Critical Incidents Reported to Manitoba Health

Period: July 01, 2019 - September 30, 2019

Fiscal Year Occurred	Degree of Injury	Description
2019/20	Death	Resident found partially on floor beside bed. Resident deceased.
2019/20	Major	A patient was admitted with an infection. A decline in the patient's status was not immediately identified and the patient required transfer to an intensive care unit at another site.
2019/20	Major	There was a delay in administering a required medication which resulted in a transfer to a higher level of care and longer hospital stay.
2019/20	Death	A patient with an acute life threatening complication post-surgery experienced a delay in diagnosis and transfer to another facility for treatment.
2019/20	Death	There was a delay in recognition of acute changes to diagnostic information leading to a missed opportunity for earlier intervention.
2019/20	Major	Resident sustained a fractured femur, mechanism of injury unknown. Resident transferred to tertiary care centre for assessment and possible surgery.
2019/20	Death	Patient treated for sepsis and transferred to a tertiary care center by ground ambulance. Patient deteriorated on route and died.
2019/20	Death	Patient with suspected incarcerated hernia transferred from a rural health center to a CT equipped surgical facility. CT confirmed incarcerated strangulated hernia. Patient deteriorated, transferred to ICU and deceased.
2019/20	Death	Early signs of patient deterioration were not appreciated. The patient required resuscitation and transfer to a higher level of care.
2019/20	Major	A pathology sample was mislabelled resulting in a delayed diagnosis and treatment plan.
2019/20	Major	The deterioration of a resident's wound was not recognized or mitigated in a timely manner.
2019/20	Death	A pregnant emergency department patient delivered her very pre-term infant in the hospital emergency department while waiting to be seen. Both patients were admitted to obstetrics.
2019/20	Major	A patient presented to hospital with stroke like symptoms that were not immediately recognized by care providers, resulting in a loss of function.
2019/20	Major	A patient presented with symptoms of infection. An initial misdiagnosis occurred and despite being corrected, the patient’s condition worsened leading to hospital admission.
2019/20	Major	A client suffered a serious burn while in the shower. As a result, the client had to be transported to hospital for treatment.
2019/20	Major	Resident of PCH developed a stage three venous stasis ulcer that deteriorated rapidly. Resident remains in PCH with ongoing wound assessment and treatment.
2019/20	Death	Gaps in monitoring of results, communication to care providers, and treatment delays led to a significant decline in a patient’s medical condition.
2019/20	Major	A resident was discovered to have developed several pressure injuries to his/her lower right limb post cast removal.
2019/20	Death	An Urgent Care patient was assessed and diagnosed with an acute illness and discharged. The opportunity for admission and expert consultation was not identified. The patient returned to the Urgent Care a few days later with worsening symptoms requiring critical care.
2019/20	Major	A patient experienced delays in recognition and treatment for clinical deterioration. The patient required escalation to a higher level of care and extended hospitalization.
2019/20	Major	There was a delay in identifying an important result on a diagnostic test which led to a missed opportunity for treatment and impacted the patient's recovery.
2019/20	Major	A patient experienced skin tissue breakdown requiring increased care and treatment. Early opportunities to provide intervention were not consistently realized.
2019/20	Death	A patient experienced delays in recognition of deterioration and treatment. The patient required resuscitation and transfer to critical care.
2019/20	Major	A patient experienced a significant deterioration as a result of medication management.

Fiscal Year Occurred	Degree of Injury	Description
2019/20	Major	A patient experienced skin tissue breakdown requiring increased care and treatment. Early opportunities to provide intervention were not consistently realized.
2019/20	Death	A patient experienced delays in recognition of deterioration and treatment. Efforts to resuscitate the patient were unsuccessful.
2019/20	Major	A patient presented to the emergency department with signs and symptoms of an infection and experienced a significant delay in diagnosis and surgical intervention.
2019/20	Major	A patient received a treatment at a higher dose than intended which resulted in a serious reaction.
2019/20	Major	A patient experienced gaps in timely care provider consultation and treatment which contributed to a worsening medical condition.
2019/20	Death	Opportunities for additional treatment and reassessment of an infection were not realized. As a result, the patient’s condition deteriorated requiring critical intervention.
2019/20	Major	An inpatient with chronic pressure-related wounds experienced a deterioration of the wounds while in hospital. Opportunities to prevent further skin breakdown were not realized.
2019/20	Death	A patient experienced an acute deterioration of a medical condition. The severity of the patient’s symptoms was not appreciated and the opportunity for additional assessment and treatment was not realized.
2019/20	Death	Opportunities for additional treatment and reassessment of an infection were not realized. As a result, the patient's condition deteriorated requiring critical intervention.
2019/20	Major	A patient presented to hospital with new medical symptoms. A delay in treatment occurred that resulted in long term disabilities.
2019/20	Major	There was a delay in recognition of and response to a patient's post-operative complication and subsequent acute deterioration.
2019/20	Death	Delay in treatment related to a delay in escalation of care and/or delay in recognition of acute infection resulting in death.