30 October 2014

Northland DHB Serious Adverse Events 2013/2014 Report

Background

DHBs are responsible for publicly releasing a summary of each Serious Adverse Event (SAE) case in 2013/2014.

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.

1. A **serious adverse event** is one that leads to significant additional treatment, but is not life threatening and has not resulted in major loss of function. A **sentinel adverse event** is life threatening or has led to an unexpected death or major loss of function.

2. DHB's have been advised to report all SAEs for 2013/2014, irrespective of preventability. This is a change from previous years, where some DHBs reported only those SAEs which were considered, following review, to have a preventable element.

Northland District Health Board reports sixteen Serious Adverse Events 2013/14

Main Summary	Findings	Progress on recommendations
A baby required a blood transfusion. 1 ¾ hours after the transfusion commenced the intravenous tubing disconnected causing blood loss. The baby required further fluid and blood transfusion.	Luer connection not tightened to extension set properly. Baby not adequately monitored. Suboptimal staffing of the Special Care Baby Unit (SCBU), may have led to delay in recognising baby's deterioration.	Double checking of luer connections introduced. More staff recruited for SCBU. Protocol developed for closing SCBU to further admissions when at full capacity. Processes developed to escalate the moving of patients to other clinical areas when unit is full

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Two patients had attended the emergency department on separate occasions with uncomfortable, painful eyes and deteriorating vision following uneventful ophthalmology procedures. One procedure involved an eye injection, the other was cataract surgery. In both cases referral to specialist treatment was delayed.	Visual testing had not been done at the initial emergency department visit. The patients waited an extended length of time then left. Both patients returned to the emergency department the following day and subsequently needed emergency surgical intervention, and antibiotics. Further treatment requiring transfer to a tertiary hospital occurred.	A protocol and programme of education has been put in place in the emergency department. A check list has been developed so appropriate information can be directed to the ophthalmology department. An ophthalmology link nurse role has been developed in the Emergency department.
Surgeon's dictation from a surgical clinic following the patient's surgery was lost. This resulted in a three month delay for a second appointment, prior to referral for further oncology treatment.	Accountability processes for missing documentation or dictations not in place. The multidisciplinary team was not taking a collaborative approach to patient management. Team meeting documentation was not electronically available. No audit of symptomatic breast cancer patients undertaken	New systems introduced to follow up cases where patients do not attend appointments Typists email the surgeons if there is any missing dictation of information and report on progress. The patients are now provided with clinic nurse contact details. Appointments are made or the patient is phoned after the team meeting. A database has been developed and maintained for follow up. Development of electronic recording of team meetings underway. Audits are done on every clinic to ensure there are outcomes documented for every patient.

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A patient received several unnecessary doses of chemotherapy following incorrectly reported biopsy results.	Results reported incorrectly. Unusual histology noted slides re-examined and found previous readings incorrect. No possibility of slides being mixed with other histology specimens.	All breast malignancy histology specimens are now double reported. Retrospective and prospective audit undertaken to check for possibility of other errors - no errors identified. Laboratory staff to keep interruptions to pathologists to a minimum. Review of workforce staffing levels to be undertaken.
On hospital readmission patient noted to have pressure injury following a previous extended stay in hospital. Problem with documentation – unclear status of injury and deterioration of pressure injury prior to discharge. Patient required surgical treatment.	High risk factors were not clearly considered. Documentation was unclear and inconsistent. Uncoordinated wound management and a variety of types of dressings used.	Northland DHB pressure injury group continues to monitor pressure injuries. In all ward areas audits of ten patients are completed each month Education continues with staff using consistent terminology in documentation and the introduction of a Pressure Injury Resource Pack to all areas.
Failure to identify and commence early treatment of a child referred for investigation of small lump. MRI showed malignancy requiring the child to be transferred to tertiary hospital for active treatment.	Lack of sonographers resulting in delays for MRI. Problems with co-ordination between paediatric MRI and general anaesthetic lists. Problems with the management and lack of	Student sonographer and locum numbers increased. Senior clinical staff will ensure effective plans are made and communicated to whānau and significant others prior to admission.

Main Summary	Findings	Progress on recommendations
	communication with whānau regarding hospital stay. Equitable access to specialist services for residents of the Far North.	
Nine patients ranging in age between 69-91 years experienced falls with harm. One patient fell and fractured their nose. Three patients fell and fractured their hips. One patient fell and fractured their femur and finger. One patient fell and fractured an arm. One patient fractured their pelvis. One patient fractured their cheek bone and eye socket. One patient suffered lacerations to their face and suffered a brain bleed related to the fall	Eight patients (one patient was an outpatient) had had a falls risk assessment done, five of those were noted to be of a high risk of falling. Two patients fell out of their chairs while sleeping, one fell out of bed reaching for their walking frame, one patient was found on the floor, three patients became unsteady when standing, lost their balance and fell, one patient slipped off the bed while getting into it and one patient fell while walking. All but the one outpatient had a fall's management plan in place.	The Northland DHB falls project continues with a variety of devices being used or trialled to alert staff that a patient with a high risk of falling has left their bed or chair. These include sensor mats and electronic devices along with the use of lowered beds. Sensor alarms attached to patients are becoming more widely used. Regular documentation audits are undertaken to confirm that risk assessments and plans are completed.