Media Statement

Date: **Thursday, 21 November 2013**

Subject: **Northland DHB Serious and Sentinel Events 2012/2013 Report**

Background

DHBs are responsible for publicly releasing a summary of each Serious Sentinel Event (SSE) case in 2012/2013

In all of this work the emphasis is on improvement, and reducing preventable harm in the future.

Increases in reported events may continue in the next few years as our reporting systems continue to improve. For example, DHBs are increasingly cross-checking their events with other sources of information, such as ACC claims.

Sharing experiences, insights and innovations is a key focus of the Health Quality & Safety Commission-led national patient safety campaign, *Open for better care*, which was launched in May this year. The campaign is being implemented by Northland DHB along with our 2013 Quality Accounts and focuses on reducing harm from falls, healthcare associated infections, perioperative care, and medication.

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 SSEs for 2012/2013, irrespective of preventability. This is a change from previous years, where some DHBs reported only those SSEs which were considered, following review, to have a preventable element.

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QUALITY & IMPROVEMENT DIRECTORATE

Northland District Health Board reports eight Serious Sentinel Events 2012/13

Main Summary	**Findings**	**Progress on recommendations**
Six patients ranging from 61- 86 years of age experienced falls with harm in Whangarei Hospital One patient fell and broke a wrist Two patients fell and had lacerations to their heads One patient fractured their shoulder One patient who was admitted with a broken hip fell and fractured their other hip.	All six patients had had a falls risk assessment done and five out of the six were found to be at high risk of falling Two patients fell while getting out of a chair , one climbed over the bed rails and had no recollection of doing so, one got out of bed to go to the bathroom and had no recollection of doing so, another patient was reaching for their walking frame and missed it and one patient collapsed and fell in shower All but one patient had a falls management plan in place	The Northland DHB Falls Prevention Project continues with a variety of devices being trialled to alert staff to the fact a patient with a high risk of falling has left their bed or chair These include sensor mats and electronic devices along with beds which are lowered right to the floor The use of sensor alarms attached to patients is becoming more widely used An audit of clinical records over the last six months shows a 20% increase in the number of patients being risk assessed for falls (73% to 93%) and individualised patient care plans have also increased from 53% to 73%
Failure to identify and act on an abnormality shown	On investigation it was found that initial	Staff advised to file provisional reports of plain

on patient's initial chest x-ray led to significant delay in management, and the patient subsequently died	management was overly influenced by an ultrasound scan in the Emergency Department Failure to involve surgeons in the patient's care soon after admission to hospital significantly contributed to the patient's death	x-rays in all cases so that Radiologists can quickly identify serious diagnoses which have been missed
Patient received 10 times the prescribed dose of a cardiac drug. This was still within the normal dose range for the drug, but led to the patient's death	It was found during investigation that staff had deviated from normal practice and had relied on familiarity with a standard dose of the prescribed medication A safety signal for this drug had previously been disseminated by the Health Quality & Safety Commission and Northland DHB, but had not led to a change in practice in the DHB	Plan developed to ensure wide dissemination of safety signals, as well as safety alerts All new staff to attend an ALERT course to reinforce the management of deteriorating patients Ensure second check medicine protocol is adhered to when administering this cardiac drug. Advised doctors within Northland DHB and in primary care to avoid prescribing the smallest dose of this drug, to avoid further potential errors