervisor Investigation Report

This incident was reported to me on 15/8/03 at 1170 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☑

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Instrument taken out & sent for repair

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: DAVID LEVINGS **Designation:** AWUM

Signature ..... Date: 15 / 8 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: NIL.

Name: Kennedy Signature: ..... Date: 20 / 8 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: ..... Signature: ..... Date: ..... / ..... / .....

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No.

BUNDABERG BASE Hospital / Service — THEATRE Ward / Department

Date and Time of incident 19 / 8 / 03 1730 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P135	Birth Date:	UR Number
Ward/Department/Area: THEATRE	Medical Officer: DR J PATEL	
Location of Incident: OR3	Time and Date Medical Officer Notified: 1730 hours 19/8/03	
Illness/Disability: Lap Cholacystectomy	Patient Mental State before Incident: ☐ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS	
Has the patient any Debility: ☐ YES ☐ NO Specify:	Does the patient use supportive aids: ☐ YES ☑ NO Specify:	

Patient injury:	Yes	No		Yes	No	OTHER (SPECIFY)
Did the patient Fall / Slip	☐	☐	Rails Up	☐	☐	EQUIPMENT
from bed	☐	☐	Safety Restraints in use	☐	☐	FAILURE
from chair	☐	☐	Staff in attendance	☐	☐	
in shower / bath	☐	☐	Staff in Attendance	☐	☐	
in toilet	☐	☐	Staff in attendance	☐	☐	
in corridor	☐	☐	Staff in attendance	☐	☐	
on wet floor	☐	☐	Signs displayed	☐	☐	

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes *
Internal Organs * CALL BUNDY
Multiple Locations *
Other & Unspecified location
* Specify location

Nature of Injury: (CIRCLE)
Fracture — Dislocation
Sprain — Concussion
Internal Injury — Laceration
Superficial — Skin Tear
Foreign Body — Burns
Poisoning — Electrocution
Other

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (CIRCLE)
Fall — Slip/Trip
Contact With — Struck
Electrical — Heat / Cold
Abuse — Other FAILED EQUIPMENT

What did person come into contact with:
Power Equipment — Hand Equipment
Chemicals — Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other FAILED EQUIPMENT
Asset number of equipment

Medical Attention Received

First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☑ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long

How did the incident occur:

I was scrubbed for Lap Cholecystectomy and needed to reload the multifire Ligaclipper. The handle jammed and I was unable to reload or use the ligaclipper again

Name of Witness/s: (1) K ZWOLAK Contact No.: 41502484

(2) A BARTHOLDT Contact No.: 41502484

Reporting Person: M GOATHAM (PRINT) SIGNATURE Date: 19/8/03

Forward to Area Supervisor

(Please turn page)

Area Supervisor Investigation Report

This incident was reported to me on 20 / 8 / 03 at 0900 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

N/A

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☑

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?

(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Instrument has been replaced + top coming 1/52 to inservice personnel

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: DAVID LEVINGS **Designation:** ANUM

Signature ..... Date: 20 / 8 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☑ No ☐

Further Comments: Nil

Name: Kennedy Signature: ..... Date: 20 / 8 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: ..... Signature: ..... Date: ..... / ..... / .....

LIK16

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No. 630410

Burnside Hospital / Service — Theatre Ward / Department

Date and Time of incident 14/5/03 13 43 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P74	Birth Date:	UR Number
Ward/Department/Area: Theatre	Medical Officer: Dr. Patel.	
Location of Incident: Scope Room	Time and Date Medical Officer Notified: 1400 hours 14/5/03	
Illness/Disability:	Patient Mental State before Incident: ☐ Anaesthetised ☑ Orientated ☐ Disorientated ☐ Aggressive ☐ Unconscious	
Has the patient any Debility: ☐ Yes ☑ No Specify:	Does the patient use supportive aids: ☐ Yes ☑ No Specify:	

Patient injury:	Yes	No		Yes	No
Did the patient Fall / Slip	☐	☐	Rails Up	☐	☐
from bed	☐	☐	Safety Restraints in use	☐	☐
from chair	☐	☐	Staff in attendance	☐	☐
in shower / bath	☐	☐	Staff in Attendance	☐	☐
in toilet	☐	☐	Staff in attendance	☐	☐
in corridor	☐	☐	Staff in attendance	☐	☐
on wet floor	☐	☐	Signs displayed	☐	☐

