MidCentral District Health Board
Serious Adverse Events Report
1 July 2018 to 30 June 2019

Introduction

This report has been written for the consumers, their whanau and communities of the MidCentral District. It provides a summary of the serious adverse events that have occurred within the 2018/19 year in our services. This report is released alongside the national serious adverse events report released by the Health Quality and Safety Commission on 21st November 2019. This report should also be read in conjunction with the Quality Account 2018/19 that has been released and is available on our website.

Summary

During the period 1 July 2018 to 30 June 2019, we reported 54 events that caused, or had the potential to cause, serious harm or death (serious adverse event). These occurred in Palmerston North hospital or other MidCentral District Health Board (MDHB) facilities 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.

A key part of our strategy is our commitment to deliver quality and excellence by design. MDHB values the national reportable events process as one way of supporting this goal. We are always seeking 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 patients, their family/whānau, other health providers, such as family doctors and primary health nurses, and our staff tell us when an incident has occurred, so we can look into what has happened. To help us with this, we have worked with our staff to implement a programme titled Promoting Professional Accountability, where all staff have the opportunity and are empowered to speak up when they see or hear something that may be unsafe.

MidCentral District Health Board
Serious Adverse Events Report
1 July 2018 to 30 June 2019

The **54** serious adverse events reported include:

Clinical Process	Medication management	Healthcare Associated Infection	Falls resulting in fracture	Mental Health and Addiction
33 events which includes 10 pressure injuries (bedsores) and 5 always report and review event	**1** event	**1** event	**10** events	**9** events
54 events in total				

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.

What is an always report and review event?

These events are a subset of adverse events that should be reported and reviewed in the same way as serious adverse events, irrespective of whether or not there was harm to the consumer/patient. Always report and review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. Examples of these types of events are wrong site surgery, wrong implant/prosthesis, wrong blood product, retained foreign object post procedure, wrong consumer/patient or child/infant abduction or discharge to the wrong family/whanau.

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 impartiality. 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.

MDHB monitors trends in our incidents including our serious adverse events. In the 2018/19 year there was an increase in reported events. This was due to a number of factors including changes in to the classification of the reports we are required to make to the HQSC and the inclusion of all significant pressure injuries in our reporting. We actively encourage our staff, our patients, their families and whanau to report all incidents. A healthy safety culture will result in increases in reported events and more importantly, allow us to learn from these incidents and make quality improvements.

In the last year a number of improvements have been made or are in the progress of being implemented. Strengthening our digital systems, including how results as flagged when they are not within normal limits, is one area where we have made changes. MDHB continues to promote the surgical safety checklist as core practice in both our planned and acute surgical service areas and we have extended this to other procedural services to strengthen safety. A number of policies, procedures and risk assessment processes have been revised and training initiatives developed.

Pressure injury prevention is an important part of our quality improvement process. MDHB has improved equipment and mattress ordering and systems, advanced the assessment tools used in our services, created a specific pressure injury data base and co-designed these improvements with consumers to further improve in this area and reduce the risk of pressure injuries.

MidCentral District Health Board
Serious Adverse Events Report
1 July 2018 to 30 June 2019

Description of Event	Investigation Findings	Recommendations
Clinical Process		
Patient required a higher level of care after a procedure was performed	Patient experienced periods of racing heart beat after insertion of a long intravenous line	Review current and planned provisions for adult long intravenous line insertion services at MDHB. To include a review of resourcing for the service.
Patient did not receive timely services which resulted in significant delay in treatment	A planned outpatient follow up appointment was not booked following discharge from hospital due to the electronic patient management system being changed	Changes to the patient management system need to include clear business rules and training for staff to prevent errors occurring. All appointments for a period to be reviewed to ensure follow up appointments had been made where required.
Higher levels of chlorine in water used for patient equipment in the renal unit	The number of renal dialysis machines operating at any one time significantly increases the pressure of water that passes through the filters	Regular biomedical monitoring to be implemented. Staff training to monitor and record pressures on machines for variance reporting.
Delay in follow up for two patients resulted in significant deterioration in vision	Changes to the electronic patient management system identified incomplete referral records, which resulted in follow ups not being flagged in a timely manner. Capacity and demand on service resulted in high waiting lists.	Investigate clinical and staffing options for service to manage demand, including training of nurse-led clinics. Reassess the discharge process for the service so new patients can be seen in a more timely manner. Implement clinical oversight of waiting lists.

MidCentral District Health Board
Serious Adverse Events Report
1 July 2018 to 30 June 2019

Description of Event	Investigation Findings	Recommendations
Inappropriate clinical decision making regarding method of delivery of deceased unborn baby	No root cause for baby death found. Factors that contributed to caesarean delivery after baby death include limited orientation for new staff, proceeding to operating theatre without following correct arrangements, failure to check mother's heartrate when checking for baby's heartrate.	Training of staff on specific policy and creating visual aids to assist staff
Hospital acquired blood clot on the lungs	Communication issues within the clinical team regarding choice of treatment. Mobility issues were evident following surgery. Early warning process was not followed.	Pathways to be developed for agreed treatments. Post-surgery mobility guidelines available for all staff. Education for staff regarding early warning scores and escalation.
Delay in reviewing results and providing follow up	Follow up booking process not completed. Review and sign off of investigation results not completed.	Training in outpatient booking system for the service. Consideration of electronic sign off of results for MDHB.
Infant born in poor condition requiring transfer to another DHB	High risk pregnant patient found it difficult to engage regularly with services. Poor clinical documentation.	External review of labour management. More consistent documentation regarding scans by clinicians (including electronic record).

