# Critical Incidents Reported to Manitoba Health

**Period: October 01, 2018 - December 31, 2018**

| Fiscal Year Occurred | Degree of Injury | Description |
|---|---|---|
| 2018/19 | Major | A patient presented to the ED with medical concerns. The patient experienced a fall that resulted in a broken bone. The opportunity to establish fall prevention strategies was not realized. |
| 2018/19 | Major | A patient received an invasive procedure that was not indicated for the patients condition. |
| 2018/19 | Major | Treatment for a skin condition was provided, however, expert consultation was not sought resulting in a misdiagnosis of the problem and delay in appropriate treatment. |
| 2018/19 | Major | A patient presented to an ER with concerns of vertigo and weakness. The patient fell resulting in a serious head injury. |
| 2018/19 | Death | A client presented with an acute medical condition and, after assessment, was discharged home with follow-up to community services. The opportunity to immediately consult expert medical services to assess the patients risk was not realized. |
| 2018/19 | Death | Unstable infant transported emergently via ground ambulance to Children's Hospital. Air transport was not available. On arrival, infant had a cardiac arrest. Difficult intubation. Admission to Pediatric Intensive Care Unit. Treatment was later withdrawn and infant died. |
| 2018/19 | Major | PCH resident fell in the hallway. Fractured hip. |
| 2018/19 | Death | An in-patient on a medical unit experienced a change in their medical status. Protocols for immediate treatment and intervention were not initiated. |
| 2018/19 | Death | Unstable premature infant required emergent transport to Children's Hospital. Life-flight declined and land ambulance transfer arranged. Infant underwent surgery for bowel obstruction the same day. Infant died the following day. |
| 2018/19 | Major | Patient had colonoscopy in 2013. Repeat colonoscopy was to be done in 2016. Colonoscopy was not repeated until 2018. Patient required hemicolectomy due to delay in cancer diagnosis. |
| 2018/19 | Major | PCH resident pushed by co-resident. Fell to the floor. Fractured hip. Died two days later. |
| 2018/19 | Major | During emergency procedure a miscalculation occurred resulting in an overdose of a medication. The patient deteriorated and required resuscitation. |
| 2018/19 | Death | Patient presented to Emergency Department with chest pain. A witnessed cardiac arrest occurred. Successful resuscitation. Vital signs supported with medication. Discussion regarding transfer to a high level of care. Indicated that transfer via STARS needed. STARS arrived almost 2 hours later without a physician on board. STARS personnel removed combitube. Unable to intubate on first attempt. Successful intubation 6 minutes later. When patient condition deteriorated, consultation with STARS physician. Decision made to transport via ground ambulance Patient died on arrival to transfer destination. |
| 2018/19 | Major | Patient was being transported by staff in a wheelchair without foot pedals. While being transported, the resident's feet dropped to the floor. The wheelchair was being moved at this time. Foot plantar flexed. Initially thought to be a sprain. Four days later, pain continued, X-ray done. Shows undisplaced fracture of ankle. |
| 2018/19 | Major | A patient developed a pressure related injury to their heel, the opportunity to provide preventative interventions was not realized |
| 2018/19 | Major | During delivery, signs of infant distress were not realized or escalated to the care team for consideration of potential earlier interventions. |
| 2018/19 | Major | A pateint developed a pressure related injury to their back, the opportunity to provide preventative interventions was not realized. |
| 2018/19 | Major | A patient presented to the ED with an acute medical condition that was treated. Additional symptoms related to a second diagnosis were not recognized resulting in a delay in diagnosis and treatment. |
| 2018/19 | Major | During the removal of a cast, two areas of skin injury related to heat were identified and believed to have occurred as a result of the reaction between the warm water and the cast material during application. The opportunitiy to monitor the temperature of the cast material during application was not realized. |

| Fiscal Year Occurred | Degree of Injury | Description |
|---|---|---|
| 2018/19 | Major | A patient experienced a skin injury related to pressure. The opportunity to provide interventions to decrease the risk of skin injury was not realized. |
| 2018/19 | Major | A patient was referred for consideration of a stem cell transplant. The BMT disease site group did not receive the referral requisition. The patient missed the opportunity to be assessed for stem cell transplant. |
| 2018/19 | Major | A patient with an acute infection was provided treatment, however, there was a delay in estabilshing antibiotics resulting in a decline in the patients condition and admission to hospital. |
| 2018/19 | Death | A resident experienced a choking event during meal time. The need to supervise the resident during meal times was not consistently communicated to the entire care team. |
| 2018/19 | Major | A patient was receiving treatment for an acute medical procedure, however, a miscommunication led to an additional procedure that was not indicated for the patient and resulted in an acute complication requiring additional intervention. |
| 2018/19 | Major | Patient was discharged from hospital with a plan for home care services. There was a gap in communication and service delivery leading to a decline in health status requiring readmission to hospital. |
| 2018/19 | Major | Surgical procedure delayed 14 months. Pathology report indicated grade 2/3 adenocarcinoma. Earlier intervention may have prevented disease progression. |
| 2018/19 | Major | A necessary medication was missed from a patient's discharge prescription. In the absence of the medication, the patient’s condition declined and readmission to the hospital was required. |
| 2018/19 | Major | A patient experienced a sudden decline in their medical status after receiving a pain medication. Protocols to closely monitor the patients response to the medication were not consistently in place. |
| 2018/19 | Death | Patient was transferred after hours from a tertiary facility and directly admitted to a medical unit. Client deterioration was recognized the next morning and client pronounced deceased about 14 hours after admission. Diagnosis upon death; possible septic shock, internal bleed and acute kidney injury. |
| 2018/19 | Unknown | Patient underwent an unnecessary surgical procedure based on a misdiagnosis. |