Serious adverse event report

1 July 2022 – 30 June 2023

Te Whatu Ora
Health New Zealand
Capital, Coast and Hutt Valley

Serious Adverse Event Report

1 July 2022 – 30 June 2023

This report describes serious adverse events that occurred and were commissioned for review between 1 July 2022 and 30 June 2023 at Te Whatu Ora Capital, Coast & Hutt Valley District (CCHV). An adverse event is an event in which a person receiving health care experiences harm.[1] This report relates to hospital and community services only and does not include public health or mental health, addictions and intellectual disability service (MHAIDS).

CCHV had 135 confirmed SAC 1 & 2 adverse events from 1 July 2022 to 30 June 2023. Three events occurred in the previous reporting period but were either not reported or not commissioned until this reporting year. Of the 135 serious adverse events for 2022/2023 there were a total of 37 SAC 1 events, and 98 SAC 2 adverse events.

Table 1: Total reported SAC 1 & 2 adverse events for the last three financial years (2020-23)

Category*	**2020/2021****	**2021/2022**	**2022/2023**
Clinical administration	3	11	6
Clinical process or procedure	95	63	84
Healthcare associated infection (HAI)	0	1	3
Medication or intravenous fluids	6	9	7
Behaviour	1	1	3
Falls with serious harm	19	37***	31
Resources or organisational management	1	0	0
Device/equipment	0	0	1
Total	**124**	**122**	**135**

** Categorisation is based on the Health Quality & Safety Commission event codes derived from the World Health Organisation classifications for patient safety*
*** Combined total of CCDHB and HVDHB numbers*
**** This includes 6 historic events that were identified by coding audit*

Each of these events involved a patient experiencing harm while in our care. We acknowledge the distress and grief that occurs as a result of health care related harm and sincerely apologise to those patients and whānau affected by the events in this report. We recognise that those people affected are also an important part of their social groups and wider communities. CCHV is committed to improving how we learn from these experiences in order to better our services.

[1] Health Quality & Safety Commission. (2023). *Healing, learning and improving from harm: Natioanl adverse events policy.* https://www.hqsc.govt.nz/assets/Our-work/System-safety/Adverse-events/Publications-resources/National-adverse-events-policy-2023_English_final_WEB.pdf

National adverse events policy

Harm from healthcare has multiple causes and the negative impacts on people are wide-ranging.[2] One in 10 patients experience unintentional harm that may have been prevented while receiving care.[3] [4] CCHV strives to deliver high quality and safe care to our community through our shared values of manaakitanga, kotahitanga and rangatiratanga. Part of that commitment is ensuring openness and transparency when things have gone wrong.

When serious harm occurs we review what happened, reflect on the findings, and take action to reduce the chance of a similar event occurring again. The lessons learned from reviewing serious adverse events provide opportunities to improve processes and systems to reduce patient harm and inform quality improvement action. By understanding what has happened, we can seek to change and improve care for our patients.

Since July 2023, we have entered a period of transition to align with the new national Healing, learning and improving from harm: National Adverse Events policy (2023). This policy will, over time, lead to a change in how we understand and learn from serious events. The events in this report occurred and were commissioned under the previous adverse event policy, however work has begun both within the district, and within the whole central region, to align our processes with the new policy.

Severity assessment codes (SAC)

The adverse events in this report are categorised as Severity Assessment Code (SAC) 1 and 2, using the SAC rating in the National Adverse Events Reporting Policy 2017. From July 1 2023 these ratings have been updated under the new National Adverse Events Policy 2023 but they did not affect the events discussed in this report. SAC 1 and 2 events are adverse events that result in permanent or severe harm, temporary loss of function, or death. All SAC 1 and 2 adverse events are reported to the HQSC.

There were 19 'Always Report & Review' (ARR) events. ARR events are those that could result in serious harm or death but are preventable with strong clinical and organisational systems.[5] The majority of the ARRs are not reflected in the numbers as all except one had SAC ratings of 3 & 4, which are not included in this report.

There has been an increase in commissioned serious adverse events compared with recent years. A safe reporting culture allows our kaimahi to feel confident in raising concerns or reporting event without there being negative consequences personally.[6] We have confidence that our reporting culture is strong and is improving over time. People report harm when it occurs and this is reflected in our SAC data.

