Southern District Health Board
Piki Te Ora

# Adverse Event Report

## Southern District Health Board

## 2018-2019

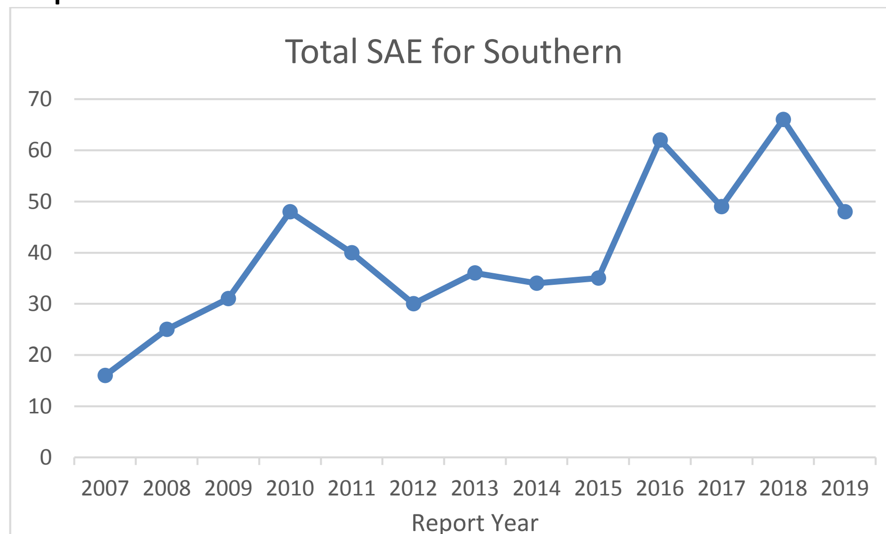
# Adverse Events 2018 - 2019

Welcome to the adverse event report from Southern District Health Board for the period of 1 July 2018 - 30 June 2019.

It is recognised worldwide that health care is a complex process, has associated risks and that patients may become harmed when receiving care intended to help them. This report provides details of the serious adverse events that have occurred within Southern District Health Board (Southern DHB), the recommendations to make the care safer and our progress with implementing these safety measures. Some events are still being investigated at the time of release of this report, and recommendations from some events are still being implemented.

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report *"Learning from adverse events – adverse events reported to the Health Quality & Safety Commission"*; available at http://www.hqsc.govt.nz

**Graph A**




**Graph A -** In the 2018/19 year Southern DHB reported 48 events.

Southern DHB Annual Report: Quality and Performance Account provides analysis of the main groups of events and the district-wide improvement work being undertaken. A Quality Account summary will also be communicated to the wider public through community newspapers. Both publications are available on our website at http://www.southerndhb.govt.nz

## What is an adverse event?

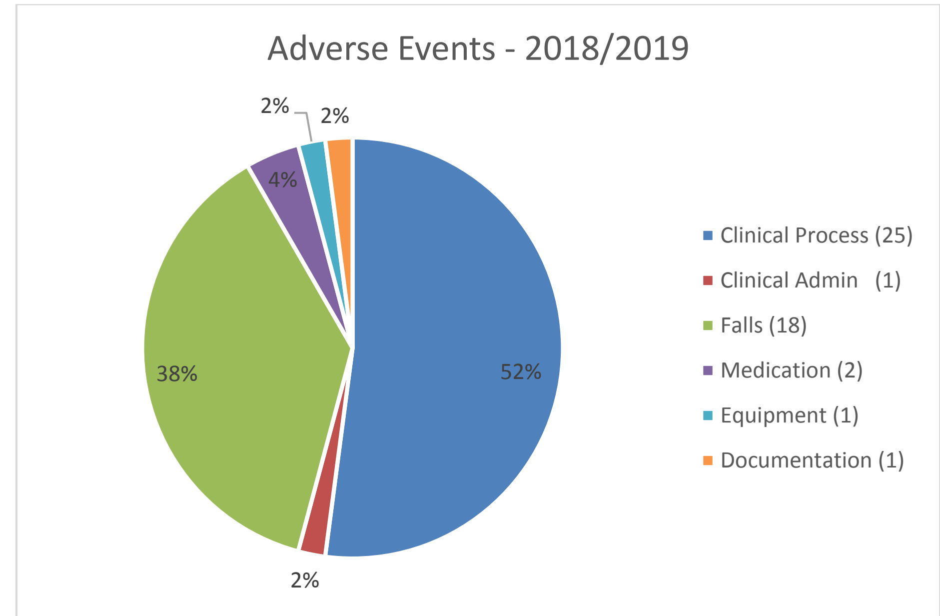
Adverse events are those that have the potential to, or have resulted in, harm to a consumer. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death. District Health Boards classify the severity of adverse events using the Severity Assessment Code (SAC). As a provider of health services we are required to report SAC 1 and SAC 2 adverse events to the Health Quality and Safety Commission.

