MidCentral District Health Board Summary
1 July 2013 to 30 June 2014
Serious and Adverse Events

Serious adverse events affecting people using MidCentral District Health Board's Mental Health and Addictions Service are not included in this report and will be reported separately by the Ministry of Heath's Director Mental Health. A timeline for this latter report is yet to be confirmed.

Description	Review Findings	Recommendations	Follow up
Unexpected neonatal death.	• Deteriorating condition of infant not recognised in a timely manner. • A second midwife was not summoned at or soon after birth to assist with unexpected circumstances. • Possible failure to identify a high risk pregnancy.	• All midwives maintain competence and are able to respond appropriately to an emergency situation. • Consider strengthening policy to include second midwife at deliveries. • Further education on factors that can change the risk level of a pregnant or laboring woman and her baby.	Well progressed
Retained tissue forcep left in patient during surgery. Removed at planned surgery the following day.	Unclear accountabilities and informal communication process between operating teams at the end of each procedure. Resulted in the final count of instruments not being confirmed prior to wound closure/dressing applied.	• At the end of each procedure and on change of operating teams, a standard count is completed. • Discrepancies/issues are noted and addressed before leaving the operating field, and handing over to the next team.	Completed
Delayed diagnosis possibly contributing to baby's death.	Delay in diagnosis which resulted in the physical condition of the unborn baby deteriorating.	• Strengthen cross service working relationships. • All 'high risk' patients need a clearly documented plan of clinical care accessible to other departments. • Review the system of ultrasound appointment bookings. • Complete the process to ensure scans are recorded and stored in the electronic system and relevant staff trained. • Review the Intra-DHB referral system to specialist Maternal Fetal Medicine (MFM) centres, giving consideration to the development of a care pathway approach for after hours. • Evidence of clinical diagnoses in high risk and complex cases should be clearly documented to	In progress

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		enable timely treatment and actions.	
Baby sustained fracture of arm during complex delivery.	Response to emergency well managed however improvements noted.	• Review all aspects of communication, notification and documentation during obstetric emergencies.	
Delayed diagnosis of fracture to hip that occurred before hospital admission.	Patient presented after fall at home. X-ray taken on knee however hip not x-rayed. No senior medical review was done. Assessment focused on other conditions rather than the fall. Patient admitted and 14 days later fracture was noted.	• Review the junior doctor training programme for musculo-skeletal injuries and the senior medical staff validation process. • All health professionals to be reminded of the need for appropriate assessment and follow up.	Completed
Delayed diagnosis of hip fracture.	Presentation to Emergency Department with leg pain over a two day period. Subsequently admitted as inpatient with ongoing complaints of pain and decreasing mobility attributed to other health condition. Fracture not noted for 10 days.	• Ensure all sections of nursing care plan completed. • Review utilisation and timing of the use of diagnostic tools.	In progress
Fall with fracture of hip sustained.	All appropriate falls intervention strategies were put in place for the patient.	• Undertake a case study in the ward for all nursing staff. • Ensure patients' essential items, e.g. drinks, tissues, are close to them on their locker. • Staff refresher on the risk factors that indicate increasing frequency of observation is required.	Completed
Fall with fracture of hip sustained.	All appropriate falls intervention strategies were put in place for the patient.	• No recommendations were made as a result of this event.	
Fall with compressed fracture of lower spine.	All appropriate falls intervention strategies were put in place for the patient.	• No recommendations were made as a result of this event.	
Fall with fracture of hip sustained.	All falls risk assessment completed and interventions in place.	• Refresher to all staff to use falls alerts sticker in clinical record to alert all staff of falls risk	Completed
Fall with fracture in right side of pelvis.	No falls assessment completed.	• Refresher to all staff that all patients aged 65 and over must have a falls assessment.	Completed

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Fall with fracture to hip sustained.	Admitted with history of falls and assessed as high risk. Fell 12 days after admission.	• Ensure falls resources are available on the ward. • Undertake a joint workshop/discussion with nursing and physiotherapy staff to strengthen mobilisation plans for patients.	Completed
Fall with fracture to upper arm.	Falls risk assessment completed on admission and regularly during hospital stay. No falls risk assessment completed after fall.	• Refresher to all staff to use the falls alert sticker in clinical records. • Ensure that falls risk assessment is redone after a fall occurs.	Completed
Fall with fracture of knee sustained.	Assessment of falls risk completed on admission. No follow up of falls risk during admission.	• Ensure falls risk is completed regularly during hospital stay.	
Fall with fracture of hip.	Appropriate assessment of falls risk on admission and documentation of changes to risk assessment during admission and transfer to another ward.	• Ensure consideration of non slip footwear, toileting requirements and impact of medication is included in all falls assessments.	Completed

NB: As part of the Health Quality and Safety Commission Open for Better Care campaign a comprehensive falls injury reduction and prevention programme is in place that includes but is not limited to implementing a falls signaling system and falls aware ward programme, developing patient and family information and purchasing new hospital beds that lower closer to the floor. Our Quality Account "A Review of our Performance 2013/14" which is expected to be published in November provides more detail on actions to reduce falls injury and other work that is being done to improve all aspects of patient safety.