Wairarapa, Hutt Valley and Capital & Coast District Health Boards Serious and Sentinel Events Report: 2012 -2013

Wairarapa and Hutt Valley DHBs have reported 16 serious and sentinel events (SSEs) and Capital & Coast District Health Board (CCDHB) has reported 22. These SSEs occurred in our hospitals and health services during the period 1 July 2012 to 30 June 2013. These SSEs were reported to the Health Quality and Safety Commission as per national Reportable Events policy requirements and include one joint DHB community pharmacy event.

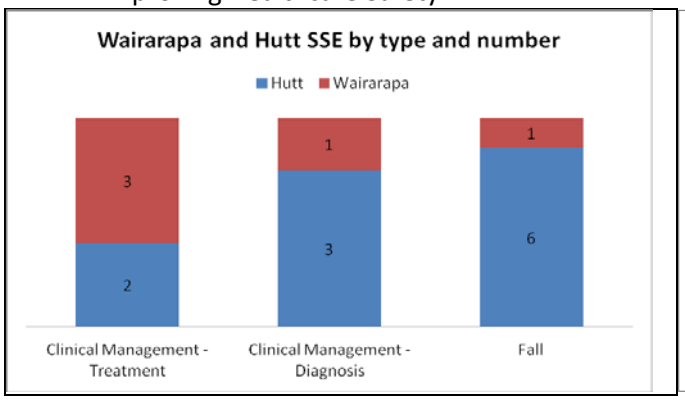
Each of the reported SSE events involves a patient suffering harm or death while in our care.
We consider one event is one too many, and apologise unreservedly to the patients and families involved. We acknowledge the distress and grief that result when things go wrong in healthcare.
We always seek to learn from these incidents and improve safety. We can't do this if we don't know about them happening. A strong safety culture means that patients and their families, other health providers like family doctors, primary health nurses, and our own staff tell us when an incident has occurred and raise concerns so that we can look into what happened.

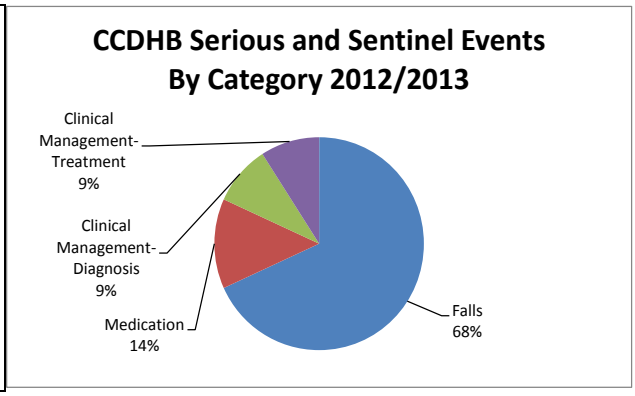
Continually strengthening our culture of patient safety and quality is a top priority for the three DHBs. We are committed to working with patients and families when things go wrong to ensure that their concerns and needs are addressed and supported, and that they are included in the process of the review.

Our practice is to communicate openly with patients and families at all times including when adverse events occur, to acknowledge what has happened and to apologise where we have got things wrong. We will listen to concerns, provide support, involve patients and families 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. In this way we aim to achieve both:

- The CCDHB goal of Zero Patient Harm, which forms part of our overall quality improvement and patient safety programme of work, and
- The Wairarapa and Hutt Valley strategic quality direction, our three objectives being:
  - Improving the Healthcare Experience
  - Improving Healthcare Outcomes (effectiveness)
  - Improving Healthcare Safety





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Wairarapa District Health Board
Serious and Sentinel Events Report: 2012-2013

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
Aug 12	SAC2	Perforated bowel by enema via colostomy	• Patient presented to ED 6 days post op hemicolectomy. The patient was prescribed an enema. • Patient developed abdominal pain one hour following the enema. CT revealed breakdown of the suture line. Patient had surgery for the repair of the leak. • Early investigation indicated that the tip of the enema perforated the ileus as the suture line was higher than normal.	• All patients presenting to ED within 4 weeks of bowel surgery to have case discussed with surgeon of origin.
Sep 12	SAC2	Patient fall resulting in fractured Neck of femur NOF	• Patient was post operative total hip joint replacement (THJR). • Patient got up from bed to mobilise from the bathroom and got feet tangled in crutches, falling to floor. • Patient initially thought to have not sustained injury but on Xray had sustained a fractured hip.	• On review of this event, it was noted that the patient had felt unsafe with the equipment being used. • Post fall interview sheet was completed with patient and whanau.
March 13	SAC2	Outpatient appointment not made for patient post fracture.	• Patient presented to ED with fractured radius. • Patient should have been seen at fracture clinic within one week to plan manipulation and fixation. Locum ED Dr incorrectly ticked the box stating that film review was not required. • Patient was lost in system until 3 weeks later when GP contacted Outpatients.	• All Locums now receive a hard copy of the ED Guide which explains the correct process for getting Xrays reviewed.
May 13	SAC2	Patient incident with a nurse on transfer between hospitals, one of the patients cohorted	• Patient returned to Masterton by Ambulance from Wellington. On the way to Wairarapa an incident occurred where a trauma injury to the	• A full multi agency review conducted • Several changes in practice and process have resulted including the development of more robust emergency plans for inter DHB

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
		sustained injury.	patients chest occurred	transfers.
July 13	SAC2	Delayed diagnosis of Septic Arthritis	• Child admitted to Paediatrics following OPD appointment. • Separate NHI for mum and baby were not linked which did not allow the clinical staff to see the whole picture. • Child found to have septic arthritis in the joints • Child had had several contacts with Doctors before being diagnosed.	• Case review undertaken. • Notes to stay with patient to avoid duplication. • Protocol re management of young babies in ED has been drafted. • Discussion being held with IT on how to place alert on system and how to link mother and baby on patient management system. • Discussions being held re electronic discharge summaries being formulated in maternity.

