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

Northland DHB Learning from Adverse Events Report 2018-2019

Background

Each year, health care adverse events are reported to the Health Quality & Safety Commission (HQSC) by district health boards (DHBs) 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.

Excerpts from HQSC Learning from adverse events document 2016-2017

Northland District Health Board reported 19 Adverse Events for 2018-2019:

Main Summary	Findings	Progress on recommendations
Seven patients, aged 23 to 99, experienced falls with harm.	Three of the patients had not had a falls assessment or plan completed. Two patients were confused. Three of the reports found that all policies and procedures were followed. No act or omission was felt to have contributed to those patients falling.	Review and simplification of falls risk assessment process; in progress. Education to increase awareness regarding the relevance and importance of a falls assessment being completed; completed and ongoing. Review and standardisation of a delirium pathway and management plan, including a standardised documentation tool; in progress.
Four patients aged 75 to 95 developed Grade 3, 4 or unstageable pressure injury whilst in hospital.	Inconsistencies in using and implementing the pressure injury tool. Variation in terminology used.	Simplification of the pressure injury assessment and process for developing plan of care; in progress. Standardisation of language used to describe pressure injuries, including the location; in progress. Photos used for documentation; completed.

Three patients suffered severe bleeding following childbirth resulting in a hysterectomy being performed.	In all three events, performing a hysterectomy was felt to be the only option to prevent ongoing bleeding.	No recommendations. These events are required to be reported to HQSC.
Delayed recognition of patient deterioration.	Abnormal Cardiotocograph (CTG) identified in labouring woman, delay in senior review, the baby required resuscitation and transfer to level 3 facility.	Review of available resources; to commence. Improvements in communication process between multidisciplinary team members; in progress.
Delayed recognition of patient deterioration.	Delayed recognition of patient deterioration resulting in transfer to intensive care, intubation and resuscitation.	Ongoing audits to monitor compliance with escalation of cares for deteriorating patients.
Delayed diagnosis.	Patient with severe kidney injury. Miscommunication led to a delay in review and second opinion.	Review and clarification of the referral / communication processes; in progress. Review supportive technology to aid processes; in progress. Trial of implementing a process to call in additional staff; in progress. Night co-ordination planning team established; in progress.
Mental health inpatient death. **Coroner's report unavailable at time of review.**	Patient died in mental health unit after being restrained. Death linked to excited delirium not related to restraint.	A review of possibilities for new model of care for patients with excited delirium; to commence. Alignment of sedation practices between departments; being developed.