Waitemata District Health Board
Serious Adverse Events Report
1 July 2015 to 20 June 2016

Summary

In the year 1 July 2015 to 30 June 2016, Waitemata DHB reported 42 events that caused or had the potential to cause serious harm or death (serious adverse events).

year	2006 - 2007	2007 - 2008	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012	2012 - 2013	2013- 2014	2014 – 2015	2015 – 2016
Number of events reported	22	11	20	17	29	29	50	51	48	42

A small decrease in the number of serious adverse events occurred in 2015 -2016 which is pleasing given the increase in the volume of clinical events each year at the DHB. What we report and investigate has changed over time and we are now also reporting events that have caused no long lasting harm and events that are near misses, that is, where no patient harm was identified.

Injuries suffered by patients when they fall are the most common serious adverse event, with 36 of the 42 serious adverse events related to falls. The injuries included broken bones, head injuries, and skin lacerations that required stitches. Each of the 36 incidents related to falls was reviewed using a systematic review protocol. Understanding where improvements to the falls prevention programme need to be made and where we can help staff keep patients safe, are the main drivers for the review. Further details about the 2015/16 falls events and our falls prevention programme are set out at the end of this report.

There were 8 other serious adverse events leading to actual or potential serious patient injury. Three events relate to delays in responding to a patient's deterioration and one event to a delay in treatment of sepsis (serious infection). In response to these events and the findings of our investigations, we have commenced a programme to improve the management of the deteriorating patient that involves early, consistent identification of clinical deterioration and early, rapid response. In addition we have commenced a 'Survive Sepsis' quality improvement programme to improve the early recognition and management of sepsis, which will also help improve the management of deteriorating patients. The Survive Sepsis improvement programme includes improving clinicians' skills in sepsis recognition and management and more timely, standardised and effective detection and management of sepsis, with the aim of achieving better patient outcomes with reduced mortality, morbidity, length of stay and a better experience for patients suffering from sepsis-related conditions.

Waitemata District Health Board
Best Care for Everyone

Waitemata District Health Board
Serious Adverse Events Report
1 July 2015 to 20 June 2016

What is a serious adverse event?

Serious adverse events are events which have generally resulted in harm to patients. A serious adverse event is one which has led to significant additional treatment, is life threatening or has led to an unexpected death or major loss of function (http://www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/).

Serious Adverse Event Review at Waitemata DHB

All serious adverse events at Waitemata DHB are investigated by a team of clinicians (e.g. doctors, nurses, midwives, allied health) and quality team staff that are not involved in the event to ensure reviews are impartial. Serious adverse event investigations are undertaken according to the following principles:

- Establish the facts: what happened, to whom, when, where, how and why
- Look at systems and processes of care delivery with a view to improvements, rather than blaming individuals
- Establish how to reduce or eliminate a recurrence of the same type of event
- Formulate recommendations and an action plan
- Provide a report as a record of the review process
- Provide a means for sharing lessons from the event

Each event report is then reviewed by the Serious Adverse Event Committee to ensure that the investigation has appropriately established the facts, addressed all issues and the recommendations and actions are robust. All actions are assigned to a responsible owner and tracked to completion by the Senior Management Team on a monthly basis.

The table and report below outlines a summary of events, findings and recommendations of the events that have occurred in 2015/2016. These events have been classified into the following themes:

- Procedural injury
- Delay / failure in follow up or treatment
- Patient misidentification
- Wrong or unnecessary procedure
- Delay in escalation of treatment
- Pressure injuries
- Medication error
- Falls
- Other

Description of Event	Investigation Findings	Recommendations/Actions
Delay / failure in follow up or treatment		
Delay in diagnosis and treatment	Information related to a planned biopsy being requested is not in the notes	Investigate adding a high suspicion of cancer flag to the electronic discharge summary

	An outpatient follow up appointment was booked but later cancelled. The reason for the cancellation was not documented.	Documentation of the reasons an appointment is cancelled and the person authorising cancellation should be included in the electronic patient information management system Add 'biopsy of lymph node' to the list of dependent investigations that can be selected by booking and scheduling staff to attach pending investigations to be completed before an outpatient appointment
Delay in escalation of treatment		
Delay in treatment of sepsis (serious infection)	There was a delay in administering antibiotic. There were a number of missed opportunities to follow up and escalate the delay including the antibiotic being delivered to the department but this was not communicated to staff.	Develop a sepsis improvement programme to improve the early recognition and management of sepsis Review the current handover process and transfer of information on the wards to facilitate more information being captured in Trendcare utilising the information from assessments and the clinical notes Implement standard operating procedures for the handover of medication to staff out of hours
Delay in response to patient deterioration of patient with influenza after giving birth	Under investigation	

