MidCentral District Health Board
Serious Adverse Events Report
1 July 2019 to 30 June 2020

Ko Ranginui ki runga
Ko Papatūānuku ki raro
Whakawātea ngā taumaha hārukiruki
Ngā taumaha mānukanuka
Waiho ake ko te mauri tau
Te mauri aho o te rangi
Kia mahuta ake ki te ao mārama
Tuturu whakamau kia tina, tina!
Hui e, tāiki e
Kei aku nui, kei aku rahi, kei aku whakatiketike ki te rangi, e pari ana ngā tai o mihi ki a koutou katoa.
Kei te mihi atu, kei te tangi atu ki a rātou kua takahi i te ara whānui a Tāne ki tua o te pūtahitanga o Rehua, ki te huihuinga o Matariki, okioki mai rā koutou. Rātou ki a rātou, tātou te hunga ora ki a tātou.
He maioha nō te ngākau nui tēnei whakaputanga pūrongo nā te Poari o te Pae Hauora o Ruahine, o Tararua (MDHB) ki ngā tūroro me ō rātou whānau tae noa rā ki ngā hāpori whānui taiāwhio i tō tātou rohe.
Nei rā mātou o MDHB e tuku kau ana ngā mihi kaniawhea ki a koutou kua pāngia e te pāmamaetanga o ēnei pāpono poautinitini i roto i tēnei pūrongo. Ko tā mātou mahi, he whai titikaha i tā mātou tūkanga arotake matua kia piki te māramatanga ki te kaupare atu te ringa kaha o aituā ā muri ake. Ko te whakatau iho kia whakapai ake, kia haumaru ake te hunga e maimoa ana i raro i te tauwhirotanga a te Pae Hauora o Ruahine oTararua.
Nā runga anō i te ngākau pono,
Kia tau te mānaakitanga a te wāhi ngaro ki runga ki tēnā, ki tēnā o tātou.

Introduction

This report has been written for our consumers, their whānau and the communities within the MidCentral District. It provides a summary of the serious adverse events that have occurred within the 2019/20 year in our services. This report is released alongside the national serious adverse events data released by the Health Quality and Safety Commission on 30 November 2020. This report should also be read in conjunction with the Quality Account 2019/20 that will be released in December 2020 and available on the MDHB website.

Summary

During the period 1 July 2019 to 30 June 2020, we reported 40 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 and were reported to the Health Quality and Safety Commission (HQSC) as required by the National Reportable Events policy.

MDHB considers even 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.

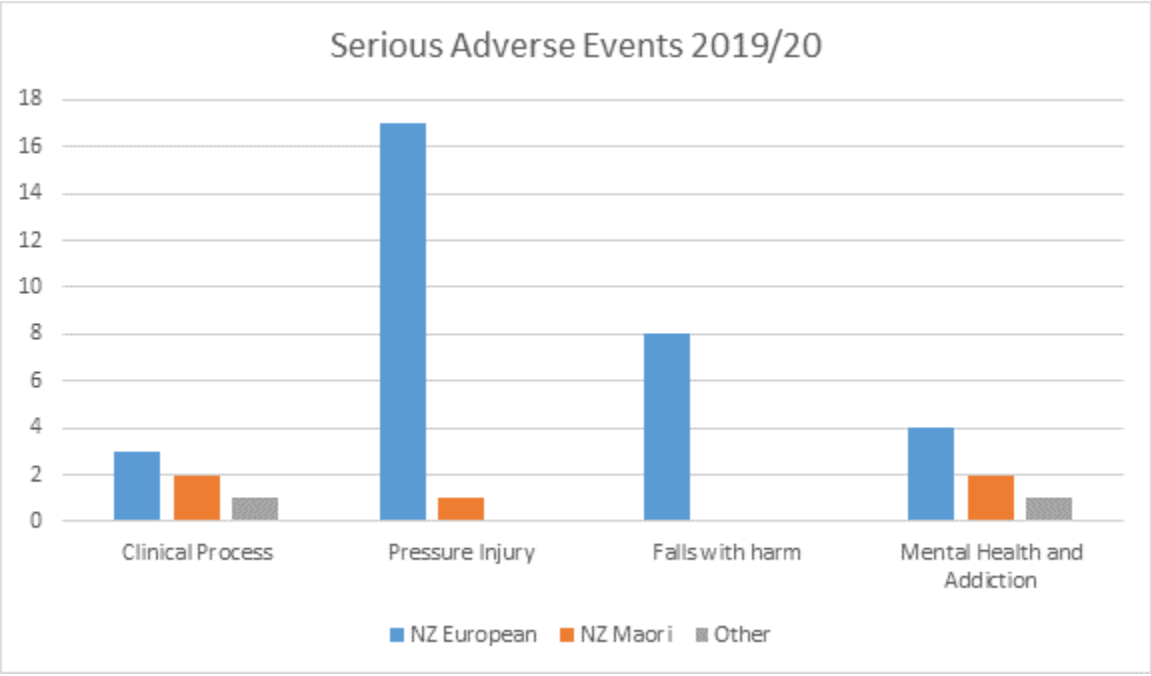
A key part of our strategy is our commitment to deliver quality and excellence by design. MDHB values the national reportable events process as one way of supporting this goal. We are always seeking to learn from these events and improve safety. In order for this to happen, we depend on events being 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. This also provides us with the opportunity to review our service in accordance with patient expectations and recognised clinical standards. To support this process further, 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.

