Serious Adverse Event Report

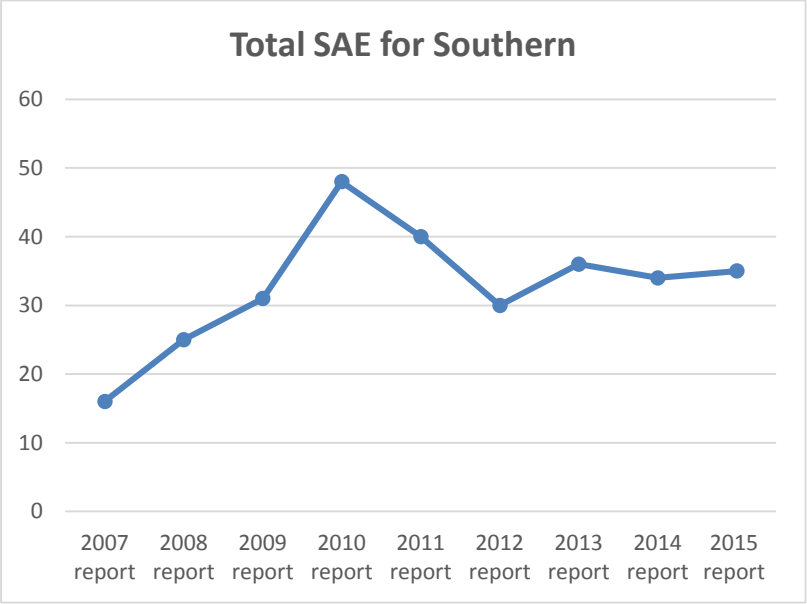
Southern District Health Board

2014-2015

Serious Adverse Events 2014 - 2015

Welcome to the serious adverse event release for 1 July 2014 - 30 June 2015 from the Southern District Health Board.
It is recognised worldwide that health care is a complex process, has associated risks and that patients may become harmed when receiving care intended to help them. This report provides details of the serious adverse events that have occurred within the Southern District Health Board (SDHB), the recommendations to make improvements to the care we provide and our progress with implementing these improvements.

The report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report *Making our health and disability services safer;* available at http://www.hqsc.govt.nz



Graph A

Graph A – 2014/15 year Southern DHB reported 35 events. *Quality Account report, available at http://www.southerndhb.govt.nz/pages/sae/* provides analysis of the main groups of events and the district-wide improvement work being undertaken

What is a serious adverse event?

Serious adverse events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

District Health Boards classify the severity of adverse events or incidents using the Severity Assessment Code (SAC). The two major SAC classifications, SAC1 and SAC2 are called **serious adverse events** which is one that is *life threatening or has led to an unexpected death or major loss of function* – and is classified as a ***SAC 1*** and one *that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function* – and is classified as a ***SAC 2***.

As a provider of health services we are required to review these events and report them to the Health Quality and Safety Commission.

You may notice that some incidents have not had their investigation completed at the time of release of this report. This means that the incident is still under investigation or that the recommendations are in the process of being finalised.

