MIDCENTRAL DISTRICT HEALTH BOARD
SERIOUS ADVERSE EVENTS REPORT: 2014-2015

MidCentral District Health Board continues working to improve the quality of care that we provide to our community. During the period 1 July 2014 to 30 June 2015 we reported 20 Serious Adverse Events (SAEs). These occurred in our hospitals and health 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 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 families/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.

Continually strengthening our culture of patient safety and quality is a top priority for us. We are all committed to working with patients and family/whanau when things go wrong to ensure that their concerns and needs are addressed and supported and that they are included in the process of the review.

Our practice is to communicate openly with patients and family/whanau at all times, including when adverse events occur, to acknowledge what has happened and to apologise. We will listen to concerns, provide support, involve patients and family/whanau to the degree they prefer, and where possible answer their questions and address any concerns that they have.

When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented.

The 20 serious adverse events reported include:

- Thirteen **clinical process** events which are varied across a range of events and age groups specifically related to a process of clinical care.
- Five **patient falls** events occurred in our hospital resulting in serious harm to those patients.
- One event occurred relating to patient **behaviour.**
- One event occurred relating to failure of **equipment.**

EVENT SUMMARIES

Event Summary One and Two

What happened

Two separate events occurred where the patients were being cared for in the community. The first was receiving intravenous therapy and suddenly became unwell and subsequently died.

The second related to a patient who was recovering following a hospital admission. His deteriorating condition was not recognised or assessed and he subsequently died following transfer from the community to the hospital.

What did we find

With the first event we found that there were confusing clinical records and that the care plan relating to a range of regular observations was not followed. It was also noted that there was no early warning score system that might alert staff to signs of a deteriorating patient in a community setting.

With the second event we found that there was duplication of nursing documentation leading to lack of clarity and again, as in the first case, no early warning score to alert staff to signs of a deteriorating condition in a community setting. There was also lack of clear handover information from one care team to another.

What did we do

We have reviewed and developed a clearer process for clinical notes in the community setting and have also developed a minimum standard for the patient handover process from one service to another. In addition work is in progress to implement an early warning score system for use in the community setting.

Event Summary Three and Four

What happened

Three patients, all of a similar age group, presented to hospital over a short period of time with potential symptoms of a heart attack. An electrocardiograph (ECG) was undertaken on each patient and treatment was given to all three patients based on the ECG results attributed to them. Following treatment it was noted that all three ECG results appeared to be the same and a review found that the same result was printed and labelled for each patient when it only related to the first patient.

What we found

One patient was treated correctly, the second and third patients received treatment they did not require. As a result of human error the printout for the first patient was reprinted for the following two patients by using the ECG machine incorrectly. At the time, the ECG printouts were manually labelled with

the patient name and National Health Index number (NHI) following printing, by the staff member doing the ECG.

What we did

All ECG machines have now been programmed so that the patient's name and NHI has to be programmed in before an ECG can commence. This information then prints out on the ECG reading. In addition a standard for orientation, mandatory training and workbook completion has been put in place for all staff. The details on all ECG readings will now be checked against the patient's label prior to treatment to ensure these are correct.

Event Summary Five

What happened

While surgery was in progress the tip of an instrument came off and was left in the patient.

What we found

During the procedure the tip of a newly introduced instrument dislodged and was retained while introducing surgical cement necessary for the procedure. This was noted on x-ray during surgery. A decision was taken not to endeavor to remove the tip due to clinical considerations.

What we did

A process for introduction of and familiarisation with new equipment has been put in place.

Event Summary Six

What happened

This patient was prepared and anaesthetised for a surgical procedure. The first incision had been made when a piece of essential equipment failed and no back up equipment was available. The patient had to be woken and surgery delayed until the next day when the equipment was again available.

What we found

The backup equipment required was being serviced and no other option was available. This had not been noted prior to the surgery being commenced.

What we did

A new procedure has been put in place to ensure that as surgical schedules are finalised essential equipment and back up options are also scheduled and are readily accessible.

Event Summary Seven

What happened

The patient was anaesthetised before the surgeon arrived to check and discuss relevant test results. As a result of concerns around blood test results the surgery was postponed and the patient was woken up.

What we found

There was no early recognition that the blood test results could indicate a potential risk for the planned surgery. Therefore no early notification of these results to the surgical team or the patient was made to enable them to take this into account in their part of the patient's care.

What we did

We have reviewed the process used at the preadmission clinic to ensure there is a mechanism for early recognition that the results of the pre-surgery tests may mean the surgery cannot proceed. This includes what action is to be taken in this event.

