February 2012

Health Quality & Safety Commission New Zealand

Kupu Taurangi Hauora o Aotearoa

Making Our Hospitals Safer

Serious and Sentinel Events reported by District Health Boards in 2010/11

This report was prepared by the Health Quality & Safety Commission based on data and information provided by district health boards (DHBs).

Thanks go to those in DHBs who have contributed to the development of this report.

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Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Foreword

Professor Alan Merry

In 2010 the Health Quality & Safety Commission (the Commission) took over responsibility for collating information about, and reporting on, serious and sentinel events. This is the Commission's second report, and the fifth time district health boards (DHBs) have publicly reported details of these events. It is pleasing to note some DHBs are now reporting events regularly in open session to their Boards. In these DHBs, this reporting has become business as usual, and I applaud their transparency.

Each year, over 2.7 million people are treated in our public hospitals[1] and, as a proportion, few suffer serious harm. However, that does not change the fact that 377 serious or sentinel events took place in our public hospitals in 2010/11 – a rate of more than one for every day of the year.

As a consequence of these incidents, some people died and many suffered serious injury or disability. They were let down by the system that exists to protect them. We should view these incidents through the eyes of our patients and their families: in short, many of the incidents described in this report should never have happened.

To that end, the Commission is supporting important programmes in relation to medication safety, prevention of falls, reduction of health care associated infections, and the fully engaged use of the World Health Organization's Safe Surgery Checklist.

The Commission has an important role to play in guiding and supporting health and disability providers in the challenging area of responding to serious and sentinel events. Without reliable data, strategies cannot be designed to improve the safety of patients in our hospitals. Accordingly, we are engaging with providers to improve consistency in the reporting of these events. More work is needed to ensure every serious and sentinel event is locally analysed, the lessons learned are implemented, and the key information is sent to the Commission for collation at a national level.

All that we do as health and disability professionals should be patient-focussed, and nothing is more important than ensuring the safety of the people in our care.

When events are presented in an anonymised list, it is all too easy to lose sight of the genuine suffering that has taken place, but each event has a name, a face, and a family. I offer my condolences to all those affected by the events described in this report. More importantly, I would like to assure those affected of our commitment to doing everything possible to prevent future patients from being harmed by the same mistakes. All that we do as health and disability professionals should be patient-focussed, and nothing is more important than ensuring the safety of the people in our care.

The Commission's role is to improve quality and safety in New Zealand's health and disability sectors, and a key aspect of that is to reduce harm from preventable errors. While some adverse events are outside our control and will always occur, there are many other preventable incidents which we should aim to erase completely.

Our objective is to improve patient safety, and we expect the chief executive officer of every DHB to sign off the recommendations arising from the review of each of these serious or sentinel events.

During 2012, a new national reportable events policy will be released. This policy will make explicit our expectations of providers to develop consistent processes of reporting, analysing and responding to serious and sentinel events in ways that genuinely advance the cause of reducing harm from preventable incidents. The Commission will work more closely with providers to this end. We are in this together, and we are not yet doing well enough.

Previous reports have included cases where a patient of mental health services has committed suicide within seven days of contact with the service. These cases have

1 Workload in public hospitals during 2010/11: Day patients: 407,000; inpatients: 634,000; outpatients: 1,744,000 (Source, Ministry of Health).

caused us particular concern. Following consultation with senior mental health professionals and consumer representatives, we have concluded these events are different in nature from, for example, a wrong-sided operation or a fall.

I share the view of experienced professionals that this report, concentrating as it does on cases which have identifiable and clearly preventable root causes, is the wrong vehicle to report cases of suicide. As a Commission, over the next year we will be working with the mental health sector and other bodies involved in reporting on suicide to develop a more appropriate report which reflects the complexity of these deaths. The Commission believes separating these events from the very dissimilar ones reported here, and bringing together appropriately qualified professionals to consider them in the wider context of New Zealand's overall mental health strategy, offers a better way to make progress than simply listing suicides in this report, as has been the case in previous years.

I believe DHBs have much to learn from each other, and the national collation of serious and sentinel events is part of promoting that interaction. Many regional ties exist between DHBs in relation to service delivery, and the Commission will be assisting with extending these ties to include regional collaboration on issues relevant to quality and safety.

Last year I emphasised that the onus is on every one of us who serves New Zealand's patients to redouble our efforts to ensure safe and effective patient care. I indicated that reading these reports is obviously part of that responsibility. To ensure everyone knew about the report we widely distributed a short summary with the key messages with links to the main report.

This year we will do the same, but in addition we are working with professional bodies to promote to members the key findings and messages of the report. There is no doubt in my mind that reading these moving stories motivates people to be even more determined to reduce avoidable patient harm in 2012.

I have every confidence in the New Zealand health and disability sector's ability to rise to the challenge of reducing harm to patients. The point of reporting on these events is to learn from them, and to take actions that will make our health services progressively safer. Obviously this is not easy, otherwise these events would already have been eliminated.

