Hawke's Bay District Health Board Summary

1 July 2015 to 30 June 2016

Description of Event	Review Findings	Recommendations/Actions	Follow Up
Communication failure.	• New Locum Specialist (short term contract) working in department. • Limited orientation for locum specialist. • Reduction of senior staff due to sick leave. • Department running at full capacity. • Calculation of potential amount of drug ingestion and likely adverse reaction not documented. • Inadequate handover between clinicians and services.	• Improvement in orientation process for locum medical specialists. • Remind staff of the importance of clear documentation. • Adhere to the handover process to ensure transfer of patient information, accountability and responsibility.	• Ongoing • Ongoing • Ongoing
Communication failure.	• Ultrasound process and reporting between primary and secondary providers needs review. • Develop a Post Natal Discharge plan for parents and babies identified as at risk.	• Implement a standardised request form with clear identification of clinical question. • Establish a standardised reporting template for scans from all providers. • Investigate the possibility of all images being stored at one location. • Sonographers to verbally communicate any findings that are abnormal to a consultant responsible for care. • Clearly identify lead clinician to ensure appropriate management of care, planning and decisions. • Ensure outstanding investigations are followed up in timely manner.	• In progress • In progress • In progress • Complete • Complete • Complete

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		• Consider a 24 hour minimum postnatal stay period for parents and babies identified as at risk.	• Complete
Medication error.	• Medication was correctly checked with appropriate staff. • Incorrect prescription.	• Reflective exemplar from staff involved.	• Complete
Medication error.	• Wrong radiopharmaceutical test given to patient resulting in the need for a repeat test. • Human error.	• Correct verification of all procedures and tests. • Daily check of scanning list to be introduced.	• Complete • Complete
Retained Item	• After the final surgical count a swab was used for a secondary procedure and inadvertently left insitu.	• Revise Surgical Count Policy and Procedure to include an extra count if a secondary procedure takes place.	• Complete
Fall resulting in fracture.	• Fall risk assessment incomplete. • Flooring potentially slippery and no signage to alert patient and staff.	• Education to team regarding falls assessment and management. • Request for assessment of flooring.	• Complete • Complete A non-slip surface has been applied to floor.
Injury resulting in fracture.	• Whilst being moved out of the scanner the patient received an injury to their arm. • Failure to check the patient's position before moving the scanner table.	• Introduction of a standard procedure to check table position before patients are removed from scanner. • Support strapping of limbs to be offered to all patients. • Two staff to assist with moving patients with mobility issues from scanner. • Staff to be reminded that incidents involving patients from other facilities must be reported to that facility.	• Complete • Complete • Complete • Complete

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Fall resulting in fracture.	• Patient was not triaged appropriately. This directly contributed to delayed assessment and treatment of fracture. • Limited evidence in the health record of the patient's suitability for leave and whether the family was advised of how to care for them. • Lack of documentation and a multidisciplinary approach led to delay treatment of fracture. • There are multiple ways to document falls risk, assessment and action plans across services.	• Event presentation as a learning opportunity. • Instructions to be developed for family members to help them in the care of an in-patient while on leave. • Case to be reviewed by team with discussion on documentation. • This process to be standardised across the organisation.	• This report was recently completed and the recommendations are in progress.
Fall resulting in fracture	• Patient identified as high falls risk. • Patient mobilised without assistance and fell.	• Discuss this event as a learning opportunity. • Reminder to staff that Next of Kin to be contacted if appropriate.	• Complete • Complete
Delayed diagnosis.	• Presenting examination findings did not correlate with the severity of the condition. • There were missed opportunities for discussion with senior team members.	• Ensure that patient referral to follow-up services has been made • Discuss this event as a learning opportunity. • All patients transferred from rural centres, under any specialty, to be discussed with a senior medical officer before discharge.	• Complete • Complete • Ongoing
Delayed diagnosis.	Investigation not complete at time of report.		

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Delayed treatment.	• Colorectal Referral Acceptance Guideline not followed. • The clinic letter was not copied to the referring service following review.	• Clinical pathway to be developed for management of this patient group and implemented. • When a referral is received from another department, a copy of the clinic letter will be sent to the original referrer and referring department.	• Complete • Ongoing
Delayed treatment.	• Seen by a locum consultant and patient to be reviewed again in six months. • Booking error by relieving staff resulting in delay in appointment. • Non reversible loss of vision.	• Patients who are seen by a locum consultant will be followed up by a DHB consultant. • Review and redesign of booking system.	• Complete • Complete