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
July 2012	SAC1	Patient died following colonoscopy	• Patient with history of bowel cancer presented with symptoms of bowel obstruction – colonoscopy indicated. • Colonoscopy difficult to perform at the time, but no symptoms of perforation following procedure and patient discharged. • Patient returned to ED four days later with abdominal pain.	None – patient was high risk, risks of procedure were fully explained and discussed and the patient consented to the procedure • Colonoscopy carries a risk of perforation in approx 1:1000 procedures With hindsight, the discussion held between the patient and the clinicians should have highlighted the views of patient regarding the possibility of follow up interventions eg surgery. Patient decided (in consultation with family and clinicians) to have no intervention following perforation and received palliative care at home. Often diagnostic procedures are undertaken knowing that the clinical risks are high. Hutt Valley DHB's current perforation rate following colonoscopy is approx. 1:2500
July 2012	SAC2	Patient sustained skin tear	• Patient with multiple co-morbidities, very fragile skin and frail. • Patient transferring with support from scales and caught leg on frame	• Patients to be supervised more closely on transfer • Staff education and training on caring of skin in the elderly • Equipment to be regularly checked. • Confirms need for Braden scale assessment and policy in place
July 2012	SAC2	Patient with complex multiple co-morbidities fell - sustained fracture to shoulder	• Patient fall - unwitnessed	• Patient re-assessed as high falls risk and monitored closely • Fall prevention strategies implemented – including use of appropriate preventer such as sensor mat • Fracture conservatively managed
July 2012	SAC2	Patient (child) - undiagnosed fracture of femur	• Patient presented with tenderness to right knee and unable to weight bear • X-ray ordered of right knee - fracture of femur not detected initially by clinicians • Patient initially treated	• Case included as part of ongoing clinical education provided to staff as reiteration that diagnostic focus has a wide view and to ensure that attention to diagnosis is not diverted by presenting history. • Case added as a learning tool for departments

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
			with plaster of paris below knee • Fracture detected on return to ED 3 days later • Films re-reviewed and repeated – fracture identified in original x-ray and on repeat view	
October 2012	SAC2	Patient fall resulting in fracture to hip and shoulder	• Patient fall - unwitnessed • Frail lady with multiple co-morbidities and moderately advanced Alzheimer's • Patient's hip fracture repaired surgically • Patient discharged to hospital level care following rehabilitation • Family involved with care and decision making throughout admission	• High falls risk patients to be identified through a "flagging" system to ease identification • Falls prevention strategies continue, such as individual patient observation, use of alert device • Falls risks assessments continue to be documented in patient care plans • Staff training ongoing
October 2012	SAC2	Patient - undiagnosed fracture in foot	• Patient seen in minor injuries clinic with pain in ankle. • X-ray form requested ankle x-ray. • Whilst in x-ray patient reported that pain was in her foot – due to communication breakdown between staff this was not reported back to ED and was not followed up. Patient discharged – diagnosis ankle sprain. • Patient attended GP one week later was x-rayed privately - fracture of foot identified. • Original x-ray reviewed and fracture present – This fracture was not picked up by the Clinical Nurse Specialist at the time, or the radiologist on reviewing the films the next day.	• Assessment process of these and similar injuries reviewed, and further teaching has been implemented as part of our ongoing training programme. • Breakdown in the passing on of information has now been addressed between the Emergency Department and Radiology staff so that information is now passed on appropriately; if patients identify problems other than those initially identified on the X-Ray form, the radiology staff will contact the requestor to clarify. • Missed identification of fracture – the advent of electronic x-ray makes requests clearer to reduce the likelihood of this happening again. • The imaging and medical staff use a preliminary read system which reduces the risk. The sticky note information placed in the report helps identify significant errors when picked up by the reporting radiologist.
December 2012	SAC2	Patient – fell and sustained fracture to hip	• Patient fell in bathroom post surgery • Patient independently	• Case presented at audit meeting • High falls risk patients to be identified through a "flagging"

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
			mobilising • Building services reviewed bathroom floor – no changes required regarding the floor or the environment	system to ease identification • Falls prevention strategies continue, such as individual patient observation, use of alert device • Falls risks assessments continue to be documented in patient care plans • Staff training ongoing
December 2012	SAC2	Patient fell and sustained fracture to elbow	• Patient fell whilst attempting to mobilise • Patient was disoriented following waking	• High falls risk patients to be identified through a "flagging" system to ease identification • Falls prevention strategies continue, such as individual patient observation, use of alert device • Falls risks assessments continue to be documented in patient care plans • Staff training ongoing
December 2012	SAC2	Patient fell and sustained fracture to hip	• Patient lost balance and fell • Patient independently mobilising with a stick. • No indication that patient was unwell prior to fall	• Case presented at Mortality & Morbidity meeting • High falls risk patients to be identified through a "flagging" system to ease identification • Falls prevention strategies continue, such as individual patient observation, use of alert devices • Falls risks assessments continue to be documented in patient care plans • Staff training ongoing.
Feb 2013	SAC2	Delay in cancer diagnosis	Patient referral for procedure was prioritised as a "B", and letter sent to patient advising that would be seen within 6 months. Patient waited 9 months for procedure.	An external review found that: • "In general terms delays over six months in the institution of treatment of colorectal cancer are thought to be associated with worse outcomes although the evidence base is poor. There is little evidence that delays of less than six months are associated with worse outcomes." • Waiting lists continue to be monitored to ensure patients are seen within the required times • Resources increased to reduce waiting times
April 2013	SAC 2	Patient fall resulting in fractured to hip.	• Patient with multiple co-morbidities and English as a second language	• No recommendations as fall deemed unavoidable

Date of Event	Event Code	Description of Event	Review Findings	Recommendations/Actions
			• Assessed on admission as high falls risk. • Appropriate preventative measures in place - including location near to the nurses station, falls flags placed outside the room, cot sides raised and frequent checks. • Patient attempted to get out of bed and catheter disconnected. Nurse lowered the bed rail to sit the patient up on the side of the bed. Patient put feet to the floor, slipped on spilt urine and fell to floor.	

Capital and Coast District Health Board
Serious and Sentinel Events Report: 2012-2013

Figure 1: CCDHB Serious and Sentinel Events reported by financial year period

* As per HQSC reporting requirements, CCDHB reported Mental Health SSEs separately in September 2013, Mental Health SSE events are not included in the 2012/13 data.