Description of Event	Investigation Findings	Recommendations
	There were different interpretations of baby's heartrate and lack of consensus about method of delivery.	Discussion with staff regarding importance of appropriate documentation. Service quality initiatives to ensure non attending women are followed up.
Unexpected death	Multiple medications were given with inadequate documentation and clinical oversight. Inadequate coordination of care across teams. Patients who require sedation are in locations that are difficult to monitor.	Update policy and procedure around sedation to include dosages, authorisation and monitoring of patients in bed spaces
Patient sustained an adverse event post operatively	Investigations preformed after pre-operative assessment clinic were not reviewed prior to surgery	Pre-operative assessment questionnaire to be revised to include recent investigations
Missing laboratory specimen which resulted in patient having secondary surgery	Nurse-led surgical safety time out not completed so specimen was not identified as missing	Refresher training for the surgical safety checklist with an emphasis on specimen collection
Patient sustained significant burns	Review under way	No recommendations at this time
Maternal death	Community Patient had developed a severe infection post birth. This was unrelated to the pregnancy.	Record and monitor vital signs of community patients, after discharge, if they report they are feeling unwell
Unexpected death	Lack of documentation of test results resulted in no follow up	Review the notification, reporting and documentation of abnormal test results. Provide education to staff on laboratory results sign off processes.

MidCentral District Health Board
Serious Adverse Events Report
1 July 2018 to 30 June 2019

Description of Event	Investigation Findings	Recommendations
Referral not actioned resulting in additional surgery	Inadequate referral and acceptance processes in surgical clinic	Review of all processes and documentation in surgical clinic to ensure best practice
Unexpected death	Review under way	No recommendations at this time
Patient was compromised during transfer in theatre	"No lift" guidelines were not fit for purpose within theatre setting	Review of "no lift" guidelines within theatre
Wrong site procedure performed	Draping of sterile cloths impaired vision of staff. Incorrect identification of the site.	Staff training to ensure site is clearly visible when performing procedures
Incorrect patient underwent a procedure	Clinician requested a procedure on the wrong patient	Reminder to staff to double check patient details before requesting tests. Review the options within patient management system for cross checking.
Wrong site procedure performed	Incorrect identification of correct side at time of procedure	Staff training on checking documentation and reconfirming with the patient at time of procedure
Retained item during surgery	Incorrect count of stiches was not picked up when surgery was completed	Staff training on correct count procedures and time out processes
Wrong site procedure performed	Process of staff in theatre discussing the surgery site and planned surgery prior to its commencement did not occur. Inadequate documentation identifying correct side for surgery.	Process whereby staff discuss the upcoming surgery prior to its commencement be completed. Consent forms to be revised to ensure correct site of surgery is clearly documented.

Description of Event	Investigation Findings	Recommendations
Pressure Injuries (Bedsores) Ten 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 ten events it was found that improvements were required in the daily skin integrity checks done by staff on the wards. It was noted that checks were often not being done or were not inclusive of skin deterioration	A revised checklist for daily skin integrity monitoring has been trialled and is being rolled out across the inpatient wards
Falls		
Ten patients had a serious fall resulting in a fracture	In three falls it was shown that, overall, good measures were in place to reduce patients' risk of falling. In three falls, improvements to the visual aids to assist staff in identifying those patients who are a falls risk has been strengthened. Four falls reviews are in progress.	Visual aids to be put in place e.g. yellow bracelet identification placed on the patient wrist and the patient display boards having clear identifiable falls risk alerts. These assist staff in identifying those patients who require further assistance and/or monitoring when moving
Medication		
The patient experienced a medical event after the administration of incorrect medication	Labelling on syringes was found to be inadequate and the trolleys used for procedures were also not labelled correctly to ensure safe use of medicines	Trolleys used for procedures have been correctly labelled where medications are required for use. Syringes are now labelled according to best practice.
Hospital Acquired Infection		
A patient developed a hospital acquired infection	Sterile techniques for the management of intravenous line needs improving	Refresher education sessions on hand hygiene and sterile techniques when dealing with intravenous lines for staff to be completed

Description of Event	Investigation Findings	Recommendations
Mental Health and Addiction		
Nine consumers of the mental health and addiction services died unexpectedly in the community	All consumers were either currently being cared for by mental health and addiction services or had recently been discharged (within 28 days) from the service. All consumers died in community settings and their cases have been referred to the coroner. Aspects of care relating to documentation, assessment and care planning were found to require improvement.	Risk assessment for the service to be reviewed to ensure it meets current best practice. Staff education on the importance of documentation in the clinical notes. All aspects of care required are to be recorded in the care plan.