MidCentral District Health Board
Serious Adverse Events Report
1 July 2016 to 30 June 2017

Summary

During the period 1 July 2016 to 30 June 2017 we reported 21 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/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 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/whanau, 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 are working 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 21 serious adverse events reported include:

- Nine classified as **clinical process** where the usual process used in providing clinical care was not followed. These events varied across a range of services. One event was noted as a hospital associated/acquired infection although unfortunately was not grouped in this way in the final report.
- One was classified as an **equipment** issue.
- One was directly related to **medication management**.
- Ten **patient falls** occurred in our hospital and health centre resulting in serious harm to those people.

Three of the reported events were reclassified following the outcome of a careful and detailed review. Reporting of events such as these shows a positive reporting culture by staff wanting to ensure we take every opportunity to learn from the reported events. These 21 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 the recommendations and actions are robust.

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Description of Event	Investigation Findings	Recommendation / Actions
Clinical Process		
Sudden unexpected deterioration and death.	This patient had been appropriately transferred to a higher level of care ward and that there was good communication and all transfer processes were carefully followed.	No recommendations were made following our review as it was found that appropriate standards of care had been followed. The rating of the event was reclassified after the review.
An unexpected death at home two days after discharge from a hospital ward.	All appropriate tests and assessments were carried out during the hospital admission. There was lack of clarity in the procedure for diagnosis and assessment of a punctured lung.	The procedure for the diagnosis and assessment of a punctured lung was revised.The rating of the event was reclassified after the review.
This patient died unexpectedly at home while living in a supported accommodation environment with ongoing service support.	Appropriate steps were being taken to manage the patient's health needs. The person had been generally unwell for some time and it was determined that he may have died as a result of complex medical problems.	Our clinical review did not result in any recommendations being made.The rating of the event was reclassified after the review.
This patient died unexpectedly following admission to hospital via the Emergency	The patient was not thoroughly assessed or treated for suspected acute coronary	A process has been established to ensure that the St John's ambulance

Department.	syndrome. The ambulance handover information was not reviewed by ED staff.	care summary and any ECGs are viewed by Emergency Department (ED) staff and subsequently documented in the clinical notes. As a core part of our medical staff orientation to ED, there are reminders of the importance of the St John's ambulance care summary being viewed at the time of handover of patients to hospital staff.
This patient was found to be unresponsive when clinical staff were doing a ward round and subsequently died.	All appropriate tests were completed. The person was unfortunately very unwell with a number of other health issues. The early warning score, a process to alert staff to a patient who is quickly becoming unwell, was not activated in a timely manner.	All clinical staff on the ward received training on the early warning score and activation of this. We are also working with the HQSC as part of a national programme to improve all systems and processes relating to the deteriorating patient with the first stage of this implemented on 15 November 2017.
This patient was found collapsed and unconscious when staff were collecting the meal trays. The person had passed away.	The nursing assessment noted that the patient required a "soft diet", swallowing precautions were present and he required assistance with meals.	Scenario based education around medical emergencies was provided. The differences in understanding the term "soft diet" is being addressed to

	There were some differences between what nursing staff and what dieticians defined as a soft diet. It was also found that he was not assisted with his meal.	ensure standard definitions are used across our hospital. Ward staff have defined what "assist with meals" means in their area so there is a common understanding for all staff.
This baby was an inpatient and was removed by persons who did not have authority to do so.	The baby, who was in the care of the Child, Youth and Family Services (CYF), was removed from the ward without the consent of staff.	A comprehensive multidisciplinary review of all systems and processes that relate to child safety, child abuse and child supervision across Child and Women's Services has been undertaken. Policies, procedures and security have all been reviewed and strengthened.
This patient died soon after admission due to a throat stricture.	The patient who had required long term support from our health services died unexpectedly on admission to hospital having been unwell at home for several days.	Our clinical review of this event resulted in no identified recommendations.
This patient picked up a hospital associated/acquired infection while they were an inpatient in our hospital.	There was a failure to recognise, investigate and appropriately treat, in a timely manner, an infection picked up during an unrelated procedure.	Regular audits of medication charts with a greater focus on prescribing. MDT processes have also been

	Documentation in the clinical record was inadequate with regard to pain/ medication management, handover and care coordination was not evident, Multidisciplinary Teams (MDT) within and across multiple services were not effective and cognitive screening was inconsistent.	strengthened to ensure where multiple services are involved, the care is coordinated and well documented. The tools used by clinical staff for cognitive screening are currently being reviewed and when completed updated education will be provided.
Equipment		
This patient was undergoing a surgical procedure when a specific item of equipment, essential to this procedure, was accidentally activated whilst being inserted into the person, by the surgeon. The person sustained damage to an internal organ.	The equipment had been inserted into the patient before the additional parts were set up by staff assisting the surgeon. This meant that when the foot pedal was moved, it activated and therefore caused internal injury to the patient.	Immediate changes were made by the surgeon to their practice resulting in a protocol that requires the equipment to be completely set up prior to being placed in the patient.
Medication		
A high dose of opioid medication was charted for and given to the wrong person who then required a higher level of care.	A high dose of opioid medication was charted for and given to the wrong person who then required a higher level of care.	Review the process for prescribing medicines on admission.

Falls		
Ten people had a serious fall, resulting in a fracture.	All ten falls showed that good falls prevention measures were in place to reduce the risk of falling. In six of the falls it was found that improvements were required in education and training of staff in; the Falls Awareness Programme, the use of ongoing assessment for cognitive function, falls risk stickers being placed on the front of patient files and falls risk assessments being printed out and placed in the front of the file.	The Falls Action Group, whose membership includes medical, nursing and allied health staff, are 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. Education has been undertaken about all aspects of the Falls Awareness Programme.