Professor Alan Merry, ONZM
Chair
Health Quality & Safety Commission

Each year, over 2.7 million people are treated in our public hospitals and, as a proportion, few suffer serious harm. However, that does not change the fact that 377 serious or sentinel events took place in our public hospitals in 2010/11 – a rate of more than one for every day of the year.

CONTENTS

Foreword i
Executive Summary v
Background 1
Role of the Commission 2
Introduction 3
- Understanding the report 3

Serious and sentinel events 2010/11 5
- Number of events 5
- Types of events 5
- Proportion of events by serious and sentinel description 6
- Main event categories 6
- Outpatient suicides 12

The Future 13
- National reportable events policy 13
- Consumer engagement 13
- Working with providers 15
- Central repository 15
- Partnership with providers and other agencies 15
- Education and training 15

Improving Quality and Safety – Examples from DHBs 16
Appendix 1: Definitions 23
Appendix 2: DHB Population Numbers 24

Other than the rate of falls, there have been no other significant changes in the pattern of serious and sentinel event reporting.

Executive Summary

This is the fifth release of serious and sentinel events information provided by DHBs, and covers events that occurred between 1 July 2010 and 30 June 2011. The total number of serious and sentinel events has risen in 2010/11 to 377, and this is mainly due to an increased number of falls being reported.

Even allowing for fluctuation in numbers according to the size of the population served and the provision of complex services, there is variation in DHBs' reporting of serious and sentinel events. This is shown in particular by the variation in falls reported during 2010/11.

Other than the rate of falls, there have been no other significant changes in the pattern of serious and sentinel event reporting.

The Commission is focussed on a number of projects to reduce preventable harm, including support for programmes to prevent falls, improve medication safety, reduce health care associated infections and implement the World Health Organization's Safe Surgery Checklist. These areas comprise a significant proportion of serious and sentinel events. The introduction of a national medication chart is underway, and it is expected all DHBs will be using the chart in most inpatient areas by the end of 2011/12. There is also a strong focus on medicine reconciliation and electronic medicines management.

Other work underway or planned includes:

- increased engagement with DHBs to develop consistent reporting and strategies to reduce harm
- a new national reportable events policy
- engagement with the wider health and disability sector, such as aged residential care, community care, primary care, private hospitals and disability services
- publication of case studies to share the lessons learnt from specific incident reviews
- development of education and training to support serious incident review and open disclosure.

Summary of events

- For the 2010/11 fiscal year, DHBs reported that 377 people treated in their hospitals were involved in a serious or sentinel event that was actually or potentially preventable. This compares with 318* people in the 2009/10 year.
- Of this total, 86 people died during admission or shortly afterwards, though not necessarily as a result of the event.
- Falls accounted for 52 percent of all serious and sentinel events reported in 2010/11 (195 incidents), a figure that has steadily increased each year from 2007/08. This increase in reporting of falls has driven the overall increase in serious and sentinel events reported, with no other category of event showing a similar increase.
- Clinical management events (eg, errors of diagnosis and treatment) accounted for 29 percent (108 incidents).
- Medication events (eg, giving a patient the wrong medicine, or an incorrect dosage) is the third largest category at 7 percent (25 incidents).

* Excluding outpatient suicides.

If the Commission is to increase patient safety in health and disability services, the publishing of serious and sentinel events data needs to become more than a recitation of numbers.

Background

The annual report on serious and sentinel events has progressed since it was first released by the Quality Improvement Committee in 2008, in line with the progress made by DHBs. In particular, DHBs have developed local systems for reporting and learning from incidents, and the concept of involving the patients and their families in any subsequent incident review is now well-recognised.

2006/07

In February 2008, the first report on serious and sentinel events was produced, covering the period 2006/07. The catalyst for this report was a series of Official Information Act requests asking for details of serious adverse events that had occurred in public hospitals.

The Quality Improvement Committee, as the ministerial-appointed committee responsible for overseeing quality improvement activities in the health sector at that time, decided to lead the response by collecting serious and sentinel events information from all DHBs. These events were released in a single report to provide consistency to the publication of such sensitive information.

In 2006/07, 182 serious and sentinel events which had occurred in public hospitals were reported by DHBs to the Quality Improvement Committee. The subsequent report set out these events, and made comparisons with other studies of serious and sentinel events.

2007/08

The following year, the Quality Improvement Committee was again responsible for releasing the report on events that had occurred in DHBs, and the report included wider commentary on the actions being taken to reduce the incidence of harmful events, including case studies.

In total, DHBs reported 258 serious and sentinel events, with falls accounting for 22 percent of the total (56 incidents).

In the report, the Chair of the Quality Improvement Committee outlined the five main programmes aimed at increasing patient safety: management of health care incidents; optimising the patient's journey; infection prevention and control; national mortality review systems; and safe medication management.

2008/09

In the next report, covering the 2008/09 period, falls were again identified as a significant issue, with 28 percent of the total 308 serious and sentinel events being in this category (85 incidents).

2009/10

The report for the period 2009/10 was released in November 2010 by the Health Quality & Safety Commission (the Commission), which had been established in the same month. A significant part of the report concentrated on 'learning from reporting', citing a number of examples from DHBs of what had been done to improve safety for patients.