## Using adverse events to promote patient safety

All adverse events are investigated to learn what happened and how things can improve to avoid recurrence. Interventions are recommended to prevent the same or similar adverse events occurring in the future. It is not an exercise to blame individuals involved in the event.

A rise in the number of incidents can indicate a number of factors including better reporting practices or actual increase in events.

Southern DHB is committed to improving patient safety in line with the HQSC programme of work; this forms part of the transparent process of identifying harm and working to learn from adverse events and improve our patient safety. Information is available at http://www.hqsc.govt.nz




**Graph B Reporting Categories for 2018-2019 – total and percentage**

**Graph B** indicates the number and type (as per the Health Quality & Safety Commission definitions) of reported serious adverse events for the period. As indicated by graph 1, the largest group of serious adverse events SAC 1 and 2 relate to Clinical Processes **52%** (i.e. assessment, diagnosis, treatment, general care), followed by falls **38%** (i.e. serious harm from falling e.g. a broken hip), medication error **4%** (i.e. dispensing, prescribing or administration of medications), clinical administration **2%** (i.e. handover, referral, discharge Resources/organisation), and **2%** documentation. This year we have seen a decrease in Adverse Events SAC 1 and 2 reported in Southern DHB.

## Themes, learning and improving in 2020

The main themes identified from our events often lead to organisation wide improvement programmes, and specific highlights are included below. In 2020 we will also continue to consolidate our improvement work aiming to reduce harm from falls, and recognition and response to deteriorating patient.

### Pressure Injuries

In collaboration with the ACC treatment safety team, an improvement project aimed at reducing pressure injuries across our District Health Board will continue in 2020. The pressure injury prevention programme is developing a pressure injury prevention module and implementing it across Southern DHB hospitals, community services and age residential care facilities. This includes expanding the availability and utilisation of best practice information and resources.

### Medication Safety

Southern DHB are joining with ACC on a project to reduce medication administration errors from November 2019. A Health Quality and Safety Commission clinical medication safety expert will work together with Southern DHB Allied Health, Nursing and Patient Safety staff on this improvement.

### Valuing Patients' Time

A programme of work aimed at improving patient flow through some key parts of the organisation commenced at the end of 2018. Areas of focus include improving acute flow through our emergency departments, internal medicine, older person's health and perioperative services. We are implementing the SAFER patient flow bundle which blends five elements of best practice all aimed at avoiding delays which can lead to patient harm. Staff and consumers are actively engaged in the Valuing Patient Time programme of work which will continue into 2020.