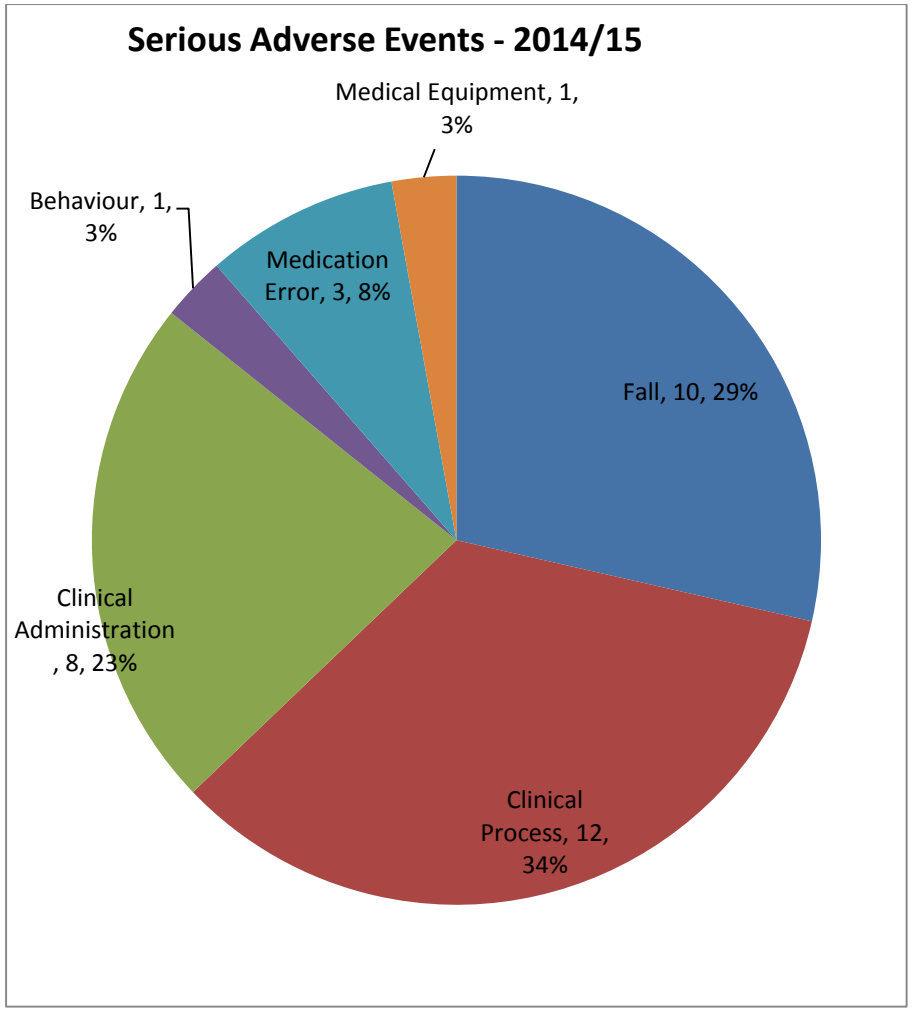
Using Serious Adverse Events to promote Patient Safety & Prevent Harm

All serious adverse events are investigated to try to determine the major cause, or causes, that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future.

The aim is therefore to enhance patient safety by learning from adverse events and near misses that occur in health and disability services and not to blame individuals who are involved in the event.

We have provided graphs to summarise the incidents that have occurred within the Southern DHB. The rise and fall in the number of incidents can indicate a number of factors including better reporting as well as the actual frequency of incidents.

The Southern DHB is committed to the *Open For Better Care* campaign developed through HQSC; this forms part of the transparent process of identifying harm and working to learn from incidents and improve our patient safety. Information available at http://www.hqsc.govt.nz



Graph B Reporting Categories for 2014-2015 – total and percentage

Graph B indicates the number and type (as per the Health Quality & Safety Commission definitions) of reported serious adverse events for the period.

Clinical process (e.g. assessment, diagnosis, treatment, general care) accounted for 34% (12) of all SAEs and *patient falls* 29% (10); *Clinical administration* incidents (e.g. handover, referral, discharge) account for 23% (8); and *medication events* (e.g., giving a patient the wrong medicine, or an incorrect dosage) 8% (3). There was one case of *behaviour 3% (1)* and one case of *failure of medical equipment* 3% (1).

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Serious Adverse Events (SAE) Report: July 2014-June 2015

Falls			
Description	**Main Findings**	**Recommendations**	**Progress**
Fall resulting in shoulder dislocation.	1. Confusion of the patient. • Individualised care plan not completed. • As per the falls policy; after an initial fall, a documented reassessment of falls risk is appropriate.	1. Education for nursing staff, surrounding re-assessment of the patient.	1. Implemented.
	2. The ability of the patient to remove the falls alarm may have contributed to the fall.	2. General guidance information being prepared via the Falls Prevention Programme, regarding falls management strategies, is to include appropriate use of alarms and patient watch.	2. Implemented.
	3. A delay in reading the X-ray post fall, may have contributed to a delay in orthopaedic assessment of the patient's arm.	3. A review of the system used to ensure that medical staff review tests.	3. A new process has been developed and introduced. Implemented.
Fall resulting in fractured left hip.	1. Delirium of patient.	1. Education in assessment of confusion and ensure implementation of proposed Delirium Guidelines.	Implementation of recommendations in progress.
	2. Delayed reporting.	2. In future all incidents whereby a patient ends up on the floor, nearly falls or collapses are treated as incidents and reported via the incident management system.	