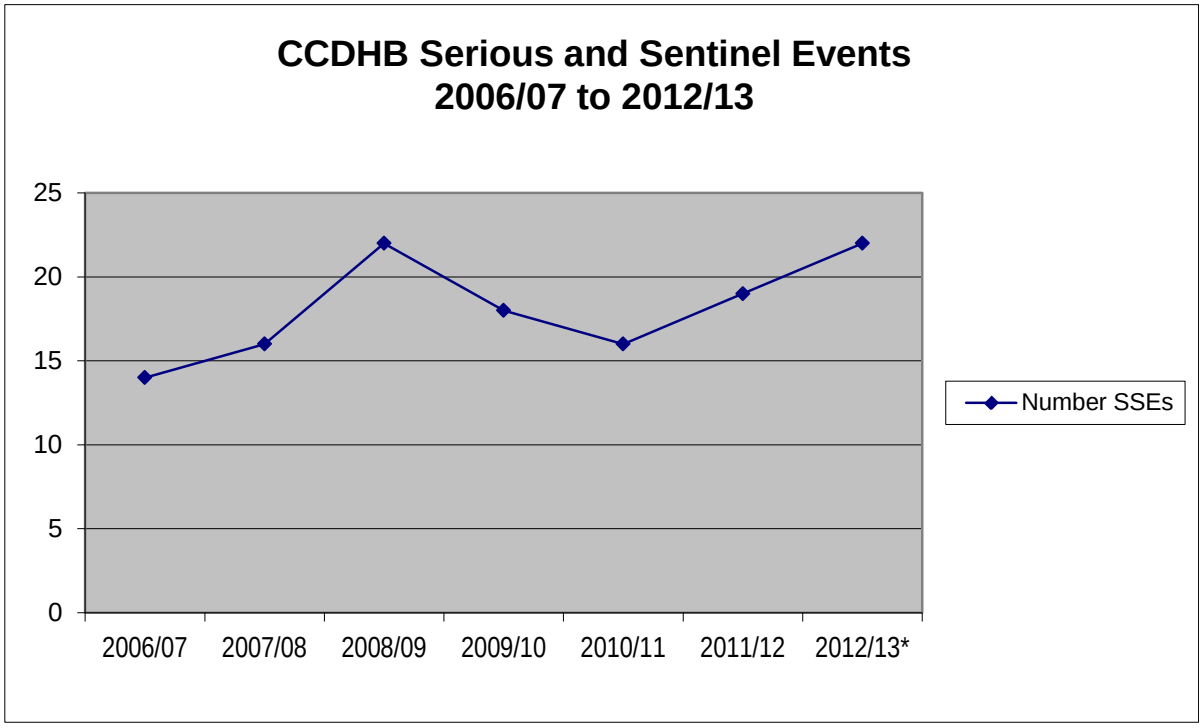
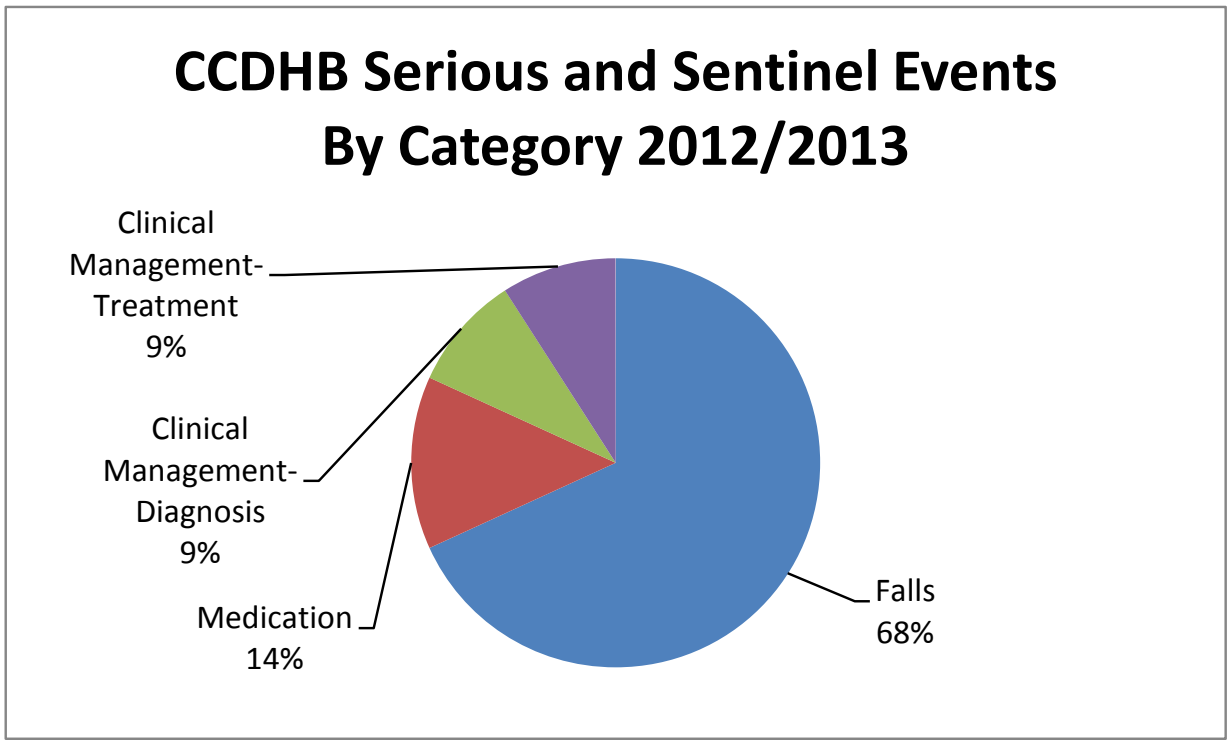


Figure 2: CCDHB Serious and Sentinel Events by category for 2012/13 period

Patient falls involving fracture or serious other injury are the majority of events reported in this period. Falls hurt – with or without injury, falls have social, psychological, physical and economic impact on our patients and their families. Falls cost – on average two patients a day fall somewhere in our hospitals and we estimate each fall costs approximately $12,000 per patient admission.



