Hawke's Bay District Health Board Summary

1 July 2016 to 30 June 2017

Adverse Event Report

Description of Event	Review Findings	Recommendations/Actions	Follow Up
Delay in diagnosis.	• Delayed diagnosis and management of a serious condition. • Emergency Department managing unexpected high volume of presentations. • Limited clinical observations. • Delayed senior medical officer review. • Limited access to MRI scans on weekends.	• Update guidelines, training and support to staff to ensure effective management of acute presentations with red flags for potential serious pathology. • Department policy changed to ensure early discussion of all patient's plan of care with a senior medical officer. • Improve Senior Medical cover for ED on weekends. • Review processes to ensure accurate and effective handover between ED and wards. • Provide weekend MRI scanning lists.	In progress. Completed. Completed. Completed. Completed.
Delay in reporting.	• Delay in reporting radiological examination. • Limited radiologist resource.	• Increase radiologist resource to ensure reporting within expected timeframes.	Completed.

Medication error.	• Medication administration policy not followed.	• Medication safety and compliance education to be completed for all staff. • Patient safety learning pamphlet to be developed for all staff on medication safety.	Completed. Recommendation to be implemented.
Deterioration of a new-born.	• Deterioration occurred following discharge. • Communication and planning around discharge was disjointed between shifts and between carer and staff. • There was no clear contraindication for discharge but in retrospect, a number of factors suggested that a longer stay might have been advisable. • Follow up after discharge was affected by lack of contact details for the carer. • Blood glucose testing was not a routine assessment for a new-born.	• Ensure conversations and information around discharge and discharge planning are clearly documented in the health record. • Review standard triage observation criteria used when unwell babies present and consider including a blood glucose level as standard practice. • Ensure women from rural location are followed up within 24 hours of discharge and are engaged with midwifery services. • Review guidance regarding discharge criteria including relevant medical, social and demographic factors.	In progress. Completed. Completed. Completed.
Delayed diagnosis.	• Delay in promptly identify a rare but potentially serious underlying diagnosis. • Restricted after hours' access to radiological investigations.	• Update guidelines, training and support provided to staff to ensure effective management of acute presentations with red flags for potential serious pathology.	In progress.

		• Discuss early the patient plan of care with a senior medical officer. • Improve Senior Medical cover for department. • Review processes to ensure accurate and effective handover. • Improve access to after-hours radiological investigations.	Completed. Completed. Completed. Completed.
Delayed diagnosis.	• Multiple transfers of information required between requesting (locum) GP, person obtaining sample, local and tertiary laboratories, regular GP and treating specialist. • Different laboratory request forms do not enable consistent provision of all required information. • Hospital and GP patient management systems did not ensure follow up of outstanding results or allow transfer of responsibility to align with treating clinicians. • The patient was unaware of the expected time for a report to be available, and was not able to provide a "fail-safe" prompt by asking about the results of their test. • Lack of understanding of responsibilities regarding the result	• A clinical governance of results policy be developed. • The new hospital electronic patient management system should address findings of review. • The two laboratories' request forms should be aligned.	Recommendations to be implemented.

	management process across multiple parties.		
Incorrect placement of chest drain.	• Complexity of patient's condition not recognised. • Chest drain insertion technique suboptimal.	• Review and update chest drain insertion guideline. • Department orientation programme revised to include insertion of chest drains.	Completed.
Adverse drug reaction leading to unexpected death.	• Adverse drug reaction leading to a cardiac arrest. • Resuscitation unsuccessful.	• Review to be shared with relevant staff as a learning example.	Completed.
Fall resulting in head injury. Patient deceased.	• Patient admitted to a non-speciality ward. • Handover process not followed.	• Patients with speciality nursing requirements should be admitted to the appropriate ward as a priority. • Review handover process and introduce the bedside handover model of care.	Ongoing. Ongoing.
Unrecognised deterioration of the patient's condition. Patient deceased.	• The patient had subtle signs of deterioration which were not recognised. • The current Early Warning Scoring system may not identify subtle signs of deterioration. • The night duty House Officer was working over capacity with limited support. • No documentation or evidence of adequacy of handover.	• Implement the new national vital signs, observations and early warning score chart • Implement the new national recognition and response to deteriorating patient programme. • Review clinical resources covering hospital after hours. • Review handover practice. • Medical service to review the timeframes for senior medical officer	In progress.

	• Patient not reviewed by senior medical officer until the morning following admission.	review of new admissions and deteriorating patients.	
Fall in ward resulting in head injury.	• The process of obtaining an afterhours' medical review of patients within this ward is unclear. • This ward is currently excluded from the inpatient rapid response medical assessment process. • Good assessment and documentation of falls risk but unclear documentation of falls prevention plan. • Adherence to the post fall management protocol was not clearly documented. • Limited documentation of review by clinical staff after the fall.	• The process for obtaining an urgent after hours' medical review of patients within this ward to be reviewed. • The rapid response team should cover this ward. • Education and training regarding the post-fall procedure. • Education and training regarding the need for immediate escalation if significant deterioration is noted. • Education and training regarding the importance of clear documentation.	Completed. Completed. In progress. In progress. In progress.
Medication error.	• Medication administration policy not followed. • There was a delay in activating the Rapid Response Team.	• Remove surplus medication from ward stock. • Staff to complete Medication Safety 2017 module. • Maximum of two members of staff to be present in the medication room at any time to avoid distraction. • Rapid response process be followed.	Completed.
Pressure injury.	• Seriously unwell patient requiring multiple intravenous lines and medication.	• Policy for intravenous line insertion and management to be followed.	• Ongoing.

	• Gross inflammation of a vein caused by intravenous fluids. • Surgical care required.	• Consideration to be given to the utilisation of extension sets when patients require multiple medications.	
Unrecognised deterioration of patient's condition.	• Review in progress.		
Fall resulting in fractured pelvis.	• Patient appropriately assessed as independent and preparing for discharge. • Fall en-route home. • All appropriate fall prevention strategies were in place.	• Leave policy to be developed and implemented. • Ensure equipment and clothing at hand when in bathroom. • Improve transfer of care information between staff.	HBDHB has a fall minimisation programme. • Fall and injury prevention addressed at both point of care and from a multidisciplinary perspective. • Best practice in fall and injury prevention includes, identifying fall risk, and implementing targeted individualised strategies which are resourced, monitored and reviewed regularly.
Fall resulting in fractured wrist.	• Patient assessed as independent. • All risk assessments completed.		
Fall resulting in fractured clavicle.	• Patient had nightmare/rolled out of bed. • Patient assessed as independent. • All risk assessments completed.		
Fall resulting in fractured wrist.	• Patient slipped retrieving towel after shower. • Patient assessed as independent. • All risk assessments completed.		

Fall resulting in fracture neck of femur.	• Patient transfer information incomplete.		
Unrecognised deterioration of the patient's condition. Patient deceased.	• Ineffective handover process leading to miscommunication of clinical information. • Limited nursing resource on ward due to high acuity demand and staff illness, which impacted on patient care. • Senior clinical staff were not alerted to patient deterioration. • There is limited documentation relating to discussions held with the patient and their family.	• The transfer of care (ISBAR tool) is to be used. • Continue to support the care capacity demand management (CCDM) programme designed to identify required staffing levels that meets the clinical demands of the unit. • Implement the new national recognition and response to deteriorating patient programme. • Introduce a standardised Goals of Treatment form to prompt documentation of discussions with family and patients.	Ongoing. Ongoing. In progress. In progress.
Unrecognised deterioration in patient's condition.	• Review in progress.		