Serious Adverse Events at Waitemata District Health Board (DHB) FY 2014/15

There were 48 serious adverse events (previously known as serious and sentinel events) reported by Waitemata DHB in the July 2014 to June 2015 year.

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

A small decrease in the number of serious adverse events has occurred in FY2014/15 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.

Serious Adverse Event Review

Serious adverse events (previously known as serious and sentinel 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/).

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 the 2014/15 financial year. 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
Procedural Injury		
Four episodes of retained swab/pack left after birth or gynaecology procedure	The DHB's guidelines for perineal repair were not followed Policy needs to be updated to clarify who is allocated responsibility for swab count Use of packing not clearly communicated to post operative theatre and ward staff	Update for all maternity and obstetric staff on the DHB's perineal repair policy Introduction of new policy specifying responsibilities for documentation of perineal repair and final check of swabs when procedure is complete Education and training in the use of vaginal packing as pressure for urethral surgery Verbal communication and documentation of post operative care instructions including removal of packing Update for all staff on the surgical count procedure at the end of the operation
A surgical wound was reopened at the end of the procedure to remove a retained swab	New staff unfamiliar with the surgeon's practice Delay in onset of surgical count	New theatre staff to observe a surgeon's practice before joining the surgical team Clearly define when the first and second surgical counts should begin
Delay / failure in follow up or treatment		
A baby died from sepsis attributed to intrapartum infection	Guidelines for recommended practice for the prevention of neonatal Group B streptococcus do not clearly describe actions to be taken for mothers with	Update guidelines in line with national guidelines for broad spectrum antibiotics in known Group B streptococcus positive mothers showing clinical symptoms of infection

	known Group B streptococcus positive showing clinical symptoms of infection Death may have been unavoidable	Update guidelines with clear instructions on when to consult with a paediatrician
Delay in diagnosis and treatment of cancer	High suspicion of cancer not flagged on triage form E-referral process is not fully electronic. E-referrals need to be printed for triage resulting in loss of visibility of urgent label marked in red on the e-referral form	Review speciality's triage process and introduce quality assurance process Implement full electronic e-referral process
Patient misidentification		
Misidentification of two patients in outpatient clinic leading to incorrect diagnosis and treatment	The patients were not clearly identified in the outpatient clinic and the wrong patient entered the procedure room when called As a result labels with incorrect patient details were placed on the biopsy specimen and request forms	Introduce a time-out check including the patient, in the outpatient procedure room and new documentation for the time-out check The pre-procedure checklist (that includes patient identification) to be undertaken once the patient has entered the procedure room
Pressure injuries		
Three episodes of pressure injury (ungradable/Grade 3)	The patients' pressure injury risk was not calculated correctly/risk assessment was not completed within 8 hours of admission The risk of pressure injury was not reviewed during the course of admission as per DHB policy A different type of dressing under a fibreglass cast may have prevented the pressure injury	Weekly audits of pressure injury risk assessments to ensure the grading is correct, risk assessments are completed with 8 hours, and patients' risk is reassessed where appropriate Case review with nursing ward team so that they are aware of the impact on patients when risk assessments, care planning and documentation is incomplete and patients are not reassessed on a regular basis The Head of Division (Nursing) has reviewed the type of prophylactic dressing that is used under plaster casts for those patients that are at high risk of developing pressure injuries

Summary of falls causing patient harm

There were **37** serious adverse events related to falls reported to the Health and Safety Commission (HQSC) by Waitemata DHB in the 2014/2015 financial year (FY). This is two less falls than the previous financial year.

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

Fracture	Number
Facial	**7**
Upper Arm	**4**
Lower Arm	**6**
Pelvis/Lower Thigh	**3**
Hip	**12**
Lower leg	**1**

The remaining four injuries were either related to the scalp e.g. laceration, or bleeding on the brain.

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 number of falls overall remains consistent as does the number of falls resulting in harm. Staff awareness and vigilance is high and reporting of fall events has increased.

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

- assessment using an evidence-based, internationally adopted form (MORSE form) within 8 hours of admission
- care planning action 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), 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.