Taranaki District Health Board
Serious Adverse Events 2015-2016
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Description of Event	Review Findings	Recommendations/ Actions	Follow up
Patient was admitted to investigate their increasing shortness of breath. A chest drain was inserted. Patient deteriorated and did not survive a cardiac arrest.	Review identified the following contributing factors: • Patient's underlying medical condition, including metastatic (spread) of bowel cancer, a large pleural effusion (abnormal collection of fluid surrounding the lungs) and extensive pulmonary embolus (clot in the blood vessels of the lung) that carries a high fatality risk for those patients with metastatic cancer. • Inadequate knowledge of the chest drain protocol relating to: indications for drain, collecting a specimen, risks of using a closed drainage system, utilising a 'Chest Drain Record Chart'. • Inadequate communication between doctor and nursing staff regarding the need to change the drainage system once a specimen had been collected. • Nurse not present for the insertion of the chest drain.	• Reinforcement of learnings from this case to all nursing and medical staff via Case Review and Departmental Meetings highlighting: indications for chest drain insertions, importance of nurses being present for procedure, importance of clear communication between all clinical teams, reiterating the risks associated with using a closed drainage system at any time on patients with a pleural effusion, adherence to protocols, and the use of a Chest Drain Records Chart to ensure safe practice. • Increase the practical skills and knowledge of Medical Registrars in relation to chest drain insertion through formal tutorials, including a simulated practical component every six months. • This event is under review by the Health and Disability Commissioner currently.	Completed Completed and ongoing
Patient's endoscopy procedure was cancelled and not rebooked causing delay and the need for surgery.	Review identified the following contributing factors: • Procedure cancelled due to a patient related medication oversight. • No protocol for cancelled endoscopy procedures in place. • Referral was not returned for rebooking and staff did not follow up that this had occurred. • Patient advised verbally that they would be rebooked but no written information given.	• Cancelled Endoscopy Procedure Protocol established along with a flow chart that outlines post endoscopy follow up procedures. • The Patient Information Booklet is to include the sentence '*if you have not received a confirmation letter from us within two weeks, please contact phone number*' on the discharge information page. • Reinforce with staff the importance of giving written information, including discharge information. • All the above have been communicated to staff in person and via email.	Completed Completed Completed and ongoing Completed and ongoing
A latex plaster was used on a patient that they were allergic to.	Review identified the following contributing factors: • All allergy related documentation and safety checks undertaken. • Human error.	• Discussed with staff member who now has a greater awareness that some plasters contain latex. • A box containing latex free tapes only is to be established. • Event to be discussed with the all department staff. • Patient to be referred for extensive allergy testing.	Completed Completed Completed Completed

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A pneumothorax developed after a nasogastric tube replacement, requiring the patient to be transferred to a specialist facility.	Review identified the following contributing factors: • Patient with poor or at times no swallow reflex. • All the usual post nasogastric replacement testing measures were undertaken with no concerns apparent.	• Careful consideration and discussion with the primary consultant needs to occur before the re-insertion of a nasogastric tube in a patient with no or a poor swallow reflex. • Consider checking nasogastric placement using ultrasound scanning. • Referring the patient for a percutaneous endoscopic gastrostomy (feeding tube directly into the stomach) should be considered.	Ongoing Ongoing Ongoing
A CT was ordered for an outpatient. The result was not reviewed by the Consultant or the GP and therefore no action was taken resulting in a delay in the patient's diagnosis.	Review identified the following contributing factors: • CTs can only be ordered by hospital consultants. • Uncertainty as to who takes responsibility for the follow up/actioning of a diagnostic test result. • Patients are unaware of where to get their diagnostic test results from.	• Whoever orders a diagnostic test is responsible for following up on the result unless there is a clearly documented handover of care to another clinician. • Written correspondence to the patient from the DHB will be updated to advise the patient to contact their GP for results. • The DHB has commenced a project to improve the way laboratory and radiology results are managed. Clear guidelines will be developed which specify who is responsible for GP referred diagnostic test results as well as improve the electronic tools available to assist clinicians to better manage the large number of results they receive.	In place and ongoing Completed and ongoing In progress
Inpatient fell resulting in fractured ribs.	Review identified contributing factors as follows: • Patient Identified as a medium risk of falling. • Patient mobilising without a walking stick or nurse assistance. • Patient had reported feeling dizzy due to low blood pressure and was advised to ask for assistance if mobilising. • Patient felt a sheering sensation in their head and leaned against the bathroom door that was partially open, that then gave way and the patient fell.	• Reiterate safe mobility messages to the patient ie utilising mobility aids, ringing the bell for assistance and asking for assistance if feeling dizzy. • Review medications to reduce low blood pressure. • Ensure the patient is aware of surroundings and especially how the bi-fold doors work and potential hazard if leaned on if not closed.	Completed Completed Ongoing

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Inpatient, admitted with a heart attack, fell resulting in a brain bleed that the patient did not survive.	Review identified multiple contributing factors as follows: • The therapeutic use of anti-coagulant and anti-platelet (blood thinning) medication, resulting in a higher risk of bleeding following any trauma. • The use of GTN spray for chest pain that can lower the patient's blood pressure. • There is no flag or warning system to identify patients who are on blood thinning medication. • All medications, including the blood thinners, continued to be administered after the fall. • Patient was transferred to a ward but met the criteria to have been admitted to the Coronary Care Unit for closer monitoring. • The patient was allowed to mobilise independently after having GTN spray. • Delay in the realisation that the patient had received a knock to the head. • Doctor informed of the patient's fall but did not physically review the patient as patient asleep and vital signs stable. The electronic doctor task request tool was signed off as completed. • Neurological observations commenced and were stable; however these were not continued during the following shift. • Inadequate communication of history of fall (verbal and written) between nursing and medical teams, between nursing shifts and between doctor shifts. • Patient was uncomplaining and appeared to have a high tolerance to pain. • Identified a sore elbow immediately after the fall but did not believe that he had hit his head until the morning. • Delayed onset (17 hours) of obvious symptoms of brain bleed.	• Patients meeting the criteria for admission to the Coronary Care Unit are not admitted to a ward. • Reinforcement of learnings from this case to all nursing staff via a Case Review presentation highlighting: safe use of GTN spray, better identification of patients on blood thinning medication, importance of good communication between teams, correct use of electronic doctor requests tool and the importance of ensuring follow up occurs. • Reinforcement of learnings to clinical staff via Case Review at the Hospital Wide Multidisciplinary Mortality and Morbidity Improvement Meeting and the Department of Medicine Mortality and Morbidity Review meeting highlighting: risks of blood thinning medications, the review of patients following falls by doctors, handover of relevant events between shifts and between doctor teams, importance of good communication between all clinical teams, importance of reviewing previous nursing shift reports. • Implementation of a flagging/alert system that identifies patients receiving therapeutic blood thinning medications. • Implementation of a post fall checklist for clinical staff to use that flags the increased risk for patients on therapeutic blood thinning medications and ensures all required actions have been completed. • This event is under review by the Health and Disability Commissioner currently.	Completed Completed and ongoing presentations occurring Completed Completed Completed and ongoing