Hawke's Bay District Health Board Summary

1 July 2019 – 30 June 2020

Adverse Event Report (excluding MH&A events)

Event	Description of Event	Review Findings	Recommendations/Actions	Follow up
1	Lack of recognition of the deteriorating patient	Lack of appropriate response to recognition of non-reassuring (Cardiotocography) CTG	All CTGs must have 'fresh eyes' interpretation every 2 hours including overview of whole CTG by senior staff member	Complete
			Activate secure data/image sharing application to be able to share CTG recordings out of hospital	Complete
			All clinicians involved undertake further training	Complete
		Lactate test not performed as per clinical guidelines and best practice	Guideline recirculated to ensure lactate testing occurs as per recommended best practice	Complete
		High acuity on labour and birthing suite	Increase current clinical midwife coordinator hours to 24/7	Incomplete
		Multiple missed opportunities to identify prior anaesthetic issue Lack of escalation Long latent phase not recognised as risk factor	Discuss escalation pathway for involvement of appropriate staff	Complete
			Admitting process must adhere to the Place of Birth policy	Complete
			Booking history and ongoing history assessments must include all relevant clinical documentation	Complete
			Patients to receive an anaesthetic letter outlining anaesthetic challenges	Complete
			Anaesthetic alert will be loaded on electronic records	Complete
2	Failure to seek specialist support in timely manner	Escalation pathway was not followed	All CTGs must have 'fresh eyes' interpretation every 2 hours including overview of whole CTG by senior staff member	Complete
			All clinicians involved undertake further training	Complete

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		Poor interpretation of CTG and delay in appropriate response	Discuss escalation pathway for involvement of appropriate staff	Complete
		Communication issues • Staff busy in theatre with another emergency case • Staff member identified the emergency but didn't feel able to speak up	There needs to be clear articulation of lead clinician To be included in course training	Complete
		Delay in preparation of patient for theatre	Discuss findings of review regarding availability of after-hours acute theatre	Complete
		Availability of acute theatre afterhours	Develop ward signage for patient areas with key messages to ask for help	Complete
3	Fall resulting in bleed into the brain and subsequent death	The cause of the fall is unknown and was not witnessed Risk assessment and individualised care planning was completed according to hospital policy	Review assessment process for patients undergoing consideration for permanent residential care.	Incomplete
			Installation of hand rails in the corridors of identified wards	Complete
			Support for the introduction of the National 4AT Score process for delirium	Incomplete
			Consider adding care associates to special care areas to meet the needs of this increasing fragile cohort and to minimise risk	Complete
			The watching assessment and request form to be reviewed and prove more functional for staff to use and record reasons for non – supply	Incomplete
4	Delay in diagnosis due to incorrect sample testing	Suboptimal sampling technique used	Change sampling technique	Complete
		Booking system not fit for purpose	Develop and implement a new booking system and process	Incomplete
			The *Waiting list booking Form* does not indicate timeframes for patients to be seen and needs to be updated	Incomplete

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5	Missed early referral leading to delay in treatment	There was a missed opportunity to detect a syndrome earlier due to a number of issues which meant that scans were not done at 16 and 18 weeks. It is impossible to know what the exact outcome would have been had it been detected earlier however earlier detection offers an increased likelihood of a good outcome.	Communication disseminated to encourage early referral in high risk pregnancies as per Obstetric and Medical related services Referral Guidelines	Complete
			Establish consultant led triage for Obstetric referral	
			Establish formal MDT 'round up' at end of antenatal clinic to confirm plans and ensure they are actioned	
			Set up formal second opinion ultrasound service	
6	Delayed treatment resulting in cardiac arrest.	Failure in clinical administration systems due to human error and insecure administration processes	Develop and implement a new booking system and process	Incomplete
			Create more Cardiologist positions in the DHB	Recruitment underway
7	Delayed treatment leading to deterioration in multi organ function	Failure in clinical administration systems due to human error and insecure administration processes	Develop and implement a booking process	Incomplete
			Introduce orientation documentation for locum consultants	Incomplete
8	Delayed treatment leading to deterioration in cardiac function	Failure in clinical administration due to human error and insecure administration processes.	Create more administration positions to assist with scheduling	Recruitment underway
		Referral Letter not written	Develop and implement an administration process for when a clinician leave the organisation to ensure completion of documentation	Incomplete
		Failure to meet national standard guidelines for follow up	Increase outpatient clinic capacity	Incomplete
			Obtain locum support	Recruitment underway
9		Patient lost to follow-up	Increase number and capacity of Congenital Cardiac Specialist clinics	Incomplete
			Create more administration positions to assist with scheduling	Recruitment underway

