Hutt Valley District Health Board
Adverse Events Report: 2015-2016

Hutt Valley District Health Board is committed to providing safe and high quality care to our community. Patients and their whānau/family are at the centre of decisions that we make as a health system, and the safety of patients and staff are our top priority at Hutt Valley DHB.

The National Reportable Events Policy requires every DHB to report adverse events to the Health Quality and Safety Commission. Hutt Valley DHB reported seven adverse events that occurred in our hospital and health services during the reporting period 1 July 2015 to 30 June 2016.

Each of the reported events involves a patient experiencing harm whilst in our care. We consider one event of this nature one too many, and apologise unreservedly to the patients and family/whānau involved in these cases. We acknowledge the distress and grief that occurs for patients and their families/whānau when things go wrong in healthcare.

Hutt Valley DHB is committed to learning from adverse events. Hutt Valley DHB is an organisation that fosters openness and transparency, particularly when things go wrong. We review what happened, we reflect on lessons, we take actions to reduce the risk of a similar event from reoccurring and we share the lessons and actionslocally, and across the health sector.

We rely on adverse events being reported by the staff members involved in order to learn from them. A positive and committed safety culture means that patients and their family/whānau, other health providers such as family doctors and our own staff tell us when an incident has occurred and raise concerns, so that we can look into what has happened.

Hutt Valley DHB is dedicated to working with patients and family/whānau when things go wrong, and we ensure that their concerns and needs are addressed and supported.

Our practice is to communicate openly with patients and families/whānau 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 families/whānau 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. Making this happen supports Hutt Valley DHB to achieve our priority of safe and high quality care. This forms part of our overall quality improvement and patient safety programme of work, and links with our strategic goal of “Improved quality, safety and experience of care” and the government goal of “New Zealanders living longer, healthier more independent lives”.

The category classification of the Serious Adverse Events reported to the Health Quality and Safety Commission is recorded in the table below:

General classification of event	**Number of reported adverse events**
Falls	2
Medication/IV fluids	1
Clinical process/procedure	4

Classification information:

Clinical process/procedures include events that occur in or impact on the clinical environment.

Falls events include falls in hospital involving a fracture or other serious harm. The reported adverse events relating to serious harm from falls has reduced at Hutt Valley DHB this year. This reduction reflects the work that Hutt Valley DHB has undertaken with our falls prevention programme.

Medication/IV fluids reporting includes events where an adverse outcome has occurred as a result of a medication prescribing, storage, or administration error. Hutt Valley DHB has a medication safety group focused on the safe use of medication in our hospital.

Hutt Valley DHB reiterates our apologies to the patients and their family/whānau who were affected by adverse events that occurred whilst in our care. These events have been reviewed, with input from the people involved, and system and process changes have been implemented to reduce the likelihood of a similar event from recurring.

1. HVDHB ID: 26468

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

Event Summary: Fall resulting in fracture

Key findings from review:

- The patient had a complex medical history
- The patient required supervision when mobilising, on this occasion the patient independently mobilised to bathroom
- The patient had not been provided with falls prevention education
- Hourly intentional rounding (nursing checks on patients to assess fundamental needs) did not include a check regarding call bell or bathroom requirements

Recommendations:

- Staff to be reminded regarding intentional rounding
- Ensure falls risk assessment and management are documented in care plan

Recommendations progress: Complete

- Intentional rounding in place and staff have been further educated about its importance
- Patient falls prevention education is in place and the "How to stay safe in hospital" video is shown to patients along with an individualised care plan
- The Falls prevention programme in place continues

2. HVDHB ID: 27442

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

Event Summary: Unwitnessed fall resulting in fracture

Key findings of review:

- Patient independently mobilised to bathroom
- Falls risk assessment completed on admission, not reassessed in a timely manner
- Change of medication not reconsidered in relation to possible increased falls risk

Recommendations:

- High-low beds to be purchased (can be set at floor level)
- Close observation package to be developed
- Delirium and dementia assessment tool to be implemented for all at risk patients
- Regular audit of falls risk from admission to discharge

Recommendations progress: complete

- High-low beds have been purchased. Beds can be hired on “as needs” basis if extra beds are required
- Close observation package rolled out throughout hospital. Includes techniques and strategies for interaction with confused and/or delirious patients
- A delirium and dementia assessment scoring tool has implemented
- The falls prevention programme in place continues

3. HVDHB ID: 3764

Event Category: Medication/IV fluids **Deceased?:** N **SAC Rating: 2**

Event Summary: Incorrect dose of asthma medication (salbutamol) administered resulting in significant patient deterioration

Key findings of review:

- The patient presented with a complex respiratory history
- The process around verbal instructions for giving and checking medication was not robust
- Staffing numbers (due to sickness and inability to be replaced at short notice) and skill mix was a contributing factor

