Hutt Valley District Health Board

Serious Adverse Events Report: 1 July 2018 to 30 June 2019

Hutt Valley District Health Board is committed to providing safe and high quality care to our community. The DHB strategy document *Our Vision for Change 2017-2020* describes the aim to deliver shorter, safer and smoother care. To achieve this, every patient's passage through the health systems requires responsive, accessible, high quality and timely services. Our clinical staff are working with patients and their whānau/family to improve the quality of care and the patient experience, which in turn drives improved health outcomes.

This report describes serious adverse events for the 2018/19 year for Hutt Valley DHB. Each of these reported events involves a patient experiencing harm while 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.

Our hospital is committed to openness and transparency, particularly when things go wrong. We have a patient safety culture where reporting is encouraged; we review what happened; we reflect on learnings; we take actions to reduce the risk of a similar event from reoccurring and we share the learnings and actions so we can improve our services.

Serious Adverse Events

An adverse event is an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned (often referred to as 'incidents' or 'reportable events'). In practice this is most often understood as an event which results in harm to a patient.

For the purposes of this report, we use the term 'serious adverse event'. The Severity Assessment Code (SAC) is a numerical rating which defines the severity of an adverse event and is specified in the Health Quality and Safety Commission's (HQSC) *National Adverse Events Reporting Policy 2017*. SAC 1 and 2 events are those where the patient has had permanent or severe but temporary loss of function, or where the patient has died as a result. The events in this report are those that have met the criteria to be considered a SAC 1 or SAC 2 event.

Each serious adverse event has been reviewed by a group of clinical staff; the delivery of care to the affected patient is considered, the factors which have contributed to the event, and what improvements could be made. Improvements are endorsed by a group of senior leaders (the Quality and Patient Safety Committee) who also monitor the implementation of these improvements.

The *National Adverse Events Reporting Policy 2017* requires every DHB to report adverse events that meet the policy's reporting criteria, to the Health Quality and Safety Commission.

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Overview of HVDHB Serious Adverse Events

During the period 1 July 2018 to 30 June 2019 Hutt Valley DHB reported to the Health Quality and Safety Commission (HQSC) 13 SAC 2 adverse events that occurred in our hospital and health services. Five mental health service events were reported to the HQSC. One event was a fall resulting in serious harm (included in the falls event data in this report) and four events were suspected community suicides (currently under review with the Mental Health Addictions and Disability Service).

After the close of the reporting period, one of the events in this report was subsequently reconsidered and re-rated as a SAC 1 event, as the fall was deemed to be a contributory factor in the patient's death. One other event is awaiting a Coroner's findings to reconsider and determine a final rating. The events have been classified into the following themes:

General classification	Number of serious adverse events
Patient falls - includes falls in hospital involving a fracture or other serious harm.	5
Clinical process (e.g. assessment, diagnosis, treatment, general care) includes events that occur in, or impact on, assessment, diagnosis, treatment, general care processes.	5
Medication or intravenous fluids - includes events where an adverse outcome has occurred as a result of a medication prescribing, storage, or administration error.	2
Clinical administration (e.g. handover, referral, discharge) includes events where an adverse outcome has occurred as a result of errors in referral, handover, discharge or clinical follow up processes.	1

Falls with Serious Harm:

What Happened?	Review and Findings	Recommendations / Actions
Five patients sustained fractures following falls in hospital.	The reviews found that: For three patients a falls screening and assessment had been completed and a care plan was in place with appropriate interventions. For two patients an initial falls assessment and screening had not been completed within the timeframe recommended, and there was no care plan in place.	The recommendations and actions following the reviews were: • Teaching sessions on falls screening and risk assessment to be held on all wards. • A wider group of staff to be involved in the auditing of risk assessments and care plans. • A change to nursing handover on the Medical Ward ensuring there are staff free to assist patients in a timelier manner. • The Falls Committee ensures completion of fall event recommendations, and oversight of other actions to prevent falls with harm. All of the above recommendations are completed or are part of ongoing improvement work.

What are we doing to further reduce falls?

The Falls Committee have a number of activities under way to promote best practice in falls prevention and reduce the overall number of falls with harm. These include:

- An increased focus on falls assessments and care plans in TrendCare (Clinical Information and Workload Management System). This has resulted in an increase in the completion of assessments and care plans in quarter three of 2019. These results are part of the Quality Safety Markers (QSMs) that are reported to the HQSC on a quarterly basis.
- Development of a post falls pack which includes a flowchart to ensure all necessary steps are taken after a fall, including actions to prevent future falls for that patient. Using data to drive safety improvements: a Falls Report is presented at the Falls Committee's monthly meeting. This report analyses event data for all falls in the hospital, describing in which wards patients are falling; and if serious harm has occurred. This gives the Falls Committee an opportunity to explore the data, identify any common themes and take action across the organisation.
- In 2020 the Releasing Time to Care (RTC), the Productive Ward Falls Prevention New Zealand Falls Module will be used. The module provides a six stage process to "*help clinicians to focus on the problem of falls and provide support to prevent falls and harm from falls within the clinical environment*".