Event Summary Eight

What happened

This patient underwent a planned investigative procedure. Following the procedure there was severe bleeding and bruising from the procedure site and the patient was returned to theatre for this to be resolved. There was also an impact on other patients waiting for the same procedure.

What we found

There was no clear protocol for the management or response to this complication or an escalation process in place for the management of other patients scheduled and waiting for this procedure.

What we did

We developed and implemented a protocol to support staff with the response to complications of this nature including requirements for supporting other patients who may be waiting.

Event Summary Nine

What happened

Following the birth of this baby there was delayed recognition and diagnosis of kidney related issues.

What we found

The communication between services about the need for the ultrasound to be completed more urgently than originally requested was not clear or escalated through an agreed process. There was also incomplete handover regarding the

antenatal ultrasound report and a delay in reporting the postnatal ultrasound scan.

What we did

We developed and implemented a referral pathway for detected antenatal abnormalities from primary to secondary care. We have also strengthened the communication and escalation pathways between services. The best practice process for fetal/renal antenatal ultrasound scanning has also been reviewed.

Event Summary Ten

What happened

This patient made an unexpected and very sudden movement striking a moving object that resulted in her sustaining a dislocated shoulder.

What we found

Thorough plans were in place to keep this patient safe however not all staff caring for her were completely familiar with the detail of these plans and as a consequence an opportunity may have been missed to prevent this harm.

What we did

Strengthened the process for ensuring all staff are aware of comprehensive care plans at the beginning of, and at periods during each shift.

Event Summary Eleven

What happened

This baby was delivered unresponsive following the mother having a severe bleed prior to the birth of the baby.

What we found

The emergency alarm bell from the patient's room was not audible to the staff who were doing shift handover, therefore their immediate response may have been slightly delayed. The resuscitation equipment in the patient's room was not easy for all staff to access and it was not being regularly checked and restocked.

What we did

The emergency alarm sound has been made more audible and a daily audit of resuscitation equipment is now undertaken.

Event Summary Twelve and Thirteen

What happened

This first mother presented approximately two weeks over her due date with the baby dying prior to birth. The mother had some known risk factors relating to being overdue.

In the second event the baby became distressed prior to birth and subsequently died. In this event the placenta was discarded and could not be analysed.

What we found

In both events it was found that the cardiotocograph (CTG) recording was not interpreted correctly or checked by a second person.

What we did

We have reviewed all training and education regarding CTG interpretation and have provided refresher training. A direction has been provided to all maternity services staff to require CTGs to be read by a second person. A revised procedure has been put in place for the retention of all placentae for a designated timeframe.

Event Summary Fourteen

What happened

This baby was delivered and remained with the mother, with the midwife being in attendance for just over one hour. On returning to the room a short time after leaving, the midwife discovered the baby not breathing and the baby subsequently died.

What did we find

The minimum requirement for remaining with the mother and baby immediately after birth was met. It was found that there was a need to strengthen the process at the commencement of each shift for all staff on duty to be clear about the level of skill and expertise each one has, and that the expertise is available for emergency events such as resuscitation of babies.

What did we do

A process for each shift to orientate to each other and be clear about expertise and roles in an emergency situation has been implemented.

Event Summary Fifteen

What happened

This pregnant woman presented to hospital with complications related to her long standing diabetes. There was a delay with the recognition of, and response to, these complications and subsequently the baby died prior to birth.

What we found

This event continues to be under investigation by a multidisciplinary team and is nearing completion.

Event Summary Sixteen to Twenty

What happened

These events are patient falls 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 compared to nine in the previous year. The findings in all the falls events were that good falls prevention measures were in place to reduce the risk of falling. The only recommendations arising from the reviews were for some areas to have additional falls risk education.

What we did

While it is not possible to stop every patient from falling when in hospital, many falls can be prevented. Our Falls Action Group is actively working to reduce the number of patient falls and prevent the harm that can occur from a fall. Our ongoing work to prevent falls and harm from falls is aligned closely to the Health Quality and Safety Commission's national patient safety campaign "Open for Better Care".

We have a whole of system approach to reducing harm from falls with a focus not only in our hospital and health centre but also in rest homes and more generally in our community. We have improved our results against the national quality and safety markers for assessing those people admitted to our hospital and health centre for risk of falls and for planning the required care and now meet the required threshold of 90 per cent. We continue to implement our Falls Aware Ward programme for our inpatient areas and also now into rest homes and the community.