Other (Specify)
Specialist Procedure performed on incorrect patient

Part of Body Injured: (Circle)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes *
Internal Organs *
Multiple Locations *
Other & Unspecified location
* Specify location

Nature of Injury: (Circle)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (Circle)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other

What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other
Asset number of equipment

Medical Attention Received
First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☑ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes (No) How long

How did the incident occur:
Directed to bed by DSU staff as first name was P74 as was the name of the pt first on operative list had the right chart but wrong patient. Procedure of OGD performed on wrong patient

Name of Witness/s: (1) M Hall Nurse Contact No.: x2407

(2) M. Goatham M. GOATHAM Contact No.: 2484

Reporting Person: Jane Edgar. (PRINT) SIGNATURE Date: 14/5/03.

Forward to Area Supervisor

(Please turn page)

QH22bis

Area Supervisor Investigation Report

This incident was reported to me on 14 / 7 / 03 at 1402 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

Normally endoscopy patients wait in chairs in DSU, RN Eager was directed to pt in bed by DSU staff without a nurse/RN present. When she spoke to pt, calling him P74 he responded as his name is also P74 but did not query RN Eager as she walked with him to the stage room. Patients ID arm band was not checked by anaesthetist or surgeon, before commencing procedure.

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☐

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Review of checking and accepting patients into the endoscopy room and team theatres, Unit meeting discussions

Property Damage / Lost — Replacement / Repair Cost $ —

Reported to Police: Yes ☐ No ☐ — (If yes) Police Officer's Name:

Report Number. Time/Date reported:

AREA SUPERVISOR'S NAME: Jennifer White Designation: NUM

Signature Jennifer White Date: 14 / 5 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: this incident should not have happened. Staff instructed to investigate fully, hence the Incident Report

Typed

Name: Kennedy Signature: C Kennedy Date: 27 / 5 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: Signature: Date: / /

Mra G. Goodman

Director of Nursing.

Jennifer White.

NPC Theatre

14.07.03

Dear Mrs Goodman,

Today Wednesday 14th May at 1405hrs I was notified that Dr Kingston's patient P74 underwent a Gastroscopy by Dr Patel by mistake.

P74 was booked second on Dr Kingston's list for a right epididymectomy, P370 was booked first on Dr Patel's list for a gastroscopy. CN J Peterson, RN's M Goatham and J Edgar were allocated to work in the endoscopy room for Dr Patel's list.

RN J Edgar went to DSU to collect the first patient for the list. Normally endoscopy patients wait in chairs in DSU. RN J Edgar was directed to the patient in a bed by an RN from DSU without a nursing handover as all the staff were at lunch. When she greeted the patient, he responded,and did not query RN Edgar when she walked with him to the endoscopy room. The patient underwent a gastroscopy without the anaesthetist or surgeon checking his ID band,realising it was the wrong patient.

Following the procedure the patient was transferred to recovery for observation. The mistake was realised when the staff in Dr Kingston's theatre called the dresser to collect their second patient ie. P74 . A/CN F Keys RN's C Dobson and D Gaddes were working in that theatre.

Following discussions between P74 Dr Kingston and Dr Patel, P74 underwent the correct procedure. RN J Edgar completed an incident form.Further discussions will be taking place between Theatre and DSU staff to identify how the mistake happened and prevent re-occurrence.

Yours sincerely

Jennifer White

LIKIT

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No. 63041030

Busselton Hospital / Service Operating Theatre Ward / Department

Date and Time of incident 9 / 5 / 03 1530 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P137	Birth Date:	UR Number
Ward/Department/Area: THEATRE	Medical Officer:	
Location of Incident: O.T. 4	Time and Date Medical Officer Notified: 1530 hours 9/5/03	
Illness/Disability: 1 Ruptured Spleen	Patient Mental State before Incident: ☑ ANAESTHETISED ☐ ORIENTATED ☐ DISORIENTATED ☐ AGGRESSIVE ☐ UNCONSCIOUS	
Has the patient any Debility: ☐ YES ☐ No Specify:	Does the patient use supportive aids: ☐ YES ☑ No Specify:	