Clinical Process

What Happened?	Reviews and Findings	Recommendations / Actions
Five patients suffered serious harm following events related to clinical processes. These events resulted in two patients being transferred to another DHB for higher level care, one following an error during a catheterisation procedure and one following a care delay during delivery and birth.		
Injury during urinary catheterisation.	The review found that : • During a urinary catheter change significant bleeding occurred, requiring transfer to another DHB for specialist urology input. The patient developed an infection and had a prolonged stay in hospital. • There were a number of areas of improvement related to the insertion of male catheters.	The recommendations and actions following the review were: • The case to be discussed at departmental morbidity and mortality meeting. • An audit of all Registered Nurses who have male catheterisation certification, including those from other DHB or health care providers. • A male catheterisation education package to be developed and implemented for all Registered Nurses. • Competency process to include: electronic learning module, a workbook, attendance at in-service training, observed catheterisation of a mannequin. • All nurses must pass the competency process and complete a competency form. All recommendations are complete or are part of ongoing improvement work.
Bowel and ureter injury during surgery (laparoscopic hysterectomy).	The review found that: The surgery was complex with the patient subsequently becoming unwell once on the ward. The patient was transferred to another DHB for specialist urology review and required further surgery to place an indwelling urinary catheter and ileostomy (an artificial opening in the abdominal wall to allow waste to exit).	The recommendations and actions following the review were: • Departmental discussion and morbidity and mortality (M&M) review to be held regarding early involvement/communication with colleagues during complex surgery and post-operative care. This recommendation has been completed.

Delayed delivery of second twin.	The review found that: The baby required resuscitation and transfer to another DHB for treatment. The baby suffered a serious brain injury from lack of oxygen. • The twin labour and birth management policy was not followed. • Foetal monitoring was inadequate and there was a failure to recognise inadequate/abnormal monitoring. • Communication between staff and clinical documentation was sub-optimal.	The recommendations and actions following review were: • The case review to be presented for learning at the multidisciplinary perinatal morbidity and mortality review for education on twin birth and decision making; appropriate monitoring of foetal wellbeing and interpretation of CTG; internal manoeuvres and maternal collapse. • Staff to attend regular PROMPT (obstetric emergency) course or similar. • Midwifery management team to develop assessment sticker when invited into a room for opinion or assistance to assist optimal clinical decision making. • Clear expectations set for documentation by senior and junior doctors. • Delivery suite to be refurbished including equipment upgrade. All recommendations are completed or are part of ongoing improvement work.
Permanent visual impairment following eye surgery.	The review found that: Following surgery for an eyelid cyst the patient experienced visual deterioration and was treated by another DHB. The patient sustained permanent visual impairment in one eye. It was not clear from the documentation if an eye shield had been utilised during the procedure.	The recommendations and actions following review were: • Case to be presented at departmental M&M meeting for education and discussion. • In each eye surgery case (excluding intraocular) the theatre nurse will be prompted from the Intraoperative Nursing Record to ask if the operating surgeon would like to utilise an eye shield, and to record its use. • Education regarding the change in practice to occur and audit to confirm that the 'prompt' is being used consistently. All recommendations are completed or are part of ongoing improvement work.

What are we doing to further reduce clinical process errors?

- Information from each review is discussed at the relevant department's quality meetings, and progress on recommendations is included in a monthly quality report.
- An external review of the Women's Health Service was undertaken to establish an understanding of where we could improve the service for women and their whānau in the Hutt Valley. The DHB has established a steering group comprising key staff and community leaders to implement the key recommendations that include staffing, equipment and environment. These are being progressed and prioritised by the DHB. HVDHB acknowledges there is a lot of work to be done; the focus is supporting our staff to improve our Women's Health Service to make it safer, more effective and efficient.

Clinical Process

What Happened?	Review and Findings	Recommendations / Actions
Pressure injury to heel that required surgical intervention.	The review found that: The initial risk assessment and skin assessment was not completed. No care plan was documented although some preventative measures were in place (i.e. air mattress). The risk of the patient developing a pressure injury was underestimated. Wound care and skin integrity documentation was inconsistent.	The recommendations and actions following review were: • Review and update Pressure Injury Prevention and Management policy. • Education sessions on risk assessment, prevention (including preventative dressings), and wound care to commence, focusing on the ward where most pressure injuries are reported. • Ongoing auditing as part of the national Quality Safety Marker programme. All recommendations are completed or are part of ongoing improvement work.

