Hutt Valley District Health Board

Adverse Events Report: 1 July 2016 to 30 June 2017

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

As part of a health system it is imperative that we have good systems and process in place for reporting, reviewing and learning from adverse events. The aim of the adverse event review process is to learn from adverse events to enhance patient safety and improve the quality and experience of patient care.

During the period 1 July 2016 to 30 June 2017 Hutt Valley DHB reported six adverse events that occurred in our hospital and health services. The National Reportable Events Policy 2012 requires every DHB to report adverse events to the Health Quality and Safety Commission.

For the purposes of this report, an adverse event is an event with negative reactions or results that are unintended, unexpected or unplanned (often referred to as 'incidents' or 'reportable events'), classified with a Severity Assessment Code (SAC) rating of SAC 1 or SAC 2. In practice this is most often understood as an event which results in harm to a consumer. The SAC is a numerical rating which defines the severity of an adverse event and as a consequence the required level of reporting and investigation to be undertaken for the event.

Each of the reported events involves a patient suffering harm while in our care. We consider one event of this nature one too many, and apologise unreservedly to the patients and family/whānau involved in these cases. We acknowledge the distress and grief that occurs for patients and their families/whānau when things go wrong in healthcare. Most patients are treated without preventable harm, but still some suffer serious harm from preventable events.

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

As an organisation we rely on adverse events being reported by the people involved, in order to learn from them; reporting adverse events is an important component of a positive patient safety culture.

A positive and committed safety culture means that patients and their family/whānau, other health providers such as family doctors and our own staff tell us when an incident has occurred and raise concerns, so that we can look into what has happened.

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

Our practice is to communicate openly with patients and families/whānau at all times, including when adverse events occur, to acknowledge what has happened and to apologise. We will listen to concerns, provide support, involve patients and families/whānau to the degree they prefer, and where possible answer their questions and address any concerns that they have.

There is an understanding that partnership between health care providers and patients is an essential dimension of providing quality health care services. Further developing partnership with patients and their families/whānau in the adverse event review and learning process is a significant focus for the coming year. Working in partnership nurtures a patient-centered approach to care and helps to shine a light on areas for learning in a complex health system.

When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented. Making this happen supports Hutt Valley DHB to achieve our priority of safe and quality care. This forms part of our overall quality improvement and patient safety programme of work, and links with our strategic approach of "Improved quality, safety and experience of care".

The category classification of the Serous Adverse Events reported to the Health Quality and Safety Commission by Hutt Valley DHB for the period 1 July 2016 to 30 June 2017 is reported in the table below:

General classification of event	**Number of reported adverse events**
Patient falls	1
Healthcare associated/acquired infection	1
Medication/IV fluids	1
Clinical process (e.g. assessment, diagnosis, treatment, general care)	3

Classification information:

Patient falls events include falls in hospital involving a fracture or other serious harm.

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Healthcare associated/acquired infections includes events where a patient acquires/gets an infection while receiving medical treatment at a health care facility.

Medication/IV fluids reporting includes events where an adverse outcome has occurred as a result of a medication prescribing, storage, or administration error.

Clinical process includes events that occur in or impact on the clinical environment.

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

1. HVDHB ID: 6074

Event Category: Hospital acquired infection **Deceased:** No **SAC Rating:** 2

Event Summary: Hospital acquired infection at Central Venous Catheter (CVL) site, leading to septic shock.

Key findings from review:

- The CVL (a tube into a major vessel) was being used to provide intravenous fluids and medications during the patient's admission. The CVL had been in place for seven days longer than the Hutt Valley DHB policy indicates.
- Documentation showed that the CVL was assessed almost every shift, however the documentation lacked evidence of recording what the insertion site looked like on a regular basis. The dressing was changed frequently, and only noted once that the dressing was having difficulty sticking.
- Medical team documentation was noted as inadequate and did not evidence that a medical review of the CVL's appropriateness had taken place.