		3. Education to teams to ensure they are aware of and use 'Post Fall Management Protocol' and know their responsibilities (including medical staff). 4. Review the layout of the area involved. Improve visibility and sight lines so more patients can be observed at one time. 5. Consider staffing model on night shift and at handover. Improve model so that a nurse always stays in the unit or can see all the patients more often. 6. Review Emergency Department handover times to the wards.	
Fall resulting in fractured neck of femur.	1. Patient mobilised to the toilet without calling for assistance. 2. Hard floors may contribute to the harm from falls. 3. This patient was transferred from the floor to the bed with a hoist. It is recognised that patients with fractured neck of femur or suspicion of fracture should be transferred using a scoop.	1. Look at strategies to prompt patient to call for assistance. 2. The organisation to consider softer flooring options in future plans. 3. Patients with fractured neck of femur or suspicion of fracture should be scooped from the floor to the bed.	1. Work under way with the falls prevention group. 2. For consideration within the master site planning project. 3. Ongoing education provided in falls workshops.

Fall resulting in head injury.			Formal review initiated.
Unwitnessed fall and subsequent death.			Formal review initiated.
Fall resulting in skin tears.	1. Patient's prime assistance equipment to enable patient to mobilise was moved from reach. 2. Patient didn't turn on the light above bed, the small light in the room under the sink isn't sufficient to enable safe mobility. 3. Patient's fall documentation was not updated as required.	1. Make sure patient mobilisation equipment is within easy reach at all times. 2. Encourage patients to either turn on the light on or seek assistance when getting up in the dark. 3. Update/educate staff regarding documentation of falls assessment.	1. Case discussed with staff and highlighted need for individual assessment and plan. Complete. 2. Frequent reminders are provided to patients. 3. Weekly audit and follow up of documentation occurring. Implemented.
Fall resulting in fractured neck of femur.	1. Ongoing neurological deficits following bleeding into the brain. 2. The patient had ongoing signs and symptoms that contributed to a high falls risk. 3. During discharge planning a decision was made to reduce the supervision provided with walking.	1. Formal family meetings should be offered to patients and families to discuss risks involved and reasons for management decisions. 2. There needs to be clarity from all disciplines with regard to patient management, and ideally through the use of a standard format. 3. There needs to be formal documentation of patient competency when significant risk	1. Implemented. 2. Systematic documentation formats suitable for the ward are being considered for development. 3. Training provided. Formal documentation of patient competency in the notes.

	However this was not communicated well to the patient and family. 4. The environment did not contribute to the patient's fall and policy and procedures were adequately adhered to with regard to falls prevention.	is involved. 4. Once the team have completed the implementation of recommendations, the report and action plan should be shared internally as a learning opportunity.	Complete. 4. Pending.
Fall resulting in fractured pelvis.			Formal review initiated.
Fall resulting in fractured acetabulum (a bone in the pelvis).	1. Patient found on the floor sustaining fractured right acetabulum. 2. The main conclusion: the level of falls prevention needed was not put in place, considering the high risk of falling and potential serious harm.	1. Education in interpretation of the Falls Risk assessment. 2. Education in level of falls' prevention strategies. 3. Education in timing of reassessment when patients condition changes. 4. Education is to include all key professions in falls training. 5. Develop a falls risk intervention checklist that would prompt staff to implement a higher level of falls	Implementation of recommendations in progress.

		prevention strategies. 6. Review policy on the reassessment of falls risk when the patient's condition declines.	
Fall with facial fracture.			Formal review initiated.