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[2] Health Quality & Safety Commission. (2023). *Healing, learning and improving from harm: Natioanl adverse events policy.* www.hqsc.govt.nz/assets/Our-work/System-safety/Adverse-events/Publications-resources/National-adverse-events-policy-2023_English_final_WEB.pdf

[3] World Health Organisation, (2019). *Patient Safety*. https://www.who.int/news-room/fact-sheets/detail/patient-safety

[4] HQSC. (2019). *Ngā Taeoro a Kupe:whānau experiences of in-hospital adverse events.* www.hqsc.govt.nz/assets/Our-work/System-safety/Adverse-events/Publications-resources/Nga_Taero_a_Kupe_final_web.pdf

[5] HQSC. (2022). Always Report and Review list 2021-22. https://www.hqsc.govt.nz/resources/resource-library/always-report-and-review-list-202122/

[6] HQSC. (2023). *Safe Reporting* www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/safe-reporting/

SAC 1 events

There were 37 SAC 1 events for the 2022-23 period, which is a significant increase from the 23 events that occurred in the previous year. Each of these events represents either the death of an individual or a person having a permanent disability or life impacting change. We extend our deepest condolences to those patients and whānau impacted by these events and acknowledge the ongoing grief of those who have lost a loved relative or friend.

Clinical process or procedure events made up the majority of SAC 1 events (n=28). The most common sub-category was delay in treatment (n=12), followed by delay in recognition of deterioration (n=7) and process of care (n=5).

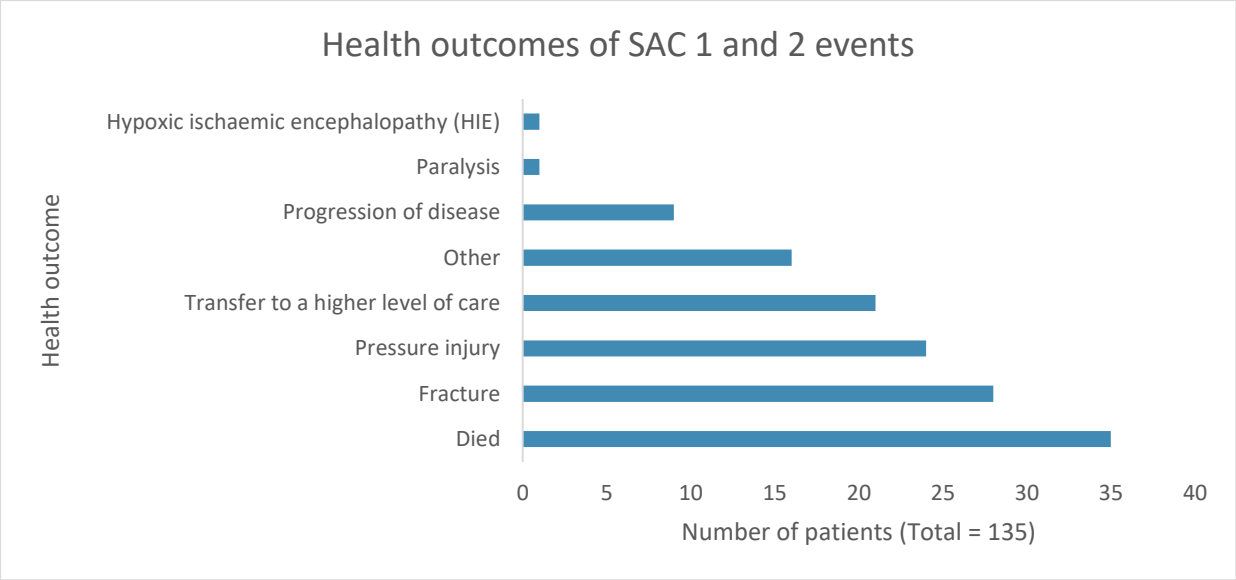
In some cases, it may not be possible to determine whether different or earlier treatment would have resulted in a different outcome for patients. However, review of these events can still provide us with information on how best to improve our services to provide the best care possible to patients and their whānau.

Delays in receiving assessment and treatment due to resource constraints was a recurring theme and is an indication of the strain on the health care system.