While it is not possible to stop every patient from falling when in hospital, many can be prevented and part of our CCDHB Zero Patient Harm programme is to reduce the number of patient falls and the harm that can occur when a patient falls. Our ongoing work to prevent falls and harm from falls is led by our Falls Prevention Group and has been enhanced by CCDHB participation in the Health Quality and Safety Commission's (HQSC) national patient safety campaign "Being Open". The first focus of the campaign has been on preventing harm from falls with a month-long promotion called 'April Falls 2013'. CCDHB took part in the trial of a new falls awareness system using simple traffic light colour coded resources which quickly identify patients who are at risk of falling. Other falls prevention work we have underway includes:

- Falls signage
- Staff education
- Minimum safety standards
- Revised risk assessment
- Standardising how we review falls, learn and improve safety
- Future work to ensure new staff know how to get falls prevention resources, ways to alert staff to the fact that the patient is at risk of falling, a checklist to ensure our reviews of falls are consistent, development of better patient information including a web page.

1.

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

Event Summary: Medication errors x 2 resulting in unanticipated cardiac rhythm requiring x 1 defibrillation. Patient recovered.

REVIEW

Key findings: A patient was unintentionally administered two doses of adrenaline (5ml & 1ml) instead of fentanyl and midazolam (the intended medications) during a procedure. The patient required one defibrillation shock for the resulting ventricular arrhythmia to restore normal sinus rhythm. The review team identified five key causal factors:

1. Normal yellow container used for emergency medications not available, this led to use of a clear container for the emergency medications
2. Use of the same clear containers for both the emergency and sedation medications, led to a selection error. The wrong container was selected, a second subsequent selection error was then predisposed and occurred when subsequently, the wrong medication (adrenaline) was used.
3. Use of the same syringes (size) for emergency and sedation medications increased the risk of the medication selection error occurring
4. The placement of the emergency and sedation containers on the same bench increased the risk of container selection error occurring
5. The absence of a clear process to check medication prior to administration increased the risk of a medication error not being detected and averted.
6. The error occurred twice before it was fully realised.

Recommendations: The review team notes that the service implemented the following risk controls immediately as a result of this incident:

- Closed lid visibly different containers have been implemented for all emergency medications that are required to be drawn up as part of pre procedure preparation.
- A requirement for the circulating and scrub nurse to double check medication prior to administration has been instigated.
- Noting the above changes have already been implemented, the review team recommended: Consideration, in consultation with the specialist team, is given to keeping emergency medications in an area separate from other routine medications given during the procedure.

Recommendations progress ie. action plan: Visibly different containers have been implemented and are now placed in a separate area from sedation drugs that is accessible. Verbal checks have been implemented prior to administration. All actions completed.

2.

Event Category: Clinical management-diagnosis **Deceased?:** N

Event Summary: Unreported finding on CT scan (chest) leading to possible delayed diagnosis of metastatic cancer

REVIEW

Key findings: The review team were unable to specifically identify the reason the metastatic cancer was not reported on the chest CT scan.

The most likely cause of the error was a combination of factors;

- review of multiple imaging,
- focus was on diagnosis of abdominal imaging related to the primary problem
- there was a delay over the weekend between the preliminary report written by the registrar being sent by the registrar for review and sign off by the consultant.
- Subsequent opportunity for the error to be detected during Multidisciplinary Team (MDT) meetings, was also missed due to a number of factors including;
- late addition of the patient to the MDT list, leaving no preparation time to review all imaging
- focus was on abdominal imaging related to the primary problem and differentiating between disease process and cancer during the MDT.

The review team noted that:

- MDT preparation time is not protected nor is there a clear provision for leave cover
- there is no guideline for the role and responsibilities of the radiologist attending the MDT

there are currently no protocols to guide staging and restaging of each tumour stream prior to radical treatment.

Recommendations: The review team recommended that:

1. The Executive Clinical Director formally apologise to the patient, provide a copy of the review report and offer to meet and explain the findings.

2. Radiology review and standardise processes for review, 2nd reporting and sign off of Registrar reports by radiology consultants.

3. Radiology undertake job sizing of Radiology Consultants roles to include protected time for preparing and participating in MDT, cover for leave and to ensure adequate Consultant resource is available for the reporting requirement associated with the CT scan workload.

4. The MDT meetings should have an identified timeframe to register patients that allows for adequate radiology preparation and develop terms of reference to define roles, responsibilities and resource requirements

5. Directorate Services develop protocols for staging and restaging of each tumour stream prior to radical treatment (staging means measuring the growth of tumours by taking scans over time).

Recommendations progress ie. action plan: An apology to the family has been sent. Standardisation of workflow processes indicated has commenced. Actions relating to job-sizing have commenced. Discussion re MDT roles and responsibilities has been identified to strategic clinical governance. Tumour stream staging requirements in progress.

3.

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

Event Summary: Patient fall on inpatient ward. Subsequent X-ray confirmed fractured neck of femur. January 2013 – Incident notified to DHB as not yet reported nationally as a SAC 2 – review initiated at this point.

REVIEW

Key findings: Preliminary event review identified that:

- A reportable event was completed severity 4 minor at the time. Subsequent X-Ray confirmed fractured neck of femur. The reportable event should have been upgraded to a higher severity-SAC 2.
- Falls risk assessment completed on day of admission. Indicated patient was at risk of falls. Appropriate falls prevention strategies implemented at that time (patient watch in place).
- Patient transferred to rehabilitation ward. Placed in single room with close observation from the nurse's station. New care plan started including falls risk assessment and interventions. Patient able to walk around the ward.

- The patient had a minor fall 5 days before this incident. No evidence of injury, reportable event form completed. Falls risk and the patient admission to discharge planner updated. Patient walking with a frame and supervision the following day.
- Two days before the fall a patient watch was in place.
- Fall occurred when patient was accompanied to toilet by watch, patient at basin, pulled away from watch and slipped sideways. Watch tried to prevent the fall. Patient able to stand with assistance and transfer to bed. Observations stable. Subsequent X-ray confirmed fractured neck of femur.

Recommendations:.