**Report provided by:**

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*Executive Director Quality and Clinical Governance Solutions.*

| Falls | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 1 | Fall resulting in periprosthetic fracture. Hip. | Patient alarm faulty. | Registered nurse caring for patient is to check alarms are functioning by incorporating this into the bedside safety checks. | Complete 31/01/2019. |
| | | Fall due to patient independently mobilising. | Ensure ongoing current falls assessments are completed and interventions implemented as documented in the Falls Documentation Guidelines. | Complete 31/01/2019. |
| | | Assessment for patient watch/family support for high risk patients. | A risk assessment is completed for patients who may require a patient watch according to the Patient Watch/Special Management process. | Complete 31/01/2019. |
| 2 | Fall resulting in fractures and surgery. Metatarsal. | No history of falls. | | |
| | | Tripped over feet while ambulating. Possibly related to tics associated with diagnosed autistic spectrum disorder. | Patient education re- regarding falls risk. | Complete 30/10/2018. |
| | | Features of this tic include completing a full turn while walking or when standing in one spot. | Consider opportunities to look at strength and balance for this patient. | Complete 29/03/2019. |

| 3 | Fall resulting in fracture. Elbow. | Patient got up from bed, legs gave way as reported by the patient. Falls assessment, care plan regular risk assessment and reviews completed. Intentional rounding undertaken. | No recommendations specific to this event – ongoing improvement focus for the organisation. | Complete 12/12/2018. |
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| 4 | Fall resulting in fracture. Periprosthetic. | The patient fell while entering the elevator on exiting the hospital on discharged. She was not assisted to exit the ward and mobilised independently to the elevator despite her clinical record indicating she had been mobilising with supervision and assistance in the ward.<br><br>The patient's high gutter frame was heavily loaded with her personal luggage, this possibly caused instability of the frame which may have contributed to fall. | Falls precautions must follow patient through entire admission. Education to be provided to staff on importance of ensuring patients requiring assistance to mobilise are supported to exit the hospital facility – this should include provision of a wheelchair transport to vehicle and assistance with transferring luggage. | Complete 31/08/2019. |
| 5 | Fall. Hemorrhage. | Fall relating to polypharmacy- patient had a change of medications which could predispose to hypotension, as well as being on an iron infusion. The fact that the patient may be at increased risk of harm if they fall due to medication is mentioned.<br><br>The patient had been assessed and had a care plan in place- it is not clear if in the care plan factored in postural hypotension due to medications and further strategies | Education be provided in the ward relating to impact of polypharmacy on falls. This includes updating the care plan/ interventions to keep the patient safe at the time if the persons condition changes. Explore wider education programme for falls to include polypharmacy as above.<br><br>Reducing Harm from Falls education in the ward to include reassessment of patients when their condition changes- in this case related to medication | Complete 16/05/2019.<br><br>Complete 16/07/2019. |

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| | | put in place. This would need to include the recognition that the patient had a mild delirium. | induced postural hypotension and mild delirium.<br><br>Link to the work that is planned by the Director of Nursing group around combined risk assessment for patients. This will include an extensive education programme that includes identifying appropriate care plans based on assessments, which are carried out every three days. | <br><br>Ongoing. |
| 6 | Fall resulting in fracture. Neck of femur. | The patient presented to the Emergency Department, (ED) from a Residential facility, utilising a walker. This created the impression that the patient was mobilising in her normal manner without apparent difficulty.<br>The patient was not assessed for falls risk on presentation to ED; this was in line with established ED processes. She was referred to Radiology for an x-ray. The referring clinician felt it was safe and appropriate for the patient to self-ambulate to Radiology using her walker.<br><br>The patient fell while moving to be seated in Radiology.<br><br>The patient was retrieved using a hoist. Best practice is using a scoop to reduce the risk of further injury to the hip. | ED to complete falls assessments earlier than the eight hour requirement if the patient is to be transferred out of the department for any reason and if their reason for presentation is following a fall. This would include assessing safe mode of transport when moving to other departments.<br><br>Radiology to locate a chair at reception for vulnerable patients to be able to utilise immediately on arrival in the department.<br><br>Education be provided to ED and MRT staff on safe retrieval of patients following a fall with injury. | Complete 31/05/2019.<br><br>Complete 31/05/2019.<br><br>Complete 31/05/2019. |

