

# Hutt Valley District Health Board

## Adverse Events Report: 1 July 2017 to 30 June 2018

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 processes in place for reporting, reviewing and learning from adverse events. The aim of the adverse event review process is to learn from such events to enhance patient safety and improve the quality and experience of patient care.

The National Adverse Events Reporting Policy 2017 requires every DHB to report adverse events that meet the policy's reporting criteria, to the Health Quality and Safety Commission. During the period 1 July 2017 to 30 June 2018 Hutt Valley DHB reported 15 adverse events that occurred in our hospital and health services. However, following review, one of these events was deemed not to meet the criteria for inclusion in the final report and has been withdrawn. One event is still under review at the time of this report.

For the purposes of this report, an adverse event is an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned (often referred to as 'incidents' or 'reportable events'). In practice this is most often understood as an event which results in harm to a consumer. The Severity Assessment Code 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. SAC1 or SAC2 events are required to be reported to the HQSC. The Always Report and Review list is a subset of adverse events that should be reported and managed in the same way as SAC 1 and 2 rated events, irrespective of whether or not there was harm to the consumer. Always Report and Review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. Reporting Always Report and Review events can highlight weaknesses in how an organisation manages fundamental safety processes.

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.

# Hutt Valley District Health Board

## Adverse Events Report: 1 July 2017 to 30 June 2018

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. 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-centred 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 Serious Adverse Events reported to the Health Quality and Safety Commission by Hutt Valley DHB for the period 1 July 2017 to 30 June 2018 is reported in the table below:

General classification of event	Number of reported adverse events
Patient falls	8
Medication/IV fluids	1
Clinical process (e.g. assessment, diagnosis, treatment, general care)	4

# Hutt Valley District Health Board

## Adverse Events Report: 1 July 2017 to 30 June 2018

Classification information:

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

**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 (assessment, diagnosis, treatment, general care).

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.



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**1. HVDHB ID: 30745**

**Event Category:** Patient fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to hip following a fall whilst in hospital care.

**Key findings from review:**

- All risk assessment and care plans were in place and regular checks were ongoing.
- All falls intervention strategies in place.
- Fall not preventable.

**Recommendations:**

- None – continue with falls prevention strategies.

**Recommendations progress:** ongoing, falls prevention bundle implementation part of 'business as usual.'



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**2. HVDHB ID: 44382**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to shoulder following a fall while in hospital care.

**Key findings from review:**

- Falls risk assessment and care plan in place.
- All falls prevention strategies in place.
- Fall unable to be prevented.

**Recommendations:**

- None – continue with falls prevention strategies.

**Recommendations progress:** ongoing, falls prevention bundle implementation part of 'business as usual.'



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**3. HVDHB ID: 27685**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to elbow following a fall while in hospital care.

**Key findings from review:**

- Frail patient with high risk of falling, all risk assessment and care plans in place and regular checks ongoing.
- All falls intervention strategies in place.
- Fall not preventable.

**Recommendations:**

- Continue with falls prevention strategies.

**Recommendations progress:** ongoing, falls prevention bundle implementation part of 'business as usual.'

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

4. HVDHB ID: 24822

**Event Category:** Clinical Process

**SAC Rating: 2**

**Event Summary:** Feeding Tube (Percutaneous Endoscopic Gastrostomy (PEG)) not inserted in correct position in stomach.

**Key findings from review:**

- Initial abdominal x-ray performed and clinicians were satisfied PEG correctly placed.
- Patient then displayed symptoms consistent with incorrect PEG insertion.
- Further scan subsequently showed tube incorrectly placed. This is a recognised but rare complication.

**Recommendations:**

- Case to be reviewed at departmental meeting.
- PEG Insertion Policy to be updated.

**Recommendations progress:** all recommendations completed.

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**5. HVDHB ID: 36190**

**Event Category:** Clinical Process

**SAC Rating:** SAC2

**Event Summary:** Surgical swab used to control bleeding left in situ following birth of child.

**Key findings from review:**

- Swab used to control bleeding in delivery suite was left in situ.
- Swabs not counted in and out in delivery suite, so swab not noticed when patient was transferred to operating theatre.
- Swab not removed as it should have been, patient presented for follow up and swab removed.

**Recommendations:**

- Creation of a departmental protocol for birth canal repairs and births where instruments have been used.
- Count in and out of swabs and needles before and after procedures in Delivery Suite.
- Clinician to document in writing if swabs are left in situ to compress bleeding when a patient is transferred to Operating Theatre.

**Recommendations progress:** all recommendations completed.



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**6. HVDHB ID: 33181**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient fell from wheelchair, sustained cut to leg that required surgical repair.

**Key findings from review:**

- Wheelchair had been left in cubicle without brakes applied.

**Recommendations:**

- Wheelchairs brakes to be applied when unattended.

**Recommendations progress:** complete, all staff ensure brakes always applied when wheelchairs left unattended. Spot checks undertaken.



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**7. HVDHB ID: 25215**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to hip following a fall while in hospital care.

**Key findings from review:**

- Patient on high/low bed that had not been lowered to the ground before staff member left the room.
- Patient slipped when getting out of bed.
- Falls prevention strategies in place.

**Recommendations:**

- Audit use of high/low beds to check if being used effectively with other falls prevention interventions.
- Consider supplying non-slip socks on admission.

**Recommendations progress:** All recommendations complete, non-slip socks purchased for use.



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**8. HVDHB ID: 27338**

**Event Category:** Clinical Process

**SAC Rating: 2**

**Event Summary:** Patient sustained hospital acquired pressure injury to both heels whilst in hospital care.

**Key findings from review:**

- Incorrect assessment of pressure injury risk.
- Incomplete documentation of care provided to prevent pressure injury.