The **40** serious adverse events reported include:

Clinical Process	Medication management	Falls resulting in fracture	Mental Health and Addiction
24 events which includes 18 pressure injuries	**1** event	**8** events	**7** events

Ethnicity Data for Serious Adverse Events

Ethnicity data is collected for all serious adverse events and for the 40 events that occurred within the 2019/2020 year, 82.5% identified as NZ European (33), 12.5% identified as NZ Māori (5), 2.5% and the remaining 5% identified as Pacifica and other. A breakdown of the event categories is in the graph below.



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 MDHB 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 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 2019/20 year there was a decrease in reported events. We actively encourage our staff, our patients, their families and whānau 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 needs to continue to improve our digital systems to support clinicians in the timely access, documentation and sharing of information between services.

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 another 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.

Below is an overview of the serious adverse events that occurred during this period as well as the recommendations and improvements that are in progress:

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Description of Event	Investigation Findings	Recommendations and improvements underway
Clinical Process		
Unexpected death	Agreed evidence based procedures and guidelines are to be followed. The medical/clinical oversight expectations for Trainee Intern and Senior House Officers in Emergency Department needs to be reviewed. Clinical documentation standards and expectations should be met. Review of Policy and Procedures with regard to Chest Pain Pathway.	Training/Orientation for the Chest Pain Pathway with new medical staff. Training in the use of the National Emergency Department Assessment of Chest Pain Score. Review the medical/clinical oversight expectations for Trainee Interns and Senior House Officers in Emergency Department. Review of the Acute Chest Pain flow chart. An audit of the chest pain pathway is underway to ensure assessment, implementation of the pathway and appropriate treatment is delivered within timeframes.
Unexpected death	There was a discrepancy between the Senior Doctor and the Registrar in the level of risk for a chest procedure.	Medical and Respiratory services Medical Leads further define expectations regarding communication for diagnostic activities which contain increased clinical risk.
Death of baby at full term	The result from the ultrasound scan, although regarded as urgent, was not communicated to the lead maternity carer with urgency. This contributed to the delay for timely and appropriate referral and transfer to hospital. The interpretation of the fetal heart	Review of urgent results from radiology providers to the DHB. To review the acute surgical booking form to include categorising caesarean sections. Socialisation of the caesarean sections policy to maternity, paediatric and theatre staff in regards to communication.

Description of Event	Investigation Findings	Recommendations and improvements underway
	monitoring on admission by the lead maternity carer was not interpreted or recognized as putting the baby at risk of death.	
Tear during childbirth	Tearing of tissue during childbirth resulted from incorrect positioning of the mother during the birth.	Midwifery education to include evidence based strategies to decrease the occurrence/severity of vaginal injuries.
Over sedated patient from medication administration	Patient had been identified as being sensitive to a particular medication. This was documented but not seen prior to administration of the medication. Patient received medications that compromised breathing.	Communication to occur with senior staff when patients are compromised physically and a procedure needs to take place that requires sedation.
Deterioration in vision	Review underway	Review underway
Pressure Injuries Eighteen 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 18 events it was found that education to enable critical thinking when identifying high risk patients is required. It was identified that there was no robust process for mattress replacement. The policy and procedure were identified as requiring reframing with a reduction in pages for ease of access and use.	Staff have been completing additional training on wound care. Clear guidelines for the use of mattresses and when they should be ordered for patients has been completed. A policy for maintenance and replacement for standard hospital mattresses, including auditing to ensure mattress are safe and fit for purpose is in place. An audit tool was developed along with a streamlined process for both auditing and purchasing. 100 mattress have since been purchased and more are on order. The guiding documentation has being reduced to 2 pages whilst the 'working flip chart' to improving ease of access and ongoing knowledge of pressure injuries, is near completion.

Description of Event	Investigation Findings	Recommendations and improvements underway
Falls		
Eight patients had a serious fall resulting in a fracture	Across all 8 falls, assessments were not completed or documented that would support a comprehensive plan for managing falls.	Routine checking of lying/standing blood pressure for patients presenting with repeated falls Assessment of fluid intake of patients. Medication review especially antihypertensive medications & anticoagulants in patient with multiple falls.
Medication		
Medication not given as prescribed	Documentation of the need to chart regular medications was not clear or documented in correct place. Handover of charting of medications was not completed.	Admission criteria including charting of current medications is updated to include responsibilities of admitting clinician.
Mental Health and Addiction		
Seven 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.	In 4 of these cases, no recommendations were made. In the remaining 3 cases, aspects of care relating to documentation, assessment and care planning were found to require improvement.