| 7 | Fall resulting in fracture. Tibial plateau. | Lack of raised toilet seat may have contributed to the patient landing heavily on the ward toilet seat. | Ward staff to be reminded that if a patient usually uses an aid in their own home then they should source one to utilise in hospital. In this case a raised toilet seat may have prevented the knee fracture. This will be raised at the next ward staff meeting. | Complete 03/04/2019. |
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| 8 | Fall resulting in fracture. Toe. | Patient independent and cleared by physiotherapist – quad stick independent.<br><br>Patient mobilised to commode during night duty with supervision and lost balance on left side whilst adjusting her nightgown.<br><br>The fall did not delay discharge home. | No recommendations. | Complete 23/05/2019. |
| 9 | Fall resulting in fracture. Neck of femur. | Falls care plan repetitive even after ongoing falls without adjustments. | Implement changes if risk has not been reduced.<br><br>Ensure concerns or risks identified on care plan and sign off the review of universal precautions.<br><br>Investigate access to other fall prevention tools such as sensor mats or other appropriate aids. | Complete 16/08/2019.<br><br>Complete 31/07/2019.<br><br>Complete 31/07/2019. |
| 10 | Fall resulting in fracture. Humerus. | | | Investigation report in draft. |

| 11 | Fall resulting in fracture. Pubic rami | Removing prevention alarms seems to be a regular occurrence in the acute areas. | Explore other devices which may be helpful in alerting staff e.g. falls prevention pressure mats, or other strategies to reduce risk (apart from patient watch).<br><br>This should also feed into the plan to look at how we document nursing assessment/ care plan (corrective action). | Complete 15/04/2019. |
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| 12 | Fall resulting in fracture. Ulna. | All appropriate care was put in place. Root cause of the fall was cognitive impairment with a combined presentation of dementia and delirium. | No recommendations. | Complete 29/08/2019. |
| 13 | Fall resulting in surgery. Head flap repair. | Ensure that staff consider how the patient may mobilise at home, and try to accommodate in hospital. This may include consideration of what side of the bed the patient gets up on at home (e.g. in case of disorientation when waking at night.) | This should be a routine requirement of falls assessment and care planning. | Planned 30/11/2019. |
| 14 | Fall resulting in fracture. Ankle. | | | Investigation report in draft. |
| 15 | Fall resulting in fracture. Perioprosthetic. | | | Investigation report in draft. |
| 16 | Fall resulting in fracture. Wrist. | | | Investigation report in draft. |

| 17 | Fall resulting in fracture. Neck of femur. | | | Investigation report in draft. |
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| 18 | Fall resulting in fracture. Humerus. | | | Investigation report in draft. |

| Medication and Intravenous Fluids | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 19 | Medication error. Patient has subsequently died. | | | Awaiting completion of external investigation. |
| 20 | Incorrect prescribing. Poisoning/Toxic effect. | | | Investigation report in draft |

| Clinical Administration – Failure to Follow Up | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 21 | Failure to follow up. | | | Investigation report in draft. |

| Clinical Process – Pressure Injuries | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 22 | Pressure Injury. Inpatient. | Patient admitted with above knee split Plaster Of Paris (POP), was picked up in fracture clinic that patient had inadequate padding under POP.<br><br>Evidence that appropriate Pressure Injury Assessment was completed on ward. Pressure injury prevention maintained.<br><br>Has highlighted the importance of floating heel when patients are admitted with back slabs or POP's, particularly with above knee POP's.<br><br>The care plan was not completed until four days after admission. | Review education for plastering- particularly in relation to padding. Ensure there are processes in place for education.<br><br>Ensure all education includes the importance of off-loading and how this is done. Ensure it is included in ongoing education development.<br><br>An organisational wide documentation working party is being set up following certification feedback with the aim of improving timeliness and completion of assessments and care plans. | Complete 13/02/2019.<br><br>Complete 13/02/2019.<br><br>Complete 30/03/2019. |
| 23 | Pressure Injury. Inpatient. | | | Investigation report in draft. |
| 24 | Pressure injury. Inpatient. | Education required for staff and staging for pressure injuries. Reporting has recently reduced.<br><br>More detail is required in clinical notes including the care that is being undertaken.<br><br>Nursing plans not reflecting pressure injuries when identified as a break on a pressure site. | Arrange training and support for nursing staff on staging of pressure injuries, reporting system and documentation of pressure area care that includes details of the care required. | Complete 02/10/2019. |