Health outcomes of SAC 1 and 2 events

The following chart describes the health outcomes for patients who experienced either a SAC 1 or SAC 2 serious adverse event:

Figure 1: Health outcomes of all SAC 1 and 2 events (1 July 2022 – 30 June 2023)

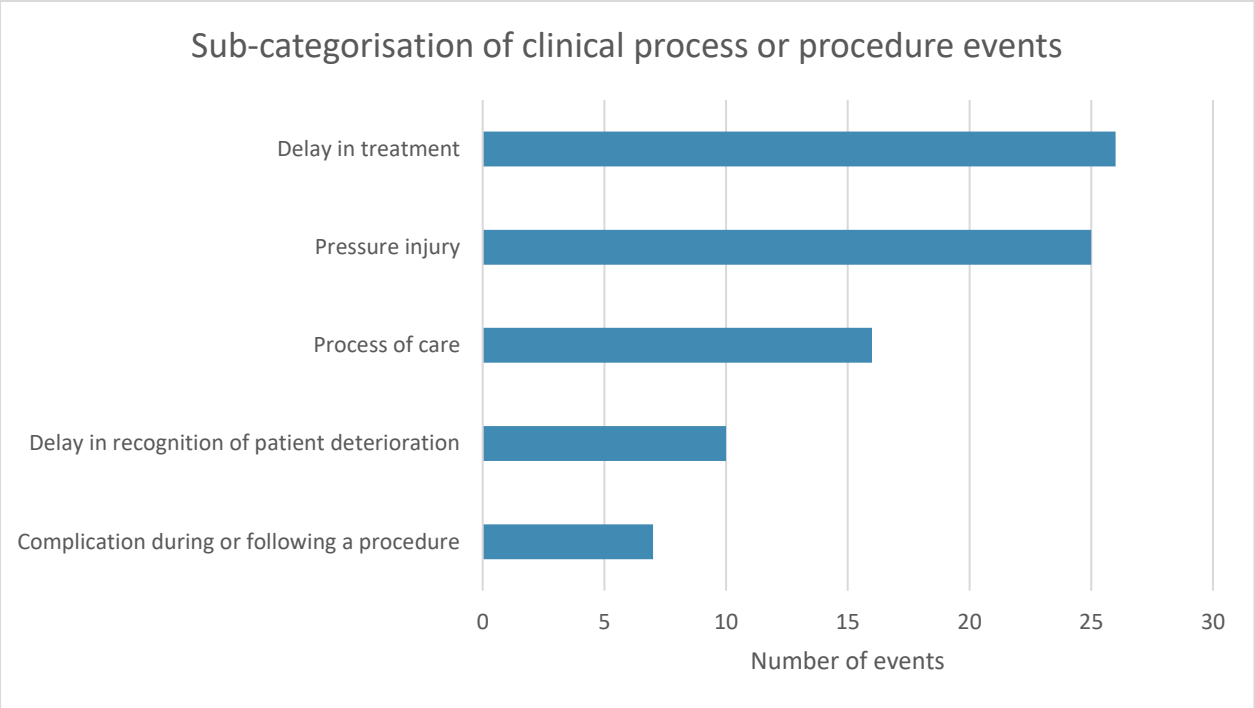


Highest areas of harm

In accordance with the 2017 policy in effect at the time, the adverse events addressed in this report refer to those that have contributed to physical harm only. However, harm may also be psychological, cultural or spiritual and a person may experience any one of these harms as part of an event. As part of the implementation of the new national policy we are working on ways to recognise and report on harms, other than physical, that people may have experienced.

A total of 84 'clinical process or procedure' events for CCHV were reviewed between 1 July 2022 and 30 June 2023. Fifty-six of these were SAC 2 events and 28 were SAC 1 events. Clinical process or procedure events represent the majority of serious events (62 percent). These have been themed into sub-categories to provide more detail.

Figure 2: Sub-categorisation of clinical process or procedure events



The category with the next highest number of events was 'falls with serious harm'. There were 31 events themed under this category. Of these, two were classified as SAC 1 events where the fall was sadly, a contributory factor in the patient's death.

Te Tiriti o Waitangi

Te Whatu Ora Capital, Coast & Hutt Valley has responsibilities and accountabilities under Te Tiriti o Waitangi and the Pae Ora Act 2022 to address persistent inequities experienced by

Māori and to improve health outcomes for Māori.[7] Te Whatu Ora Capital, Coast & Hutt Valley are committed to improving health outcomes for Māori in our district by prioritising tino rangatiratanga (self-determination); ōritetanga (equity); whakamaru (active protection); kōwhiringa (options) and pātuitanga (partnership).[8]

The Quality and Patient Safety (QPS) team continues to work to improve responsiveness to Māori who experience serious harm. The Serious Event Review Committee (SERC) has Māori representation and teams reviewing events involving Māori patients include a Māori staff member, where possible. Earlier this year the team attended workshops on Te Tiriti o Waitangi and the ongoing effects of colonisation on the health system.

