# Serious Adverse Event Report

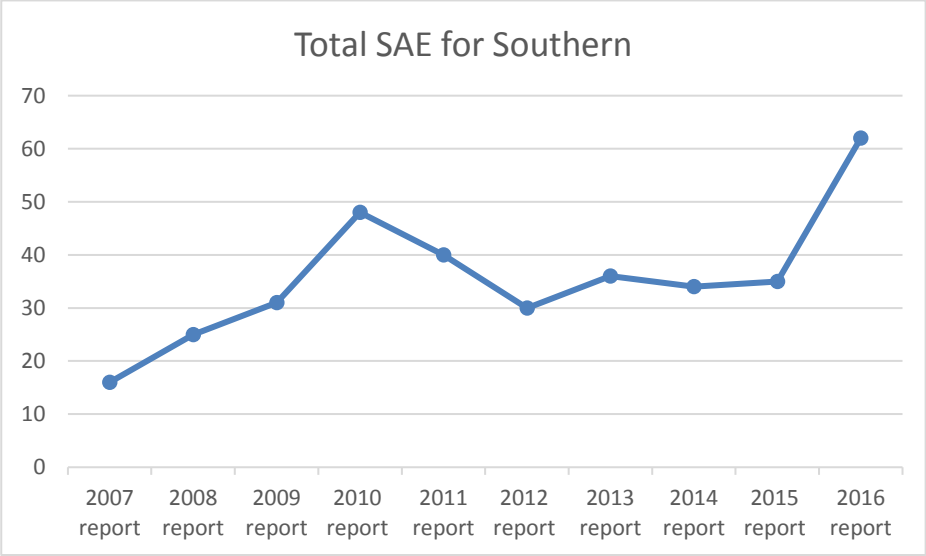
## Southern District Health Board

## 2015-2016

# Serious Adverse Events 2015 - 2016

Welcome to the serious adverse event release from the Southern District Health Board for 1 July 2015 - 30 June 2016.
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 Southern District Health Board (SDHB), the recommendations to make the care safer and our progress with implementing these safety measures.

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 –** 2015/16 year Southern DHB reported 61 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.**

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 events have not had their investigation completed at the time of release of this report. This means that the event is still under investigation or that the recommendations are in the process of being implemented.

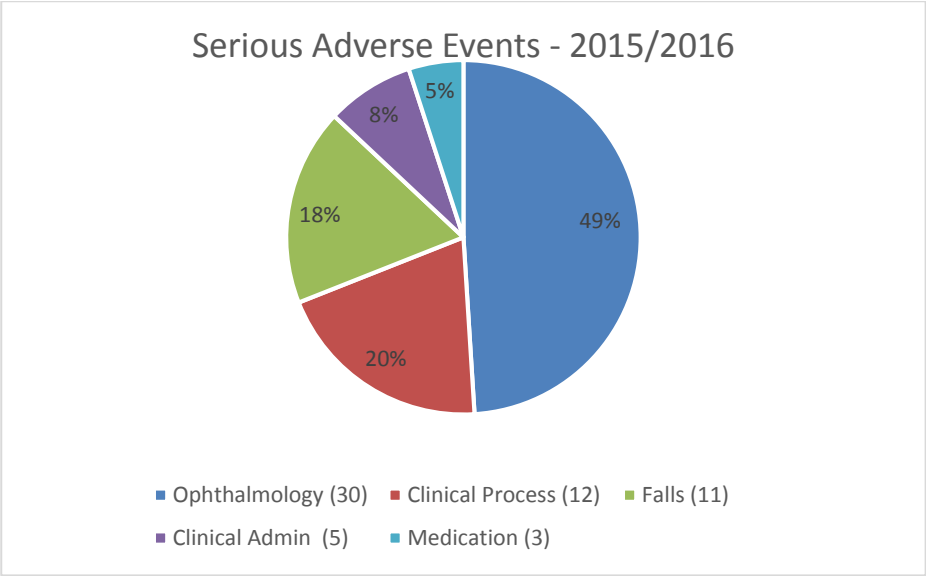
## Using Serious Adverse Events to promote Patient Safety & Prevent Harm

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 rather than blame those individuals who are involved in the event.

We have provided graphs to summarise the incidents that have occurred within 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.

Southern DHB is committed to improving patient safety in line with the HQSC programme of work; 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.

