Hawke’s Bay District Health Board Summary

1 July 2014 to 30 June 2015

Serious Adverse Events Report

EMBARGOED UNTIL 12 noon 4th December

Description of Event	Review Findings	Recommendations/Actions	Follow Up
Delayed presentation of operative complication	• Surgery performed laparoscopically giving reduced visualisation of abdominal contents. • Anticoagulation prescribed post-operatively. • Transferred to rural hospital post-operatively.	• Increased vigilance of those patients who require post-operative anticoagulation.	Now part of surgical management plan.
Clinical processes (general care)	• Long period of hospitalisation which included surgery and complex wound management. • Number of post-operative complications. • Need to strengthen the processes and focus around assessment, planning, implementing and evaluating care.	• Improve multidisciplinary case management and documentation. • Clinical oversight of hospital wide procurement process for beds and mattresses.	In progress. In progress.
Clinical processes	• Patient required to undergo unnecessary anaesthetic/surgical procedure to retrieve retained specimen (patient sample).	• Specimen container to be opened intra-operatively over a sterile field to confirm intended specimen is complete in its entirety prior to completion of surgery.	Policy and procedures reviewed and change implemented.
Clinical processes (delayed diagnosis)	• Incomplete reporting of radiological investigation.	• Investigation still in progress.	
Clinical processes (delayed diagnosis)	• Multiple co-morbidities. • Rare lesion. • Missed opportunity for earlier diagnosis on the basis of radiologic (x-ray) evidence.	• Multidisciplinary meetings in difficult cases may provide forum for discussion regarding alternative diagnoses and prompt other investigations.	Underway.

Description of Event	Review Findings	Recommendations/Actions	Follow Up
Clinical processes (delayed diagnosis)	• Delayed diagnosis of rare medical condition.	• Review access to specialist services and equipment in rural health centre. • Ensure all radiology reports have a summary to highlight significant findings. • Unexpected radiology findings to be are brought to the attention of the referrer.	In progress. Actioned.
Patient accident (burns).	• Elderly patient sustained serious burns from hot water bottle.	• Hot water bottles and personal heat packs not to be used in hospital environment.	Notice sent to all staff not to use hot water bottles and wheat packs.
Fall resulting in fractured femur.	• Fall attributed to wearing of unsuitable footwear.	• Review footwear of patients identified to be at risk of falling ("falls risk").	Completed and on-going.
Fall resulting in fracture fractured femur.	• Patient know to be at risk of falling. • Limited number of fall prevention strategies in place.	• Implement Falls Minimisation Programme in specialist ward. • Implement Intentional Rounding in line with the Falls Prevention Action Plan.	Underway. Underway.
Fall resulting in fracture of wrist.	• Unclear instruction with patient attempting to walk without assistance.	• Clinical Staff to ensure patient instruction clearly understood.	Ongoing.
Fall resulting in fractured ankle.	• Multiple co-morbidities. • Patient twisted awkwardly during transfer process.	• No recommendation.	

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Incident codes – 2014/15 DHB SAE report

General classification of event	Event code
Clinical administration (e.g. handover, referral, discharge)	01
Clinical process (e.g. assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (e.g., wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (e.g., intended self-harm, aggression, assault, dangerous Behaviour)	10
Patient accidents (not falls) (e.g., burns, wounds not caused by falls)	11
Patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14

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