Patient Injury:	Yes	No		Yes	No
I the patient Fall / Slip	☐	☑	Rails Up	☐	☐
from bed	☐	☐	Safety Restraints in use	☐	☐
from chair	☐	☐	Staff in attendance	☐	☐
in shower / bath	☐	☐	Staff in Attendance	☐	☐
in toilet	☐	☐	Staff in attendance	☐	☐
in corridor	☐	☐	Staff in attendance	☐	☐
on wet floor	☐	☐	Signs displayed	☐	☐

OTHER (SPECIFY)
Traumatic needle broken off, left inside abdomen

Part of Body Injured: (CIRCLE)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes *
Internal Organs *
Multiple Locations *
Other & Unspecified location
* Specify location

Nature of Injury: (CIRCLE)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (CIRCLE)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other Needle
Broke off injury

What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other
Asset number of equipment

Medical Attention Received
First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☑ Other ☑

Has this incident caused the patient a longer stay as inpatient? Yes/No How long

How did the incident occur:
Whilst oversewing splenic vessels traumatic needle broke - left inside patient as deemed unsafe to retrieve retrieve as patient haemodynamically unstable at the time.

Name of Witness/s: (1) J Patel Contact No.: 4150 2484

(2) Albert van Zanten RN Contact No.: 4154426

Reporting Person: GAIL DOHERTY (PRINT) SIGNATURE Date: 9/1/03

Forward to Area Supervisor

(Please turn page)

QH22bis

Area Supervisor Investigation Report

This incident was reported to me on 9 / 5 / 03 at 1535 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

See attached

What unforeseen hazard/s contributed:

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☑

ENVIRONMENTAL / PERSONAL FACTORS THAT CONTRIBUTED TOWARDS THE ACCIDENT

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other............	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?
(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

CN G. Doherty suggested pt be X-rayed Dr Patel declined due to patients unstable condition

Property Damage / Lost — **Replacement / Repair Cost $** —

Reported to Police: Yes ☐ No ☑ (If yes) **Police Officer's Name:**

Report Number. — **Time/Date reported:**

AREA SUPERVISOR'S NAME: [illegible] **Designation:** NPC

Signature [signature] Date: 13 / 5 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: Unfortunate incident but understandable [illegible]

Name: [illegible] Signature: [signature] Date: 20 / 5 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

Name: .... Signature: .... Date: ...... / ...... / ......

BUNDABERG HOSPITAL SEX UR NO

P137

HOSPITAL OPERATION REPORT

DATE: 09.05.03

START: 14.44 FINISH:

(Label Here)

TOURNIQUET TIME ON OFF

SURGEON/ASSISTANT PATEL / IGRAS / COLEMAN

ANAESTHETIST EDWARDS / CARTER G.A ☐ L.A. ☐

DIAGNOSIS & OPERATION PERFORMED

DELAYED SPLENIC RUPTURE POST LAP ADRENALECTOMY

DETAILS OF OPERATION (including FINDINGS, PROCEDURES, CLOSURE)

betadine prep & drape before induction

laparotomy

finding: ? large volume intraperitoneal blood with clot.

lacerated spleen with active bleed from pedicle vessels.

avascular tissue ? spleen adherent to small bowel in lower abdo

blood & clot evacuated & abdo packed to provide haemostasis to allow volume replacement.

packs removed

splenectomy

ligaclip to short gastric vessels

2-0 Dexon - ties to splenic A.

2-0 Dexon stitch & running bleeding vessels

+ broken needle could not be retrieved when stitching bleeding splenic vessels - unsafe to dissect into pelvis to retrieve needle.

∴ left in situ.

warmed saline wash

MR73a

OPERATION REPORT (cont.)

closure [illegible] layers
[illegible] monofil to [illegible] layers / rectus
sheath.
clips to skin

DRAINS, TUBES, CATHETERS, GAUZE etc.	REMOVED BY	CHECKED BY	DATE AND TIME
1. Bellovac FG18/6.0mm			
2.			
3.			
4.			