As indicated by graph 1, the largest group of serious adverse events relates to *Ophthalmology (*involving delay in follow up*)* (49%)*,* followed by *the failure in clinical processes* (involving clinical management (including delays in treatment, assessment, diagnosis and observation) (12%), *falls* (serious harm from falls e.g. broken hip) (18%), *clinical administration (*handover, referral, discharge) (8%), *medication error* (dispensing, prescribing or administration of medications) (5%).

**Report provided by:**

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**Patient Serious Adverse Events (SAE) Report: July 2015-June 2016**

**FALLS**

| | Description | Main Findings | Recommendations | Progress |
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| 1 | Fall resulting in fracture. | Patient mobilising independently despite advice to seek assistance. | No recommendations. | Complete. |
| 2 | Fall resulting in wound complication. | The light weight plastic shower chair use in the bathroom was not suitable as it tipped easily when weight was applied on patient transfer.<br><br>Staff and the patient made an assumption that the patient would be able to transfer independently, based on his previous competency and confidence in transferring independently, however the change of bathroom type with an unfamiliar shower chair significantly impaired the patient's ability to transfer safely. | Light weight plastic shower chairs are systematically replaced in the Unit, with sturdy shower chairs that have a minimal risk of tipping when weight is applied during patient transfer.<br><br>Staff are educated to orientate patients to new environments and any new equipment to be used, including a one to two person assist of the patient to ensure their safety prior to transferring independently.<br><br>Patients should have an allied health assessment to ensure their safety and competency prior to moving independently. | Complete.<br><br>Complete.<br><br>Complete. |

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| 3 | Fall resulting in fracture. | Poor communication between services regarding risk of climbing out of bed and recent falls. | Await recommendation from the delirium working group regarding appropriate care for high risk falls patients with delirium in the first 24 hours.<br><br>When assessing patients for a patient watch extra consideration should be given to patients with suspected new-onset or worsening confusion. | Complete.<br><br>Complete. |
| 4 | Fall resulting in fracture. | The patient had a history of syncope. On standing she fainted and fell to the floor, hitting her left side on the chair fracturing her ribs. The falls risk assessment on admission identified the patient deemed to be a falls risk and to be observed as was impulsive re mobilising. Falls assessment re-done post admission and following the fall. | No recommendations as this was considered to be an unpredictable event. | Complete. |
| 5 | Fall resulting in fracture. | Mechanical fall.<br><br>The patient experienced delirium. Currently no delirium assessment or management pathway consistently used across Southern District Health Board. | Falls alarms to be used for those with significant falls risk.<br><br>Intentional Nurse Rounding. Introduction of the Confusion Assessment Method (CAM) and delirium pathway in Southland Medical ward when it is ready for district wide Roll out. | Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| | | Medication patches had been ceased on discharge but this was not communicated in the clinical notes. | Improved communication when medications ceased. | Recommendation to be implemented. |
| 6 | Fall. Subdural haematoma. Patient deceased. | Risk assessment completed but not put in clinical note.<br><br>Individualised care plan was not updated when confusion developed.<br><br>Not all reasonable actions to prevent the fall were taken.<br><br>Nursing staff did not identify management strategies in care plan for confusion. | Reinforce the requirement to print assessments and place in clinical notes.<br><br>Reinforce the requirement to document risks in individualised care plans and monitor in particular new and/or developing confusion. Develop and implement a process for the management of confusion.<br><br>Develop some key measures of fall reduction improvement activity for the ward; individualised care plans, risk assessment completed, medication review, time to physiotherapy. | Complete.<br><br>Complete.<br><br>Complete. |
| 7 | Fall resulting in fracture. | The team information was not collated and used to form a Falls intervention strategy for patients whose needs are identified to be beyond universal precautions for falls preventions. | Implement a system where patient assessments are continued and information is not lost in case notes.<br><br>Implement team Falls Injury Prevention Plans for high risk patients. | Complete.<br><br>Complete. |
| 8 | Fall resulting in fracture. | Removal of 1:1 patient watch, placing patient on 5-15 minute frequent observations. Insufficient | Careful reassessment of level of observations – review need for 1:1 vs. frequent 5-15 minute observations. Priority use of rooms with availability of bedside call bell (8 & 9) for high falls risk patients. | Complete |

