Hawke's Bay District Health Board Summary

1 July 2017 to 30 June 2018

Adverse Event Report

Description of Event	Review Findings	Recommendations/Actions	Follow Up
Delayed diagnosis due to inability to access scan result.	• The radiology report was available in the radiology electronic system but not in the system used by clinicians.	• Review the error reporting system to ensure that reports are exported from one system to another.	Complete
	• Electronic copy of result received to a generic practice account and not a named general practitioner.	• Highlight potential difficulties with generic accounts receiving results.	Complete
	• Lack of defined system for ensuring follow up of a pending result by clinical staff.	• Review the DHB systems for governance of clinical results. • Implement the Regional Clinical Portal information system which includes results management.	In progress
Lack of recognition of the deteriorating patient.	• The escalation policy for the early warning system (EWS) system is specifically designed to enable interpretation of early deterioration. • Non-adherence of the EWS escalation policy places patients at significant clinical risk.	• All clinical staff must be familiar with Early Warning System Policy. • The escalation strategy must be adhered to at all times to ensure and enable patient safety. • Continue with the implementation of the HQSC recognition and response systems.	Ongoing
	• Communication is the most important factor in patient safety. Without good, timely and appropriate communication between all staff, concerns around patient care may be overlooked.	• ISBAR handovers are to be used for exchanges, transfers and requests for assistance by clinical staff in all settings. • Implementation of a 24 hour Patient at Risk service to provide nursing and medical support and education surrounding the deteriorating patient.	Ongoing

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	• Written communication is an important aspect of communication, and in this case, clinical notes were not written when the patient was reviewed, nor were clinical notes read by appropriate staff. • There are clear policy and medico legal guidelines, and these were breached.	• All staff to adhere to documentation standards, policy, and medico legal requirements. • Appropriate staff to attend ACT training course for recognition and management of deteriorating patients.	Ongoing
	• Medicine reconciliation was not performed correctly. This contributed to the patient deterioration.	• Medicine Reconciliation process to be followed as per policy.	Ongoing
Lack of recognition of the deteriorating patient.	• All staff that provide reports on test findings must follow the departmental critical finding notification procedure.	• Immediate communication detailing expectation for staff.	Complete
	• The notification procedure lacks specificity regarding what constitutes a critical finding and how to manage findings after hours.	• Update to policy/procedure to provide clarity. • Share with all staff.	Complete
Lack of recognition of the deteriorating patient.	• Failure of teamwork in an emergency specifically related to crew resource management (CRM).	• Staff to undertake regular, documented and auditable simulation training scenarios to ensure optimal CRM methods and understanding of processes, roles and responsibilities.	Ongoing
	• Lack of standardisation of equipment across services.	• Purchase new equipment to standardize across services.	Complete
Lack of recognition of the deteriorating patient.	• Inadequate communication and documentation relating to inter-hospital transfer. • Lack of recognition of deteriorating patient.	• Review process for referral and acceptance of patients from outside the DHB. • Orientation and ongoing training for staff regarding recognition of deteriorating patient.	In progress In progress

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Fall resulting in fractured femur requiring surgery.	• 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.	In progress
	• Staff are required to inform the next of kin when an event takes place.	• All staff to be reminded regarding their responsibly to provide open communication to next of kin.	Complete
Fall resulting in fractured femur requiring surgery.	• Staff were not provided with falls minimisation training	• All nursing and care associate staff to complete falls prevention training.	Ongoing
	• No handrail in ward hallway for support.	• Install hand rails in ward hallway.	In progress
Fall resulting in multiple fractures.	• Motion sensors failed to identify the patient standing in the doorway. This entry is one of the main doors to the hospital and as such has high traffic volumes. As some patients and visitors have mobility issues it is reasonable to include additional heat sensors to provide better patient safety. • The door was inspected and found that it appeared to be operating as required.	• Install heat sensors to main entrance door.	Complete
Fall resulting in dislocated ankle that required surgical repair.	• Fall occurred in car park outside facility. • Patient tripped over a concrete garden barrier.	• Concrete garden barriers have since been painted white to ensure visibility and reduce risk of a similar event.	Complete
Fall from hoist resulting in fractured femur.	• Sling selection was inappropriate for hoist/patient. • Not all staff had completed mandatory manual handling training.	• All staff to complete mandatory manual handling training – including hoist/sling use. • All nursing and care associate staff to complete falls prevention training.	In progress In progress
Unwitnessed fall resulting in fractured femur.	• Staff were not provided with falls minimisation training.	• All casual resource nursing staff are to complete falls prevention training.	In progress

