Hauora Tairāwhiti: Adverse Events July 2019 – June 2020

What happened	What are we doing to prevent this happening again?
Unexpected death	• Review sepsis protocol
Unexpected death	• Provide more support for clinical staff out of hours • Provide training, education and support to clinical staff on recognising the deteriorating patient • Support staff to escalate concerns with prompt communication and clear handover • Implement the Early Warning Scoring System in two departments • Review the off site call back system • Formulate robust guidelines for good nursing/ clinical care that can become serious clinical complications • Ensure all patients in the pre-anaesthetic assessment clinic are reviewed by a senior medical officer.
Unexpected death	• Reinstate Orderlies onto the emergency call to bring defibrillator and act as extra pair of hands • Install a digital clock in the unit so minute by minute recordings can be correct • Consider having available pre-labelled drawn up medications • Regular crash trolley checks
Unexpected death	• Develop a process to ensure communication from a tertiary hospital is provided • Staff training on the massive transfusion protocol and when to use it • Education on medical condition be provided to staff to raise awareness
Unexpected death	• Reinforce importance of using epidurals to staff • All Registered Medical Officers to go through theatre/scrubbing-in orientation • Review when blood gases to be taken
Unexpected death	• No system recommendations identified
Non-HAPI Unstageable pressure injury (HAPI)	• Information to be provided to patient and whānau on pressure injuries • Patient education on repositioning
Behaviour	• Reviews still being completed
Medical Device	• Staff training on using the medical device • Machine software to be updated
Documentation	• External provider to send documentation with patient during an emergency • External provider to be contactable when required