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| | | response to the increased indication of risk following first fall.<br><br>No call bell or method of alerting staff available to the patient. Walking stick out of reach. Distance of patient's room from the nurses' station.<br><br>No medical review after the first fall. Delay in diagnosis and commencement of treatment for a urinary tract infection.<br><br>Perceived difficulty in obtaining appropriate aids, particularly overnight or at weekends. | Obtain portable call bell for use in other rooms if Rooms 8 & 9 not available; consider installation of wall alarm capability in one of the specialist suite rooms adjacent to nurses' station.<br><br>Increase staff awareness of potential for adverse events to occur at handover times and ensure that vigilance with observations is maintained over this period.<br><br>Further education sessions with staff around falls risk screening, assessment & interventions, and rescreening after falls and on a weekly basis.<br><br>Reinstate Falls Individualised Care Plan Tool into all patient files – consider colour printing so this stands out (edge of page is yellow).<br><br>Clarification/education around special equipment and aids for high falls risk patients and multidisciplinary involvement and how to access these after hours.<br><br>Review medical cover for the unit over weekends/after hours; review procedures for access to same. Further staff education around post-falls response/care.<br><br>Investigate availability/purchase of true floor level bed/s.<br><br>Review Health & Safety implications for staff if nursing patients on mattresses on the floor. | Complete.<br><br>Complete.<br><br>Complete.<br><br>Complete.<br><br>Ongoing.<br><br>Complete.<br><br>Ongoing.<br><br>Complete. |

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| | | | Review availability of bed rails as enablers – currently not compatible with the beds in the unit – if use of these is appropriate.<br><br>Investigate availability/purchase of alarms which alert staff when patient gets out of bed.<br><br>Improved signage on wall water controls in Low Stimulus Area (LSA). | In progress.<br><br>In progress.<br><br>Complete. |
| 9 | Fall. Subdural haematoma. | The patient was prone to incontinence and insomnia and had cups of tea/coffee during night which acted as a caffeine stimulus to the bladder.<br><br>There were no staff available to respond to the patient, due to them attending to other ward requirements. The delay in answering the patient's call bell leading to the patient attempting to remove the urinal on his own without assistance.<br><br>No regular documentation was observed in the patient notes from the hourly ward rounds. | When a patient is prone to incontinence and/or insomnia staff should attempt to dissuade patients who request cups of tea/coffee during night and offer an alternative if possible. This is to avoid caffeine stimulus to the bladder.<br><br>Review staffing levels on night shift to ensure two staff are available at all times.<br><br>All staff reminded to complete the forms that are required for patient's admission, care and discharge. Auditing for compliance is recommended. The number of forms required for patient care/treatment should be reviewed, and where possible consolidated to ensure no information/key messages | Complete.<br><br>Complete.<br><br>Complete. |

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| | | There was no mention on the "Resident Transfer/Discharge" form, that the patient was a falls risk when the patient was transferred to residential care. | are overlooked by staff due the amount of reading that is required.<br><br>On discharge to residential care, a falls alert should be recorded. A fresh falls alert bracelet should be attached to the patient's wrist as a further prompt for the admitting facility. | Complete. |
| 10 | Fall resulting in fracture. | When the patient was playing with a rugby ball, the slope of the courtyard grass area and the patient's level of physical ability made it difficult to safely negotiate. | The washing line to be moved to allow more space for games and activities on the flattest surface of the courtyard. | Complete. |
| 11 | Fall. Subarachnoid haemorrhage. | Regular neurological observations were omitted until specifically requested to be 2 hourly by the ED registrar.<br><br>Full Falls risk assessment was not completed until the patient had been in the Observation unit for 3 hours and fallen a second time. | Feedback to Emergency Department (ED) Charge Nurse Manager.<br><br>Educate and improve compliance of Neurological Observation in a potentially head injured patient.<br><br>Include falls screening policy in operational policy of ED observation unit. If initial screen indicates the need to go on to a full falls screen this should be completed within 30-60min after being transferred to the Observation unit. | Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |

**MEDICATIONS AND INTRAVENOUS FLUIDS**

| | Description | Main Findings | Recommendations | Progress |
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| 12 | Respiratory depression associated with opioid use. | No alert on the patient's record regarding Obstructive Sleep Apnoea (OSA).<br><br>There is no policy or guidelines for patients with OSA who are scheduled for surgery.<br><br>There is no specific and robust criteria for patients who deviate from the Total Hip Replacement (THR) pathway.<br><br>Bedside handover was not completed on day 2 post surgery despite patient still having Patient Controlled Analgesia (PCA) and Intravenous (IV) in situ. | Consider possibility of an alert to be attached to all patients' clinical records who have severe OSA.<br><br>Develop guidelines around patients with OSA who are scheduled for planned surgery.<br><br>Develop specific and robust guidelines with regard to variations for patients on a THR pathway.<br><br>Institute bedside handover specifically for patients with PCA and IV fluids and document. | Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |
| 13 | Medication omission. | | | Investigation to be initiated. |

