Hauora Tairāwhiti: Adverse Events July 2017 – June 2018

What happened	What are we doing to prevent this happening again?
Medication Error	• Review and update of the thrombolysis for acute MI in ED policy and procedure • Staff education / training on the policy and procedure
Patient Deterioration	• Review escalation process to senior clinicians for deteriorating patients • The communication technique – SBARR – to be used for clinical handover • Documentation – care provided / intervention to be documented in patients file • The Jehovah Witness Policy to be updated and awareness of the policy to follow to be highlighted to staff at different forums • Review management of patients 'out of hours'
Patient Deterioration	• A complete and thorough nursing assessment to be done on patients • Review escalation process to senior clinicians for deteriorating patients • Update current sepsis protocol and disseminate to all Senior and Registered Medical Officers (SMO/RMOs) and nursing staff • Review of patient flow from ED to the ward 'out of hours' • Update of the patient transfer form from community facility to hospital
Unexpected death	• Update current sepsis protocol and disseminate to all Senior and Registered Medical Officers (SMO/RMOs) and nursing staff • Review escalation process to senior clinicians for deteriorating patients • Ceiling of care discussions need to be triggered earlier
Communication Error	• Documentation – care provided / intervention to be documented in patients file • A complete and thorough nursing assessment to be done when patients present initially to ED
Complication	• When there is a change in a patient condition to review current orders in place • Planned theatre lists for patients • The communication tool – speak up for safety to be used as a tool