A total of 318* serious and sentinel events were reported as having occurred, with falls representing 35 percent of the total (130 incidents).

The report emphasised actions being taken to reduce falls, extending the use of the World Health Organization's Safe Surgery Checklist, and in reducing medication errors, which in 2009/10 accounted for 5 percent of events (17 incidents).

* Excluding outpatient suicides.

Role of the Commission

Publishing serious and sentinel events data is a responsibility the Commission has inherited from the Quality Improvement Committee. If the Commission is to increase patient safety in health and disability services, this activity needs to become more than a recitation of numbers. The events described in this report are incidents which did, or could have, resulted in significant harm to a patient in hospital. These are the incidents all health care professionals agree should not happen, and the Commission's role is to help prevent them from recurring.

Since central reporting of serious and sentinel events began, there has been a gradual change from reporting the overall frequency of incidents (2006/07), to a more detailed breakdown of incident types (2007/08 and 2008/09), to a wider commentary of what is being done by DHBs to prevent the incidents (2009/10).

The Commission is working with health and disability care providers to identify, understand and rectify systemic issues that affect patients adversely, and develop a learning culture within health and disability settings.

By developing partnerships with DHBs and other providers, the Commission can ensure that consistent and accurate data is produced, with the ultimate goal of working with providers to implement strategies that reduce patient harm. The wider health and disability sector has already expressed interest in adopting the national reportable events policy,[2] and the Commission has already started to build relationships with disability support networks, and primary and home care providers. Ultimately, the Commission expects all health and disability providers to comply with the national policy, particularly in relation to the reviewing and reporting of serious adverse events.

2 The national reportable events policy sets out key principles in relation to the review of reportable events, and the reporting of serious and sentinel events to the Commission.

Introduction

All DHBs have formal systems to identify and review adverse events involving patients, visitors and staff. This report concentrates only on events involving patients DHBs have identified as having the most severe outcomes: those that have been identified as serious or sentinel adverse events.

A **serious adverse event** is one that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function.

A **sentinel adverse event** is life threatening or has led to an unexpected death or major loss of function. A list of definitions used in this report can be found in Appendix 1.

This year, the data are dominated by two categories of serious and sentinel events: falls and clinical management incidents.

Aside from falls, several recurring themes arise within the findings of events reported by DHBs:

- delays in responding to a patient's changing or deteriorating condition
- medication errors, including incorrect doses, and administration of drugs to which a patient was known to be allergic
- poor communication between health professionals resulting in harm to a patient
- delayed diagnoses due to failings in referral processes and the reporting of investigation results.

Understanding the report

The following context is crucial to understanding and interpreting the data in this report.

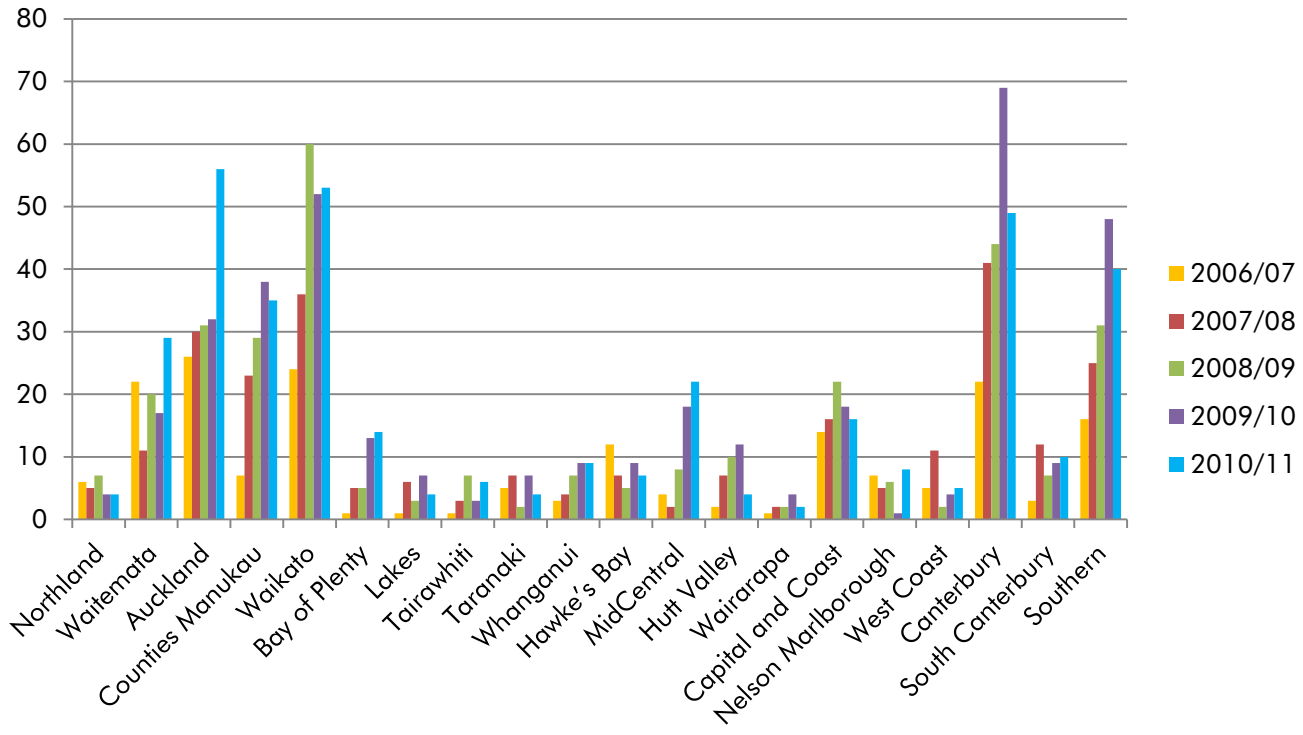
- Over 2.7 million inpatients, day patients and outpatients were cared for in New Zealand during 20010/11,[3] the great majority without incident.
- The data on serious and sentinel events should be read in the context of the population each DHB is responsible for. These figures are set out in Appendix 2.
- DHBs voluntarily report on these adverse incidents. DHBs reporting the most events in the greatest detail may have better local systems for reporting and investigating events, and perhaps a superior safety culture. A low rate of events reported by a DHB may indicate under-reporting and under-investigation of matters that go wrong; conversely, it may reflect the outcome of a very successful risk management programme – or a combination of both.
- International literature does not support the use of the number or rate of reported events as a way of judging a hospital's safety, as there is considerable variation in the rates of reporting, not just in the rate of events.
- The report does not capture all adverse events that occurred in New Zealand public hospitals, only those events considered by each DHB as serious or sentinel events. All DHBs are required to have processes in place to ensure all adverse events, of all levels of seriousness, are reviewed.
- In previous serious and sentinel events reports, cases where a person has committed suicide within seven days of contact with a mental health service have been included. This report has excluded these cases, but has included suicide of inpatients.

