Hawke's Bay District Health Board Adverse Event Reviews Summary

1 July 2018 – 30 June 2019

WHO Code	Description of Event	Review Findings	Recommendations / Actions	Final SAC
12	Fall Fall resulting in a head injury and subsequent death.	Gaps identified in the care related to the management of a patient at risk of a fall and the post fall procedure	All nursing and care associate staff to complete falls prevention training	1
1	Clinical Administration Delayed follow up	Failure in care/service coordination from June 2016 to 2 July 2018. Insufficient cardiologist hours and clinics available to process outpatient follow up in a timely fashion. The patient experienced a delay in recognition, treatment and disease management as consequence.	Create and submit an operational service plan to Clinical Risk and Event Advisory Group (CREAG) which demonstrates that the risk surrounding a specific patient group (follow ups predating November 2017) will be reduced over the next six months. Monthly monitoring and reporting to CREAG and Health Services Leadership Team (HSLT) of: Number of follow up appointments predating November 2017 who are still awaiting review. Number of current follow up appointments awaiting review. Develop a Cardiology service procedure/protocol whereby an experienced Cardiology Nurse is allocated the task of triaging and coordinating cardiology referrals for clinics and cardiology investigations, in a consistent manner and once a predetermined threshold is reached where Cardiologists are unable to triage referrals in a timely manner.	*2*
12	Fall Fall resulting in fractured femur.	Falls risk not reassessed according to patients fluctuating stability.	Recruitment to additional funded nursing/care associate staff positions in Assessment, Treatment and Rehabilitation (AT&R). All nursing and care associate staff to complete falls prevention training.	2

12	Fall Un-witnessed fall resulting in fractured femur.	Step down of patient watch from 1:1 watch to shared watch as part of assessment prior to discharge to residential care facilities.	Review and resolve residential care facilities discharge criteria regarding watchers.	2
2	Pressure injury	Incorrect application of dressing/tape to secure IV cannula. Lack of documentation that confirmed staff had checked the site each duty.	Raised staff awareness regarding policy, and standard dressings used. Review and adapt Intensive Care Unit (ICU) chart to include visualisation of IV cannula site.	2
2	Patient deterioration Unexpected deterioration of patient post-surgery.	Inappropriate transfer to ward post-surgery resulting in the need for respiratory support and emergency airway management.	Patients with “at risk’ airways should have an extended post-operative period in Post Anaesthetic Care Unit (PACU), or an High Dependency Unit (HDU) overnight stay.	*2*
2	Pressure injury.	Failure to prescribe and administer patient regular medications post operatively leading to severe spasms causing friction between elbow suture line and arm splint. Delayed recognition of sinus pressure injury.	Medical staff reminded of the importance of ensuring complete medication history recorded and prescribed as required for patients needs during in-patient stay.	*2*
12	Fall Fall resulting in fractured femur.	Gaps identified in the care related to the management of a patient at risk of a fall and the post fall procedure.	All nursing and care associate staff to complete falls prevention training. Falls assessments should include identification of medicines that increase the risk of falls. Electronic copy of falls assessment to be completed, printed and filed in records.	2

1	Clinical Administration. Delay in referral to Cardiology Clinic resulting in delayed diagnosis	Failure in care/service coordination from June 2016 to 2 July 2018. Insufficient cardiologist hours and clinics available to process outpatient follow up in a timely fashion. The patient experienced a delay in recognition, treatment and disease management as consequence.	Create and submit an operational service plan to CREAG which demonstrates that the risk surrounding a specific patient group (follow ups predating November 2017) will be reduced over the next six months. Monthly monitoring and reporting to CREAG and HSLT of: Number of follow up appointments predating November 2017 who are still awaiting review. Number of current follow up appointments awaiting review. Develop a Cardiology service procedure/protocol whereby an experienced Cardiology Nurse is allocated the task of triaging and coordinating cardiology referrals for clinics and cardiology investigations, in a consistent manner and once a predetermined threshold is reached where Cardiologists are unable to triage referrals in a timely manner.	*2*
1	Clinical administration. Delayed appointment for cardiology; patient died before appointment sent.	*Investigation in progress* *Scheduled for CREAG Dec 2019*		2
2	Patient deterioration. Patient deterioration, resulting in patient death.	Failure to communicate the deterioration of a septic patient and escalate level of care Delay in flight transfer, patient deceased	Ongoing staff training on Sepsis Bundle pathway. Amend Wairoa Early Warning Score (EWS) mandatory action document to include mandatory reporting to ICU Intensivist with scores 8 and above EWS to be recorded on all patients being transported to secondary care facilities.	1
1	Clinical administration. Delayed treatment / appointment delayed loss of vision due to glaucoma and emergency surgery required.	Failure in care/service coordination. Insufficient ophthalmologist hours and clinics available to process outpatient follow up in a timely fashion. The patient experienced a delay in recognition,	Plan implemented and monitored through CREAG, to address capacity issues and includes: Virtual consultations, appointment of additional Ophthalmologist, nurse triage, additional clinics.	2

		treatment and disease management.		
2	Patient deterioration. Lack of recognition of deteriorating patient	Failure to appropriately diagnose and recognise deteriorating condition resulting in significant infection and surgery.	Agree protocol between Emergency Department (ED) and Ata Rangi confirming that all postnatal women are to be seen and triaged in ED prior to transfer to ward. Implementation of new national Maternity Early Warning System (MEWS) programme. Ongoing discussions with senior leadership and executive team regarding funding for 24/7 clinical co-ordinator roles. Re-socialise Adult Sepsis pathway. Implementation of Health Quality Safety Commission (HQSC) Sepsis bundle. To include staff training and procedure to follow when escalation to more senior personnel required Raise staff awareness regarding availability of interpreting services.	2
2	Pressure Injury. Pressure areas both heels. Patient since deceased.	Skin assessment not undertaken in timely way.	Staff briefing on pressure area cares and refamiliarisation of Pressure Injury Guidelines	2
2	Delay in treatment. Delay in diagnosis, adeno carcinoma in colon.	*Investigation in progress*		*2*
12	Fall resulting in head injury Unwitnessed fall resulting in	Gaps identified in the care related to the management of a patient at risk of a fall and the post fall procedure.	Falls assessments to include identification of medicines that increase the risk of falls. Staff to be reminded to update risk assessment following fall. Consider implementation of Delirium and Patient Engagement projects on ward.	2

	subarachnoid haemorrhage			
05	Medication error. Medication wrong dose adjustment	Failure to follow blood results to titrate dose correctly	The Dermatology service will create a protocol for checking blood results for patients prescribed Methotrexate. An urgent GP letter should be emailed directly when urgent and regular monitoring of bloods is required for patients on Methotrexate	*2*
2	Retained item	Retained item	Classified as HQSC always-reportable event. Good care planning and documentation of wound care.	*2*