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| | Patient readmission. | | | |
| 14 | Respiratory depression associated with opioid administration. | The frequency of clinical observations did not enable detection of deterioration in the patient's condition when there was an increase in patient-controlled analgesia (PCA) bolus dose.<br><br>PCA prescribing not carried out by acute pain service (ACSP)<br><br>Pump malfunction cannot be excluded as a contributor as servicing not up to date. | The Acute Pain Service (APS) to restrict long acting oral opioid use with a PCA to those who have been on long acting oral opioids long term prior to commencing PCA. This will require a multipronged approach including but not limited to restricting PCA prescribing to a limited number of prescribers (APS anaesthetic consultant and registrars), Medchart prompts and changes to the PCA prescription form. The APS to require increased observation frequency after an increase in the PCA bolus dose above the standard 1ml (1mg morphine, 20 mcg fentanyl). Recommend at least hourly for 12 hours (MIDAS documents/PCA prescription charts/PCA training will need to be altered to reflect this change)<br><br>All PCA requests are to be through the APS. There should be an accessible, structured referral process for APS review and PCA administration.<br><br>Clinical Engineering team will provide schedules for PCA servicing which will be audited for compliance. The Service Manger will ensure adequate resource is available to carry out PCA safety checks as per the manufacturers' specifications. | Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |

**CLINICAL ADMINISTRATION**

| | Description | Main Findings | Recommendations | Progress |
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| 15 | Delay in diagnosis. | Poor communication from the community to the cardiology department and also within the emergency department (ED).<br><br>This event occurred first thing in the morning, and communication at handover time is often difficult. | The supervising overnight registrar to always carry the ED phone.<br><br>Switchboard has been told to contact this phone at all times for communications from paramedics, or alternatively the ED Senior Medical Officers (SMOs) departmental mobile phone.<br><br>Ongoing education with the ED team about the importance of discussing any potential ST Elevation Myocardial Infarction (STEMIs) with cardiology as early as possible.<br><br>Ongoing work both locally and nationally to implement a programme of STEMI management, including formalising the role of the STEMI co-ordinator; in SDHB it is likely that this individual will be the cardiologist on call. | Complete.<br><br>Complete.<br><br>Complete.<br><br>Complete. |
| 16 | Delay in referral. Metastatic cancer. | | | Investigation initiated. |
| 17 | Delay in follow up. Breast cancer. | The referral was lost as a result of multiple entries into the system combined with having to move it around the district. | Re-prioritisation of all outstanding patients checking for risk and re-booking as appropriate. Pending introduction of electronic referral management system (September 2016) the referral system will be examined and rectified to ensure nothing is missed. Travel of referrals will be examined. | Complete. |

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| | | The current triage system does not have accuracy audits. No training or recertification for nurses.<br><br>The summer shutdown period contributed. | Re-examine the nurse triage system to develop a system of checks as well as robust training and certification for all nurse triagers.<br><br>Forward planning to provide continuous cover especially when staffing or service capacity may be reduced. | Complete.<br><br>Complete. |
| 18 | Child Protection failure. No multiagency planning. | History taking was incomplete and the communication and sharing of information within and between clinical teams was inconsistent.<br><br>A national multi-agency safeguarding protocol Memorandum of Understanding (MoU) was not followed prior to discharge home.<br><br>Important clinical information was not communicated to clinical teams and was not included in the clinical details section of radiology request forms. | Ensure that the multidisciplinary team adopts a systematic approach to gathering, sharing, and documenting relevant information. Initiate a process to develop "shared care" principles between paediatrics and surgical specialties for patients admitted to Children's Ward.<br><br>Ensure all staff are aware of, and follow, the national MoU.<br><br>Ensure all children's health staff can access training and support in managing family violence / child protection issues.<br><br>Convene a meeting regarding the findings of this investigation, and to consider findings from other agency reviews.<br><br>Review service requirements and staffing requirements to ensure alignment.<br><br>Clinicians should be reminded of their responsibility to follow up inconclusive radiology reports. This could be by directly contacting the reporting radiologist (including from an outsourced service) or the relevant subspecialist radiologist. | Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Complete.<br><br>Recommendation to be implemented. |