Recommendations:

- CVLs should be removed within 14 days of placement (as per policy), random audits are to be undertaken to verify policy adherence.
- The need for a CVL should be reviewed every day by the patient's medical team, and the review recorded in the patient's notes.
- CVL site checks and the condition of the insertion site and dressing should be documented by nursing staff daily in the patient's notes.
- Patients who require prolonged intravenous access should have a Peripherally Inserted Central Catheter (PICC line – a tube inserted into a vein) placed as soon as practical, if clinically appropriate.

Recommendations progress: complete

- All actions in the recommendations have been completed.
- A weekly review of patients with CVLs and the patient's Central Line Associated Bloodstream Infections bundle documentation (the CLAB bundle is a care process to prevent infections) is now undertaken by the Infection, Prevention and Control (IPC) Nursing team; this supports potential issues to be raised in a timely manner and supports CVL policy adherence. Patient line types, insertion details and line days are now recorded in a central database. Ongoing review and education supporting the use of the bundle continues.
- A CLAB 'champion' role has been developed for each ward, the aim is to provide education and support staff in each area and ensure that the correct process is being followed.

2. HVDHB ID: 7435

Event Category: Clinical Process **Deceased:** No **SAC Rating:** 2

Event Summary: Patient noted to have developed a pressure injury whilst receiving community health services care.

Key findings from review:

- The assessment, documentation and interventions relating to the patient's decline in function did not meet expected standards of care.
- The relationship between the patient's diagnosis of progressive dementia and declining function failed to trigger a change in management plan that emphasised the need for pressure relief and a review of care by the patient's general practitioner.
- The transition of care between agencies failed to emphasise the risk or sense of urgency required to address potential pressure injury risk.
- The referral for pressure relief was delayed by the process in use at the time for managing referrals and resources in community occupational therapy.
- Despite a number of agencies being involved in the provision of care, there was no clear lead provider to ensure regular on-going assessment of health needs for the patient.

Recommendations:

- The knowledge deficit in the Community Health team with regard to assessment of risk of pressure injury is to be urgently addressed.
- Training is to be provided to all community health staff on the SKIIN bundle (SKIIN is a five step model for pressure injury prevention).
- Review of the process for referrals of occupational therapy equipment for pressure relief.
- Learnings from the review to be discussed with Primary Care sector, shared record keeping between key health care providers.

Recommendations progress: complete

- All of the recommendation actions have been completed.
- Training on the SKIIN bundle is ongoing.
- The internal process for referrals requesting occupational therapy equipment for pressure relief has been reviewed and modified.
- The lessons from this event have been shared with primary care.

3. HVDHB ID: 18713

Event Category: Clinical process **Deceased?** No **SAC Rating:** 2

Event Summary: Following delivery of baby, patient experienced large bleed which was immediately controlled and sutures inserted. Approximately 6 weeks later, patient presented with a retained swab, which was subsequently easily removed.

Key findings from review:

- The clinician involved did not recall using the small swab which was retained following the procedure.
- Probable cause is that the small swab was inadvertently inserted along with one of the larger swabs used to control the patient's bleeding. When the large swab was retrieved, the small one was left behind unnoticed.

Recommendations:

- The packs used for suturing post birth have been reviewed and replaced with a pack containing no small swabs, and the large swabs in the pack have a string and radiologically visible strip.
- A system for counting the swabs in and out has been introduced; used swabs are placed on a metal device while being counted out.
- Education for staff in the use of the new pack and swab counting system has been completed.

Recommendations progress: complete

- All actions from the recommendations have been completed.

4. HVDHB ID: 20379

Event Category: Clinical Process **Deceased:** No **SAC Rating:** 2

Event Summary: Client admitted to mental health inpatient unit, became physically unwell, collapsed and was admitted to medical ICU.

Key findings from review:

- Client admitted to ward - no physical examination of client in ED prior to admission.
- Limited monitoring of client's physical condition in the inpatient unit.
- Nurses on inpatient unit did not notify medical staff of need to review client medically.
- Clinical concerns were not clearly documented.
- Staff were not familiar with resuscitation protocols and some equipment expired on resuscitation trolley.