| 25 | Pressure injury. Inpatient. | | | Investigation report in draft. |
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| 26 | Pressure injury. Inpatient. | | | Investigation report in draft. |
| 27 | Pressure injury. Inpatient. | It is possible the pressure injury may have started prehospital during the transfer period. The patient was very unwell by the time she arrived at the hospital and would have been poorly perfused for an extended period of time, which put her at very high risk of developing a pressure injury.<br><br>The patient was repositioned as able in the ICU; however there were times when she was left on her back for extended periods due to her unstable condition, haemofiltration dialysis (HFD) and problems with the line during the first few days in ICU. | No recommendation.<br><br>Discussion in the ICU team meetings to ensure consideration is given to opportunities of changing the mattress when the patient is transferred to radiology/ MOT for a very unwell patient, as a strategy to try to minimise the risk of pressure injury.<br>Investigate a lift device which may enable patients to be lifted flat and the bed changed underneath the patient (this would include provision of training in the use of these devices for all nursing staff if they are fit for purpose). | <br><br>Planned 30/11/2019. |
| 28 | Pressure injury. Inpatient. | | | Investigation initiated. |

| Clinical Process – Deteriorating Patients | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 29 | Unexpected deterioration. Patient deceased. | Early Warning Score (EWS) escalation of pathway not followed consistently.<br><br>Patient was borderline for indication of the need for an escort from Emergency Department (ED) to Radiology.<br><br>The news of the patient's death was not passed on to the family in the most supportive way. | Continuing education for EWS escalation as per EWS protocol.<br><br>Feedback to ED of this case and importance of decision making based on patient transfer policy.<br><br>Update policy to reflect how best to break bad news to families particularly in unexpected or sudden death situations and at night. | Complete 05/10/2018.<br><br>Complete 05/10/2018.<br><br>Complete 05/10/2018. |
| 30 | Unexpected death. Polypharmacy. Overdose. | | | Investigation report in draft. |
| 31 | Responding to deterioration problem. Opiate toxicity. | | | Investigation initiated. |

| Clinical Process – Delay in Diagnosis | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 32 | Delay in diagnosis. Cancer. | Did not have a second radiologist to review MRI report. | Either;<br>Outsource Second reading.<br>Upskill radiologists to specialist in breast MRI. | Complete 30/05/2019. |
| 33 | Delay in diagnosis. Loss of vision. | Clinic overload/supervision. | Capacity issues to be addressed as per the ophthalmology review 23.3.2017. | Complete 30/11/2019. |
| | | Anchoring bias' resulted in focus on Dacryocystorhinostomy procedure as cause for "lump" in left eye region. | Use this as teaching tool. | Complete 30/09/2019. |
| 34 | Delay in diagnosis. Urology. | A typical presentation of torsion of the testis resulting in infarction of the testis. | Use this event as a case study in teaching sessions. | Complete 02/04/2019. |
| | | Missed opportunity for urologic assessment of continuing testicular pain and swelling. | Review of Emergency Department (ED) and Urology Resident Medical Officer handbook for suspected testicular torsion. | Complete 02/04/2019. |
| | | Failure to contact urology team with repeat re-presentation. | Any unexpected re-presentation to ED with recurrence or exacerbation of symptoms previously assessed by specialist service should be referred back to that service. | Complete 14/05/2019. |

| 35 | Unexpected death. | | | Investigation initiated. |
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| 36 | Diagnosis delayed. Patient died. | | | Investigation initiated. |

