Wairarapa, Hutt Valley and Capital & Coast District Health Boards Serious and Sentinel Events (SSEs) Report: 2014-2015

Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) continue to work closely to improve the quality of care that we provide to our three communities. During the period 1 July 2014 to 30 June 2015 Wairarapa DHB reported 9 Serious and Sentinel Events (SSEs), Hutt Valley DHB 7 SSEs, and Capital and Coast DHB 27 SSEs. These SSEs occurred in our hospitals which meant that patient's suffered harm or death while in our care. We sincerely apologise to the patients and family/whanau involved in these cases and acknowledge the distress and grief that occurs when things go wrong in healthcare.

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 in the review to the degree they prefer, and where possible answer their questions and address any concerns that they have.

Working together as a sub-region enables us to learn from each other and utilise our different areas of expertise to improve the care we provide. We depend on events being reported by the people involved and for this to occur we rely on a just culture (balancing accountability of individuals and the organisation) that focuses on improving systems and not blaming individuals. We want our patients and their family/whanau, other health providers such as family doctors and primary health nurses, and our own staff to tell us when an incident has occurred and raise concerns, so that we can look into what has happened to try to minimise the chance of a similar event happening again.

When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented. This process assists us to achieve our 2014/15 priority of Zero Patient Harm, which forms part of our overall quality improvement and patient safety program of work.

The 2014/15 SSEs are reported to the Health Quality and Safety Commission according to category. For each DHB these were:

CATEGORY	WDHB	HVDHB	CCDHB
Patient Falls	2	7	7
Clinical Processes	2	1	17
Medication/IV Fluids	2	1	2
Blood Products	1	0	0
Medical Device	0	0	1
Total	7	9	27

NB: WDHB – the number of events reported to HQSC (9) differs from the number in the above table (7) as the reports withdrawn were after the cut off date in September, 1 event was downgraded following review and 1 event will be reported in the Office of the Director of Mental Health's report in December 2016.
HVDHB – the number of events reported (7) differs from the number in the above table (9) due to a reconciliation error.

Clinical Processes (assessment, diagnosis, treatment, general care)

These events have highlighted communication issues that have led to delays in treatment, allocation of care, surgical complications (wrong site surgery/retained items), test processing delays and interpretation. The three DHBs have focussed on improving communication and documentation through the use of communication tools, enhancing the early warning score (EWS) pathway that focuses on documentation and an early escalation of the deteriorating patient pathway. The Health Quality and Safety Commission's Safe Surgery campaign for 2015/16 is aimed at improving communication and team work within Theatres, through the use of briefing and debriefing.

Patient Falls (includes falls in hospital involving a fracture or other serious harm)

These are still the leading category of harm nationally. For CCDHB patient falls have decreased and significantly there were no patient falls SSEs from December 2014 to May 2015. This is as a result of our ongoing work to prevent falls, which is aligned to the Health Quality and Safety Commission's national patient safety campaign "Open for Better Care" that commenced in 2013. The CCDHB Falls Prevention Groups have implemented key system changes that have significantly reduced patient falls due to the practice change and engagement with the improvement focus owned by the clinical staff. As well as the successful implementation of the falls signalling system, we have improved staff engagement through real time auditing focussed on best practice (Point of Care Audits), and ward specific data on audit results/action and actual ward fall's rate. Patient engagement in improving communication about falls risks (co-design), and a footwear campaign in April 2015 focussing on safe footwear to prevent falls.

Wairarapa DHB continues to work with Aged & Residential Care providers in promoting falls prevention. The Occupational Therapy (OT) team monitors and follows up on all falls presentations and discharges to Emergency Department to ensure patients have the resources to remain safe in their own homes. WDHB have focused on individualising patient care plans where falls risks are highlighted. The Assessment Treatment & Rehabilitation ward introduced non slip socks following a footwear campaign in April along with the falls signalling system and individual colour signs to encourage patients to use their call bells when mobilisation assistance is required.

Hutt Valley DHB has recently linked the Central Region Falls Signalling system to the Mobility Indicator in TrendCare (an electronic patient acuity and workload system) onto the patient electronic whiteboards in clinical areas (Self /Partial Assistance /Total Assistance – is a mandatory indicator in TrendCare). This means that the level of assistance required by a patient is automatically pulled across into the patient's information, this results in an increased visibility of individuals mobility needs for all staff, improved compliance with falls assessments. The level of assistance required by an individual will adjust in line with the patient's needs. The next step in this improvement is to have the falls assessments available in TrendCare. This will ensure that all assessments are standardised, accessible and more easily reportable. These actions are part of the falls prevention improvement work that is being undertaken to increase engagement with clinical staff and reduce the harm from falls in our hospital.

All three DHBs are actively engaged in the regional Integrated Falls Prevention Action Plan.

Medications

Medications are a very important part of a patient's therapy, however all medications carry risks and some have significant risk of patient harm, and must be prescribed, given, monitored and taken very carefully. CCDHB has focussed on ensuring those that prescribe and administer medications check the patient's allergy status. Wairarapa DHB has had a focus on palliative care pain relief. Hutt Valley DHB are currently establishing medication safety groups in each clinical area with the aim of learning from errors as part of the continuation

for a culture of zero tolerance of medication errors. We have focussed on the safe use of opioids and insulin, increasing the safe use of medications for patients.

Blood Product

The Wairarapa DHB event was related to an error in the checking process for blood transfusions. Wairarapa DHB has enhanced the education provided regarding the double checking process in relation to blood product administration by an Intravenous Nurse Educator.