3 Workload in public hospitals during 2010/11: Day patients: 407,000; inpatients: 634,000; outpatients: 1,744,000 (Source, Ministry of Health).

Falls accounted for 52 percent of all serious and sentinel events reported in 2010/11, clinical management events 29 percent and medication events 7 percent.

Serious and sentinel events 2010/11

Figure 1: Serious or sentinel events, by DHB, 2006/07 to 2010/11[4]



Number of events

The number of serious and sentinel events reported each year has increased, more than doubling in the five years from 2006/07 to 2010/11.

Figure 1 shows each DHB's serious and sentinel events from the past five years of reporting. It should be noted that the 2010/11 data in this report does not include outpatient suicides, which are included in previous years' totals.

Table 1: Serious or sentinel events, by DHB, 2010/11

	2010/11
Northland	4
Waitemata	29
Auckland	56
Counties Manukau	35
Waikato	53
Bay of Plenty	14
Lakes	4
Tairawhiti	6
Taranaki	4
Whanganui	9
Hawke's Bay	7
MidCentral	22
Hutt Valley	4
Wairarapa	2
Capital and Coast	16
Nelson Marlborough	8
West Coast	5
Canterbury	49
South Canterbury	10
Southern	40

4 Southern DHB columns combine data for Otago and Southland DHBs.

Types of events

Table 2 summarises the types of serious and sentinel events reported, noting that the data in 2006/07 was not separated into individual categories, so is not included in this table.

Falls accounted for 52 percent of all serious and sentinel events reported in 2010/11 (195 incidents), a figure that has steadily increased each year from 2007/08 (22 percent, 56 incidents), 2008/09 (28 percent, 85 incidents), to 2009/10 (35 percent, 130 incidents). This increase in reporting of falls has driven the overall increase in serious and sentinel events reported, with no other category of event showing a similar increase. The second largest category, that of clinical management events, has not changed significantly over the past three years.

Table 2: Summary of event types reported by DHBs[5]

	2007/08	2008/09	2009/10	2010/11
Wrong patient, site or procedure	19	11	5	11
Retained instruments or swabs	6	4	9	7
Clinical management events[6]	107	123	126	108
Medication event	21	15	17	25
Falls	56	85	130	195
Missing/absent without leave patient	8	2	3	4
Physical assault on patient	1	2	1	3
Delays in transfer	3	2	0	2
Hospital-acquired infection[7]			8	2
Inpatient suicide	16	8	4	5
Other[8]	21	27	15	15
Total	242	279	318	377

Proportion of events by serious and sentinel description

Sentinel events can be generally described as having a more serious outcome for the patient – either death or a severe injury or disability resulting from the incident. It is noted that, while the number of events reported has increased in the last four years, the proportion classified as sentinel events has decreased. In 2009/10, 33 percent of events (78 incidents) were classified as sentinel; in 2010/11, 19 percent were classified as sentinel (60 incidents).