POST-OPERATIVE ORDERS

Investigations X-RAY ☐ LAB ☐ Specimen to Pathology TISSUE ☐ CULTURE ☐

Drugs as per medication chart ☐ I.V. fluids as per I.V. therapy chart ☐

Observations and Orders ICU
IV A/B - 48h
NBM
NG [illegible] drainage.

Details of count-items	Before operation	Added during operation							First count				Final count
SPONGES	10	5	5	5	10	5	5	5	50	5			55
SWABS	5								5				5
PEANUT SWABS Sticks	3								3				3
HAEMOSTATS	10								10				10
HAEMOSTATS–Long	10								10				10
CLAMPS / Blades	1/2								/2				1/2
TOWEL CLIPS	6								To show				6
Roberts / Right angles	2/2	2/							4/2				4/2
Tissue forceps	10								10				10
NEEDLES													
NEEDLES–Atraumatic		3	2	1	2	2		1	10				10

INITIAL TO INDICATE CORRECT FINAL CHECK OF OTHER INSTRUMENTS

SIGNATURES [illegible] (SLOW [illegible]) FIRST COUNT: 10 needles: [illegible] Fuschia [illegible]
SECOND COUNT: 10 needles: [illegible] [illegible]

Theatre Sister [signature] (DOHERTY) SCRUB Surgeon [signature]

W 265—Govt. Printer, Qld.

L/K18

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

B'Berg Base Hospital / Service

Cost Centre No. ____ Surgical Ward / Department

Date and Time of incident 1 / 6 / 03 1600 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P28	Birth Date: / UR Number
Ward/Department/Area: Surgical.	Medical Officer: DR PATEL
Location of Incident: NURSES ST.	Time and Date Medical Officer Notified: 1600 hours 1/6/03
Illness/Disability:	Patient Mental State before Incident: ☐ Anaesthetised ☑ Orientated ☐ Disorientated ☐ Aggressive ☐ Unconscious
Has the patient any Debility: ☐ Yes ☑ No Specify:	Does the patient use supportive aids: ☐ Yes ☑ No Specify:

Patient injury:	Yes	No		Yes	No
Did the patient Fall / Slip	☐	☐	Rails Up	☐	☐
from bed	☐	☐	Safety Restraints in use	☐	☐
from chair	☐	☐	Staff in attendance	☐	☐
in shower / bath	☐	☐	Staff in Attendance	☐	☐
in toilet	☐	☐	Staff in attendance	☐	☐
in corridor	☐	☐	Staff in attendance	☐	☐
on wet floor	☐	☐	Signs displayed	☐	☐

Other (Specify) .....

Part of Body Injured: (Circle)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *.....
Feet & Toes *.....
Internal Organs *.....
Multiple Locations *.....
Other & Unspecified location
* Specify location

Nature of Injury: (Circle)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other.....

Nature of Disease:
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other .....

What happened: (Circle)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other .....

What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other .....
Asset number of equipment .....

Medical Attention Received
First Aid ☐ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☐ Other ☐

~~Has this incident caused~~ the patient a longer stay as inpatient? Yes/No How long .....

How did the incident occur:
DR PATEL R/V THIS PT. ON R/V CHARTS, PR NOTICED NO REPORTS OF URINE OUTPUT (PT distended) + ASKED FOR INCIDENT FORM TO BE FILLED RE: THIS (NO NOTIFYING OF ON CALL RE: NO OUTPUT)
See pt's notes.

Name of Witness/s: (1) DEL ROSS (ACN) Contact No.: 41502330.

(2) ..... Contact No.: .....

Reporting Person: Lucinda Keene (PRINT) SIGNATURE Lkeene Date: 1/6/03

Forward to Area Supervisor

(Please turn page)

QH22bis

WM

Area Supervisor Investigation Report

This incident was reported to me on 2 / 6 / 03 at 0700 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

• Pt status Re HNPU as per previous page.

What unforeseen hazard/s contributed:

N/A

Probable recurrence rate within Department: Frequent ☐ Occasional ☐ Rare ☐ N/A

ENVIRONMENTAL / PERSONAL FACTORS THAT CONTRIBUTED TOWARDS THE ACCIDENT

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other............	

