

# Northland DHB Adverse Events Report 2014-2015

## Background

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.

Main Summary	Findings	Progress on recommendations
<p><b>Falls with Harm</b>  <b>Eight patients, aged 65-90, experienced Falls with Harm.</b></p> <p><b>Harm included fractured hips, fractured ribs, fractured pelvis, a dislocated hip, fractured ankle and a head injury.</b></p>	<p>Seven of the patients had been identified as being at high risk of a fall. These patients had all been risk assessed, and plans had been completed to minimise their risk of falling.</p> <p>One patient who fell had not been identified as high risk.</p>	<p>All patient falls with harm are reviewed by a specialist team which focuses on falls prevention.</p> <p>The case reviews contribute to hospital policies which aim to minimise the risk of patient falls.</p> <p>As a result of the reviews during 2014-2015, new guidelines are being developed to guide and monitor the use of bedrails.</p> <p>The use of medications which may increase the risk of falls is also being carefully monitored.</p>
<p><b>Injection given on the incorrect side of the spine.</b></p>	<p>Surgical time out process was not completed correctly prior to the administration of the injection.</p>	<p>Education provided to theatre staff to encourage use of the Surgical Timeout for all patients, not just those having procedures under general anaesthetic.</p> <p>A wider safety project to improve all aspects of perioperative safety was also commenced.</p>



<p><b>Oncology patient developed overwhelming infection.</b></p>	<p>Care of the patient had been jointly provided by Northland DHB and Auckland DHB.</p> <p>Review of this case revealed some failures in communication between the two hospitals, lack of a consistent treatment plan, and lack of protocols regarding use of the chemotherapy drugs involved.</p>	<p>Closer working relationship established with the tertiary DHB provider, with shared use of their protocols and regular audit to check compliance with protocols describing use of chemotherapy drugs.</p> <p>Haematology Oncology Registrar appointed at Northland DHB and Haematology Oncology Consultant to start work at Northland DHB full time in late 2015. This will provide much closer oversight for this group of patients.</p>
<p><b>Delay in transfer to higher level of care.</b></p>	<p>Sub-optimal care co-ordination for a known oncology patient.</p> <p>Local protocols not available, only available through tertiary hospital.</p>	<p>Local guidelines and pathways written for the management of neutropaenic sepsis for the emergency department teams.</p> <p>Closer links established with tertiary hospitals.</p> <p>Haematology Registrar appointed at Northland DHB.</p>
<p><b>Post-operative respiratory depression and complications.</b></p>	<p>Systems Event Analysis (SEA) in progress.</p>	<p>To be advised.</p>
<p><b>Accidental vascular injury during surgery resulting in severe blood loss and transfer to tertiary hospital.</b></p>	<p>Handover between Anaesthetics and ICU lacked detail.</p> <p>ICU Consultant not immediately available to provide patient care.</p>	<p>Formal handover process instituted.</p> <p>Backup plan to ensure ICU coverage at all times if Consultant called away from Unit.</p>
<p><b>Delayed transfer to higher level of care unavailable.</b></p>	<p>Severity of injuries following road traffic accident not immediately apparent.</p> <p>Transfer to ICU not considered necessary as severity of injuries had not been identified.</p> <p>Ward staff did not immediately escalate concerns to medical staff.</p> <p>Some poor communication between medical teams.</p>	<p>Business case developed to support ICU Outreach Service overnight.</p> <p>Review of hospital telemetry system.</p> <p>Education to reinforce plans for management of major trauma.</p>
<p><b>During patient activity on a ward, a patient asked a staff member to arm wrestle, during which activity the patient fractured his upper arm</b></p>	<p>A lack of diversionary activities available, compounded by a shortage of staff.</p>	<p>Ban on arm wrestling and other physical contact sport.</p> <p>Review of appropriate diversional and recreational activities</p>



<p><b>Unrecognised severe aortic stenosis.</b></p>	<p>Monitoring of echocardiogram test results inadequate.</p> <p>Lack of clear process for bookings between Wards and Outpatient Dept.</p>	<p>Improved process being implemented to support outpatient appointments being made from wards.</p> <p>Review of echocardiogram result monitoring.</p> <p>Regular clinical audit established to ensure no significant diagnoses are missed.</p> <p>Review Medical team handovers to Cardiology Service.</p>
<p><b>Failure to recognise a deteriorating patient, with a resulting delay in escalation of care.</b></p>	<p>Early Warning Score (EWS) protocols not followed.</p>	<p>Project to review EWS system and ensure clear communication between and within nursing and medical teams.</p> <p>Introduce Rapid Response ICU Outreach Service overnight.</p> <p>Conduct regular audits to check compliance with Early Warning Score protocols.</p>
<p><b>Possible wrong patient blood transfusion (another patient's blood label found in notes, but unable to confirm if patient received wrong blood).</b></p> <p><b>No adverse effects were noted.</b></p>	<p>Two patients in theatre recovery area with very similar names.</p> <p>Blood Administration policy not followed.</p> <p>Blood had been checked in Operating Theatre, but not re-checked in Recovery Room.</p>	<p>In-service education session on blood administration delivered to all theatre staff.</p> <p>Patient Safety team established in Post Anaesthetic Care Unit to identify and address this and any other safety issues in the Unit.</p>