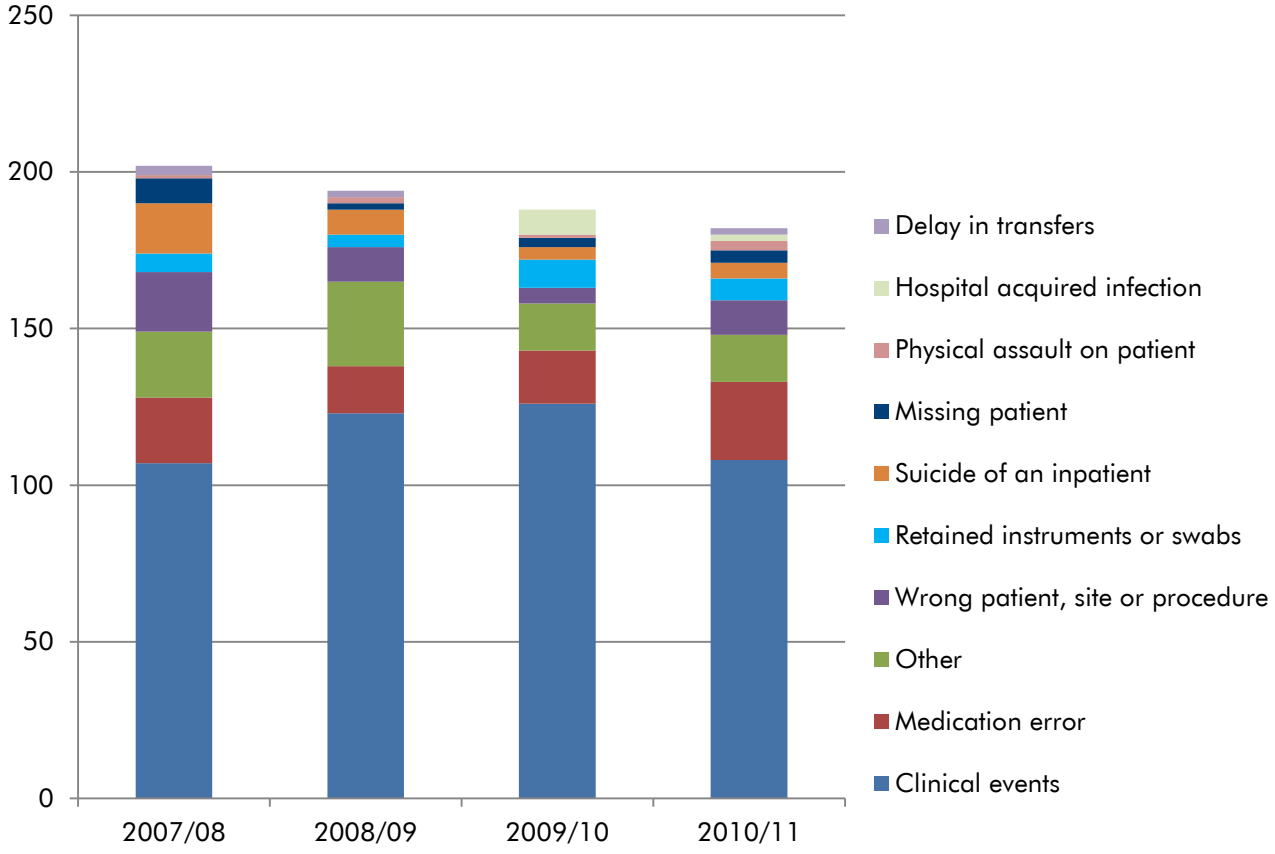
Main event categories

Once falls have been excluded from the overall figures, the total number of serious and sentinel events reported has shown a gradual decrease from year-to-year.

Clinical management events (eg, errors of diagnosis and treatment) are, after falls, the next largest category of incidents, at 29 percent of total serious and sentinel events (108 incidents). Medication events (eg, giving a patient the wrong medicine, or an incorrect dosage) is the next largest category at 7 percent (25 incidents).

5 Excluding outpatient suicides.
6 For example, delays in diagnosis or treatment; failings in patient monitoring or general care; and adverse events that occurred during, or as a result of, a procedure or operation.
7 Data on hospital-acquired infections was not specifically collected prior to 2009/10.
8 Diverse incidents which include patient self harm, failings in hospital laboratory system, and events under review where the full facts are still unknown.