- CCDHB notify the Health Quality and Safety Commission (HQSC) of the incident as a SAC 2.
- Review findings be tabled at Directorate Quality Forums to share learning related to both the Reportable events process and the prevention of harm from falls.
- CCDHB continue ongoing falls improvement working group activity and continue to audit the completion of patient admission to discharge planner and compliance with falls risk assessment and risk controls requirements, and ensure strategies are in place to assist with compliance.

Recommendations progress ie. action plan:. Health Quality and Safety Commission (HQSC) notified of event. Event presented to Clinical Governance and service level areas. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

4.

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

Event Summary: Patient fall on inpatient ward. Subsequent X-ray confirmed fractured neck of femur. January 2013 – Incident notified to DHB as not yet reported nationally as a SAC 2 – review initiated at this point.

REVIEW

Key findings: Preliminary event review identified that:

- A reportable event was completed severity 4 minor at the time. Subsequent X-Ray confirmed fractured neck of femur. The reportable event was rated SAC 3 on review. It does not appear the severity was upgraded after the fracture was identified.
- In 2011 the timeframe for a falls assessment to be completed was within 24 hours of admission. There was no documented falls assessment completed. The patient was admitted via Emergency Department (ED) and the Medical Assessment and Planning Unit (MAPU) to an acute Medical ward.
- The patient fall occurred approximately 8 hours after admission.
- Clinical notes indicate that the patient was extremely confused and disorientated, was verbally and physically aggressive, (had required police intervention at home prior to admission) would not allow observations to be taken and refused medication.
- The patient was to be transferred to a bed in the safe care bay in the medical ward however this did not occur prior to the fall.
- The patient had a watch in ED and MAPU. Documentation does not specify if the watch remained in place after transfer to the Medical ward. Notes record a security orderly assisting the patient after the fall.
- The patient tried to run away and slipped and fell.

Recommendations:

- CCDHB notify the Health Quality and Safety Commission (HQSC) of the incident as a SAC 2.
- Review findings be tabled at Directorate Quality Forums to share learning related to both the Reportable events process and the prevention of harm from falls.
- CCDHB continue ongoing falls improvement working group activity and continue to audit the completion of patient admission to discharge planner and compliance with falls risk assessment and risk controls requirements, and ensure strategies are in place to assist with compliance.

Recommendations progress ie. action plan: HQSC notified of event. Event presented to Clinical Governance and service level areas. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

5.

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

Event Summary: Feb 2012 - Patient fall on inpatient ward (night duty). X-ray later that day confirmed fractured neck of femur. Jan 2013 – Incident notified to DHB as not yet reported nationally as SAC 2 – review initiated at this point.

REVIEW

Key findings: Preliminary event review identified that:

- The patient had got out of bed, walked to the toilet without usual aids, call bell not used (unwitnessed fall-night duty).
- Reportable event recorded severity minimal. Post fall patient alert and oriented, no injury evident. Medical review noted no immediate action indicated, for possible X-ray in morning.
- The need to update the reportable event when the fracture was diagnosed the following day was overlooked. At this time a SAC 2 or 3 rating would apply depending on likelihood.
- Falls risk assessment was completed two days post admission (standard = completion within one hour of admission). Indicated the patient was at risk of falls. Appropriate falls prevention strategies were implemented at that time. Patient alert and oriented and shown call bell system.
- The day after the falls risk assessment was completed, the patient suffered a minor fall and was transferred to the Safe Care Bay (SCB) for closer monitoring.
- While patient admission to discharge planner, and falls risk assessments were not completed within specified timeframes, appropriate falls prevention strategies were in place.
- Although the patient was transferred to the SCB for increased monitoring this did not prevent the fall from occurring.
- It was determined no further review was indicated.

Recommendations:

- CCDHB notify the Health Quality and Safety Commission (HQSC) of the incident as a SAC 2.
- Review findings be tabled at Directorate Quality Forums to share learning related to both the Reportable events process and the prevention of harm from falls.
- CCDHB continue ongoing falls improvement working group activity and continue to audit the completion of patient admission to discharge planner and compliance with falls risk assessment and risk controls requirements, and ensure strategies are in place to assist with compliance.

Recommendations progress ie. action plan: HQSC notified of event. Event presented to Clinical Governance and service level areas. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

6.

Event Category: Clinical management-diagnosis

Deceased?: Y **SAC Rating:** 2

Event Summary: Patient had two separate Hepatitis B positive serology reports and an abnormal liver CT scan report. Appears no follow up for same.

REVIEW

Key findings: Review found that:

- The patient had pre op hepatitis serology testing (2010-prior to cardiothoracic procedure) reported positive for Hepatitis B. No record of follow up. A month later the patient was admitted with chest pain. During admission a CT scan was reported abnormal, showing possible early liver cancer. No record of follow up. Six months later the patient was admitted for orthopaedic surgery and required a cardiothoracic procedure for which pre op hepatitis serology testing was ordered and reported positive for Hepatitis B. No record of follow up. On this admission the CT report from six months previous was noted as not having been followed up.
- A number of failures contributed to both the failure to follow up the patient's Hepatitis B status once reported positive, and the failure to follow up the patient's CT scan report which was indicative of cancer. As a result, there was a 21 month delay in the diagnoses being acted upon (hepatitis) or confirmed (liver cancer).

- The review team note that while the outcome for the patient may not have been different, the patient was not informed of the diagnoses and his options at that time, and by the time the diagnoses were acted upon he was not considered a candidate for more than palliative care.
- The failures related to lack of a formal process to sign off on receipt of results, lack of a formal results management process for tests requested, and failure of issues noted for follow up to be formally recorded in either a problem list and actioned, or referred to the appropriate specialty for investigation.

Recommendations:. Review recommended: C&C DHB formally apologise to the patient's family, provide them with a copy of the review report and the opportunity to meet and discuss as desired. The review team recommend that the DHB complete implementation of a system for electronic sign off of results, that an electronic 'problem list' be considered for implementation and that services review their processes for the requesting and follow up of hepatitis serology results as part of pre-operative testing.

Recommendations progress ie. action plan: Apology sent to family. Electronic sign off project implemented and in place at CCDHB. Electronic problem list option on Concerto to be actioned. Cardiology reviewed process prior to E sign off implementation; E sign off now actioned.