Our population

The CCHV district encompasses Hutt Valley, Kapiti, Porirua and Wellington and includes Wellington Regional, Hutt and Kenepuru hospitals. It is a region diverse in cultures, ethnicities, abilities and geographic settings and it is constantly changing. Our population is expected to grow, age and become more diverse.[9]

Table 2: Population data for CCHV District from NZ Census 2018[10]

Ethnicity	Number	Percentage*
Māori	61,050	14%
Pacific peoples	26,238	6%
Asian	56,190	12%
Middle eastern/Latin American/African (MELAA)	7374	2%
Other	4962	1%
European	296,376	66%
Total	***452,190***	

[7] Te Whatu Ora (2023) 'Changing the system'. https://www.tewhatuora.govt.nz/whats-happening/changing-the-system/

[8] Waitangi Tribunal. (2023). *Hauora report on stage one of the health services and outcomes kaupapa inquiry: WAI 2575 Waitangi tribunal report* https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf

[9] Capital & Coast District Health Board (2021). *Capital & Coast District Health Board Annual Report*. https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-2021-22-annual-plan-final.pdf

[10] Stats NZ (2018). 2018 Census https://nzdotstat.stats.govt.nz/OECDStat_Metadata/ShowMetadata.ashx?Dataset=TABLECODE8320&ShowOnWeb=true&Lang=en

Equity

"In Aotearoa New Zealand people have differences in heath that are not only avoidable, but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes"[11]

Te Whatu Ora, Capital, Coast & Hutt Valley is a pro-equity organisation committed to working with tangata whenua, people and partners across the region to achieve health equity.[12] We recognise that we still have some way to go particularly for Māori, and our priority populations, pacific peoples and disabled people as well as those with enduring mental illness and with fewer resources. Institutional racism and colonialism provide a historical context for the inequities that particularly affect Māori and Pacific peoples and we continue to see the impacts of these processes in ongoing inequitable health outcomes.

Māori and Pacific peoples are proportionally over-represented in adverse events when compared with the district population. Māori make up approximately 14 percent of the total CCHV population but made up 16 percent (n=22) of those affected by serious adverse events. Though there is limited research, this reflects a national trend in which 14 percent of Māori experienced an in-hospital adverse event compared with 11 percent of non-Māori.[13] Pacific peoples make up approximately six percent of the district population however eight percent (n=11) of those affected by serious adverse events were Pacific peoples.

Historically, our methods of identifying harm have not recognised the cultural, spiritual and psychological harm that many Māori and Pacific peoples experience when engaging with a health care system designed on European colonial principles.[14] [15] With the introduction of the new HQSC SAC guidelines we hope to work towards addressing this imbalance.

CCHV are guided by seven equity principles to achieve equitable health outcomes. A key focus of the organisation is developing a workforce representative of and connected to communities, improving accessibility and experience for disabled people and supporting Māori, Pacific and disability leadership.

A note on ethnicity data

As part of serious adverse event reporting we collect ethnicity data to better plan, tailor and deliver policies and services.[16] We have used the following ethnicity groupings consistent with the current ethnicity data protocols from Manatu Hauora Ministry of Health: Māori, Pacific Peoples, Asian, Middle Eastern/Latin American/African (MELAA), Other and

[11] Te Whatu Ora (2023) *Achieving equity* https://www.tewhatuora.govt.nz/whats-happening/about-us/who-we-are/achieving-equity/

[12] Te Whatu Ora Capital Coast & Hutt Valley (2023) *Pro-equity https://3dhb.sharepoint.com/sites/spc/SitePages/Equity.aspx*

[13] HQSC. (2019). *Ngā Taeoro a Kupe:whānau experiences of in-hospital adverse events.* www.hqsc.govt.nz/assets/Our-work/System-safety/Adverse-events/Publications-resources/Nga_Taero_a_Kupe_final_web.pdf

[14] Ryan D., Grey C., Mischewski B. (2019). Tofa Saili: A review of evidence about health equity for Pacific Peoples in New Zealand. Wellington: Pacific Perspectives Ltd. ISBN 978-0-473-48927-4

[15] Graham, R. & Masters-Awatere, B. (2020) Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research, *Australian and New Zealand Journal of Public health* 44(3) p193-200

[16] Ministry of Health (2017) Ethnicity Data Protocols https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

European.[17] Where a patient identifies with multiple ethnicity groups, we have used prioritised output reporting.