Medication and Intravenous Fluids			
Description	**Main Findings**	**Recommendations**	**Progress**
Oral medication given intravenously.	Lack of adherence to the five rights of medication administration.	1. Safety alert newsletter to be sent out to all nursing staff regarding administration of oral medications in oral syringes and rationale. 2. Medication Management education module to be developed for students/nursing staff. 3. Ensure all wards have an adequate supply of oral syringes and that they are in a visible location. 4. The standardisation of policies	1. Complete. 2. Work in progress. 3. Implemented. 4. Work in progress.

		and guidelines that refer to checking and administration of controlled drugs is recommended across the district. 5. MedChart time out function. 6. Redeployment of staff by Integrated Operations Centre (IOC) and the senior nurses who manage redeployment to take into account the level of expertise and number of times the staff member has been sent away in recent days.	5. Investigate with the MedChart team whether it is possible to add a "save or delay" function to MedChart. 6. Implemented.
Medication Error.			Formal review initiated.
Medication error.			Formal review initiated.

Clinical Administration			
Description	**Main Findings**	**Recommendations**	**Progress**
Cluster of patients with visual loss secondary to delay in treatment.	1. Lack of service planning. There are not enough appointments available for patients that require them.	1. A service plan is developed and implemented that incorporates the current and predicated future demands with a long term sustainable solution for delivery of care.	1. Planning and performance monitoring has been initiated via a clinic prediction tool. This provides information for the service plan.

	2. Variation in options for clinical treatment regimens.	2. Develop clinical guidelines/pathway or a management plan in alignment with Ministry of Health (MoH) work, with the aim of more standardised clinical practice when clinically appropriate.	2. Clinical Leader confirms that service functions within MoH guidelines. Complete.
	3. Lack of quality processes within the system to ensure that care is provided in a timely manner.	3. a) Patients who are currently overdue for treatment are urgently re-triaged and appropriate plans put in place to ensure that there will be no further serious outcomes. b) The patient booking system is changed so that patients receive the next appointment prior to leaving the department. c) A process to be developed that audits patient's waiting times for treatment, to ensure that patients are being seen within the recommended timeframes.	3. a) A priority booking tool has addressed the booking issue. Implemented. b) Implemented. c) Monthly performance monitoring and reporting back enables the team to respond to care capacity demand management issues.
	4. There is no workforce development plan for the department.	4. Develop and implement a workforce development plan to ensure the safe delivery of patient care.	4. Implementation has commenced.
	5. Team members elevated issues to	5. The service is to provide clear	5. Visual management boards

	managers but there was an acceptance that because of the resource constraints improvements would be difficult.	guidance to its team regarding how to elevate clinical capacity issues, and then for the service to demonstrate how it will feedback to the team regarding action taken in response.	and daily meetings give the team a process to raise clinical issues. Implemented.
Delay in treatment.	1. Inability of the current RIS (Radiology Information System) to confirm that the radiology report has been received and read by the intended recipient. 2. Even if the abnormal report is acknowledged there is no certainty that some follow up is undertaken. 3. Ultimately the medical team requesting the chest X-ray is responsible for following up the result.	1. Allow the service to identify when an abnormal report has not been viewed or acknowledged, and to escalate to whom the report should then be sent. 2. Continue the current process of copying the report to Chest Clinic and the Medical Director Patient Services (MDPS) Assistant, preferably in both electronic and hardcopy formats to avoid the risks identified in recommendation 1 above. 3. Each specialty is required to outline: a. Which member(s) of the team should receive all chest X-ray reports? b. Who is responsible for reading and acknowledging	A multispecialty, multidisciplinary project team lead by the newly appointed Clinical Leader is working on these corrective actions which are due to be completed by December 2016.

		all chest X-ray reports? c. What is the escalation process if reports are not read and acknowledged? d. What is the process in the event of an unexpected chest X-ray finding?	
Delay in treatment.	1. A radiological abnormality was missed. However only expert readers of chest images (e.g. Radiologist or a respiratory physician) should be expected to always recognise an abnormality such as this. 2. No formal and universal introduction of a paperless patient management system (PMS). Currently all patients have a paper clinical record and an electronic medical record. • There is confusion with regards to the best process of viewing and acknowledging results electronically in the PMS used at this site. 3. There is no process to ensure that unacknowledged reports do not go unacknowledged for any length of	1. Provide tools for continuous medical education for medical officers to allow up-skilling in the interpretation of plain x-rays. 2. Finalise the work currently undertaken by the department involved, to clearly define a process for the paperless acknowledgement of results. • Develop a DHB wide project plan on introducing a fully paperless report system. • Have a consistent approach to the roll out of the electronic requesting of medical imaging investigations. • Electronic request of imaging tests needs to occur. 3. Audit all other clinical services their process surrounding acknowledgment and escalation	A multispecialty, multidisciplinary project team lead by the newly appointed Clinical Leader is working on these corrective actions which are due to be completed by December 2016.