7.

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

Event Summary: Patient fall on inpatient ward. Subsequent X-ray confirmed fractured neck of femur. January 2013 – Incident notified to DHB as not yet reported nationally as a SAC 2 – review initiated at this point.

REVIEW

Key findings:: Preliminary event review identified that:

- A reportable event was completed severity 4 minor at the time. Subsequent X-Ray the following day confirmed fractured neck of femur. The severity was not upgraded after the fracture was identified.
- Falls assessment not completed on admission but documented in notes high falls risk and supervision and assistance recommended for all transferring and mobility.
- Appropriate falls prevention strategies in place, patient alert and oriented, shown call bell system. Call bell was in reach and commode beside bed.
- Patient had earlier un-witnessed fall beside bed on morning of same day. Medical review-no obvious injuries found, patient alert and no concerns.
- Patient reminded to ring bell if needed to go to toilet, supervised with personal cares and assisted to the toilet throughout the day. For supervision and assistance for all transferring and mobility.
- The second fall (which resulted in the fracture) occurred in the evening. The patient attempted to mobilise from bed to the bathroom without staff noticing, and fell.

Recommendations:

- CCDHB notify the Health Quality and Safety Commission (HQSC) of the incident as a SAC 2.
- Review findings be tabled at Directorate Quality Forums to share learning related to both the Reportable events process and the prevention of harm from falls.
- CCDHB continue ongoing falls improvement working group activity and continue to audit the completion of patient admission to discharge planner and compliance with falls risk assessment and risk controls requirements, and ensure strategies are in place to assist with compliance.

Recommendations progress ie. action plan: HQSC notified of event. Event presented to Clinical Governance and service level areas. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

8.

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

Event Summary: Patient fall resulting in fractured neck of femur (hip).

REVIEW

Key findings:: The review found that the Patient Admission to Discharge Plan (PADP) which includes falls risk assessment was not completed during admission to the assessment unit but was completed on transfer to the ward half an hour before the fall. Review found that appropriate falls prevention strategies were in place for this patient at the time of the fall.

Recommendations:

- Regular audit and reporting of Patient Admission to Discharge Planner completion at organisation and directorate level with specific focus on falls risk assessment.
- Findings to be fed back to ward staff and directorate clinical governance
- Staff education
- Purchase of falls resources.

Recommendations progress ie. action plan: Regular audits of PADP conducted as per project plan and development of PADP. Falls risk safety group established. Findings presented to Clinical Governance and ward staff. Staff education completed on ward.

9.

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

Event Summary: Patient fall resulting in peri prosthetic fracture right femur shaft.

REVIEW

Key findings:: The review found that all falls prevention strategies were in place at time of fall, green wrist band insitu, patient orientated to the environment (patient had previously been on the ward for 6 weeks), except optimal visibility to staff – patient in room not able to be directly visualised from nursing station.

Recommendations: The review recommended:

- Continue with falls prevention forum –two monthly with nursing staff and Clinical Nurse Educator and Charge Nurse Manager.
- De-clutter 6 bedded cubicles, remove 2 unused beds and store in basement
- Nursing staff to ensure when mobilising patients to reflect physiotherapist recommendations.
- Nursing staff complete falls risk assessments on admission and change of plan, treatment, fall.
- Implementation of prevention strategies.
- Multidisciplinary teams update care plans.

Recommendations progress ie. action plan: Falls safety group established. Bed spaces de-cluttered. Education given regard mobilising patients. PADP education ongoing and audited as per CCDHB wide policy. Falls prevention mitigation strategies implemented as per falls safety group. MDT's educated on contribution to PADP and discussed at clinical governance.

10.

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

Event Summary: Voluntary patient admitted intoxicated, left ward, on returning further intoxicated, fell resulting in fracture left femur.

REVIEW

Key findings:: The preliminary event review found that the patient's actions were not predictable, and that falls prevention strategies would not have prevented this incident. No further review indicated.

Recommendations: Nil.

Recommendations progress ie. action plan: Not applicable.

11.

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

Event Summary: Dispensing community pharmacist changed usual liquid morphine concentration, patient's family informed. Appears patient took usual volume of higher concentration resulting in unintended overdose. Hypoxic brain injury resulted..

REVIEW

Key findings:: Review found that during routine review of an oncology patient, dehydration and significant pain issues were identified. In addition to fentanyl patches the patient was taking very small doses of morphine elixir 2.5 mg (in a 1 mg/ml solution) for breakthrough pain relief. Prescription increasing the patient's morphine dose was given. The patient and spouse were informed about the change in dose and the possible side effects. The new dose was administered while the patient was in the oncology day unit, on two occasions, with good effect and no side effects. The patient returned home on this new regime.
Later that day the patient's spouse took the prescription to a community pharmacy the pharmacist dispensed 10mg/ml strength of morphine. This was an appropriate formulation perceived to be more convenient for the patient to swallow, i.e. 1 ml for each dose. The pharmacist informed the patient's spouse that the patient was to take 1ml each time up to 5 times a day. Later that day the visiting community nurse noted the change of medication dose and discussed this with the patient and her spouse. The patient was noted to be comfortable. The following day the patient attended the oncology unit with her spouse. It was noted pain had improved. No concerns, side effects or significant issues were noted.
The following day the patient was admitted to the Emergency Department and Intensive Care Unit with hypoxic brain injury, acute hepatitis and acute kidney failure. It was noted that it appeared the patient had self administered the usual volume thereby giving a cumulative overdose of morphine due to the higher concentration dispensed (10 mg/ml compared with 1 mg/ml).
The review team found that several efforts were made to provide information about the change in dose and formulation to the patient and spouse by both the DHB and the community pharmacy. Despite this an overdose occurred. An incidental finding was that there was no evidence of communicating the oral morphine dose to the patient's General Practitioner (GP). The most likely factor that contributed to event was confusion about the volume of oral morphine to be taken after the change in dose prescribed. This occurred despite information being provided on several occasions by both C&C DHB and the community pharmacy, within the two days prior to the accidental overdose taking place.