District and national context

The Pae Ora (Healthy Futures) Act 2022 saw the beginning of significant national health reform and the formation of Te Whatu Ora and Te Aka Whaiora. This has had impacts on both the structure of the organisation and how we deliver care, with a number of changes happening during this transition.

With the background of major health reform and chronic under-resourcing, CCHV, like other districts, has continued to see increased demand for services and high occupancy, which causes flow on effects for those waiting to be seen in our hospitals. We have an ageing population who are requiring longer hospital stays with more complex needs. This, combined with limited capacity in the residential care sector means there can be delays to discharge for the older adult population. A primary health care sector under considerable pressure, with long waits for seeing General Practitioners has further exacerbated the pressure, particularly on emergency departments (ED).

Nationally, increased presentations and longer wait times in emergency departments have been highlighted as areas of concern. This is also true for Hutt & Wellington ED's as well as the Accident & Medical Centre in Kenepuru. Even when fully staffed, the volume of patients in ED remains high and waiting times often fall outside the recommended timeframes. Ongoing high occupancy and hospitals working at near or over capacity has further exacerbated waiting times in ED with minimal beds available for new admissions. Other admitting areas such as the Surgical and Medical Assessment and Planning Units (SAPU & MAPU) are limited by a lack of assessment beds. These constraints are a contributing factor in some of the adverse events mentioned in this report.

September 2022 saw the end of the COVID-19 protection framework and while the hospital no longer had the challenge of working under COVID restrictions, COVID continues to impact both patients and staff. COVID admissions have fluctuated throughout the year and isolation requirements of patients with COVID have remained, which can be challenging in terms of bed management.

There have been improvements in increasing the nursing and medical workforce however staffing levels for allied health professions and specialist areas are an ongoing issue. It was acknowledged during the certification audit (September 2022) that the national workforce shortage is impacting individual districts' ability to improve workforce capacity.

[17] Ministry of Health (2017) Ethnicity Data Protocols https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

Clinical administration events

There were six events as a result of clinical administration errors. All events involved the administration of outpatient appointments.

Patient ethnicity: Māori (n=2), Pacific peoples (n=1), Asian (n=1), European (n=2)

Table 3: Clinical administration

Event summary	
3	Three patients did not receive follow up appointments within the planned timeframe
2	Two patients had first specialist appointments that did not occur within the target timeframe
1	One patient was part of a group review related to delayed breast screening appointments

What are we doing to further reduce clinical administration events?

- An IT project is underway looking at e-referral processes across the district and how these can be streamlined and improved
- Audits of electronic surgical bookings have been undertaken to quantify the occurrence of booking failures and identify process issues.
- Changes have been made to the discharge summary template to require a specified timeframe for any requested follow up

Clinical process or procedure events

The number of adverse events related to clinical processes or procedures increased from 63 to 84 in the last year. This reflects the effects of ongoing under-resourcing and a system under significant pressure from increased admissions, limited capacity and patients with more complex conditions.

These events have been themed into five categories:

1. Delay in recognition of patient deterioration
2. Pressure injury
3. Delay in treatment
4. Complication during or following a procedure
5. Process of care

1. Delay in recognition of patient deterioration

Ten serious events occurred due to a delay in recognition of patient deterioration across a range of healthcare settings. Sadly, seven of these were SAC 1 events.

Patient ethnicity: Māori (n=2), Pacific peoples (n=3) and European (n=5)

Table 4: Delay in recognition of patient deterioration

Delay in recognition of patient deterioration: event summary	
6	Six events related to abnormal vital signs or investigation results not being recognised or not escalated
3	Three events involved delayed vital signs leading to late recognition of deterioration in a patient's condition
1	One event related to a delay in resuscitation during transfer between departments
What are we doing to improve our clinical processes for early recognition of patient deterioration? • A 777 Emergency Alerts working group has been formed to improve and standardise clinical 777 processes • Regular simulation training, involving obstetrics and NICU, to improve management and communication during maternity emergencies • A range of workshops and online education is available to staff including serious illness communication workshops and open communication training. Staff can also access training on different communication tools via online and face-to-face education • Department-wide communication on lessons learned from adverse events has been implemented in ED • A business case was submitted for increased nursing and senior medical officers in ED • The Patient Deterioration Governance Group has become district-wide which ensures appropriate governance of recognition and response to deteriorating patients • Goals of Care discussion and documentation continues to be supported district-wide • The National Paediatric Early Warning Score (PEWS) system was implemented across the district in June 2023. • The Patient at Risk (PAR) Service has expanded to cover Kenepuru Hospital on weekdays and the PAR service at Hutt Hospital is working towards becoming a 24-hour service • The patient deterioration tracer audit is being reviewed to ensure data captured is relevant and of a high quality	

