**MIDCENTRAL DISTRICT HEALTH BOARD**
**SERIOUS ADVERSE EVENTS REPORT: 2015-2016**

MidCentral District Health Board continues working to improve the quality of care that it provides to its community and values the national reportable events process as one way of supporting this improvement. During the period 1 July 2015 to 30 June 2016 we reported 18 Serious Adverse Events (SAEs). These occurred in our hospital services and were reported to the Health Quality and Safety Commission as required by the National Reportable Events policy.

Each of the reported events involves a patient suffering serious harm or death while in our care. We consider one event of this nature one too many, and apologise unreservedly to the patients and family/whanau involved in these cases. We acknowledge the distress and grief that occurs for patients and their family/whanau when things go wrong in healthcare.

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/whanau, other health providers such as family doctors and primary health nurses, and our own staff tell us when an incident has occurred and raise concerns, so that we can look into what has happened.

When reviews result in recommendations for changes and action, we ensure that these are implemented in a timely manner and regularly reviewed until fully implemented.

The 18 serious adverse events reported include:

- Thirteen events were classified as **clinical process** where the usual process used in providing clinical care was not followed. These events varied across a range of services with several in maternity care.

- Five **patient falls** events occurred in our hospital and health centre resulting in serious harm to those patients.

## EVENT SUMMARIES

### Event Summary One

#### *What happened*

This event occurred where the patient suffered a dislocation of a recent hip replacement, had a lengthy wait in the Emergency Department (ED) and then required urgent surgery for a second health issue. This patient died some two weeks after surgery.

#### *What we found*

We found that this patient did not meet ED's medical or surgical admission criteria however still required admission to hospital, which was delayed as a result of this uncertainty. There appeared to be a primary focus on one health issue rather than all presenting problems.

#### *What we did*

We have reviewed and developed a clearer process for management of patients who do not clearly fit the medical or surgical admission criteria and have also developed an education programme for ED staff regarding comprehensive patient assessment and documentation.

### Event Summary Two, Three and Four

#### *What happened*

These three events related to the management of labour and birth, where best practice requirements were not met following indications of risk to the baby.

#### *What we found*

The decisions made in relation to the cardiotocograph (CTG) recordings for each baby, were not in line with best practice and there was no policy or guideline for how to manage CTG results after hours.

#### *What we did*

Work has been undertaken regarding all processes for reading CTGs and associated decision making including development of a risk assessment tool, development of a verbal "repeat back" system of communication, review and update of all policies and guidelines, along with progressing work on transfer of care audits. Work continues with the implementation of an improvement programme addressing these and other findings from a wider review of Maternity Services.

## Event Summary Five

### *What happened*

This patient was moved to the recovery area following surgery that carried high risk. The patient subsequently died in the recovery area before staff were able to complete a transfer to a more appropriate area for end of life care.

### *What we found*

While the outcome to the surgery was not entirely unexpected the request for transfer to a more appropriate area for end of life care was delayed.

### *What we did*

The policy for admission, discharge and transfer for the recovery area has been reviewed to ensure that it applies to all staff and includes options for very unwell patients remaining in this area for longer than the usual time of up to two hours.

## Event Summary Six

### *What happened*

This newborn baby was noted to have a low temperature and was assessed as requiring heating to increase the temperature. Following the heating it was noted the baby had a reddened and blistered area on an arm.

### *What we found*

The heating undertaken did not meet established standards of practice. There was limited access to the required equipment.

### *What we did*

A heating unit for baby linen/clothing and fluids has been purchased and is in use. Warm cots are now available and additional blood sugar testing kits have been purchased. Information has been provided to all staff within delivery suite about access to and use of these items.

## Event Summary Seven

### *What happened*

This woman, under the care of another DHB (District Health Board), presented acutely approximately two weeks over her due date with the baby dying prior to birth. The woman had some known risk factors.

### *What we found*

The other DHB had no guidelines in place for management of women with these known risks. A standardised handover process was not used between providers.

### *What we did*

A guideline is being developed and a handover process is now in place for the other DHBs.

## Event Summary Eight

### *What happened*

This patient presented to hospital with pain and fever and was discharged following assessment. They presented again four days later and required surgery and hospital care.

### *What we found*

The assessment information noted by ambulance staff was not followed up by ED staff and as a result certain investigations were not completed by the junior medical staff. This may have contributed to a delayed identification of the problem that later required additional treatment.

### *What we did*

A process is now in place to ensure that the senior staff managing the roster have information on junior staff skills and expertise ahead of their placement in ED.

## Event Summary Nine

### *What happened*

This patient died suddenly in the community following hospital admission 10 days prior and ED presentation two days prior.

### *What we found*

The patient was admitted initially for surgical treatment of a fracture and was discharged four days later. Subsequently they presented to ED, were treated and discharged home where they died two days later. Management protocols, patient information, patient education and documentation were not consistent.

### *What we did*

Work is progressing well on the development of standard protocols, patient education and written information, documentation requirements, care pathways, review of medication packs and the use of medication charts.

## Event Summary Ten

### *What happened*

This person died unexpectedly at home while on home dialysis.

### *What we found*

It appears that the process of health care did not contribute to this event however opportunities for improvement have been noted regarding initial and refresher training for patients, along with clearer documentation by our staff.

### *What we did*

A review of training programmes for all home dialysis patients including documentation by staff is in progress. In addition a wider service review is underway.

## Event Summary Eleven

### *What happened*

During a surgical procedure a specific piece of equipment was required, however it was not available as it had just been used on another case.

### *What we found*

That the type of surgery was not clearly noted on the operating theatre booking sheet to enable the equipment to be booked and available for this case.

### *What we did*

Additional equipment has been purchased to ensure spare sets are always accessible and there has been agreement on the booking terminology to be used.

## Event Summary Twelve

### *What happened*

This event relates to the management of a woman, by both hospital and a lead maternity carer, during labour and birth when the wellbeing of the baby became of concern.

### *What we found*

That it was not clear who had the lead responsibility for care of the woman and that when complexities arose during labour this created uncertainty amongst the team as to who was making the decisions.

### *What we did*

Work is in progress to ensure that lead responsibility for care is clear at all points, to all involved, including the woman and her partner. This will be part of the formal transfer of care process. Best practice requirements with regard to regular medical review based on risk assessment of the woman and baby are also being reviewed and reinforced.

## Event Thirteen

### *What happened*

This event relates to the antenatal care of a woman with a high risk pregnancy, where the baby died prior to birth.

### *What we found*

The result of this independent review, which is in the final stages, will be known as soon as it is finalised.

### *What we did*

Initiated an independent review. Recommendations arising from this review will be implemented.

## Event Summary Fourteen to Eighteen

### *What happened*

Five patient falls occurred in hospital involving a fracture or other serious harm. We know that falls have a social, psychological, physical and economic impact on our patients and their family/whanau.

### *What we found*

Five patients had a serious fall while an inpatient in our hospital this year. The findings in all the falls events were that good falls prevention measures were in place to reduce the risk of falling. However in two cases it was found that improvements were required when transferring patients at risk of falling from one ward to another. There was also a need for consistent information to be included on the patient status board regarding falls risk and reviewing education given to Healthcare Assistants.

### *What we did*

We have streamlined the process for providing information when patients are transferred from one area to another. In addition consistent wording has been agreed for the patient status boards. An educational resource is being developed for Healthcare Assistants.