| **Clinical Process – Missed Diagnosis** | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 37 | Missed diagnosis. Malignant skull lesion. | Interpretive error in reporting CT scan.<br><br>This area of the skull base can be difficult to review and assess.<br><br>Noted all reports on electronic system, however is misleading as looks as though clinical director of Radiology has reported these. | Review this patient's imaging at regular audit session alongside the review article as learning process.<br><br>When patient's symptoms worsen, consider requesting further Radiologist review of recent imaging.<br><br>Radiology reports will no longer have clinical director of Radiology on them. | Complete 02/04/2019.<br><br>Complete 30/04/2019.<br><br>Complete 30/04/2019. |
| 38 | Incorrect diagnosis. Cancer. | Learning need identified for the reporting Radiologist.<br><br>Delay in treatment once a positive finding reported. | Further training for reporting Radiologist.<br><br>Once an occurrence of error delaying diagnosis has occurred, the affected patient is fast tracked through the system to further investigation and | Complete 08/03/2019.<br><br>Complete 30/06/2019. |

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| | | Family distress regarding delay in reporting liver lesion was compounded by letter from oncology acknowledging receipt of referral and giving priority and timeframe. | treatment. Cancer nurse coordinator to be contacted.<br><br>Oncology service review 'acknowledgement receipt of referral letters' and consider direct contact with patient who have experienced delays. | Complete 07/05/2019. |

| **Clinical Process – Complications During Surgery** | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 39 | Complication during procedure. Perforation. | This patient had an open insertion of suprapubic catheter performed by a consultant urologist. 10 months later, and after multiple catheter changes in the community by the District Nursing service, a routine catheter change resulted in catheter failure. After appropriate management of this problem both by the District Nurse and by ED, he was found to have a vesico-entero-cutaneous fistula caused by erosion of the catheter into the small bowel. The management throughout was appropriate. | No recommendations. | Complete 13/09/2019. |
| 40 | Unanticipated complication of surgery. Hemorrhage. | Pre-operative work up was not robust. | Pre-operative work the surgeon's cases be critiqued by the Clinical Director of Urology prior to surgery proceedings. The critique is to continue until the Clinical Director of Urology is satisfied | Complete 28/05/2019. |

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| | | | that the pre-operative work up of patients has reached an adequate standard. | |
| | | The question was posed as to whether the surgical approach was appropriate. (The SMA was identified incorrectly as the renal artery and clipped during the laparoscopic procedure and the resultant action of removing the clip caused catastrophic haemorrhage). | The laparoscopic approach to the surgery and the intraoperative decision making, particularly with regards to the Weck Hemo O Lok Clip needs further expert review. | Complete 28/05/2019. |
| | | Intraoperative decision making of removing the Weck Hemo-O-Lok not by the recommended method. | Weck Hemo O Lok be removed by recommended method only. Hemo O Lok remover be purchased. | Complete 23/05/2019. |
| | | Lead Carer not clear with multiple teams involved. Needs to be clear lines of communication, particularly in a complex patient with multiple teams involved, as to who makes the definitive decision. | Intensive Care Unit develop a process to ensure the Lead Carer is documented and visible to all staff. | Complete 28/05/2019. |
| | | Informed consent process and documentation not consistently followed particularly in regard to patients unable to consent. | Informed Consent Working group to review the issues with consent raised in this case and use in the current review of consent policy and planned educational sessions. | Complete 28/05/2019. |
| | | Open disclosure policy and guidelines awareness be raised. | Clinical Directors be asked to raise this within their teams to ensure all staff aware of policy. | Complete 28/05/2019. |

| 41 | Major complications Of surgery. Patient deceased. | | | Investigation initiated. |
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| 42 | Haemorrhagic complication during surgery. Perforated blood vessel. Patient deceased. | | | Investigation in progress**.** |
| 43 | Unanticipated complications of surgery. Perforation. | The notes record that no ultrasound was available.<br><br>Staff performing Termination of Pregnancy (TOP) may not have completed ultrasound training.<br><br>Documentation was incomplete. | Ultrasound should always be present for TOP clinic.<br><br>All medical staff should be trained to ensure that they are competent in the use of ultrasound or have adequate supervision from a qualified clinician.<br><br>All staff working in clinic should be competent in clinical documentation. Six monthly compliance audits to be introduced. | Complete 16/04/2019.<br><br>Complete 15/09/2019.<br><br>Complete 30/05/2019. |