Pressure injuries

Twenty-five patients sustained a pressure injury graded as either three, four, deep tissue or unstageable,* and one event was a SAC 1. Twenty-one pressure injuries were sustained while patients were in hospital and the other four occurred while under outpatient care. Vulnerable areas for developing pressure injuries are the heel and sacrum and this was reflected in the reported events. The higher incidence of pressure injuries may be reflective of an ageing population with increased frailty, reduced mobility and complex care needs including underlying peripheral vascular disease. Other contributing factors included staffing and resource shortages.

Patient ethnicity: Māori (n=2), Pacific peoples (n=2), Asian (n=1) European (n=20)

Table 5: Pressure injuries

Event summary	
17	Seventeen patients developed a pressure injury on their heel, sacrum or other area while in hospital
6	Six patients developed pressure injuries under plaster casts or medical devices
2	Two patients under the care of district nurses developed pressure injuries at home

What are we doing to further reduce pressure injuries?

- The nursing leadership team are undertaking a review of assessment and care planning documents district wide
- The role of Nurse Practitioner Intern – Tissue Viability has been established for the District
- The Tissue Viability Working Group have overseen a number or initiatives to reduce pressure injuries including:
    - Aligning pressure injury resources across the district
    - A pressure injury prevention focus month was held in November to align with World Pressure Injury Day. This included education sessions and communications for staff around pressure injury prevention
    - A standardised pressure injury study day has been developed for the district
- Improvements to ordering processes for pressure relieving equipment have been made to ensure timely ordering and delivery of equipment
- Patient Event Review Sub-committee (PERS) has continued to oversee pressure injury and falls event processes in order to reduce patient harm by learning and improving from serious events across the district
- The quality team undertook a group review of outstanding pressure injury reviews. By looking at a large group of similar events it was possible to identify common themes that will inform the district pressure injury prevention strategy

**Pressure Injury Classification:*
Deep tissue: There is no open wound but the tissue beneath the skin's surface has been damaged.
Stage 3: Subcutaneous fat may be visible, no exposed bone tendon/muscle.
Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle.
Unstageable: Depth unknown. Full thickness tissue loss and base of the pressure injury covered by slough and/or eschar.

2. Delay in treatment

Twenty-six serious events occurred due to delays in treatment. These were mainly due to a delay in assessment or delays while waiting for surgery or a procedure. Twelve of these were SAC 1 events. The delays in diagnosis or treatment were due to multiple factors including tight staffing restrictions, services operating at capacity and increasing need.

Patient ethnicity: Māori (n=5), Pacific peoples (n=4), Asian (n=5) and European (n=12)

Table 6: Delay in treatment

Event summary	
8	Eight patients had a surgery or procedure cancelled or delayed
5	Five patients had a delay in appropriate assessment
3	Three patients suffered further deterioration after initial decisions to treat conservatively
3	Three patients had delayed recognition and appropriate treatment of sepsis
2	Two patients did not have radiological imaging ordered when recommended
2	Two patients had radiological imaging that was not reviewed or acted on in a timely manner
2	Two patients had delayed treatment as a result of delayed correct diagnosis
1	One patient had a delay in receiving a prescribed medication

What are we doing to improve clinical processes that have contributed to delays in treatment?

- A district wide sepsis awareness campaign was held which included targeted education to different clinical groups focusing on recognition and treatment of sepsis, clinical forums on sepsis recognition and activities for World Sepsis Day
- A sepsis working group has been established to review and improve current sepsis pathways
- Work continues on the “Front of Whare” capital infrastructure project to reduce bed block and improve patient flow through ED
- There has been a reduction in Trans-catheter Aortic Valve Implantation (TAVI) wait times and a business case to permanently increase resourcing for TAVI has been submitted for consideration
- Department wide communication on lessons learned from adverse events has been implemented in ED
- A business case has been submitted for increased nursing and senior medical officers in ED
- A range of workshops and online education is available and advertised to staff including serious illness communication workshops and open communication training. There is also access to training on different communication tools via online and face-to-face education
- Work has started on reviewing the process for reporting and signing off radiological results

3. Complication during or following a procedure

There were seven events related to complications during or following a procedure. Three patients developed a complication during a procedure and four following a procedure. Three of these were SAC 1 events.

