Northland DHB Adverse Events Report 2016-2017

Background

Each district health board is responsible for releasing an annual summary of adverse events. The report emphasises areas for improvement and ways in which preventable harm can be reduced in the future. The following points are important to understand when reviewing the information 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 21 Adverse Events for 2016-2017:

Main Summary	Findings	Progress on recommendations
Falls with Harm **Nine patients, aged 50 to 93, experienced falls with harm.** **Harm included a dislocation, cerebral bleeds and limb fractures.**	Four of the patients had been identified as being at high risk of a fall. All had been risk assessed, and plans had been completed to minimise their risk of falling. Of the other five patients, four had yet to be risk assessed. The other had not been identified as high risk.	All patient falls with harm are reviewed by a specialist team which focuses on falls prevention. The case reviews contribute to hospital policies which aim to minimise the risk of patient falls.
Delayed follow up	Delayed follow up post banding of haemorrhoids resulted in late discovery of a rectal tumour.	Increased involvement of clinicians prioritising outpatient follow up appointments introduced.
Delayed recognition of patient deterioration	Rapid deterioration was poorly communicated to senior medical staff resulting in a delay in appropriate treatment.	Standardisation of ward round communication to include review of vital signs.
Patient death post discharge	Patient discharged from hospital following motor vehicle accident.	Review in progress.

Unnecessary surgery	Patient underwent unnecessary surgery for nerve root compression. A lung tumour was missed on the preoperative scan.	Referred for individual performance review.
Extravasation burn	Formation of blister at cannula site post antibiotic administration. Patient required plastic surgery referral.	Review method of administration of intravenous antibiotics.
Delayed diagnosis	Medical staff unaware radiology report available with significant unexpected findings, resulting in a significant delay in treatment.	Alerting system developed for significant unexpected findings radiological.
Unrecognised patient deterioration	Delayed recognition of sepsis along with unclear communication regarding appropriate interventions.	Development of a sepsis pathway and an electronic admission to discharge planner with clear documentation regarding appropriate levels of care.
Failure to monitor during labour	Delayed transfer following abnormal cardiotocography.	Introduction of leadership roles within the area; standardising the staffing model.
Delayed follow up	Delayed follow up post ultrasound scan, resulting in delayed diagnosis of liver mass.	System upgrade with inbuilt safety net processes.
Cerebrospinal fluid leak	Cerebrospinal fluid loss post spinal decompression resulting in subarachnoid haemorrhage.	Change in clinical practice regarding the use of suction drains.
Medication error	Antibiotics prescribed and administered to patient with known allergy. Severe allergic reaction resulted.	Raising awareness and processes regarding allergy identification.
Delayed follow up	Delayed follow up for treatment of macular degeneration resulting in loss of sight.	Standardised processes for arranging follow up appointments