NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Northland DHB learning from adverse events report 2019-2020

Background

Each year, health care adverse events are reported to the Health Quality & Safety Commission by district health boards (DHBs) and other healthcare providers.

The Commission works with these providers to encourage an open culture of reporting, to learn from what happened and put in place systems to reduce the risk of recurrence.

The purpose of adverse events reporting is to respect and understand the experience of the affected consumers and whānau to improve consumer safety.

The process of national reporting on adverse events openly demonstrates to the public a provider culture of open communication and learning from these events.

Excerpts from HQSC Learning from adverse events document 2016-2017

Main Summary	Findings	Progress on recommendations
Falls with Harm **Eight patients, aged 61 to 88, experienced falls with harm.**	Four patients had no falls assessment completed. Two patients had been on the ward for less than six hours Two patients were confused. Four patients had all assessment and treatment processes followed	Implementation and standardisation of improved processes and documentation including, delirium and falls pathways and management plans.
Accident	A closing lift door made contact with a patient in wheel chair resulting in a fracture	Lift manufacturer informed Hazard tape applied to lift
Five patients aged 5 to 73 developed Grade 3, 4 or unstageable pressure injury whilst in hospital	Three patients had incomplete documentation Three pressure injuries developed under a cast	Implementation and standardisation of improved processes and documentation of skin assessment Education regarding risk of developing pressure injuries when a cast is in place
3 Maternal adverse events	Two events identified delays in recognition and treatment One event resulted in an unplanned peri-partum hysterectomy	Interdisciplinary scenario-based training Implementation of Growth Assessment Programme
Wrong site surgery	Two patients had removal of the wrong skin lesion. Both patients required a second procedure	A full service review including streamlined access pathways
Patient requiring admission to higher level of care	Allergy identification error Medication prescription error Electrolyte disturbance	Standardisation of communication process in regard to known allergies

		Review of the procedures and documents in use Interdisciplinary scenario-based training
Delay in diagnosis and treatment	Two patients with cardiac issues experienced a delay in diagnosis and treatment One delay in diagnosis of hip fractures	Review of processes & re-socialisation of processes and pathways Standardisation of communication process in regard to medical diagnoses Presentation at grand round about Cognitive/confirmation bias HQSC