Healthcare is complex and all procedures carry a risk of complication. While steps can be taken to reduce the risk of adverse effects from interventions, we acknowledge that not all complications are avoidable. Many patients in this group had complex health needs involving non-linear health journeys.

Patient ethnicity: Māori (n=2), Asian (n=1), MELAA (n=1) and European (n=3)

Table 7: Complication during or following a procedure

Event summary	
2	Two patients experienced complications related to post-operative or post-procedural bleeding
2	Two patients experienced complications related to aspiration during a procedure
2	Two patients had a cardiac arrest during an invasive procedure
1	One patient suffered an intracranial bleed during a procedure
What are we doing to lower the risk of complications during or following a procedure? • CCHV has adopted the new standardised national Massive Haemorrhage Pathway as a replacement for the Massive Transfusion Protocol (MTP). The new pathway recognises that different causes of bleeding require different management and includes three pathways for standard, traumatic or obstetric bleeding. • A range of workshops and online education is available to staff including serious illness communication workshops and open communication training. There is also access to training on different communication tools via online and face-to-face education. • Two of these reviews, when completed, found no process issues or preventable causes	

Process of care

There were 16 process of care events. Process of care refers to actions or interventions performed during the delivery of patient care in accordance with evidence based best practice. Five of these were SAC 1 events.

Patient ethnicity: Māori (n=3), Pacific peoples (n=1), Asian (n=1) and European (n=11)

Table 8: Process of care

Event summary	
5	Five patients experienced a delay in receiving the correct diagnosis
5	Five patients experienced complications or a worsening in their condition after discharge or self-discharge
2	Two patients suffered harm as a result of incorrect management of a heparin infusion
1	One patient died unexpectedly, the cause of death is unknown
1	One patient had a procedure performed on the wrong side
1	One patient did not receive a test that was clinically indicated
1	One patient received an incorrect diet type

What are we doing to improve our process of care?

- Reviews into a number of these events are currently in progress so recommendations have not yet been identified
- Discussion around expansion and re-scoping of thrombosis service to provide equitable care across the district
- The heparin prescription and monitoring chart has been updated to align with updated APTT reference ranges
- Implementation of the Smart Page paging system at Hutt Hospital to improve communication around patient care between wards and medical teams overnight
- A pilot of a sepsis screening tool for paediatric patients has begun in one ED
- A range of workshops and online education is available to staff including serious illness communication workshops and open communication training. There is also access to training on different communication tools via online and face-to-face education.
- A district-wide central venous access device maintenance chart has been created and work is currently in progress to create a similar chart for community patients

Healthcare associated infection (HAI)

There were three healthcare associated infection events. One of these was a SAC 1 event.

Patient ethnicity: European (n=3)

Table 9: Healthcare associated infection (HAI)

Event summaries	
2	Two people developed an infection from an intravenous (IV) access device
1	One person developed a surgical wound infection

What are we doing to reduce the incidence of HAIs?

- The introduction of an IV needle-less connector for all IV access devices and the re-introduction of alcohol impregnated caps for central venous access devices across the district. Both devices will reduce the risk of infection related to IV access devices.
- A new antimicrobial and anti-coagulant locking agent for central venous access devices has been implemented to help maintain patency and reduce central line associated blood stream infections
- An ED led initiative to prevent unnecessary peripheral IV cannulas being inserted when bloods are taken has been established
- Increased use of negative pressure wound therapy in patients at high risk of surgical site infection. An audit is currently in progress to monitor the effectiveness of this for orthopaedic patients.

Medication and Intravenous (IV) Fluids

There were seven medication-related events, two of these were SAC 1 events. There were no events related to intravenous fluid administration.

Patient ethnicity: Māori (n=2), Asian (n=1) and European (n=4)

Table 10: Medication and intravenous (IV) Fluids

Event summaries	
2	Two patients experienced complications related to the incorrect prescription of anticoagulants
3	Three patients required admission to the Intensive Care Unit for opiate toxicity
1	One patient received a medication that was not prescribed for them
1	One patient was prescribed a medication to which they had a known allergy

What are we doing to reduce harm from medication and IV fluids?