Delay in response to patient deterioration of patient with bleeding from the bowel	Under investigation	
Delay in response to deterioration in Patient with bowel obstruction	There were several opportunities to insert a nasogastric tube prior to a procedure under sedation. However, this did not happen. The seriousness of the patient's deterioration was not recognised which led to a lack of appropriate escalation of the patient's condition and a delay in administering antibiotic There was inadequate handover of care	Undertake a review of systems of care for patients undergoing acute gastroenterology procedures including: • An improved triage process for patients undergoing acute gastroenterology procedures • An alternative schedule with a view to reducing time pressure and list over-runs Clarification of the indications for insertion of a nasogastric tube in patients with acute bowel obstruction who are at risk of aspiration. Dissemination of this information to all staff involved in the care of these patients. Investigate adapting and implementing a new escalation pathway and training programme
Cardiac arrest secondary to bleeding duodenal ulcer	The patient was stable though was at significant risk of deterioration. Given this, the procedure should have occurred in the operating theatre with anaesthetic assistance The resuscitation call was made in a timely fashion with an appropriate response.	Develop written guidelines for a triage process for patients requiring acute gastroenterological intervention. Develop a resuscitation protocol for acute endoscopy patients and specify appropriate locations for this to occur. Develop guidelines for continuity of care of acute endoscopy patients and disseminate of this information to all stakeholders
Other		.

Fracture during transfer in radiology	Under investigation	
Airway obstruction leading to asphyxia and death	After eating, the patient was assisted to the toilet. The patient collapsed while being transferred to the bed after returning from the toilet Staff responded in a timely and appropriate way as soon as they recognised the patient showed signs of airway obstruction.	Review case with staff across all wards to increased awareness of the importance of supervision during protected mealtimes In-service education session on the recognition and management of airway obstruction and pulmonary aspiration

Summary of falls causing patient harm

There were **34** serious adverse events related to falls reported to the Health and Safety Commission (HQSC) by Waitemata DHB in the year 1 July 2015 to 30 June 2106. This is three less falls than the previous year (2014/15).

Fractures sustained as a result of these falls are as follows:

Fracture	Number
Facial	**3**
Arm	**5**
Vertebrae	**1**
Pelvis	**4**
Hip	**12**
Leg	**4**

The remaining injuries were head injury (4) and injury resulting in laceration (1).

What are we doing to minimise patients' sustaining major harm from falls?

Waitemata DHB has implemented a range of initiatives to identify people at risk of falls and minimise the potential for falls, and has put in place improvements following investigation of fall events. Despite these preventive measures, the total number of falls and the number of falls resulting in harm has remained relatively stable. Staff awareness and vigilance is high and reporting of fall events has increased.

Universal falls assessment and risk minimisation processes have been introduced and include:

- assessment using an evidence-based, internationally adopted form (MORSE form) within 8 hours of admission
- care planning that depends on the relevant individualised needs:

Universal care plan [falls risk score<25]	Medium care plan [25-44]	High risk care plan [>45]
Patient oriented to area and shown how to use call bell	***Universal PLUS*** **Bed positioning optimised**	***Universal and Medium PLUS*** **Patient wearing RED wrist**
Hourly rounding completed and	**Night light on in patients bed space**	**Correct footwear or non-slip**
All areas are free of clutter	**Patient educated re mobility aid**	**Physiotherapy referral made**
Mobility aids and call bell placed within	**Need for IV line reviewed**	**Pharmacist medication review**
Patient wearing supportive footwear or non-slip socks	**Physiotherapy referral made due to concerns about balance or advice re need for aid**	**Flag patient on ward whiteboard**
Bed signage is completed and up to date	**Fluid balance monitored**	**Assistance/ supervision as prescribed**
Fall risk score and interventions documented in clinical notes	**Pharmacist medication review considered and request made**	**Bed positioned against wall**
Patient mobilised/transferred according		**Floor line bed used**
Toileting plan in place as per continence flowchart		**Discuss falls risk and prevention strategies with patient/family**
Do NOT use bed rails		**Patient wearing hip protectors**
	PLUS if Patient Confused	***PLUS if Patient Confused***
	Nursed in position of high visibility	**Do NOT use bed rails**

Patient orientated to place and time at each contact	**Do not leave alone in bathroom/on commode**
Delirium screening completed	**15/60 checks or continuous**
Family given a copy of 'Falls prevention pamphlet'	**Encourage family to sit with patient**
Do NOT use bed rails	**Bed location close to nurses' station**
	Use of personal alarm / pressure mat/ bed sensor/ chair alarm

Our focus is on *reducing falls with serious harm*. Emphasis has been placed on completing falls risk assessments within 8 hours of a patient's admission, with particular emphasis on people over 75 years old (55 years for Maori/Pacific Island patients), and a daily review of the patient's care plan. Monthly auditing of falls risk assessment has demonstrated increased compliance with both falls risk assessment and individualised falls care planning (consistently >95%). A post-fall assessment investigation checklist and reporting system has been developed that clearly identifies actions and reinforces learning. There is ward-by-ward reporting of falls using the 'Safety Cross' as part of the ward quality boards, to raise awareness of falls frequency and the importance of falls prevention.