Serious Adverse Events Report: 1 July 2019 to 30 June 2020

Hutt Valley District Health Board is committed to providing safe and high quality care to our community. Part of that commitment is openness and transparency when things have gone wrong; when serious harm is occurs we review what happened; we reflect on the findings; we take actions to reduce the chance of a similar event occurring again. We continually foster our organisation's safety culture where we encourage everyone to speak up to improve patient safety.

This report describes serious adverse events for the 2019/2020 year for Hutt Valley DHB. Each of these reported events involves a patient experiencing harm while in our care. We apologise unreservedly to the patients and family/whānau involved in these cases. We acknowledge the distress and grief that occurs for these patients and their families/whānau.

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 understood as an event which results in harm to a patient.

For the purposes of this report, we use the term 'serious adverse event'. This term encompasses adverse events categorised as SAC 1 and 2 events using the Severity Assessment Code (SAC) rating in the *National Adverse Events Reporting Policy 2017*[1]. 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. These events are included in this report and reported to the Health Quality and Safety Commission.

Each serious adverse event has been reviewed by a group of clinical staff; they consider the delivery of care, the factors which have contributed to the event, and what improvements should be made. A group of senior leaders (the Quality and Patient Safety Committee) endorse the review findings and monitor the implementation of improvements.

[1] Health Quality and Safety Commission, 2017. National Adverse Events Reporting Policy 2017 New Zealand health and disability services. https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933/

Overview of HVDHB Serious Adverse Events

During the period 1 July 2019 to 30 June 2020 Hutt Valley DHB reported 20 events to the Health Quality and Safety Commission: one SAC 1 event and 19 SAC 2 adverse events.

General classification	Number of serious adverse events
Patient falls – includes falls in hospital involving a fracture or other serious harm.	10
Clinical process (e.g. assessment, diagnosis, treatment, general care) includes events that occur in, or impact on, assessment, diagnosis, treatment, general care processes.	10

Of the ten clinical process events, seven were people who acquired pressure injuries. The other three events are a person with a serious injury to the mouth that occurred during a procedure, a woman with a tear of the perineum during childbirth, and a still birth. Nineteen reviews have been completed, the review of the stillbirth is underway but yet to be completed so will not be included in the following section.

Falls with Serious Harm:

What Happened?	Review and Findings	Recommendations / Actions
Ten patients sustained fractures following falls in hospital.	Nine falls were in adults, with seven occurring in one ward. A range of environmental, assessment and care planning, and process factors were found to have contributed. One infant fell from the side of the bed and sustained a fracture.	• A broad Falls Improvement Project has commenced. This project is led by the Director of Nursing and has undertaken further analysis to also include a group of falls which did not result in fracture; a human factors review and using improvement science methodology. • Interventions to improve the assessment, care planning and implementation of falls prevention strategies are underway, with actions specific to the care of older and confused patients, and those requiring assistance to mobilise. • The maternity ward has an ongoing programme around safe sleep practices for mothers and babies, and a staff member with responsibility for falls prevention.

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:

- Use of the Releasing Time to Care (RTC) New Zealand Falls Module as the template for its work plan in 2020. 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*".
- Continuing improvements seen in the proportion of patients assessed for risk of falling and appropriate care planning, as part of the Health Quality and Safety Commission's Quality and Safety Marker programme.

Pressure injuries (Clinical Process category):

What Happened?	Reviews and Findings	Recommendations / Actions taken
Seven people acquired serious pressure injuries, these were reported and reviewed. There were two stage 4 pressure injuries (the most severe), four stage 3, and one unstageable pressure injury. Three pressure injuries occurred on the sacrum and four occurred on the heel.		
Pressure injuries to the heel and sacrum in patients admitted to hospital wards	The reviews found that risk of pressure injury was not adequately assessed nor preventive measures put in place in the Emergency department and inpatient wards	• Pressure injury education as part of initial orientation of staff to inpatient ward, and through regular study days • Pressure injury education, screening for risk and appropriate mattresses made available for the emergency department – specifically to prevent pressure injury in patients experiencing delays in transfer to inpatient wards • Ongoing programme of work to reduce pressure injury, as below
Two patients acquired pressure injuries under casts applied to immobilise a fracture.	The reviews found that risk of pressure injury was not adequately assessed nor preventive measures put in place	• Development and testing of pressure injury resources for fracture clinic • Staff education in pressure injury risk, prevention and care specific to casts • Improved work environment and equipment in clinic to enable documentation of assessment and management plan

What are we doing to further reduce pressure injuries?

Hutt Valley DHB is in the second year of comprehensive workplan to prevent, identify and improve the management of pressure injuries. There is an ACC-funded Pressure Injury Nurse Coordinator leading implementation, and oversight by an organisation wide steering group. In FY19/20 significant progress has been made including education and training on the revised policy, a bundle of care using the 'SKINN' approach, and information made easily accessible to staff in their area of work. Importantly, an audit of pressure relieving mattresses resulted in purchase of new mattresses and a long term replacement schedule. A workplan is being developed for future pressure injury prevention work in the community including NGOs and aged residential care providers.

Clinical Process

What Happened?	Review and Findings	Recommendations / Actions
One patient suffered a serious injury to the mouth during a procedure in theatre	The review found that appropriate consideration was taken to balance the risks of the procedure, and the injury was an unintended consequence.	• The relevant guideline will be updated by the service involved
A woman suffered serious perineal tear during childbirth	The review found that following induction of labour at 41 weeks, an instrumental delivery was required. A serious perineal tear occurred with repair performed in the operating theatre.	• Education and training regarding management of perineal tears has occurred with staff

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, these patients have suffered 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.