Figure 2: Main event categories (minus falls) 2007/08 to 2010/11

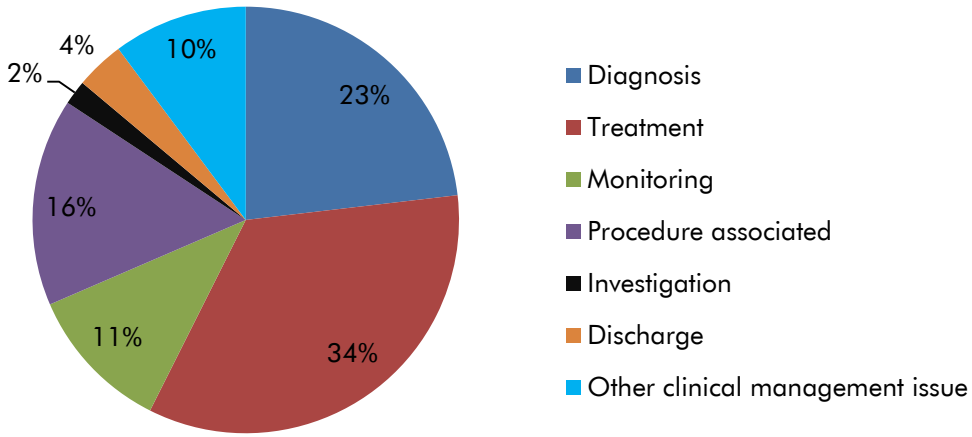


CLINICAL MANAGEMENT EVENTS

Clinical management incidents make up the second largest category of reported serious and sentinel events, at 29 percent (108 incidents).

While the number of such events has fallen since 2009/10, there has been no clear trend shown over the past four years.

Figure 3: Clinical management events 2010/11

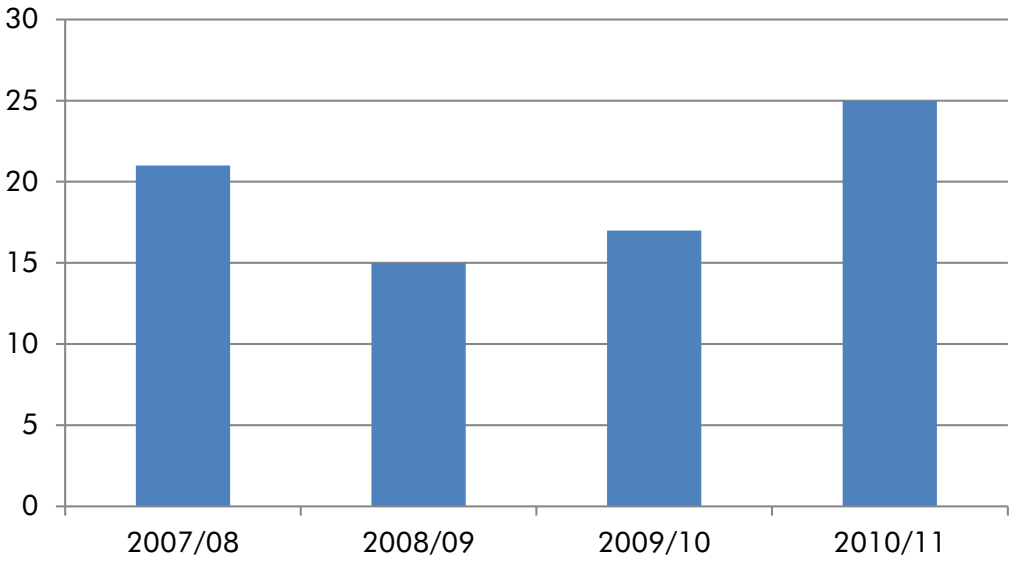


MEDICATION EVENTS

The third largest category is medication events, at 7 percent. While the overall numbers are relatively small compared with falls or clinical management events, they have increased over the past three years.

Figure 4 shows that the number of serious and sentinel events related to medication incidents has increased in 2010/11. While some of these incidents may have a complex origin, the majority are common to most serious and sentinel events – a basic error that has had an adverse consequence. For example, the misreading of a medication chart so a ten-times dose was administered, or administering drugs to a patient with a known allergy to that drug.

Figure 4: Medication events 2007/08 to 2010/11



Medication Safety Programme

The Medication Safety Programme is one of the Commission's key work areas. The focus for the Commission to date has been the introduction of two paper-based projects – the national medication chart and medicine reconciliation, concentrating initially on the DHB hospital environment.

These tools will be extended into the broader health and disability sector as the programme develops, with engagement already underway with the aged-care sector. The Commission is also partnering with the National Health Board and the National Health IT Board, to implement clinically-led electronic medicines management, building on the foundations of the paper-based initiatives. Brief descriptions of the key programme components are set out below.

National medication chart

The national medication chart is intended for use for inpatients throughout New Zealand, so every person involved in managing medicines (eg, prescribing, dispensing/supply, administration and review of medicines) will use the same documents.

The expected benefits include better documentation of prescribing and medicines administration, fewer adverse events, and less patient harm resulting from clinicians' unfamiliarity and individual hospitals' unique practices/systems. Having one common chart will also simplify the education and training of all health professionals.

To date, 15 DHBs have begun implementation of the national medication chart.

Medicine reconciliation

The medicine reconciliation process checks what, if any, changes are made to an individual's medicines so that, at each point where there is transfer of care, an up-to-date list of a patient's medicines is available and transfers with that patient. The aim is to have medicines reconciled for all patients on admission, transfer to another ward or hospital, or discharge home.

To date, 19 DHBs have implemented medicine reconciliation.