N/A

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?

(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

. R.N. who was allocated to pt on Sun 1/6 stated pt passed urine in toilet in AM. was not commenced on FBC until after IV1 commenced.

Property Damage / Lost .... **Replacement / Repair Cost $** ....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** ....

Report Number. .... **Time/Date reported:** ....

AREA SUPERVISOR'S NAME: .... **Designation:** ....

Signature .... [signature] Date: 2 / 6 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: Agree to AS's R/

Name: Kennedy Signature: [signature] Date: 2 / 6 / 03

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

....

....

Name: .... Signature: .... Date: .... / .... / ....

LTR14

PATIENT | CLIENT | ACCIDENT / INCIDENT REPORT

Cost Centre No.

BUNDABERG Hospital / Service — THEATRE Ward / Department

Date and Time of incident 18 / 7 / 03 08 35 hours

Please tick appropriate boxes ***(Lodge within 24 hours of incident)***

Patient Name: P150	Birth Date:	UR Number
Ward/Department/Area: THEATRE.	Medical Officer: DR PATEL.	
Location of Incident: OR 4	Time and Date Medical Officer Notified: 0850 hours 18 / 7 / 03	
Illness/Disability: —	Patient Mental State before Incident: ☑ Anaesthetised ☐ Orientated ☐ Disorientated ☐ Aggressive ☐ Unconscious	
Has the patient any Debility: ☐ Yes ☑ No Specify:	Does the patient use supportive aids: ☐ Yes ☐ No Specify:	

Patient injury:	Yes	No		Yes	N/A
Did the patient Fall / Slip	☐	☑	Rails Up	☐	☑
from bed	☐	☑	Safety Restraints in use	☐	☑
from chair	☐	☑	Staff in attendance	☐	☑
in shower / bath	☐	☑	Staff in Attendance	☐	☑
in toilet	☐	☑	Staff in attendance	☐	☐
in corridor	☐	☑	Staff in attendance	☐	☐
on wet floor	☐	☑	Signs displayed	☐	☐

Other (Specify): TOWEL CLIP APPLIED TO SKIN R) ~~SHOULDER~~ AXILLA. AXILLARY

Part of Body Injured: (Circle)
Eyes Left/Right
Ears Left/Right
Face / Nose / Mouth
Head
Neck
Back
Trunk
Shoulders & Arms Left/Right
Hands & Fingers *
Feet & Toes * R) AXILLARY
Internal Organs * AREA
Multiple Locations *
Other & Unspecified location
* Specify location

Nature of Injury: (Circle)
Fracture Dislocation
Sprain Concussion
Internal Injury Laceration
Superficial Skin Tear
Foreign Body Burns
Poisoning Electrocution
Other SKIN PINCHED IN
Nature of Disease: TOWEL CLIP.
Eye disorders
Dermatitis
Infectious diseases
Mental disorders
Other

What happened: (Circle)
Fall Slip/Trip
Contact With Struck
Electrical Heat / Cold
Abuse Other
SKIN CAUGHT IN TOWEL CLIP
What did person come into contact with:
Power Equipment Hand Equipment
Chemicals Outdoor Environm.
Indoor Environment
Patient / Visitor / Staff
Body Fluids
Vehicle Accident
Other
Asset number of equipment

Medical Attention Received
First Aid ☑ Obs. Taken ☐ Private Doctor ☐ Hospital Doctor ☑ Other ☐

Has this incident caused the patient a longer stay as inpatient? Yes/No How long

How did the incident occur:
WHILE APPLYING TOWEL CLIP TO DRAPE, DR PATEL INADVERTANTLY CLIPPED PT. SKIN.

Name of Witness/s: (1) JANICE LARSEN Contact No.: 41502450
(2) FRANCES KEYS Contact No.: 41502450

Reporting Person: JANICE LARSEN (PRINT) SIGNATURE Jan L Date: 18 / 7 / 03

Forward to Area Supervisor

(Please turn page)

QH22bis

Area Supervisor Investigation Report

This incident was reported to me on 14 / 7 / 03 at 0900 hours

What sequence of circumstances contributed to incident: (What happened prior to accident)

.....