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| | | | All hi-tech imaging requests for children up to age of 12 years should be triaged and protocoled by a paediatric radiologist.<br><br>Clinicians should be reminded that providing relevant clinical details in radiology requests helps improve the quality of the reports.<br><br>SDHB paediatric radiology service should implement a district radiology policy for Non-accidental Injury to children.<br><br>A clear process is in place for general radiologists to access paediatric radiology support if SDHB paediatric radiologists are unavailable. | Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |
| 19 | Delay in diagnosis. Chest malignancy. Patient deceased. | Follow up of the unexpected abnormal finding on audit involved communication by email to the referring clinician but the Chest Clinic was left unaware of the abnormal finding<br><br>We have had a poorly integrated patient radiology reporting system and IT radiology imaging systems. | That the Assistant to the Medical Director of Patient Services directly refers patients to chest clinic for further evaluation on receiving radiological reports that have not been actioned within an appropriate period of time.<br><br>That our current system is re-emphasised to the radiology department whose consultants and registrars have to specifically mention on the report that the patient needs further evaluation.<br><br>That current work with Picture Achieving and Communication System (PACs) reporting system provide an effective alerting system for abnormal radiology findings. | Complete.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| | | Chest clinic did not receive a copy of the radiology report. | That the staff who are "typing the reports" are made very aware that, if the patient is recommended for further evaluation, then copies of the report are sent both to the chest clinic and to the Assistant of the Medical Director of Patient Services. | Recommendation to be implemented. |

**CLINICAL PROCESS**

| | Description | Main Findings | Recommendations | Progress |
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| 20 | Unrecognised deterioration of patient's condition. | Communication problem between medical staff. | Formal education process regarding Early Warning Score and actions to be instituted. | Recommendation to be implemented. |
| | | | Discussions with the Medical staff involved regarding appropriate documentation following clinical review of a patient. | Recommendation to be implemented. |
| | | | A group to be to appointed to review the Medical Handover between shifts specifically for patients of concern and develop improvement to this process. | Recommendation to be implemented. |
| | | | Charge Nurse Manager to resolve the process regarding response to Early Warning Scores. | Complete. |