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10		Follow up appointments not made	Create more cardiologist positions in the DHB	Recruitment underway
		Prolonged waits for Echo assessments	Create more echo sonographer positions in the DHB	Recruitment underway
		Long waits for Echo reporting	Obtain locum support	Recruitment underway
		Failure to meet national standard guidelines	Obtain additional administration overview when a clinician leaves to ensure completion of documentation	Incomplete
11		Failure to refer to specialist appointment	Introduce an administration process induction document for locums	Incomplete
12	Fall resulting in fractured neck of femur requiring surgery	Patient fell while mobilising independently The risk assessment and the individualised care planning was completed according to hospital policy Evidence indicates that patients often want to care for themselves in hospital and see staff as busy. Advice to ask for help and wait for help can be disregarded	Develop ward signage for patient areas with these key messages.	Incomplete
			Re-circulate 'Use of bed rails' guideline	Complete
13	Delay in treatment leading to death	Communication issues surrounding handover of care	Re-socialise Handover of Care policy	Complete
		Interpretation of CTG and response	Staff to complete training in Management and Interpretation of CTGs	Complete
		Escalation pathway not adhered to	Reminder of responsibility of all clinicians to escalate early	Complete
		Urgency of caesarean section not communicated	Recirculate the categories for caesarean section and ensure standardised understanding and required responses to each category	Complete

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		Clinical documentation must occur at the time of care provision or in the case of an emergency as a retrospective note	Emphasise current documentation standards and requirements in the next communication.	Complete
14	Death following complication after medicine administration	Procedure was in keeping with established local policy	Development of standardised Adult and Paediatric Procedural Sedation Policy	Incomplete
			Development of a memorandum of understanding for advice and referral so that appropriate level of advice is received in a timely manner	Incomplete
		Whilst sufficient staff were present in this instance, this would not have routinely been the case	Review staffing requirements and develop an escalation pathway to call in additional staff	Incomplete
15	Missed diagnosis leading to death	Missed diagnosis due to inadequate triaging of signs and symptoms and lost to follow up.	Develop a process where complex caseloads can be coordinated to avoid disjointed care.	Incomplete
			Service to develop and implement a process where all new and complex patients at rural centres are discussed with a Senior doctor on a regular basis.	
			Appropriate senior staff must be available at MDT.	
			Development of a process for ensuring any requested follow up for services, referrals and tests is not lost to the system.	
			DHB to outline its expectations to contracted service providers regarding timeliness of sharing clinical information with clinical staff to ensure patient safety.	
			Investigate, process map and potentially redesign current pathway/s to develop an action plan for improvement & integration into wider systems.	

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			Radiology HBDHB to establish an agreement for work with another service provider when an urgent result is required.	
			Staff to be advised that patients with unclear diagnosis requiring further medical investigation and are to be assessed in the ED before admission.	
16	Lack of recognition of the deteriorating patient	Lack of antenatal care	Encourage early engagement with midwives and continue to socialise "The top 5 for my baby to thrive" campaign	Incomplete
		Foetal heart rate not auscultated in theatre	Ensure Foetal Heart Rate monitoring is continued in theatre	Complete
		No documentation for a period of care	Reminder that clinical documentation must occur at the time of care provision or in the case of an emergency as a retrospective note	Complete
17	Fall resulting in dislocation of hip joint	• Independent patient with no history of falls. • Slipped on shower floor. • Shower floor is non slip with hand rails in place.	This fall was an accident and there are no recommendations.	
18	Lack of recognition of the deteriorating patient	Immediate routine observations not documented	Re circulate the Maternity Early Warning Score (MEWS) policy	Complete
			Audit the use of the MEWS tool	Complete
		Routine postnatal MEWS not undertaken	Complete and implement the sepsis pathway document	Complete
		Sepsis pathway not followed completely	Re - socialise the sepsis policy	Complete
19		This fall was an accident	Education to be provided to staff about event classification	Complete

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	Fall resulting in fractured neck of femur	However, there was a failure to comply the Falls policy.	Education to be provided to staff about repeat assessment following a fall or transfer to another ward.	Complete
			Education to be provided to staff about requirement to complete Action Plan points.	Complete
20	Pressure injury	Failure to follow Pressure Injury management policy Refresher education around Pressure Injury management communication protocol Failure to repeat risk assessment as per protocol	Audit adherence to Pressure Injury management and treatment protocol	Incomplete
21	Fall resulting in fractured mandible	Unpreventable fall	Signage in bathrooms to remind patients to wait for assistance	Incomplete
			Reminder to staff to declutter bathrooms	
			Refer review to Falls Risk Group re. delirium assessment	
22	Delayed diagnosis due to lost to follow up	Failure to identify lesion on imaging resulting in delayed diagnosis	Discuss event at regular Department Meeting	Completed
			Memo to Department staff reasserting the 'all images' approach	Completed
			Audit of specific images to ensure lung bases are reviewed and findings documented	Due in December 2020
23	Delayed recognition of deteriorating patient	Failure to recognise pathological CTG Failure to communicate urgency of the situation when escalating to the SMO	Complete online training	Complete
			Use of ISBAR communication tool to ensure effective information sharing with midwifery and/or medical staff	

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		High acuity on Labour and Birthing suite	Resocialisation of the Primary/Secondary interface document	
			Re-escalate the requirement of accurate TrendCare data input to reflect evident acuity both on staff allocate screen and inpatient patient types	
			Use maternity bulletin to socialise "flexing staff"	
			Re-publish and re-orientate team to escalation pathway and variance response management	
24	Missed diagnosis	Review due for completion in December		