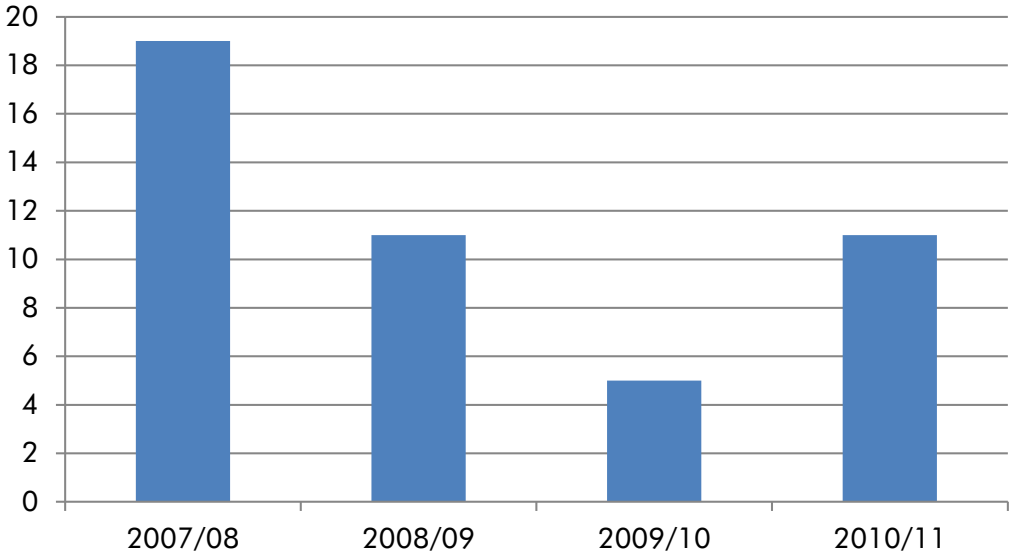
Electronic medicines management

A focus of this programme is the introduction of electronic medicine reconciliation and electronic prescribing and administration to all public hospitals by 2014. Considerable progress has been made during the first stage of the programme, with four lead DHBs participating in the pilot.

WRONG PATIENT, SITE OR PROCEDURE

The United Kingdom's National Health Service, through the National Patient Safety Agency, has listed a number of events which are described as 'never' events; these involve serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.[9] The first such type of event on the list is 'wrong site surgery'. In 2010/11, DHBs reported 11 events of this type as either a serious or sentinel event.[10]

Figure 5: Wrong patient, site or procedure 2007/08 to 20010/11



Safe Surgery Checklist

One of the key programmes being supported by the Commission is the Safe Surgery Checklist, which specifically targets the category of events related to incorrect surgery being performed – surgery on the wrong patient, the wrong site, or the wrong type of operation.

The checklist has been used in New Zealand since early 2009 with varying application. Previous implementation of the checklist has been through a public awareness campaign and by endorsement of the professional Colleges.

The Commission is working with the sector to ensure the checklist is used in an engaged fashion for every surgical procedure, with the aim of eliminating wrong site and wrong patient events, and of improving outcomes through promoting better communication and teamwork in the operating room.

Three major international studies have confirmed the substantial improvements in patient outcome that can be achieved through this approach.[11] It is not enough to simply go through the motions – this is about adopting methods tried and proven in other industries (notably aviation) that require new and innovative approaches to implementing the checklist.

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124552

10 ACC advised that, in 2010/11, there were five accepted claims from DHB treatment for 'wrong, unnecessary and wrong site surgery' (2007/08: 10 accepted claims; 2008/09: 8; 2009/10: 6).

11 Neily J, Mills PD et al. 2010. Association between implementation of a medication team training program and surgical mortality. *JAMA* 304(15):1693–1700 (doi:10.1001/jama.2010.1506).
De Vries EN, Prins HA et al. 2010. Effect of a comprehensive surgical safety system on patient outcomes. *N Engl J Med* 363:1928–37.
Birkmeyer J. 2010. Strategies for improving surgical quality – checklists and beyond. *N Engl J Med* 363(20):1963-5.

FALLS

DHBs reported 195 falls in the 2010/11 year that were classified as a serious or sentinel event. This figure represents 52 percent of the total number of serious and sentinel events reported. The number of falls reported as serious and sentinel events has increased by approximately 50 percent every year since 2007/08. (See Figures 6 and 7.)

There are two issues to consider in the category of falls:

1. a possible variation in reporting by DHBs
2. the increase in reported numbers over the past four years.

Figure 6: Falls, 2007/08 to 2010/11[12]