**Recommendations:**

- All pressure injury events to be reviewed at the Pressure Injury group to identify areas for improvement and adherence to local policies and practices.
- Pressure Injury teaching package to be updated to align with best practice

**Recommendations progress:** All recommendations complete.

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

9. HVDHB ID: 27528

**Event Category:** Patient fall

**SAC Rating: 2**

**Event Summary:** patient sustained fracture to hip following a fall, while in hospital care.

**Key findings from review:**

- Patient did not receive appropriate level of observation given history of falls, cognitive state and increased frailty.
- Surveillance and assistance indicated in falls assessment plan not followed at time of event.
- Patient wearing socks at time of fall.

**Recommendations:**

- Review close care bay guidelines to ensure patients with dementia are included for close observation.
- Consider supplying non-slip socks on admission.

**Recommendations progress:** All recommendations completed and non-slip socks purchased for use.

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**10. HVDHB ID: 28468**

**Event Category:** Clinical Process

**SAC Rating:** SAC2

**Event Summary:** Patient required instrumental assistance for delivery, experienced allergic reaction (likely due to anaesthetic agent) following induction and C-section.

**Key findings from review:**

- Delay in commencing medication (Syntocinon) for induction – decision to delay appears to have been based on interpretation of baby’s heart rate (thought to be worse than it was) and poor pain control.
- Epidural management – No problems with the insertion or function of the epidural but a prolonged duration without an epidural top-up lead to a period of inadequate labour analgesia.
- Supervision of junior staff – Obstetrics & Gynaecology Senior Medical Officer (SMO) not consulted early in labour. Inappropriate support for junior doctor. No senior Registrar cover on site, no SMO on site to support and ensure actions were followed up. Review determined correct decisions made.
- Clinicians decision making process for use of instruments not clear (e.g. from forceps to Ventouse).
- Process for decision to move to theatre for Category 1 Caesarean Section not well communicated.
- After hours acute staffing in Operating Theatres – no second team on call.
- Patient suffered allergic reaction at time of anaesthetic induction.
- Lack of available ICU beds in the Wellington region at that time.

**Recommendations:**

- Hutt Valley DHB to adopt the guidelines for use of labour induction medication (Syntocinon) as used at Auckland DHB.
- The introduction of Patient Controlled Epidural Analgesia (PCEA) should be prioritised to ensure maternity patients are able to control their own rate of analgesia.

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

- At the time of decision to move to use of a second delivery instrument (e.g. from forceps to Ventouse), a Time Out should occur in order to allow assessment of risk factors and the appropriate place to continue.
- The communications flow from Delivery Suite staff to Operating Theatre staff to be reviewed. Parameters to be established as to when a decision to continue with a Category 1 C-Section should be reviewed. This should include establishing an Obstetric Time Out.

### Recommendations progress:

- Guidelines for use of syntocinon in place. **Complete.**
- All core midwives have completed training and PCEA is in use. **Complete.**
- Time Out measure is in place as part of Midwifery/Theatre team process. **Complete.**
- Associate Charge Midwifery Manager roles now established, communication between Operating Theatre and Delivery Suite part of the role. Theatre Midwifery Team established to ensure core midwives attend assisted births in OT and take part in Time Out. **Complete.**

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**11. HVDHB ID: 36457**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to hip following a fall whilst in hospital care.

**Key findings from review:**

- All risk assessment and care plans were in place and regular checks were ongoing.
- All falls intervention strategies in place.
- New model of high/low bed not able to be lowered to ground.

**Recommendations:**

- Bed supplier to replace new model high/low bed with older model.
- Continue with falls prevention bundle implementation.

**Recommendations progress:** Complete

- Supplier has encoded previous High/Low bed model in to their electronic ordering module for all high/low bed supply.
- Falls prevention bundle implementation ongoing.



# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**12. HVDHB ID: 43944**

**Event Category:** Patient Fall

**SAC Rating: 2**

**Event Summary:** Patient sustained fracture to hip following a fall whilst in hospital care.

**Key findings from review:**

- Frail patient with high risk of falling, all risk assessment and care plans in place and regular checks ongoing.
- All falls intervention strategies were in place.
- Fall unable to be prevented.

**Recommendations:**

- None – continue with falls prevention strategies.

**Recommendations progress:** ongoing, falls prevention bundle implementation part of 'business as usual.'

# Hutt Valley District Health Board

## Adverse Events Report: 2017 – 2018

**13. HVDHB ID: 40790**

**Event Category:** Medication

**SAC Rating: 2**

**Event Summary:** Medication error in discharge summary – medication (clopidogrel) not listed in discharge summary, medication therefore not prescribed. Patient subsequently readmitted with a stroke.

**Key findings from review:**

- Discharge medication list summary not cross checked prior to discharge.
- Lack of contingency planning for when junior medical staff go on unexpected leave that can impact on staffing levels and safety processes such as cross checking medications.
- No direct correlation evident between omitted medication and subsequent presentation of patient.

**Recommendations:**

- Discharge summary to be cross checked against current drug chart as standard practice.
- Consider improved processes for junior medical staff cover for periods of staff unavailability.

**Recommendations progress:**

- Chief Medical Officer presented case (anonymised) at Clinical Grand Round for organisational awareness of the potential issues and highlighted the need for cross checking, as the lessons identified from this case are applicable across the organisation.
- Improved process for junior medical staff cover progressing.