What are we doing to further reduce pressure injuries?

The Pressure Injury Steering group has oversight of pressure injuries acquired in the hospital. Well supported by an ACC-funded Nurse Coordinator (Pressure Injury Prevention and Management), the group has a comprehensive work-plan and network of ward-based champions. The group have revised

the relevant policy documents, implemented training on this policy using a 'back to basics' education programme for all clinical areas; and are auditing preventive measures including air mattresses. The processes for the new Quality and Safety Marker auditing have been put in place: in quarter two Hutt Valley DHB was lower than the national average for risk assessments at 70%. Where pressure injuries do occur, a standardised review process is in place to identify common contributing factors and to make relevant recommendations for the whole organisation.

Medication and/or Intravenous Fluids

What Happened?	Review and Findings	Recommendations / Actions
Two patients received incorrect dosage and/or administration of medications, resulting in serious harm.	The reviews found: One patient received a prescribed oral medication (potassium) for longer than was clinically indicated. This caused high levels of potassium in the patient's blood and an abnormal heart rate. This resulted in a prolonged hospital admission and subsequent deconditioning which required a period of rehabilitation. One patient with a long term condition was receiving regular prescribed medication (botulinum toxin) as an outpatient. A higher dose was administered due to an error in the dose required for different brands of the medication. The patient deteriorated in the following weeks and subsequently died. The clinical review was uncertain as	The recommendations and actions following the reviews were: ***Potassium*** • The guidance for prescribing (the Preferred Medicines List) to be updated with specific thresholds for commencing potassium replacement, and an instruction to prescribe with a stop/review date. • Education for junior doctors regarding potassium replacement. All recommendations and actions have been completed ***Botulinum toxin*** • Change the way botulinum toxin is prescribed and administered in the outpatient setting to allow the dose to be reviewed by the administering physician, the nurse ordering the dose and the dispensing pharmacist. • Education regarding this case to occur widely in the DHB. All recommendations and actions have been completed. Changes to other medications administered in outpatient settings is also being considered.

	to whether this error was a contributory factor in the patient's death. The case is before the Coroner. The DHB will review the SAC classification of the event following the Coroner's findings.	Medsafe was notified and subsequently issued advice in a national Prescriber Update.

What are we doing to further reduce medication/IV fluid events?

Alongside the recommendations outlined in the review of these two serious adverse events, the Medicines Committee has a number of activities under way to promote best practice in medicines management. These include:

- Further development of ward / unit based medicines committees and their connection to the Hutt Valley DHB Medicines Committee. Each ward-based group describe their serious adverse events for the month, themes, audit results, education and/or mitigation strategies, or medicine quality initiatives. This work is ongoing in 2020.
- A review of the Hutt Valley DHB's Medicines Management Policy.
- Using data to drive safety improvements: a Medication Events Report analyses event data for all reported medication events in the hospital, describing in which wards events are occurring, what types of errors are occurring and if serious harm has occurred. This gives the Committee an opportunity to explore the data, identify any common themes and take action across the organisation.
- A pharmacist from the local Primary Health Organisation (PHO) is also on the Medicines Committee to provide a community perspective to issues that arise, in particular, from prescribing / reconciliation practices upon discharge.

Clinical Administration:

What Happened?	Review and Findings	Recommendations / Actions
One patient has suffered serious harm as a result of a delayed diagnosis of bowel cancer.	The review found that: There were a number of contributory factors that led to this event; which included: • The DHB underestimated the capacity to meet the increased demand for colonoscopy services	The recommendations and actions following review were: • Increase in colonoscopy capacity through multiple measures including locum staff, outsourcing and additional staffing.

	following the introduction of the National Bowel Screening Programme (NBSP). • Awareness raised by the screening programme prompted clinical review and referrals for symptomatic patients who needed colonoscopy as well as those patients who required screening as part of the NBSP. • Waiting times increased despite several actions taken prior to and following the introduction of the NBSP. • While other patients were diagnosed with cancer after a prolonged waiting time this patient's subsequent treatment and prognosis were significantly impacted by the delay.	• Review of risk management processes across HVDHB. • External review commissioned and commenced in November 2019. • Ongoing review of patients diagnosed with bowel cancer after waiting longer than the maximum timeframes.

Final Comment

Adverse event reporting and review of these events is fundamental to enhancing patient safety. Whilst most patients are treated in our DHB without preventable harm, some patients still suffer serious harm. The DHB reiterates that we consider one event of this nature one too many, and apologise unreservedly to the patients and family/whānau involved in these cases. By learning from these events we identify areas for improvement and further development to assist our staff to deliver safe and effective care to our community.