Northland DHB Adverse Events Report 2015-2016

Background

DHBs are responsible for publicly releasing a summary of each Serious Adverse Event case in 2015-2016. In all of this work the emphasis is on improvement and reducing preventable harm in the future. The following context is important to understand when interpreting the data in this report.

- Adverse Events (previously known as serious adverse events, and serious and sentinel events) are incidents which have generally resulted in harm to patients.
- The title has changed to signal a new direction in the programme, with a greater emphasis on learning from all events – not only the serious adverse events, but also near misses – as learning about these events can be as powerful.
- The emphasis is on improvement, and reducing preventable harm in the future. Northland District Health Board reports 18 Adverse Events for 2014-2015.

Northland District Health Board reports 17 Adverse Events for 2015-2016

Main Summary	Findings	Progress on recommendations
Falls with Harm		
Six patients, aged 53-93, experienced falls with harm. **Harm included fractured hip, fractured humerus, fractured pubic rami, fractured nose and head injuries.**	Four of the patients had been identified as being at high risk of a fall. Two of these patients had been risk assessed, and plans had been completed to minimise their risk of falling. One patient who fell had not been identified as high risk. One patient who fell was an out-patient.	All patient falls with harm are reviewed by a specialist team which focuses on falls prevention. The case reviews contribute to hospital policies to minimise the risk of patient falls. As a result of the reviews during 2015-2016, new guidelines have been developed and implemented to guide and monitor the use of bedrails. The use of medications which may increase the risk of falls is also being carefully monitored.

Thrombolysis (blood thinner) administered on old cardiac condition.	Old ECGs were not electronically available at the time of this emergency. Therefore it was not possible to identify that the cardiac condition was old. 'Clot busting' treatment was given unnecessarily.	Enhancements are in progress to enable old ECGs to be stored on electronic patient record.
Medication error – high dose of thrombolytic (blood thinner) given to patient who had suffered a stroke.	Specialist stroke physician not available overnight. Unavailability of specialist staff leading to misinterpretation of the guideline. Staff unfamiliar with the medication due to very infrequent use in the area. Similar packaging of medications increased potential for error.	Stroke thrombolysis is now only administered by a specialist physician. Stroke and cardiac thrombolysis medications now kept in separate rooms in clearly marked containers.
Leakage of intravenous antibiotics into tissues around vein.	Securing the intravenous line prevented visual inspection of the insertion site. No guidance to the frequency the site was required to be inspected.	Policy and guideline developed with education for the securing of intravenous lines to enable visual site checks to occur every hour for paediatric patients.
Empyema developed secondary to chest drain insertion	Absence of a formal insertion and management guideline for chest drains. The use of chest drains from multiple different suppliers increased the risk of complications as staff were not familiar with equipment. No senior medical oversight at weekends on some high risk patients	Working toward implementation of simulation training for chest drain insertion and management. Standardisation of the chest drain equipment used throughout the organisation is in progress. Weekend on call senior handover of all high risk patients in medicine is being introduced

Unrecognised narcosis	Reduced number of clinical staff available over public holiday weekends. Sub-optimal communication hindered the transfer of essential information. Poor use of early warning score escalation protocol.	Rostering changes to ensure safe staffing levels maintained. Enhancements have been implemented to both medical and nursing communication systems. A clinical audit has been requested across the organisation to identify barriers to escalating patient care.
Route of sedative medication adjusted without changes to dose.	Absence of clear guidelines for use and monitoring of sedative medications within low acuity areas.	Recommendation for organisation wide project to enable the safe use of the sedative medication across the organisation.
Early discontinuation of treatment to enable patient transfer to a ward.	Multiple unclear guidelines and inexperience with treatment.	Organisation wide single policy to be developed. Simulation training to be provided with competencies in line with the policy
Retained surgical swab.	Not all aspects of the swab count policy were adhered to. The responsibilities for monitoring staff under supervision were unclear.	Swab count policy reinforced and audited. Responsibilities of supervisors to be clearly documented.
High risk patient, post-partum haemorrhage, cervical/uterine tear requiring hysterectomy and ICU admission.	Required much earlier input of care from consultant.	Pathways for shared care developed
Accidental full thickness skin graft taken partial thickness was intended.	Second check for equipment use not in place. Distraction due to educating new staff at time of equipment assembly.	Responsibility of second check given to surgeon prior to use of equipment. Education not to be performed at time of equipment assembly in theatres. Manufacturer contacted.
Medications were given to the wrong patient resulting in a decreased level of consciousness.	Medication management system and mismatch of care availability to meet the needs of patients	Review of medication management processes. Embed a culture of medication safety.