Medical Device

The CCDHB event was related to a balloon becoming detached from a guide wire during stent placement. CCDHB has discontinued using this product and have notified Medsafe

Hutt Valley District Health Board
Serious and Sentinel Events Report: 2014-2015

1. HV2015-02

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Unwitnessed fall resulting in fracture

REVIEW

Key findings:

- Patient was identified as high falls risk on admission
- General falls prevention strategies in place
- Evolving diagnosis of previously unknown cognitive issue impacted on patient's ability to understand advice to seek assistance
- Impact of sedation related to use of opioid analgesia

Recommendations:

- Staff education regarding impact on advanced analgesia on falls risk
- Review Acute Pain Service referral and advice process
- Confirm pharmacy review medications for patients identified at risk of falling

Recommendations progress (i.e. action plan):

- Findings of review shared with the team. Incorporated into Medical staff teaching by Acute Pain Service
- Acute Pain Service has improved process for documenting verbal advice to ensure consistency
- It is standard practice to review medications of patients at risk of falling

2. HV2015-18

Event Category : Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Unwitnessed patient fall resulting in fracture

REVIEW - Key findings:

- Patient was identified as high falls risk on admission
- General falls prevention strategies in place, but required more individualised strategies in light of delirium
- Delirium a key factor in fall but was appropriately recognised and was being actively managed
- Delay in obtaining appropriate low bed
- Issue with bed rails

Recommendations:

- Audit of bed rails to be undertaken and actioned
- Nursing staff education on falls strategies and presentation of case for learning
- Purchase low beds to increase availability
- Re-establish Falls Focus Group
- Audit of nursing assessment and care plans to improve documentation

Recommendations progress (i.e. action plan):

- Bed rail audit completed and issues identified addressed
- Nursing staff education on falls strategies and presentation of case for learning completed
- Trial of low beds completed, purchasing process commenced
- Falls Focus Group re-established and meeting bi-monthly
- Senior nursing staff identified to undertake documentation audit and share results

3. HV2015-12

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Unwitnessed patient fall resulting in fracture

REVIEW - Key findings:

- Patient was identified as high falls risk on admission
- Falls risk assessment completed and falls care plan in place
- Physiological cause for fall with significant history of recurrent falls

Recommendations:

- No recommendations were made by review team as fall was related to physiological condition and all possible falls prevention strategies were in place

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme

4. HV2015-01

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Patient fall resulting in dislocation to hip

REVIEW - Key findings:

- Patient with history of recurrent hip dislocations
- Falls prevention strategies in place
- Inappropriate toilet chair in bathroom
- Initial check of patient following fall did not identify injury, process for further review not followed

Recommendations:

- Appropriate toilet chair purchased for permanent placement in bathroom

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme
- Appropriate chair in place
- Staff reminded of process for medical review following fall and documentation requirements for progress notes

5. HV2015-14

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Patient fall resulting in fracture

REVIEW - Key findings:

- Patient able to independently mobilise with aid of walking stick
- Fall occurred at night when patient went to bathroom
- Falls prevention strategies in place

Recommendations:

- No recommendations were made by review team as fall was related to physiological condition and falls prevention strategies were in place

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme

6. HV2015-16

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: Patient fall resulting in fracture

REVIEW - Key findings:

- Falls risk assessment not completed on admission, patient identified as falls risk during admission
- Nursing plan documented patient required assistance mobilising
- Patient assisted to bathroom, staff in attendance and walking frame utilised
- Physiological cause for fall

Recommendations:

- No recommendations were made by review team as fall was related to physiological condition and falls prevention strategies were in place

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme

7. HV2015-06

Event Category: Medication Error **Deceased:** N **SAC Rating:** 2

Event Summary: Incorrect dose of regular sedation medication

REVIEW - Key findings:

- Overdose of sedation due to nurse's misinterpretation of prescription, compounded by illegible writing by prescriber
- Second nurse checking prescription also misinterpreted dosage
- Medication information and dosage ranges not checked with prescriber prior to administration

Recommendations:

- Education of nursing staff to increase knowledge of medication dosage minimum and maximum ranges to include:
  - promotion of culture of questioning dose requiring more than 2 tablets or 2 ampoules to be administered to a patient
  - use of medication formularies to check unfamiliar medications and doses
  - requesting prescribers to write numerals more clearly and carefully

Recommendations progress (i.e. action plan):

- Education ongoing
- House Surgeons now undertake a prescribing module before starting at HVDHB in order to minimise prescribing errors
- Each clinical area is developing a multi-disciplinary medication safety group to learn from mistakes and develop a culture of zero tolerance towards medication errors

8. HV2014-09

Event Category: Patient Fall **Deceased:** N **SAC Rating:** 2

Event Summary: patient fall resulting in fracture

REVIEW - Key findings:

- Patient was identified as high falls risk on admission
- Falls plan in place
- Patient fell when attempting to get up from commode

Recommendations:

- Ability of falls risks patients to request assistance for toileting to be checked at admission

Recommendations progress (i.e. action plan):

- No further recommendations as falls prevention strategies in place at time of fall

10. HV2014-06

Event Category: Clinical Process **Deceased:** N **SAC Rating:** 2

Event Summary: Incorrect tooth removed by dental therapist

REVIEW - Key findings:

- X-ray of teeth placed wrong way round prior to reading – standard process for mounting x-ray for reading not followed
- Therapist did not check clinical notes prior to procedure and consequently removed tooth on the wrong side

Recommendations:

- Extra check to be put in place prior to treatment commencing to prevent a reoccurrence in the future
- Further training for staff to ensure correct procedures followed

Recommendations progress (i.e. action plan):

- All actions completed