| Clinical Process – Complication During Procedure | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 44 | Emergency system issue. Patient deceased. | The equipment *Emergency Stop Button* was located adjacent to the *Emergency Call Bell*. | The *Emergency Stop Button* that was located adjacent to the *Emergency Call Button* has already been removed in the Cath Lab. There is one remaining in an appropriate area within the department. | Complete 14/12/2018. |
| | | | A stocktake of *Emergency Stop Buttons* occurs in all other areas that use imaging procedures. They should be removed in clinical areas, leaving them only where they must be consciously accessed. Building and Property should work with the managers and clinical staff from these areas to complete this recommendation.<br>The *Emergency Stop Button* must not be located adjacent to other emergency call type bells. | Complete 14/12/2018. |
| | | Combination of staff who were reasonably new or inexperienced in the Cath Lab, not being orientated to the *Emergency Call Bell*. | Ensure emergency procedures, including raising awareness of the location of call bells is part of the orientation. | Complete 14/12/2018. |
| | | | As the Cath Lab is about to undergo refurbishment, location of call bells should be based on recommended best practice. | Complete 14/12/2018. |

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| | | There is no clear leadership in emergency events in the Cath Lab. This is likely to fall to a second doctor, or an experienced Registered Nurse in the area. | The Cath Lab establishes clear emergency procedures that includes nominating a designated person to take the lead in similar situations.<br><br>Simulation events relevant to the Cath Lab are held monthly, with all staff expected to attend at least one simulation training session every three months. | Complete 14/12/2018. |
| | | | Noisy environment:<br>Part of the simulation must be how to manage an escalating situation, e.g. asking those not involved/required to leave.<br>The designated lead should assume responsibility for managing an escalating situation e.g. asking those not involved/required to leave. | Complete 14/012/2019. |
| | | No one present knew how to restart the radiological equipment. | Staff working in the Cath Lab (or other areas with Emergency Stop Buttons) are educated in how to restore functionality in an emergent situation. Instructions must be clearly documented and located at each switch. | Complete 30/10/2019. |

| Clinical Process – Retained Item | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 45 | Retained item. | | | Investigation report in draft. |

| Clinical Process – Care Plan Discharge Issue | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 46 | Medication prescribing error. Hemorrhage/ Organ failure. Patient deceased. | Patient assessment not completed as planned as rectal examination day prior to discharge.<br><br>Documentation including the Older Persons Health Orthogeriatrics form was not signed.<br><br>Discharge planning appeared 'rushed' on discharge to rest home. | It is recommended that the house officer be reminded about the importance of completing tasks and documentation.<br><br>It is recommended that all staff be reminded to date and sign documentation.<br><br>Importance of orthogeriatric review be emphasized. | Complete 19/03/2019.<br><br>Planned 30/11/2019.<br><br>Complete 28/05/2019 |

| **Documentation** | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 47 | Medication prescribing error. Incorrect dose. | New medications to have dosages clearly documented in clinic letters. | The learnings from this event be used within the department to reinforce importance of documentation. | Planned 30/11/2019. |
| | | The use of Mosaiq for monitoring of administration of Zoladex was not used. | Discuss at Medical Directors meeting. | Planned 30/11/2019. |
| | | | Zoladex entered into Mosaiq at beginning of treatment. Use HealthOne system to check dispensing. Use new Pharmac report when available as back up. | Planned 30/11/2019. |
| | | The General Practitioner used an incorrect dose. When protocols are sent to GP practices they can be overlooked in a busy practice. Need to ensure that the right people in the practice have the correct information. | PHO WellSouth to discuss at Well South Quality group to consider quality improvement initiatives in regard to this adverse event and communicate with GPs to encourage confirmation of dosage when not recorded and to encourage practice nurses to email or fax Zoladex administration to research nurse with patient NHI and dosage. Encourage fax/email from GP practice to research nurse following administration. | Planned 30/11/2019. |
| | | | Review Zoladex protocol letter in regard to finite end and addition of contact numbers and include phone contact on protocol letter. | Planned 30/11/2019. |