Recommendations:

- The contingency plan for staff shortages to be reviewed
- Reinforce the "five rights" (safety process) of medication administration with all staff
- Review process for giving medication via verbal instructions

Recommendations progress: complete

- The contingency plan has been reviewed, revised and implemented for staffing shortages
- The planned organisational review of nursing staffing levels progressing
- Five rights of medication administration has been reinforced with staff
- Verbal orders given by medical staff are repeated back to prescriber to ensure clarity of the medication order given

4. HVDHB ID: 740

Event Category: Clinical Process/procedure **Deceased?: N** **SAC Rating: 2**

Event Summary: Wrong tooth removed

Key findings from review:

- Incorrect tooth removed
- Pre procedure checklist ("time-out") not followed

Recommendations:

- "Time-out" checklist to be electronically implemented on the dental record system
- Further service wide training for staff on electronic "time-out" checklist

Recommendations progress: complete

- "Time out" checklist added to electronic system
- Initial staff training has occurred and is now ongoing. Regular audits are undertaken to ensure compliance with the "time-out" checklist.

5. HVDHB ID: 3980

Event Category: Clinical Process/procedure **Deceased?:** N **SAC Rating: 2**

Event Summary: Bleed into chest, following a known complication during a procedure to drain fluid from around the heart. Procedure further complicated by false reading for blood clotting time (INR) which was higher than reported. Surgical intervention was required.

Key findings of review:

- The bleed into the chest was a known complication of the procedure performed
- The procedure would have been delayed if the correct INR level had been reported
- The consequence of the complication was magnified by a longer clotting time
- An unexpected equipment error led to incorrect report of blood clotting time.
- The INR level was higher than reported, this error extremely rare.
- The error in levels was not escalated appropriately for senior clinical oversight
- The staff on duty managed the error response well and ensured that any potentially affected patients were treated appropriately

Recommendations:

- None for procedure complication; this was a known complication that is prevented as much as possible
- Clinically-relevant events requiring immediate escalation to a senior level are defined
- Senior leader(s) are identified and notified to lead the response to such an event
- Services that manage clinical equipment are aware of expectation to notify a designated senior leader
- Messaging about a clinically-relevant event is communicated to appropriate senior and frontline staff in a timely manner

Recommendations progress:

- An escalation and communication process has been drafted and provided to staff for consultation. Final sign-off on the collaboratively agreed process is due by end of November 2016.

6. HVDHB ID: 2016-06

Event Category: Clinical process/procedure **Deceased?: Y** **SAC Rating: 1**

Event Summary: Intrauterine foetal death

Key findings of review:

- The patient was a high risk patient
- There was no active consultation with anaesthetics
- The maternal and foetal heart rates were not differentiated (not recognised as different), foetal bradycardia (slow heart rate) was not picked up.
- When called, the senior doctor sent a senior registrar to review the patient, the senior doctor did not attend at that time
- The escalation plan for medical and midwifery staff in the busy acute unit was not followed

Recommendations & progress:

- A discussion now occurs with the anaesthetic team regarding high risk patients following their admission
- If a senior doctor is called to review a patient, the senior doctor attends in person prior to passing on the care to another doctor
- When CTG (electronic foetal monitoring) is in progress, maternal pulse is to be monitored at the same time. The current policy for foetal monitoring has been amended to reflect this recommendation.
- All HVDHB practitioners in maternity care, are undertaking foetal monitoring education and refresher training
- An escalation plan for medical and midwifery staffing for when the maternity unit is busy and for unplanned admissions is in process, as is the strengthening of senior leadership oversight of the maternity unit

7. HVDHB ID: HV2016-05

Event Category: Clinical Process/procedure **Deceased?: Y** **SAC Rating: 1**

Event Summary: Intrauterine foetal death

Key findings of review:

- There was inadequate supervision by senior Doctors of junior medical staff during care of an acutely unwell patient
- Consultation with other specialists was not considered for inclusion as part of the patient's care planning, notably anaesthetics
- The Labetalol (medication to control blood pressure) protocol not readily accessed by staff
- Thorough documentation was not present for all file entries during the patient's admission, including the treatment plan
- The escalation plan for medical and midwifery staff in the unit was not followed

Recommendations & Progress:

- An antenatal and postnatal care plan review is in progress
- Acutely unwell patients are now directly managed by the senior doctor
- The 'management of pre-eclampsia' policy has been reviewed and recirculated
- All acutely unwell patients are now assessed by an anaesthetist on or soon after admission
- Protocols for the use of medications are readily available to all staff, and accessibility has been highlighted
- Education and planned audit of documentation standards is a continual process
- An escalation plan for medical and midwifery staffing for when unit is busy and for unplanned admissions is in progress, as is the strengthening of senior leadership oversight of the maternity unit