Critical Incidents Reported to Manitoba Health

Period: July 01, 2018 - September 30, 2018

Fiscal Year Occurred	Degree of Injury	Description
2018/19	Major	Resident with progressive neuromuscular disease admitted to PCH for respite. Staff determined that the resident could not be positioned properly in their motorized wheelchair with their mechanical lift so that they could use their head controls independently. Staff were moving the resident around the facility using the head controls. While exiting the facility, staff lost control of the wheelchair. The chair crashed into electric doors knocking the doors off the track.The resident's leg was pinned. Fractured tibia/fibula. Awaiting orthopedic consultation.
2018/19	Major	A patient received treatment, including laboratory tests, for an acute condition. Miscommunication of critical test results led to a delay in diagnosis and treatment resulting in a need for critical care intervention.
2018/19	Major	Patient recently discharged from hospital presented to the Emergency Department multiple times with concerns regarding risk of falls and living conditions. Had an unwitnessed fall. Fractured left femur. Admitted to unit with failure to cope and dementia. Falls risk assessment completed identified patient as high risk for falls. No documented falls prevention plan.
2018/19	Major	Patient with contractures to their hand developed Stage 4 pressure injury to fingers on both hands. Wound to thumb infected and abcessed. Required surgical debridement.
2018/19	Major	Inpatient on a mental health unit received Methadone as part of their morning medication. Patient was found outside the facility with unconsicous, floppy uncoordinated movements, pinpoint pupils and slow shallow respirations. Brought to the Emergency Department. It was determined that the patient received ten times the ordered dose of Methadone. Naloxone administered multiple times during six hour ED stay. On return to the mental health unit, found to require additional Naloxone due to continued respiratory depression.
2018/19	Major	PCH resident, independently mobile, had an unwitnessed fall. Found in the floor in the hallway. Co-resident was kicking the resident's side as she laid on the floor. Fractured hip. Surgical repair completed. Given the history of both residents, it is thought that the resident was pushed to the floor by the co-resident.
2018/19	Death	A post-surgical patient required feeding through a tube inserted into the stomach. After several days it was noted that the feeding tube was no longer in the correct position requiring additional surgical intervention.
2018/19	Death	A patient with an acute cardiac condition experienced a change in their heart rhythm that was not immediately recognized and treated leading to a need for intensive intervention and admission to critical care.
2018/19	Major	PCH resident wheelchair bound requested to go outside with staff assistance. Resident leaned forward in chair normally. Did not require use of any wheelchair restraint. Wheelchair was pushed forward facing out the door. Fell forward out of the chair to the ground. Fractured tibia. Patient is not a surgical candidate. Requires one month of bedrest.
2018/19	Death	A patient experienced an out of hospital traumatic injury and emergency medical services were deployed. There was a delay in recognizing the severity of the patients injuries and need for transfer to a trauma center for urgent intervention.
2018/19	Death	A patient was admitted to an acute mental health unit for treatment following a suicide attempt. The patient died by suicide while on the unit.
2018/19	Major	A labouring mother experienced a prolonged labour with signs of fetal distress that were not recognized by the care team leading to the need for fetal resuscitation and admission to critical care.
2018/19	Death	Patient had unwitnessed fall. Found lying on the floor. Large pool of blood at face and under head. CT scan shows acute subdural hematoma. Fractured nose. Fractured maxilla. Died the following day. Fall was believed to have been preventable.
2018/19	Death	A patient was noted to be missing from the patient care area. Procedures to alert all staff and security to look for the patient were not initiated. The patient was later found deceased.

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2018/19	Major	A patient experienced a skin injury associated with a cast. The opportunity to regularly assess the patients skin during care visits was not realized and mitigation strategies to reduce the risk were not implemented
2018/19	Major	A patient was not referred to the Blood Marrow Transplant clinic at the appropriate time in their cancer treatment. The delay in referral resulted in the patient missing the window for being a candidate for transplant.
2018/19	Major	A patient experienced skin breakdown after admission to hospital. Strategies to decrease the risk of skin injury were not initiated at the time of admission.
2018/19	Major	A patient experienced skin breakdown. Regular skin assessments were not documented and interventions to prevent further skin injury were not initiated.
2018/19	Major	Patient discharged home from rehabilitation unit at rural hospital with Stage 2 pressure injury to the buttocks. Home Care Services were in place. The wound deteriorated over time under the provision of services. Patient was re-admitted to hospital for further wound care management three weeks later.
2018/19	Major	A patient with an acute injury and was assessed in the emergency room, treated and discharged. The patient returned to the ER and was later diagnosed with an acute problem requiring surgical intervention. The opportunity to have identified the acute problem at the initial ER visit was not realized.
2018/19	Death	A patient required urgent treatment with an intravenous medication. The dose of the medication was miscalculated and the patient received more medication than intended. The patient experienced a cardiac arrest and efforts to resuscitate the patient were unsuccessful.
2018/19	Major	PCH resident developed a pressure injury. Wound progressed to Stage 3 despite treatment. Resident developed signs of sepsis. Transferred to Nursing Station for assessment and ultimately to tertiary care centre. Upon admission to tertiary centre it was noted pressure injury had progressed to unstageable.
2018/19	Unknown	Patient treated in 2016 for melanoma. Bilateral axillary lymph node dissections in 2018 found lymph node involvement in both axilla.
2018/19	Death	A patient experienced a traumatic injury and was taken to hospital. Recognition of diagnostic information and consultation to specialty services did not take place. The patient’s condition deteriorated requiring critical intervention and intensive care.
2018/19	Major	PCH resident experiencing constipation. While sitting up on the commode, an enema was administered. Resident had rectal pain and bleeding immediately following. Discomfort increasing so transferred back to bed. Over the next two days, increasing rectal pain and constipation. Transferred to acute care where rectal perforation confirmed. Cancerous lesion detected. Required bowel resection with colostomy and extended hospital stay.
2018/19	Death	Patient was noted to be absent from their room and found in the courtyard below the room’s window. It is unknown if the fall from the window was accidental or intentional
2018/19	Major	There was a delay in obtaining a specialized mattress for a patient who was high risk for skin injuries. The delay resulted in worsening of existing skin wounds.
2018/19	Death	A wheelchair bound patient was found on the floor several feet away from their wheelchair. There were no concerning findings on the patient's initial post fall assessment. Patient was able to weight bear with assistance and sit in wheelchair without complaints of pain. No obvious deformity seen. A few hours later, wincing in pain. Transferred to Emergency Department where fractured hip confirmed. Non operative management of fracture suggested. Advanced care plan changed to comfort care. Died five days later.
2018/19	Death	A patient experienced symptoms of a serious infection that were not recognized by the care team. The patient’s condition deteriorated resulting in the need for admission to the intensive care unit.
2018/19	Major	PCH resident was given a cup of hot tea. Tea spilled on the right side of the body burning right side of abdomen, hip and leg. Extensive ongoing treatment required to burn wounds.
2018/19	Death	A patient was treated for an acute medical condition that required regular follow-up. Follow-up appointments with diagnostic testing did not occur resulting in an unrecognized worsening of the patient’s disease.
2018/19	Major	A patient had surgery to repair a broken bone. Post-operative complications were not recognized and permanent impairment occurred to the limb.

Fiscal Year Occurred	Degree of Injury	Description
2018/19	Major	Patient experienced delay in diagnosis and treatment of cancer.