	time. 4. The currently used patient management systems are viewed by some clinicians as cumbersome and not user-friendly. 5. There has been a long-standing shortage of radiologists and in 2011 the DHB contracted plain x-ray reporting to an external provider. 6. The reporting radiologists are off-site external providers and have no linkages with the local clinicians. There is no agreed process to allow radiologists to alert a clinician if there is a significant abnormality on a patient's chest x-ray. 7. There has been no other option, to ensure adequate steps are taken after a report of an abnormality has been issued. 8. Local senior medical officers have been alerting the organisation about the inherent weakness for some time. It is understood that the matter has been raised with the external provider and that this is to	of test results. 4. Review the content of the orientation to all new medical staff surrounding the use of the patient management systems and the process to ensure proper communication to other medical practitioners 5. Review the possibility to have plain x-rays read and reported by the on-site Radiologists. 6. Escalate the discussions with external provider to ensure there is a system for the flagging of abnormal imaging results completed on this site. 7. Consider a district process that all "flagged" reports of abnormal chest films are copied to the relevant Respiratory Service. 8. Once a system to deal with significant abnormalities on plain chest x-rays has been finalised and trialled, consider to extend this to other plain x-rays (and possibly other imaging studies)	

	be addressed again. 9. No radiology report was sent to the General Practitioner (GP), this is common practice. 10. Imaging report was not sent to the patient. 11. The patient attended Mental Health (MH) services in 2013 and 2014 and had urine and blood tests in relation to some of those MH attendances, however there are no referrals made relating to respiratory symptoms. 12. Lung cancer is a condition with an often poor outcome: Only 50-60% chance of cure even with early stage lung cancer. If the cancer has already spread to other organs, as	9. Develop a process to ensure all reports of medical imaging investigations are copied to the patient's GP. 10. Develop a process to ensure all Emergency Department clinical summaries are sent to the patient's GP. • Develop a process to copy reports of certain investigations to patients/consumers. This will require discussion with consumers, relevant services and primary care providers. 11. The Mental Health Service should consider whether there are possibilities to evaluate patients who have a significant smoking history and are admitted to the service, for the presence of respiratory symptoms or conditions, and to consider criteria for referrals for chest x-ray or spirometry tests. 12. Develop a process to continue the ongoing activities to improve the care for patients suspected to have and/or diagnosed to have lung cancer, and to implement the	

	was the case with this patient when finally diagnosed, less than 1 in 20 patients will survive 5 years and only about 1 in 2 patients will survive 1 year 13. A diagnosis of Chronic Obstructive Pulmonary Disease (COPD) is often made on clinical grounds. This is not reliable. COPD was thought to be present in this case but no further action was taken or recommended.	Standards of Service Provision for Lung Cancer patients in New Zealand. 13. Patients suspected to have COPD should have a formal, pathway-based, primary care-based evaluation including spirometry and chest x-ray.	
Delay in treatment.			Formal review in progress.
Delayed diagnosis.			Formal review to be initiated. Investigator to be appointed.

Clinical Process			
Description	**Main Findings**	**Recommendations**	**Progress**
Unexpected death during procedure.	1. Sedation induced respiratory arrest. 2. Large particulate vomit due to lack of fasting pre procedure. 3. Delayed recognition of respiratory depression as face draped for	1. Consider fractionation of sedative doses in high risk patients, or those where monitoring is more difficult. 2. Review patient draping to ensure to face remains visible to the practitioner at all times. 3. Carbon dioxide monitoring is a gold standard and to be	1. Implemented. 2. Implemented. 3. Implemented.