- New IV smart pumps with Dose Error Reduction Software (DERS) were introduced at Hutt Hospital
- A dedicated Smart Pump pharmacist has worked with the newly formed Smart Pump Governance Group to build a drug library that supports safe administration of IV medications and reduces the potential for error
- Work is underway to standardise practice across the district for the administration of common IV medications. A standardised administration method for amiodarone has already been created.
- A medication self-assessment audit was conducted to highlight areas of medication safety that could be improved and set priorities for future work
- A quality advisor from the Centre of Clinical Excellence has contributed to the development of a national anti-coagulation stewardship programme in collaboration with the Health Quality and Safety Commission
- The heparin prescription and monitoring chart has been updated to align with updated APTT reference ranges.

Behaviour

There were three behaviour related events. One of these was a SAC 1 event. We endeavour to capture peoples' well-being holistically but this remains challenging, and we are not always able to predict a person's behaviour.

Patient ethnicity: Māori (n=1) and European (n=2)

Table 11: Behaviour

Event Summary	
3	Three events involved intentional self-harm during or immediately following a hospital admission
What are we doing to address behaviour related events? • Reviews into some of these events are currently in progress so recommendations have not yet been identified. One review has been completed and found no process issues or preventable causes. • Where appropriate we work in collaboration with the MHAIDS quality team to either complete cross-service reviews or to ensure a mental health perspective is included in the review.	

Falls with serious harm

There were 31 falls causing serious harm in this reporting period. Two of these were SAC 1 events.

The falls primarily occurred amongst the older adult population across different hospital locations. A range of environmental, assessment, care planning, and process factors were found to have contributed to these events. Unfortunately, sometimes falls do occur despite safety huddles and appropriate falls assessment and management.

Patient ethnicity: Māori (n=3), Asian (n=1) and European (n=27)

Table 12: Falls with Serious Harm

Event summary	
28	Twenty-eight patients sustained fractures following falls
3	Three patients sustained head injuries following a fall, with one person requiring surgery

What are we doing to further reduce falls?

- The district-wide PERS Committee has continued to oversee pressure injury and falls event processes in order to reduce patient harm by learning and improving from serious events across the district
- A business case has been submitted to purchase Raizer Chairs for Hutt Hospital as part of the falls retrieval to ensure equitable access to falls retrieval equipment
- Promotion of the Multi-Disciplinary Team safety huddle by the falls committee
- Ongoing education for clinical staff on falls prevention, falls assessment and care planning
- Ongoing action to calculate ward staffing requirements through CCDM and TrendCare data and recruit to vacant nursing positions. There has been a steady decline in vacant nursing FTE across the district since July 2023.
- Intentional rounds have been introduced on wards to have more frequent checks on patients that may need assistance
- The Patient Quality & Safety Indicator (PQSI) Committee has set “decreasing in-patient falls” as a key focus for 2024

Device/equipment related events

There was one SAC 1 event related to a medical device or piece of equipment.

Patient ethnicity: European (n=1)

Table 13: Medical Device/Equipment

Event summaries	
1	One event involved a person who required a more invasive procedure due to the unavailability of specific equipment
What are we doing to reduce the incidence of medical device/equipment events • A working group has been established to investigate options for the creation of a hybrid theatre suite at Wellington Regional Hospital. Information from reportable events has been used to support and strengthen the business case.	

Final comment

Te Whatu Ora Capital, Coast and Hutt Valley aims to provide safe, equitable and effective care for all patients and our intent is always to minimise harm. The majority of patients that engage with our services do so without preventable harm occurring to them. However, those patients who were affected by the adverse events in this report have experienced serious harm or in some cases, have died. We acknowledge that each event represents a person who is a loved part of a whānau or community and apologise to all who have been affected.

With the passing of the Pae Ora (Healthy Futures) Act 2022 and the establishment of Te Whatu Ora and Te Aka Whaiora, the health system has undergone some significant changes in the past year. By continuing to report and review these events we strive to learn from harm and, based on these learnings, to identify improvements to the care we provide and to inform our work as an organisation. Our kaimahi work every day to improve the care provided for people in our district but we acknowledge that there is still a lot of work to be done to ensure the care we deliver is safer, more effective and more equitable. We look forward to implementing the new national Adverse Events policy in order to better understand and learn from adverse events.