Recommendations:

- On-call Registrar / House Surgeon to be responsible for physical exam of patient on admission.
- Staff to attend refresher training for update on management of patient emergencies.
- Reminder to staff regarding professional responsibilities for medical management of patients' physical condition.
- Training for medical staff on accessing resources for information on effects of harmful substances.
- Resuscitation trolley to be regularly checked by staff.

Recommendations progress:

- Business case for an additional House Surgeon for mental health inpatient unit is under consideration.
- Nursing staff reminded of their professional responsibilities. All referrals for medical checks are now followed up by a phone call to the Medical Registrar.

- Senior nursing staff have engaged in refresher training for management of physically unwell patients.
- Resuscitation refresher training completed for the unit. All staff are up to date with required training. Medical Emergency simulation training is ongoing.
- Equipment on the resuscitation trolley has been updated, and a regular check has been implemented. Results of the check are regularly audited.

5. HVDHB ID: 22227

Event Category: Patient Fall **Deceased:** No **SAC Rating:** 2

Event Summary: Patient had a fall that resulted in a fractured neck of femur requiring surgical intervention.

Key findings from review:

- Patient was admitted with a known falls risk, a falls risk assessment and care plan had been completed in line with current guideline.
- The patient was identified as being medically complex, frail and confused. This increased the patients falls risk.
- Review of the clinical notes indicated a disparity between the degree of independence achieved in physiotherapy sessions, and that reflected in nursing staff notes. The patient's level of independence fluctuated when observed over a 24 hour period, reflecting the patient's fatigue levels.
- In the notes from the Occupational Therapists and Physiotherapists, it was not clear whether the patient had been specifically deemed safe to mobilise to the bathroom independently.
- The review noted that all falls prevention actions were undertaken as appropriate.

Recommendations:

- Discuss lessons learnt from the review at the Older Persons Rehabilitation Service Morbidity and Mortality meeting.
- Where practical, the same Physiotherapist should follow up a patient who has complex health needs, to keep consistency in observations and assessment of the patient's abilities.
- Continue with regular care planning actions for patients who are at risk of falls, following the Falls Prevention project guidelines.
- Continue with falls prevention strategies e.g.: checking the safety of the environment and use of appropriate equipment.

- Continue to ensure that falls risk assessments and management plans are documented in the care plan, continue to audit for compliance.
- Continue with falls prevention education for staff, including the Falls Committee "Releasing Time to Care – Falls Prevention" project through the Health Quality and Safety Commission.

Recommendations progress: complete

- All recommendation actions have been completed, or form part of the continuous falls prevention programme delivery.

6. HVDHB ID: 23308

Event Category: Patient Falls **Deceased:** No **SAC Rating:** 2

Event Summary: Patient had a fall that resulted in a fracture of the hip socket.

Key findings from review:

- The patient did not have an initial falls risk assessment on admission, although an assessment was indicated. The lack of an initial and ongoing falls risk assessment was noted to be a contributory factor in the patient's fall.
- The nursing plan lacked documentation of a falls risks reduction plan.
- The patient's physiotherapy mobilisation plan recommended two people to assist the patient with mobility; this instruction was not being followed at the time the fall occurred.
- The patients fall was noted as being preventable. Regular falls risk assessment, care planning and an intervention guide would have reduced the likelihood of the fall occurring.

Recommendations:

- Review of falls risk assessment and care planning compliance.
- Continue with falls prevention strategies e.g.: checking the safety of the environment, regular checks, use of appropriate equipment.
- Continue to ensure falls risk assessment and management plans are documented in the patient care plan.
- Continue staff falls prevention education including the Falls Committee's "Releasing Time to Care – Falls Prevention", a patient safety programme through the Health Quality and Safety Commission.

Recommendations progress:

- A regular auditing program to monitor falls assessment and care planning compliance; targeted education continues.
- The lessons learnt from the review have been presented at a team education session, to highlight falls care planning requirements and the importance of falls prevention strategies in reducing preventable harm to patients.
- The falls prevention programme continues.