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| 21 | Delay in follow up. Admitted with vomiting and diarrhoea. Patient deceased. | | | Investigation to be initiated |
| 22 | Significant haemorrhage of home dialysis patient. | | | Investigation initiated. |
| 23 | Retained wound packing item with delayed removal. | | | Investigation initiated. |
| 24 | Post-surgical complication. Patient deceased. | That a formalised protocol recognise that the relatively low volume of major head and neck surgery being performed should have a bearing on the level of care placement immediately postoperatively (i.e. ICU vs HDU).<br><br>On calling for and getting the ultrasound machine in order to establish the exact position of the airway, the ultrasound machine did not function appropriately, and so time was lost while another machine was provided. | That the surgical teams plus the intensive care/HDU staff develop specific protocols and parameters for the post-operative care of major head and neck surgery in patients particularly with respect to airway management in the first 24-hours following surgery.<br><br>That the maintenance of vital equipment be meticulously performed and monitored. | Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| 25 | Delayed diagnosis. Infection. Loss of fingers and toes. | When the initial set of vital signs were done, the Early Warning Score (EWS) was not calculated. The EWS was not in use as it should have been. A score of 1, which this patient scored, would have mandated a repeat set of observations in 2 hours<br><br>Policy whereby observations are done when a patient is transferred to the Observation area of the ED was not followed.<br><br>Time from Triage to being seen by a Medical Practitioner was long (over 2 hours for a Triage Category 3 patient). The CT scan was done in a timely fashion but no report was available for two hours.<br><br>Even when the diagnosis was clear and action was taken, there was a long delay for antibiotics to be given.<br><br>There is no sepsis pathway in use in Emergency Department.<br><br>In investigating the case it was often difficult to interpret signatures in clinical notes and some entries were not clearly time stamped. | Recommend that the EWS is calculated for patients having observations done, and that further action taken is related to this score. This needs to be audited.<br><br>Recommend that a set of observations is done at the time a patient arrives in the Observation area of the Emergency Department. This requires audit.<br><br>Recommend reviewing attendances to ensure that this is not a common occurrence. If this is the case then work flow processes and staffing levels on shift should be reviewed.<br><br>Recommend the case should be discussed with the Radiology service for their comment.<br><br>Education for Medical and Nursing staff to reinforce to them the time critical nature of antibiotics in sepsis. This needs to be audited as part of a pathway (below) and quality key indicators.<br><br>Recommend that ED consider initiating an evidence-based "Sepsis Pathway" and auditing the use of such a pathway with clear measures such as time to antibiotics in sepsis.<br><br>Recommend reinforcing the need for legibility for identifying staff and time of actions. | Complete.<br><br>Complete.<br><br>Complete.<br><br>Complete.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| | (34392)<br><br>This event has been reviewed and de-notified. | | | |
| 26 | Delay in diagnosis. Adenopathy. Cancer. | | | Investigation initiated. |
| 27 | Delay in diagnosis. Breast cancer. | | | Investigation initiated. |
| 28 | Delay in diagnosis. Herpes Simplex Encephalitis. Cognitive sequelae. | Early presentation of an evolving illness at a time when there was headache but no other clinical features of the disease.<br><br>Diagnostic difficulty due to a history of alcohol use, and abnormal liver function tests.<br><br>Overlooked subtle CT scan findings.<br><br>Observations not repeated while in the Emergency Department (ED) on the first presentation.<br><br>There is no evidence that the involvement of a nurse practitioner | It is recommended that emergency doctors and internal medicine physicians review this topic as part of continuing medical education.<br><br>It is recommended that the use of repeated observations and the maintenance of observation charts be formalised in the ED setting. Early Warning Score or equivalent tools should be used to inform decisions regarding frequency of observations on patients in ED.<br><br>In the ED setting, the nurse practitioner role should be clearly defined and separate from the nursing role, and this should be | Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| | | contributed to the outcome in this case. In discussion, however, it emerged as a possible risk in the future, if the role of the nurse practitioner is not clearly defined. | explicit. In particular the nurse practitioner should not be responsible for performing repeat observations. | Recommendation to be implemented. |
| 29 | Retained surgical item. | Lack of awareness of the current surgical count policy that had been put in place two months prior to the patient's surgery.<br><br>Whilst the new surgical counts policy (2014) theoretically would prevent the retention of this item happening again, the review of the case still showed that there is some lack of uniformity as to what items are added to the formal count.<br><br>Communication of risk nationally. | That a very clear and formal procedure be established for the introduction of new/updated policies changing clinical practice within the peri-operative environment.<br><br>Recommend that there be formal educational sessions with theatre staff with regards to the details of the surgical count policy.<br><br>That the surgical count policy (2015) be reviewed, with a view to developing uniformity as to what added in sundry items are formally noted on the surgical count list for each procedure.<br><br>That Women's, Children's and Public Health Directorate review the resourcing, scheduling and planning of outpatient appointments for post-operative gynaecological cases further to this case.<br><br>The Chief Medical Officer, in association with the Health Quality and Safety Commission, to notify other District Health Boards and the manufacturer of this event and the risk identified. | Complete.<br><br>Complete.<br><br>Complete.<br><br>Recommendation to be implemented.<br><br>Recommendation to be implemented. |

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| 30 | Malpositioned positioned gastric tube. Perforation. | | | Investigation initiated. |
| 31 | Malpositioned gastric tube. Perforation. | | | Investigation initiated. |

**OPHTHALMOLOGY**

| | **Description** | **Main Findings** | **Recommendations** | **Progress** |
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| 32-33 | Loss of visual function. | Lack of direction to the booking staff regarding high risk patients.<br><br>Organisation of the clinics.<br><br>The methods for communicating the need for further appointments. | Review the way in which follow-up appointments are booked for patients to include:<br><br>Review of the documentation used to inform booking staff.<br><br>Ensure booking staff are given the appropriate direction or tools to decide which patients need to be booked in a resource constrained environment.<br><br>Review the number and type of each clinic that is run to ensure that the group of patients at the highest risk of adverse outcomes by delayed appointments, are able to have the shortest delays.<br><br>Ensure that the workload of operational management staff is regularly reviewed especially when dealing with a service with recruitment difficulties. | Complete.<br><br>Complete.<br><br>Complete.<br><br>Complete.<br><br>Complete. |

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| | | Clinic capacity not meeting the demand. | Undertake a review of the roles and responsibilities of those involved in the management of the ophthalmology service. Clinically review the current waiting list to identify other potential patients at risk of an adverse outcome. | Complete. |
| 34-61 | Loss of visual function. | | | Investigation initiated. |