Recommendations:

- Community pharmacies consider how and when adjunct written information should be given to patients, particularly with a change of dose and or formulation, and while this may not guarantee that the information provided is understood and/or acted upon it would be an additional source of information that could be referred to by the patient and her carer.
- The review team also notes that daily dispensing of liquid morphine can reduce the chances of the patient being in possession of an excessive or toxic dose of the drug. This technique is used in pain services and in the opiate treatment service. However, daily pick up would in its own right pose problems of access and may lead to distress for the patient and carer and would therefore need to be considered on a case by case basis.
- Community pharmacies consider provision of a syringe to reduce the risk of taking or being given an excessive volume of medication when small volumes of high risk such as opiate liquid medication are dispensed.
- The DHB Medicines Committee chair communicate to all prescribers, the need to provide adjunct written information to patients/carers, particularly with a change of dose and/or formulation. While this may not guarantee that the information provided is understood and/or acted upon it would be an additional source of information that could be referred to by the patients/carers.
- The DHB Medicines Committee considers the value of requiring that a copy of the controlled drug script is made and kept in the patient record.

Recommendations progress ie. action plan: Community Pharmacy recommendations approved by Community Pharmacy involved in review. Recommendations relating to Community Pharmacy presented to Primary Secondary Clinical Governance Group for discussion and actioning. PSO to produce national alert regard this event. Medicines Review Committee actioning communication and provision of adjunct information. MRC have communicated with National Medicines group regard fourth copy of Controlled Drugs prescription.

12.

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

Event Summary: Patient fall resulting in fracture right neck of femur (hip).

REVIEW

Key findings:: The preliminary event review identified that the patient had been identified as a falls risk and appropriate falls risk mitigation strategies were in place at the time of the fall in particular use of a walking frame and supervision. No further review indicated.

Recommendations:

- No specific recommendations from this incident. All appropriate strategies were in place.
- Findings will be used in general education and awareness for staff and tabled at appropriate forums.

Recommendations progress ie. action plan: Nil specific. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

13.

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

Event Summary: Patient fall resulting in fracture right neck of femur (hip). Decision to provide palliative care. Patient deceased.

REVIEW

Key findings:: The review found that:

- The Patient Admission to Discharge Planner (PADP) was initially completed appropriately (including falls risk assessment/mobility assessment and falls strategies) however, on transfer to the rehabilitation ward, no re-assessments were formally completed.
- Appropriate falls prevention strategies were in place for the patient however these did not prevent the patient falling.

Recommendations:

- Formal apology, meeting with and provision of report to patient's family
- Regular audit and reporting of Patient Admission to Discharge Planner (PADP) completion at organisation and directorate level with specific focus on falls risk assessment.
- The requirement for new PADP forms for patient's transferring between wards be revised to a requirement for completion of the "Patient Plan" section as soon as practicable on arrival of the patient in order to reflect any changes to the status/risk of the patient and the changed environment

Recommendations progress ie. action plan: Regular auditing of PADP and reporting of same to HHS Clinical Governance ongoing. Apology to family completed. Requirement for completion of 'Patient Plan' on transfer to Kenepuru Hospital in place.

14.

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

Event Summary: Patient fall resulting in fracture right neck of femur (hip).

REVIEW

Key findings::The preliminary review identified that a falls risk assessment was completed and that appropriate falls prevention strategies in place. Findings related to incomplete documentation are being addressed through recommendations from other recent falls reviews. No further review indicated.

Recommendations:

- Recommend letter of apology and findings of preliminary event review be provided to patient's family with offer to meet as required.
- Recommend no further review indicated above actions will address findings from this preliminary event review.

Recommendations progress ie. action plan: Nil specific. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

15.

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

Event Summary: Patient fall resulting in fracture shaft of femur.

REVIEW

Key findings: Review found that the patient was admitted to the assessment unit for headache.

- The Patient Admission to Discharge Planner was completed including assessment for falls risk soon after admission. The patient was noted as being at risk of falling and appropriate falls risk prevention strategies in place. The patient was advised to wait for staff assistance to mobilise to toilet to empty catheter bag.
- The patient mobilised independently to toilet, attempted to drain catheter bag and appears to have slipped on spill on the floor.
- All appropriate actions taken to assess injury and provide care to patient subsequent to fall. Patient suffered spiral fracture proximal shaft of femur. Surgical repair.

Recommendations:

- No specific recommendations from this incident. All appropriate strategies were in place.
- Findings will be used in general education and awareness for staff and tabled at appropriate forums.

Recommendations progress ie. action plan: Nil specific. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

16.

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

Event Summary: Patient fall on inpatient ward resulting in a mid shaft spiral fracture of R) femur.

REVIEW

Key findings: Reportable event recorded at time of event – no apparent injury - severity rated minimal. X-Ray imaging later the same day confirmed a fractured neck of femur. The reportable event was referred to the Quality Manager. Preliminary event review identified that:

- Patient admitted to orthopaedic ward after a fall at home, had surgery for a post revision of right Total Knee Joint Replacement, patient later transferred to rehabilitation ward the day before the fall.
- The Patient Admission to Discharge Planner (PADP) falls risk assessment and interventions were commenced on the orthopaedic ward. PADP updates were documented every two to three days on both wards. Falls risk assessment indicated that the patient was at risk of falls-green wrist band on to signify the falls risk.
- Night staff investigated a noise and found the patient lying on the floor beside the bed. Side rails were up and call bell in reach. Patient had been reluctant to call for assistance and tried to get out of bed and fell.
- X-ray later the same day confirmed peri- prosthetic fracture spinal mid shaft femur..

Recommendations:

- That this preliminary event review be tabled at the appropriate Quality forums for MCC.
- That this event be notified to the Health Quality and Safety Commission (HQSC) by way of a Reportable Event Brief as a SAC 2 rated event.
- That CCDHB continue the ongoing projects already underway in order to help reduce the incidence of falls.
- That CCDHB continue to audit the timeliness of completion of the new PADP and ensure strategies are in place to assist with compliance..

Recommendations progress ie. action plan: Review presented to Clinical Governance and service level areas. HQSC notified of event. Incorporated into DHB Patient Safety Programme - zero patient harm - falls prevention workplan.

17.

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

Event Summary: Patient fall from bed resulting in a right periprosthetic distal spiral femur fracture.