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Medication prescribing error.	• A medicine was prescribed without following safe prescribing practices.	• Safe prescribing practice to be included in orientation programmes for all prescribers.	In progress
Unwitnessed fall resulting in fractured femur.	• The risk assessment and the individualised care planning was not completed according to hospital policy.	• All nursing and care associate staff to complete falls prevention training.	Ongoing
Unwitnessed fall from bed.	• Postoperative care were undertaken correctly. • Staffing levels and patient acuity was well controlled.	• No recommendation.	
Unwitnessed fall resulting in a spinal fracture.	• Falls assessment inadequate and mitigating strategies not in place. • Delayed notification to family regarding fall.	• All nursing and care associate staff to complete falls prevention training. • Patient's family to be informed of as soon as reasonably practicable of an incident.	Ongoing Ongoing
Unwitnessed fall resulting in fractured femur.	• Falls assessment and care plan documentation was incomplete.	• All nursing and care associate staff to complete falls prevention training. • Update the Falls Minimisation policy to include requirement to print TrendCare falls assessment and place in health record.	In progress In progress
Unwitnessed fall in hospital resulting injury and death.	• The patient roused suddenly and climbed over the cot sides and landed on the floor sustaining injury.	• Discussion regarding best practice when leaving patients unattended and how risks such as falling can be mitigated.	Complete
	• The patient was assessed as a falls risk but the subsequent falls prevention strategies put in place were inadequate.	• All nursing and care associate staff to complete falls prevention training.	In progress
Head trauma following fall.	• Specialised patient lifting equipment used inappropriately.	• Develop a Safe System of Work for use of patient lifter.	In progress

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	• Staff not appropriately trained for requirements in the use of this piece of equipment.	• Staff training to be undertaken. • Develop a formal process to record training.	In progress
	• Inadequate communication and documentation relating to inter-hospital transfer.	• Review the process for transfer of clinical patient care between hospitals using a standardised document.	In progress
Fall resulting in fractured humerus.	• Failure of bed brakes. • Aging bed fleet across organisation with no maintenance programme for non-electrical equipment.	• Maintenance programme to commence.	In progress
	• Process for identifying and removing faulty equipment not clear.	• Education to be provided with regard to the process when faulty equipment is identified.	In progress
Fall resulting in fractured femur.	• Falls risk assessment not completed.	• All nursing and care associate staff to complete falls prevention and safe handling training. • Falls prevention tools signage to be at patient bedside.	In progress
	• Patients own frame was not utilised due to a miscommunication.	• Process for communication with patient/family regarding care and equipment to be developed.	In progress
Delay in treatment leading to cerebral injury.	• Delayed echocardiogram.	• Review demand and capacity schedules. • Review procedure for follow-up echocardiograms.	In progress
Delay in treatment resulting in death.	• Referral priority selection did not enable appropriate triage.	• Change referral prioritization categories to reflect urgency based on clinical assessment.	Complete
	• Current referral management system is not fit for purpose.	• Review and develop new system.	In progress

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	• Insufficient clinical 'non-contact time' to appropriately manage the increasing number of referrals.	• Clinic timetables and resourcing to be reviewed.	In progress
	• Staff covering leave arrangements had limited experience in this subspecialty.	• Ensure leave cover arrangements met the need of the service.	In progress
	• Inadequate clinic availability.	• Review current clinic availability and waiting times and compare to referral demand.	In progress
Retained item.	• Non-standardised use of surgical dressing. • Initial operative documentation unclear	• Patient Safety learning to be disseminated to all staff.	Complete
		• Case to be discussed at surgical meetings to ensure dissemination of learnings.	Complete