	procedure. 4. Standardise resuscitation equipment. 5. Cardiology monitoring data is to be stored if an adverse event occurs.	considered for all patients undergoing conscious sedation regardless of specialty or location. 4. Standardise resuscitation equipment in this area. 5. Cardiology monitoring data is to be stored if an adverse event occurs.	4. Implemented. 5. In progress.
Delay in responding to deteriorating patient.			Formal review initiated.
Delay in treatment leading to organ failure.			Formal review initiated.
Wrong side surgery.			Formal review initiated.
Delay in treatment.			Formal review initiated.
Pressure injury.	1. Lack of assessment and documentation, awareness and adherence to pressure injury prevention and management.	1. Review of current hip pathway documentation with focus on increasing detail of patient assessment and care provided. 2. Formal education for all staff	Implementation of recommendations in progress.

	2. The patient's inability to articulate needs related to significant dementia. 3. The majority of morning shifts had low nursing staff levels.	around pressure injury prevention and management. 3. Education for all staff related to open disclosure.	
Unanticipated complication of procedure.			Formal review in progress.
Delay in treatment.	1. Adverse weather conditions. 2. The burden of having to make repeated calls should not rest with the staff caring for the patient in a rural hospital. 3. When the retrieval team cannot retrieve a patient it would be useful for the medical staff in Dunedin Intensive Care Unit (ICU) to visualise the patient to assist care and decision making. 4. If a backup radiology processor is dependent on other facilities/providers this should not be restricted out of hours. 5. Clinical management in LDH was	1. The weather is out of our control so we must look for alternative transport options. 2. Develop a clear communication pathway for inter-hospital transfers when aero-medical retrieval is unavailable. 3. Explore the possibility of a video link between Dunedin ICU and Lakes District Hospital (LDH) Emergency Department. 4. A contingency plan is required to ensure emergency radiology is available at LDH 5. Resuscitation/diagnostic equipment and blood product availability in LDH need to be reviewed.	1. Work in progress. 2. Work in progress. 3. Trial of system in place. 4. Bedside x-ray machine has been repaired as part of the contingency backup. Completed. 5.

	hampered by a lack of radiology and some technical difficulties with the ventilator and suction equipment. 6. The Wakatipu report (2011) indicates that a CT scanner is needed in Lakes District Hospital.	• New ventilator is required. • Invasive Arterial blood pressure monitoring. • A new bedside ultrasound machine. • Review by NZ Blood Service of the blood products held in the Lakes region, to ensure it is appropriate to meet the needs of this remote region. 6. A CT scanner sited at LDH would assist evaluation and decision making in patients with head and multiple injuries.	• Purchased. • Purchased. • Work in progress. • Memorandum of Understanding between sites is in draft. 6. This recommendation is to be considered within the strategic health services planning for Southern DHB. Also note that this recommendation does not address the root cause of the problem.
Unanticipated adverse outcome of labour.	1. Obstetric emergency occurring at rural facility. • Possible unidentified antenatal risk factors. • Lack of secondary care consultation when labour arrested. • Lack of multi-disciplinary education. 2. Communication within facility and with Communications Centre	1. Regular neonatal resuscitation education for all permanent staff groups likely to be associated with an emergency in the rural maternity setting to ensure appropriate monitoring and referral. One off full day education followed by annual updates. 2. Review of communication processes/policy, engage staff, and educate and train to ensure communication is effective	Implementation of recommendations in progress.

	(Regional) did not work well in this situation 3. Monitoring failure and unfamiliarity with use of emergency monitoring equipment/procedures. 4. Cluttered environment - with medical and midwifery equipment mixed together. Equipment and drugs were not easily accessible or easy to locate 5. Inadequate documentation of an emergency event. 6. Patient sent unaccompanied by a midwife to Dunedin in adverse weather conditions after a	3. Annual multidisciplinary provision of emergency education. Review policy, protocols and provide multidisciplinary education and training where necessary for all staff groups in the rural setting around obstetric/neonatal emergency procedures and use of equipment. Consider undertaking regular practice scenarios 4. De-clutter environment. Review emergency equipment resource for resuscitation and consider procurement of separate neonatal resuscitation trolley. 5. Documentation standards to be met by all multidisciplinary groups utilising the DHB clinical notes. Consideration should be made as to using the SDHB proforma documentation for shoulder dystocia. 6. Review transfer of care requirements, process and protocols, particularly with regard patient risk factors, consideration of accompanying clinical staff and early transfer where weather conditions are forecast to	