REVIEW

Key findings:

- The patient was an acute admission due to chronically infected right hip joint replacement. Complex history including diabetes – insulin dependent. Revision surgery the following day, multiple subsequent dislocations, managed in traction until 2nd stage revision – 3 days later. An episode of delirium post-operatively - CT showed no abnormalities, improved with reduced opiates. Multiple blood transfusions.
- Transferred to a rehabilitation ward 12 days post admission. Care plan updated on admission – continued from admitting ward. Patient identified as high falls risk, fall minimisation strategies put in place. Care plan regularly updated.
- Two weeks after transfer to the rehabilitation ward the patient was medically reviewed due to concerns re wound, minimal food or fluid intake, low mood and energy. Blood sugar levels unstable. Low haemoglobin and high potassium levels noted. Two units of red blood cells transfused the following day.
- In the early hours of the following morning the patient was found sitting on the floor beside the bed having "dreamt she was walking". Medical review completed. Patient transferred to orthopaedic ward. X-ray showed periprosthetic fracture of the R femur. Subsequent surgery open reduction and internal fixation of fracture. Patient later transferred to rehabilitation ward.
- A reportable event was recorded by nursing staff- Severity 2. Preliminary event review showed falls risk assessment and risk controls were in place for this patient. Concerns about the patient's condition were notified and responded to appropriately.
- The patient was unwell with post surgery problems, wound concerns, extended hospitalisation, unstable blood sugars and recent blood transfusion. All appropriate actions were taken when the fall occurred. It was noted incidentally that it was not documented whether the patient was wearing a green falls risk wrist band - the review team note that the wrist band's presence or absence would not have been material in preventing such a fall.

Recommendations: The findings of the review will be incorporated into the Ward, Directorate and DHB preventing harm from falls programme.
No further review indicated

Recommendations progress ie. action plan: No further review indicated. CLOSED.

18.

Event Category: Clinical management-treatment

Deceased?: Y **SAC Rating:** 1

Event Summary: Patient deceased in community on same day as attended 4 week post op orthopaedic clinic follow-up appointment. Interim post mortem indicates Pulmonary Embolism (clot in lungs) secondary to Deep Vein Thrombosis (DVT-clot).

REVIEW

Key findings: The review found that the patient received appropriate care, the sudden death from a clot was not predictable from the signs, symptoms or history and that the clinical team carefully reviewed the patient's care at each outpatient appointment. Review noted CCDHB is finalising a Venous Thromboembolism (VTE) Prophylaxis (prevention) guideline including Orthopaedic Risk Assessment Form, that the patient received prophylaxis consistent with the draft guideline and greater than the American College of Chest Physicians guidelines currently recommend.

Recommendations: Review recommended:

- Provision of the report to the patient's family and an offer to meet
- Completion of the VTE prophylaxis (clot prevention) guideline as soon as practicable including consideration of inclusion of an information leaflet for patients

- Orthopaedic services to further research the efficacy of oral anticoagulant agents, consent information and clarification of information for patients and families.

Recommendations progress ie. action plan: Note: Family advised of review and report provided. The family chose not to meet formally. The action plan is still in progress:

- A research project re "aspirin versus rivaroxaban in below knee casts for Achilles Tendon and non-weight bearing follow fracture" has been submitted for a feasibility grant,
- The Orthopaedic Services Consent checklist and updated Achilles Tendon Rupture forms are being updated presently.
- The organisation guideline for prevention of venous thromboembolism (VTE-clots) has been completed and implemented.
-

19.

Event Category: Clinical management-treatment

Deceased?: N **SAC Rating:** 2

Event Summary: Non-reassuring fetal heart rate tracing-during labour. Proceeded to emergency caesarean section-full thickness uterine rupture identified. Woman retained uterus, prolonged stay, baby spent several days in Neonatal Intensive Care Unit (NICU).

REVIEW

Key findings: The review found that a number of factors resulted in a situation where trial of labour was allowed to continue and the opportunity to delivery prior to uterine rupture was missed. The number of clinicians involved in the planning and care coupled with unclear communication at times meant that clarity for all involved and uniform expectations of intervention did not occur.

Recommendations: Review recommended:

- An apology to the patient's family, provision of the report and an offer to meet
- Letter to all medical staff assess for vaginal birth after caesarean section highlighting the importance of clearly documenting the management plan agreed with the Lead Maternity Carer and woman/couple
- Memo to all Women's Health clinicians re importance of attending handover
- Audit of documentation re options and consent for VBAC
- Registrar teaching
- Registrar assessments of level of competence regularly discussed.

Recommendations progress ie. action plan: Note: Woman and family advised of review, report provided and meeting held with the family. The action plan is now complete.

20.

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

Event Summary: Concern re prescription of opiate medication for patient with history of chronic renal failure. Patient required admission to ICU for haemodialysis-acute on chronic renal failure, acidosis, anuria and opiate overdose.

REVIEW

Key findings: The draft review report is awaiting staff feedback before being finalised.

Recommendations: NA

Recommendations progress ie. action plan: Family to be provided with report when complete.

21.

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

Event Summary: Patient admitted with mild delirium secondary to urinary tract infection with consideration for confusion and social situation. Three days later in the early hours of the morning the patient fell. Oblique fracture through the surgical neck of the humerus diagnosed. Subsequent deterioration agreed not for active

resuscitation in discussion with family. Care transferred to Internal Medicine. Three days later the patient transferred to rehabilitation. A further nine days later the patient deceased having developed pneumonia and a palliative approach taken. Coroner advised including of fall. Coroner satisfied with information.

REVIEW

Key findings: The draft review report is awaiting staff feedback before being finalised.
Recommendations: NA
Recommendations progress ie. action plan: Family to be provided with report when complete.

22.

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

Event Summary: Patient fall. Initial assessment appeared no injury. Subsequent CT Scan showed small acute on chronic sub dural bleed, no midline shift. 5 days later developed seizures, required intensive care admission. A further 5 days later required burr holes. Later transferred to rehabilitation.

REVIEW

Key findings: The review is in progress and due to be completed in November 2013.
Recommendations: NA
Recommendations progress ie. action plan: Family to be provided with report when complete.