

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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<p>In progress.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed.</p>
Delay in reporting.	<ul style="list-style-type: none"> • Delay in reporting radiological examination. • Limited radiologist resource. 	<ul style="list-style-type: none"> • Increase radiologist resource to ensure reporting within expected timeframes. 	<p>Completed.</p>

Medication error.	<ul style="list-style-type: none"> Medication administration policy not followed. 	<ul style="list-style-type: none"> Medication safety and compliance education to be completed for all staff. Patient safety learning pamphlet to be developed for all staff on medication safety. 	<p>Completed.</p> <p>Recommendation to be implemented.</p>
Deterioration of a new-born.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<p>In progress.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed.</p>
Delayed diagnosis.	<ul style="list-style-type: none"> Delay in promptly identify a rare but potentially serious underlying diagnosis. Restricted after hours' access to radiological investigations. 	<ul style="list-style-type: none"> Update guidelines, training and support provided to staff to ensure effective management of acute presentations with red flags for potential serious pathology. 	<p>In progress.</p>

		<ul style="list-style-type: none"> • 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. 	<p>Completed.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed.</p>
Delayed diagnosis.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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. 	<p>Recommendations to be implemented.</p>

	management process across multiple parties.		
Incorrect placement of chest drain.	<ul style="list-style-type: none"> • Complexity of patient's condition not recognised. • Chest drain insertion technique suboptimal. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Adverse drug reaction leading to a cardiac arrest. • Resuscitation unsuccessful. 	<ul style="list-style-type: none"> • Review to be shared with relevant staff as a learning example. 	Completed.
Fall resulting in head injury. Patient deceased.	<ul style="list-style-type: none"> • Patient admitted to a non-speciality ward. • Handover process not followed. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none"> • Patient not reviewed by senior medical officer until the morning following admission. 	<p>review of new admissions and deteriorating patients.</p>	
Fall in ward resulting in head injury.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<p>Completed.</p> <p>Completed.</p> <p>In progress.</p> <p>In progress.</p> <p>In progress.</p>
Medication error.	<ul style="list-style-type: none"> • Medication administration policy not followed. • There was a delay in activating the Rapid Response Team. 	<ul style="list-style-type: none"> • 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. 	<p>Completed.</p>
Pressure injury.	<ul style="list-style-type: none"> • Seriously unwell patient requiring multiple intravenous lines and medication. 	<ul style="list-style-type: none"> • Policy for intravenous line insertion and management to be followed. 	<ul style="list-style-type: none"> • Ongoing.

	<ul style="list-style-type: none"> • Gross inflammation of a vein caused by intravenous fluids. • Surgical care required. 	<ul style="list-style-type: none"> • Consideration to be given to the utilisation of extension sets when patients require multiple medications. 	
Unrecognised deterioration of patient's condition.	<ul style="list-style-type: none"> • Review in progress. 		
Fall resulting in fractured pelvis.	<ul style="list-style-type: none"> • Patient appropriately assessed as independent and preparing for discharge. • Fall en-route home. • All appropriate fall prevention strategies were in place. 	<ul style="list-style-type: none"> • Leave policy to be developed and implemented. • Ensure equipment and clothing at hand when in bathroom. • Improve transfer of care information between staff. 	<p>HBDHB has a fall minimisation programme.</p> <ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Patient assessed as independent. • All risk assessments completed. 		
Fall resulting in fractured clavicle.	<ul style="list-style-type: none"> • Patient had nightmare/rolled out of bed. • Patient assessed as independent. • All risk assessments completed. 		
Fall resulting in fractured wrist.	<ul style="list-style-type: none"> • Patient slipped retrieving towel after shower. • Patient assessed as independent. • All risk assessments completed. 		

Fall resulting in fracture neck of femur.	<ul style="list-style-type: none"> • Patient transfer information incomplete. 		
Unrecognised deterioration of the patient's condition. Patient deceased.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<p>Ongoing.</p> <p>Ongoing.</p> <p>In progress.</p> <p>In progress.</p>
Unrecognised deterioration in patient's condition.	<ul style="list-style-type: none"> • Review in progress. 		