MidCentral District Health Board
Serious Adverse Events Report
1 July 2017 to 30 June 2018

Summary

During the period 1 July 2017 to 30 June 2018 we reported 20 events that caused or had the potential to cause serious harm or death (serious adverse event). These occurred in our hospital and health services and were reported to the Health Quality and Safety Commission (HQSC) as required by the National Reportable Events policy.

We consider one event of this nature one too many, and apologise unreservedly to the patients and family/whānau involved in these cases. We acknowledge the distress and grief that occurs for patients and their family/whānau when things go wrong in healthcare.

We continue working to improve the quality of care that we provide to our community and value the national reportable events process as one way of supporting this improvement. We always seek to learn from these events and improve safety. In order for this to happen, we depend on events being reported by the people involved. A strong safety culture means that patients and their family/whānau, other health providers such as family doctors and primary health nurses, and our own staff tell us when an incident has occurred, so that we can look into what has happened. To help us with this, we have worked with our staff to implement a programme titled Speaking up for Safety, where all staff will have the opportunity to learn skills to speak up when they see or hear something that may be unsafe.

The 20 serious adverse events reported include:

- 14 classified as **clinical process** where the usual process used in providing clinical care was not followed. These events varied across a range of services. This includes nine serious **pressure injuries** (bedsores) which are new to national reporting.
- One was related to **medication management**.
- Five **patient falls** occurred in our hospital and health centre resulting in serious harm to those people.

These 20 events exclude all Mental Health and Addiction Services serious adverse events which are reported by the Ministry of Health.

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.

Serious Adverse Event Review at MidCentral DHB

All serious adverse events at our District Health Board are investigated by clinical and quality teams who were 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 report is then reviewed by the Serious Adverse Event Governance Group to ensure that the investigation has appropriately established the facts, addressed all issues, and that the recommendations and actions are robust.

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Description of Event	Investigation Findings	Recommendation/Actions
Clinical Process		
The patient passed away while waiting for transfer to another hospital.	Patient died while awaiting aeromedical transfer to a tertiary hospital.	Review the policy of inter-hospital aeromedical transfers. Continue with improvements to align with the NZ Out-of-Hospital urgent transfer pathways.
The patient presented to the Emergency Department (ED) and was discharged, subsequently the patient collapsed at home and returned to the ED and passed away.	Missed diagnosis of a medical condition.	An external review has been undertaken with actions to be implemented. Continued improvements are being made in line with these actions.
The patient experienced an episode of unresponsiveness whilst self-caring during haemodialysis and later passed away.	This was due to an unexpected medical event unrelated to his treatment.	There has been a review to ensure the patients are provided ongoing training and education to ensure safe self-care.
The patient experienced a loss of sensation to pass urine following a period of urinary retention, requiring self-catheterisation.	There was a delay in recognition and treatment of urinary retention following early removal of catheter.	Further education on time frames for catheters to be in place, ensuring urine measurements are acted upon following catheter removal.
The patient experienced dislocations following revision of their total hip joint replacement and also sustained a pressure injury.	This frail patient sustained both hip dislocations and a pressure injury. The treatment for the hip dislocations prevented some aspects of pressure injury preventative care.	A refreshed approach to the prevention of pressure injury awareness and management is being undertaken across the wards. (Refer to the Pressure Injury Section on page 4)

Description of Event	Investigation Findings	Recommendation/Actions
Pressure Injuries (Bedsores) Nine patients sustained a serious pressure injury. The pressure injuries are graded using a standard process. The pressure injuries reported were suspected deep tissue injuries.	Across all nine events it was found that improvements were required in staff education relating to the grading of pressure injuries; including appropriate risk assessment and preventative strategies implemented.	A refreshed approach to the prevention of pressure injuries, including accurate risk assessment and pressure relieving equipment, is being undertaken across the inpatient wards.
Falls		
Five patients had a serious fall resulting in a fracture.	In four falls it was shown that, overall, good measures were in place to reduce patients' risk of falling. In one fall, improvements to the fall risk assessment has been made to reduce the risk of falling. Other areas identified for improvement include de-cluttering corridor space and communication around assistance to mobilise patients.	A working group is undertaking an audit of all falls incidents (regardless of the type of harm to the patient) to identify trends and where further improvements can be made. The Group includes medical, nursing and allied health staff. Education has been undertaken about all aspects of the Falls Awareness Programme. A combined risk assessment tool has been introduced in ward areas. Reduction in unnecessary storage of items in ward areas has taken place.
Medication		
The patient experienced a medical event following a recent transfer of care.	Required medication on transfer of care not prescribed.	Services involved will explore the role of Pharmacy and Services in medication management on transfer of care.