Taranaki District Health Board
Adverse Events 2014-2015

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Description of Event	Review Findings	Recommendations/ Actions	Follow up

Five patients fell resulting in:
• Fractured hip (1)
• Fractured wrist (1)
• Fractured leg (1)
• Dislocated recent hip replacement (1)
• Brain bleed that the patient did not survive (1)
	For most reviews, multiple contributing factors, rather than a single root cause, were identified as follows:
	• Patient related factors including:
	  ○ confusion,
	  ○ lack of insight into ability to undertake activities,
	  ○ not wanting to bother the nurses and therefore not ringing the bell for assistance,
	  ○ not using mobility aids eg walking frame,
	  ○ wearing socks on a slippery floor,
	  ○ underlying medical condition(s)
	• Environmental Factors including:
	  ○ Unfamiliar surroundings.
	  ○ Wet floor and inadequate wet floor warning signage.
	  ○ Mobility aid not within the patient's reach.
	  ○ Facility layout
		• Regularly review fall reduction strategies (sensor mats, sensor clips, non-slip socks, close watch, specialling) for each patient and update the patient's care plan as appropriate.
		• Reiterate safe mobility messages to patients ie utilising mobility aids, ringing the bell for assistance, wearing suitable footwear.
		• Ensure mobility aids are within reach of the patient.
		• Review floor cleaning practices that result in the reduction of water left on the floor eg smaller area of floor is mopped at any one time and that 'wet' floor signage is clearly displayed.
		• Explore other fall reduction strategies eg intentional rounding, distraction strategies, pet therapy.
		• Ensure the Preventing Falls information leaflet is available for patients and their families.
		• Continue regular staff education including increasing the uptake of the Preventing Falls electronic learning course.
			Ongoing
			Ongoing
			Ongoing
			Completed
			Ongoing
			Ongoing
			Ongoing

Patient given food that they were allergic to.	Review identified the following contributing factors: • Inadequate documentation and alerting of the patient's allergy. • Human error.	• Link allergy information contained in the electronic patient management and medication systems to the 'allergy alert' available on the patient 'White Boards' in each ward and ensure staff are trained. • Enhance 'diet' section on the 'WhiteBoard' to display more detail, including food allergies and enable access to food services staff.	Implemented Implemented
Patient with abdominal pain and vomiting discharged from the Emergency Department and died approximately 30 hours later from peritonitis.	Review identified the following: • Based on the patient's presentation and test results at the time, it was determined that appropriate assessment, treatment and follow up advice was given in the Emergency Department. • A need for patient follow up (via phone) in some cases should occur.	• Ensure phone follow up review for patients considered at risk of possible deterioration occurs.	Ongoing

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Five patients received delayed follow up appointments/ treatments than what had been determined.	Reviews of all events were undertaken and causal factors included:
	• Process Factors:
	  ○ Referral to the service was not actioned.
	  ○ Manual referral process without confirmation of receipt.
	  ○ Wait list management
	  ○ Communication between team members
	• Patients not advised to contact the hospital should their appointment not be forthcoming.
	• Multiple clinicians providing care to an individual patient.
		• Communication to all clinical staff sent from the Chief Medical Advisor advising about the events and the need for vigilance regarding internal referrals ie the referral has been sent and it has been received.
		• Exploration and implementation of an electronic referral system that includes notification of referral receipt.
		• Advise patients that if their appointment is not forthcoming, that they contact the hospital.
		• Appointment of a Co-ordinator who is, amongst other tasks, responsible for ensuring that treatment and follow up is booked appropriately, as well as acting as a key contact for patients.
		• Increase the number of outpatient clinic sessions to ensure that all patients are seen in a timely manner.
		• Implement monthly wait list audits.
		• Implement fortnightly wait list review meetings for the Administrator and Co-ordinator.
		• Assign a clinic nurse to each speciality as a 'liaison' for clerical staff.
		• Development of surveillance databases to be explored.
			Completed
			In progress
			Ongoing
			Completed
			Completed
			Implemented
			Implemented
			Implemented
			In progress

Delayed follow up of a cancerous lesion.	Review identified the following key contributing or combination of factors: • Manual referral process without confirmation of receipt. • No written information/communication to the patient following a day procedure. • Human error.	• Exploration and implementation of an electronic referral system that includes notification of referral receipt. • In the meantime, implement manual checks and retain for 12 months 'follow up' request documents. • Discharge instructions and discharge summary document to be communicated/given to the patient. • Advise patients that if their appointment is not forthcoming, that they contact the hospital. • Consultant's first name(s) or initial(s) as well their title and surname to be included on the patient label to ensure the correct consultant is chosen. • Explore the development of a report that identifies patient tissue results that have not been viewed by the consultant. • Event and learnings shared with involved staff.	In progress Implemented and ongoing Implemented and ongoing Implemented and ongoing Implemented In progress Implemented

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Chest drain inserted into the patient's right ventricle of their heart.	Review identified the following key contributing or combination of factors: • Rationale for inserting a chest drain not clear. • No formal guidelines outlining the clinical indications and parameters for insertion of chest drains at TDHB. • Formal chest drain training in place but not compulsory. • No formal guidelines for the use of bedside ultrasound. • Communication issues. • Human error.	• Implement formal guidelines outlining clinical indications and parameters for chest drain insertion at TDHB. • Implement compulsory training sessions, including supervision and competency assessment. • Define and agree the appropriate utilisation of bedside ultrasound, including competency, within the DHB. • Ensure consultation and telephone advice is clearly communicated and recorded. • Ensure individual learning recommendations for staff involved are defined and actioned.	Completed and ongoing Completed and in progress In progress Ongoing Completed
5 patients over a period of 4 years experienced radiology related events involving interpretation/misinterpretation of Xrays or failure to follow up Xray report recommendations.	An independent review along with internal reviews were undertaken of the five events and identified the following contributing factors or combination of factors: • Radiologist staffing levels • Communication issues • Work interruptions • Human error	• Improve radiologist staffing levels. • Better radiologist leave management. • Increased radiologist presence at multi- disciplinary department meetings. • Introduce more formal guidelines for reporting incidental findings. • Implement measures to reduce radiologist interruptions. • Include more explicit recommendations for follow up or need for further high tech imaging to be included in radiology reports. • More interaction with referring clinicians to reinforce correct imaging methods to establish the right diagnosis at the right time for the best patient care management. • Emphasize the need to specify time frame for any follow up in patient discharge information. • Development of more patient focussed discharge information to be given out to patients.	Completed Completed Implemented Implemented Implemented Ongoing Ongoing Completed In progress
Patient prescribed and given a medication that they were allergic to.	Review identified that not all sources of allergy information were checked.	• All sources of allergy information, including the patient's paper and electronic records, are to be checked prior to prescribing, dispensing and administering any medication. • Email notification to all clinical staff re the above.	Ongoing Completed
Patient prescribed and given another patient's medication.	Review identified that the patient's identification details were not checked.	• Patient identification details are to be checked to ensure that the right patient's medications are prescribed. • Unable to follow up with staff member involved as they had left the DHB's employment.	Ongoing