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| | | | Consider follow up phone call to primary care with new protocols. | Planned 30/11/2019. |

| **Medical Device/Equipment** | | | | |
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| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
| 48 | Possible medical device failure. Patient deceased. | The Prime Agreement between SDHB and St John defines that the DHB will provide a suitable qualified person 24/7 to respond to and assist with patient care at any medical or accident related incident in the coverage area. The coverage area is within the Stewart Island boundaries. Stewart Island only has a small road accessible area. | Define the Area of Operations for PRIME nurse response on Stewart Island. If responses are to include areas outside of road-accessible sites around Oban, there needs to be clear activation criteria, and clear limits on when activation is not appropriate (e.g. weather, distance, available personnel, etc.).<br>Corrective Action<br>- Define area of response<br>- Define standard operating procedure for response when activation is not appropriate. | Planned 13/12/2019. |
| | | No clear standard operation procedure for PRIME nurse to respond to medical emergencies at remote locations. | If PRIME nurses are to respond to incidents outside the road-accessible Oban area, clear standard operating procedures (SOP) should be designed.<br>Corrective Action:<br>- Development of standing operating procedures; | Planned 13/12/2019. |

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| | | | - Review response equipment, location beacons and satellite phones if to attend in remote locations; | |
| | | There was no clear transfer of ownership of the AED in 2013, so neither SDHB nor St Johns had the AED listed as an asset requiring maintenance. There was no training or equipment checking programme established for the AED. | All equipment used by the PRIME nurse (including equipment stored in the clinic and the ambulance) should be clearly owned (labelled) and managed by the DHB, including equipment donated from other agencies. All major pieces of equipment should have associated programmes of orientation, periodic training, maintenance, checks, and replacement.<br>Corrective Action<br>- Asset register up to date with all equipment<br>- Maintenance schedule in place for all equipment<br>- Equipment and stock check lists in place with standardised checking procedures | Planned 30/11/2019. |
| | | There are no clear standard operating procedures for PRIME nurses responding to medical emergencies at remote locations. | PRIME staff on Stewart Island should have access to regular education and training and support provided on the Island.<br>Corrective Action<br>- Standing operating procedures developed | Planned 13/12/2019. |

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| | | | around staffing and clinical response. Stewart Island District Nurses will undergo formal orientation to the standard operating procedures and Island requirements. | |
| | | The on call Registered Nurse was accompanied by another nurse who had finished on call but was waiting to come off the Island. The Registered Nurse was also accompanied by St John volunteer and DOC staff but she could have been left to manage the situation with less resource. There was no coverage left in Oban. | Review of the current staffing model, with consideration of back-up for the nurse on duty.<br>Corrective Action:<br>- Standard operating procedure to specify staffing response and PRIME nurse coverage region. | Planned 13/12/2019. |
| | | From the time of the 111 call until the first responder arrived at the scene was 1 hour, 18 minutes. The time from 111 until the helicopter paramedic arrived was 2 hours, 10 minutes. There was confusion and communication difficulties over the exact location of the incident. | Communicate with Stewart Island DOC to discuss navigation aids for the Rakiura Track, such as numbered marker posts.<br>Corrective Action:<br>- Meet with DOC to discuss navigation aids;<br>- Discuss locator beacons for this type of incident; | Planned 13/12/2019. |

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| | | On-call registered nurse ran a debrief after the incident but this was not well supported by the DHB and other agencies. | Offer a DHB-initiated formal debrief to all those involved in the incident.<br>Corrective Action<br>- Explore opportunity for a formal debrief and or presentation of the review to those present at the event. | Planned 30/11/2019. |