	documented post-partum haemorrhage (PPH) and fourth degree tear. This is a potential risk as if she had a delayed secondary PPH, the patient could have been at jeopardy and therefore seriously compromised. 7. Lack of emergency medication.	deteriorate. 7. Review access to appropriate medications for maternal and neonatal emergency situations.	
Unexpected severe neck injury.			Formal review in progress.
Unexpected inpatient death.	1. Unwitnessed collapse in community while on outing. 2. Delay in providing treatment due to the patient not showing clear signs of distress.	1. Ensure there is district wide consistency in CPR training by team based instructors, in particular that they include management of foreign-body airway obstruction in their CPR revalidations. 2. Continue to develop the established education around the increased risk of choking in people with a mental illness, and ensure this is happening district wide. 3. Ensure clients, family and significant others have access to	Implementation of recommendations in progress.

		information/education about the increased risk of choking for people with a mental illness. 4. CPR and choking management posters to be displayed in clinical areas within Mental Health, Addictions and Intellectual Disabilities (MHAID) services. 5. Flash-cards to be made for MHAID clinicians which can be carried with ID cards as prompts in emergency situations. 6. Further consideration of whether it would be useful to have a choking assessment checklist combined with the falls checklist.	
Unexpected deterioration of patient on transfer between hospitals.	1. Delay in accessing CT imaging. 2. Unclear referral pathways.	1. The CT service in the rural site is increase to provide 24 hour availability. 2. District-wide head injury management guidelines are developed with the agreement of all services involved, to support management of patients in rural facilities with or without CT and provide clear pathways for their care.	Implementation of recommendations in progress.

	3. Absence of reliable inter-hospital transport options. 4. Lack of blood alcohol testing availability. 5. Team in ambulance lost contact with rural hospital site via phone in part of the journey.	3. Inter hospital transfer is to be more robust. That involves both increasing the availability of road transfer and maximising the options for transfer by both air and road. 4. That facility for blood alcohol testing is available both at bedside and laboratory level and is used more routinely. 5. Look at improved radio communication for ambulance. 6. Address transfer staff training and orientation and also provide ambulance based emergency scenarios as part of resuscitation training. 7. Look at IT system links with its contributing practices, to improve timely access to patient information.	

Medical device/Equipment			
Description	**Main Findings**	**Recommendations**	**Progress**
Failure of cardiac bypass pump.	1. No checklist developed related to the management of the perfusion machine.	1. Introduce a documented checklist and include tubing connections checked. This must be placed in the patient record.	Implementation of recommendations in progress.

	2. Setup process for the perfusion machine did not include documented systematic checking of integrity of the oxygen tubing supplying the oxygenator. This allowed the tubing to become less adherent, and introduced the possibility that traction would result in disconnection.	2. Develop process to improve documentation of unexpected complications in care. 3. Purchase and introduction of a sensor downstream of the oxygenator measuring the "oxygenated" blood.	

Behaviour			
Description	**Main Findings**	**Recommendations**	**Progress**
Self-harm resulting in asphyxiation.	1. Agitated behaviour due to egress from building being obstructed and the patient being told that they could not access the service. 2. There was a delay in removal of the ligature.	1. Implement a formal process to communicate patient watch requirements to the Security Team. This will ensure that patient needs are communicated across the teams. • Recommend that if hospital lock down is required due to a clinical situation to detain a patient, it must occur only after consultation with key clinical staff. • Patient reaction to not meeting criteria for access of service at that time is unable to be resolved. 2. The Security Team to provide staff with ligature removal tools.	Recommendations allocated but not yet implemented.

	3. Not all staff routinely access electronic patient alerts. 4. Paper management plans for the patient were located in the Emergency Department Management Plan folder but not accessed by staff.	3. Area to develop a system where all staff involved in the patient's journey must review alerts on each admission. 4. Consider locating all management plans on electronic patient management systems to ensure the most current information is at hand. 5. A back-up plan needs to be developed to mitigate the risk of Mental Health Emergency Team being delayed due to responsibilities elsewhere.	