NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Northland DHB Adverse Events Report 2017-2018

Background

Each year, healthcare adverse events are reported to the Health Quality & Safety Commission by district health boards and other health care providers. The Commission works with these providers to encourage an open culture of reporting, to learn from what happened and put in place systems to reduce the risk of recurrence.

The purpose of adverse events reporting is to respect and understand the experience of the affected consumers and whānau to improve consumer safety. The process of national reporting on adverse events openly demonstrates to the public a provider culture of open communication and learning from these events.

The emphasis is on improvement and reducing preventable harm in the future.

Northland District Health Board Reported 19 Adverse Events for 2017-2018:

Main Summary	Findings	Progress on recommendations
Falls with Harm **Nine patients, aged 0 to 89, experienced falls with harm.**	Four of the patients had not had a falls assessment completed or documented. Two of the patients were confused.	A team that specialises in reducing patient harm reviews each adverse event that involves a patient falling. A new falls assessment and care plan has been created and implemented.
Wrong level surgery	Wrong level decompression surgery, required second surgery	All of the suggested measures to reduce the risk of wrong level surgery were implemented on this case.
Pressure injury	Developed Stage three pressure injury whilst in hospital	Implementation of a documentation tool to prompt skin assessment. Pressure injury risk assessment to be completed on admission and an individualised care plan implemented.
Delayed recognition of patient deterioration requiring unplanned transfer to ICU	Sedation given for agitation for a patient with hyponatraemia. Delayed recognition of deterioration led to cardiorespiratory arrest, and ICU admission	Hyponatraemia protocol has been created. Development of clear referral process is in progress.

Delayed diagnosis	Referral by GP for change in bowel pattern. Initial scan identified lung nodule on second radiologist report. Report not seen by requesting doctor. One year later, patient developed a plural effusion secondary to lung cancer.	An electronic referral and electronic acknowledgement system is being created. The radiology pathway has been updated, refined and implemented.
Epilepsy medication given to pregnant lady, resulting in harm to baby	Anti-epileptic medication continued to be prescribed and dispensed to a pregnant lady	A resource document created by PHO. Creation of education resources (for patients and clinicians). A high risk check list has been created which is inserted into patient's notes.
Delayed diagnosis	Incidental finding of lung mass occurred on two occasions, reports and images not seen by clinician. Incidentally identified on a third image. Confirmed adenocarcinoma of the lung.	The radiology alert system is to be extended to include in-patients. Electronic referral and electronic acknowledgement systems are being created.
Pressure injury	Grade Four pressure injury developed following surgery.	A new care plan has been created. The pressure injury assessment is to be completed within six hours of admission to ward
Delayed recognition of patient deterioration	Chest pain following surgery. Delayed recognition and escalation. Patient transferred to level one hospital, but died during surgery.	The national NZ Early Warning Score (EWS) observation chart has been implemented, which aids with recognising deterioration and escalating patient care. ECGs are being faxed to CCU with telemetry request form.
Healthcare associated/acquired infection	Patient developed endophthalmitis following an intravitreal injection	All of the suggested measures to minimise the risk of post procedure infection were performed.
Pressure injury	Patient developed Grade Three pressure injuries whilst in hospital	A new care plan was created. The pressure injury assessment is to be completed within six hours of admission to ward.