.....

.....

.....

What unforeseen hazard/s contributed:

.....

.....

.....

.....

Probable recurrence rate within Department: Frequent ☐ Occasional ☑ Rare ☐

Environmental / Personal Factors That Contributed Towards The Accident

Nil	☐	Language Problems	☐	Safety Precautions	☐
Alcohol or Drugs	☐	Lighting	☐	Slow Reaction	☐
Emotional Problem	☐	Misconduct	☐	Temperature	☐
Moisture	☐	Lack of Understanding	☐	Personal Protective Equipment	☐
Ventilation	☐	Housekeeping	☐	Warning Systems	☐
Physical Handicap	☐	Work Area Layout	☐	Lack of Supervision	☐
Plant & Equipment-Maintenance	☐	Works Practices	☐	Other.....	

Outcome

WHAT ACTION HAS BEEN TAKEN TO PREVENT A RECURRENCE OF THIS TYPE OF ACCIDENT?

(It is the responsibility of Management to take appropriate action to prevent a recurrence of accidents.)

Discussion with staff regarding importance of ensuring hoses always do not cross the path.

Property Damage / Lost ..... **Replacement / Repair Cost $** .....

Reported to Police: Yes ☐ No ☐ (If yes) **Police Officer's Name:** .....

Report Number. ..... **Time/Date reported:** .....

AREA SUPERVISOR'S NAME: [illegible] **Designation:** [illegible]

Signature ..... Date: 15 / 7 / 03

FORWARD TO DEPARTMENT HEAD

Department Head's report:

Have corrective action/s been implemented? Yes ☐ No ☐

Further Comments: .....

.....

.....

Name: ..... Signature: ..... Date: ..... / ..... / .....

FORWARD TO HEALTH AND SAFETY OFFICER

Health and Safety Officer's Comments:

.....

.....

Name: ..... Signature: ..... Date: ..... / ..... / .....

Queensland Government
Queensland Health

LIKAU

Bundaberg Health Service District
Accident/Incident Report Form

Facility: BUNDABERG BASE
Unit/Department: SURGICAL
Patient Name: P306
UR Number
Principle Diagnosis: POST HARTMAN'S
Location of Incident: XRAY.
Time of Incident:
Mental State: ☑Orientated ☐Anaesthetised ☐Disoriented ☐Aggressive ☐Unconscious

Does the patient have any disability? (Specify) NO
Does the patient use supportive aids? (Specify) NO.

Patient Injury	Yes	No		Yes	No
Did the patient fall/slip	☐	☐	Rails up	☐	☐
From bed	☐	☐	Safety restraints	☐	☐
From chair	☐	☐	Staff in attendance	☐	☐
In shower/bath	☐	☐	Staff in attendance	☐	☐
In toilet	☐	☐	Staff in attendance	☐	☐
In corridor	☐	☐	Staff in attendance	☐	☐
On wet floor	☐	☐	Signs displayed	☐	☐

Other: (Specify) INTRODUCER/CANNULA FOR PIG TAIL CATHETER LEFT IN PATIENT FOUND IN PATIENT DURING REMOVAL OF CATHETER

Part of Body Injured:
- θ Eyes
- θ Ears
- θ Face
- θ Head
- θ Neck
- θ Back
- θ Trunk
- θ Shoulders & arms
- θ Hands & fingers
- θ Feet & toes
- θ Internal organs
- θ Multiple locations
- ☑ Other and unspecified location — ABDOMEN

Nature of Injury:
- θ Fracture
- θ Sprain
- θ Internal injury
- θ Superficial
- θ Foreign body
- θ Poisoning
- θ Dislocation
- θ Concussion
- θ Laceration
- θ Skin tear
- θ Burns
- θ Electrocution
- ☑ Other: PAIN ON REMOVAL

Nature of Disease:
- θ Eye disorders
- θ Dermatitis
- θ Infectious diseases
- θ Mental disorders
- θ Other:

Agency of Injury/disease:
- θ Fall
- θ Contact with
- θ Slip/trip
- θ Electrical
- θ Abuse
- θ Struck
- θ Heat/cold
- θ Other:

Breakdown agency:
- θ Power equipment
- θ Chemicals
- θ Indoor environment
- θ Patient/ visitor/ staff
- θ Body fluids
- θ Vehicle accident
- θ Hand equipment
- θ Outdoor environment
- θ ~~Other~~ PROCEDURE

Medical attention received:
☐ First Aid ☐ Obs taken ☐ Private Doctor ☑ Hospital Doctor ☐ Other

Name of Medical Officer: PATEL/RADIOLOGIST
Time & date Medical Officer notified: 10.00 19/1/04

Describe the incident: whilst removing catheter CN Merchant saw blue object in side of ~~catheter~~, Probe of [illegible] proved object there Dr Patel advised & he removed cannula/introducer & forceps

Witness details: Name: J MARKMAN Position: CN Phone Number: 2330
Reporting Person Name: [signature] Signature: D TRAKLIN Date: 19/1/04

Please forward this form to Department Head

Area Supervisor Report:
Date and Time incident reported: self reported.

What sequence of circumstances contributed to the incident?
As described

What unforseen hazards contributed? ~~during procedure~~ Failure to remove catheter/introducer ~~following~~ insertion of Catheter – appropriate site.

Probable recurrence rate within the department: ☐ Frequent ☐ Occasional ☑ Rare

Where there any environmental/personal factors that contributed towards the incident? (Specify)
Nil identified

Outcome – What action has been taken to prevent a recurrence of this type of incident?
Xray. manager advised re incident

Reported to police: ☐ Yes ☐ No
Police Officer's Name:
Report Number:

HOD Name: D TRAKLIN Signature: [signature] Date: 19/1/04

Forward to ADON/WHSO

ADON/WHSO comments:
Referred to A/DMS to ask Dr Patel to see pt & explain happening

Name: Kennedy Signature: [signature] Date: 19.1.04

Temporary Incident report form for use until February 2004

D/E Dr [illegible] — this has been done Carlos

From: Kees Nydam
To: Carolyn Kennedy
Date: 20/01/2004 4:04pm
Subject: Re: Incident

Carolyn

I have spoken to Di and she informs me that Dr Patel went back and apologised last night.

Kees

Dr Kees Nydam

>>> Carolyn Kennedy 01/19/04 01:03pm >>>

Dear Kees,

Di Jenkin (Surg Wd) asked me to pass on to you details of an incident which occurred on her ward today. Jeroen Meerman was told to remove a catheter from a pt's abdo and on doing so noticed something blue in a separate stab wound. Dr Patel arrived at this time and proceeded to remove the object which turned out to be a cannula/ introducer which should have been removed at the time the cath was inserted.

The patient suffered quite a lot of pain as Dr Patel removed the object and Di would like Dr Patel to see the patient again and explain what happened and offer an apology. Apparently this lady has had several upsets since being in hospital and is very fragile at the moment.

I will send the incident report up.

Thank you

Carolyn

Carolyn Kennedy ADON
Nursing Admin
Base Hospital
BUNDABERG. 4670
Ext. 2254

19 January 2004

Carolyn Kennedy,

In response to the accident/incident report form dated 19/01/ 04, P306

Medical imaging acknowledges the incident occurred in our department. Unfortunately I have no control over the action of medical staff. Our staff are here to assist the hospital doctors.
There was no radiologist present at the time.

Bryan Williams

LTR21

From: Peter Leck
To: Raven, Leonie
Date: 21/10/2004 9:09:15
Subject: Re: Adverse Event forms

Thanks

Peter

>>> Leonie Raven 21/10/2004 9:07:33 >>>

Hi Peter

There was never a report put in for this perforated bowel incidence.

Found the great long letter that Toni wrote about ventilated patients, and one incident about a wound breakdown but the doctor involved is not named.

That's about all we have

>>> Peter Leck 5:17:03 pm 20/10/2004 >>>

Leonie,

Can you please see me urgently relating to any adverse events concerning Dr Jay Patel.

Thanks

Peter

LTR22

From: Peter Leck
To: Raven, Leonie
Date: 21/10/2004 9:11:34
Subject: Hi Leonie,

Hi Leonie,

Can you please see me and bring the letter re the ventilated patients.

Thanks

Peter