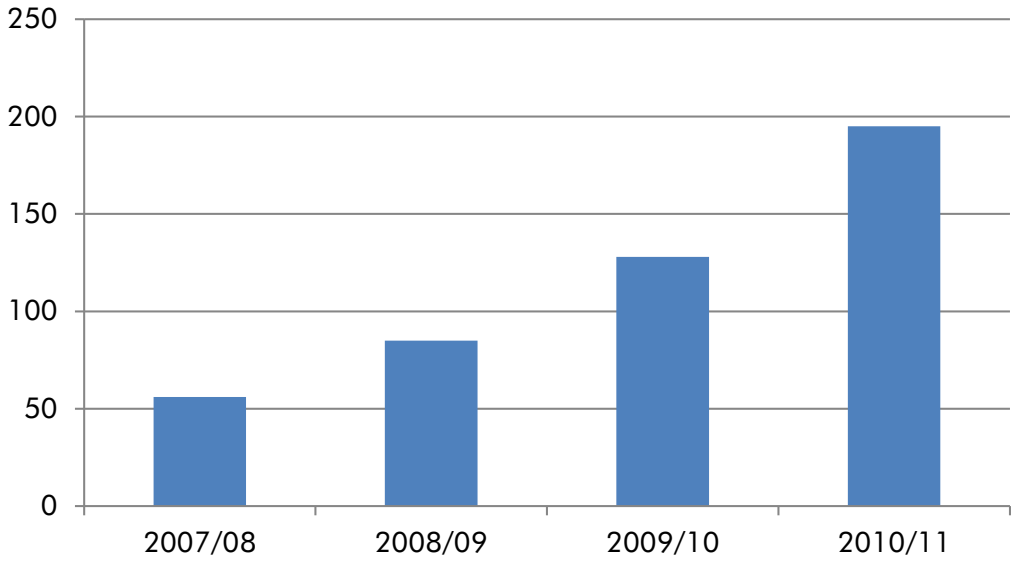
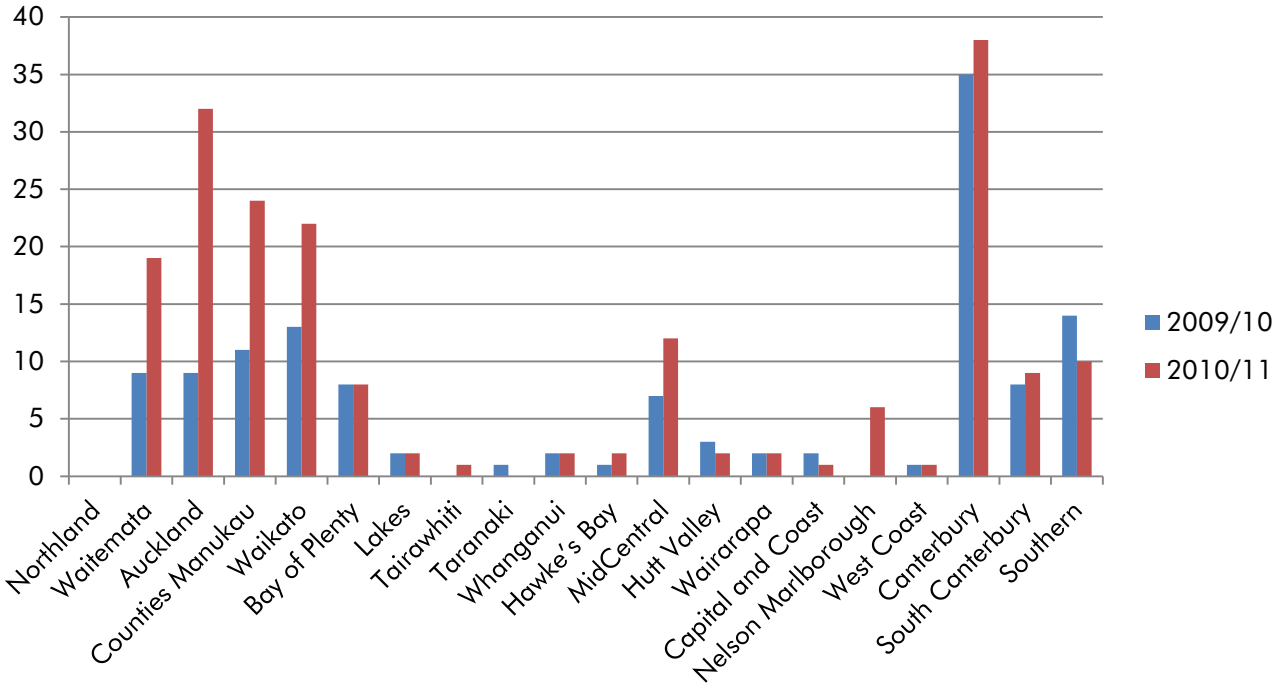


Figure 7: Falls reported as serious and sentinel events 2009/10 and 2010/11[13,14]



12 Falls not separately collected in 2006/07, and data not available to separate serious and sentinel events in 2007/08 and 2008/09.
13 Auckland DHB changed the criteria for reporting falls during 2010/11, which increased the number reported from previous years.
14 Data for Otago and Southern DHBs combined.

Variation

As can be seen from Figure 7, there is significant variation in how many falls have been reported by DHBs as serious and sentinel events. While it is possible that 10 DHBs have had fewer than three serious patient falls, it is also possible that many falls are not being reported as serious or sentinel events.

This variation in reporting includes DHBs:

- automatically classifying a fall as a serious or sentinel event if a patient falls and suffers a significant injury such as a fracture or a significant flesh wound
- not classifying a fall as a serious or sentinel event if a patient suffers a fracture and does not require surgery – for example, needing a cast or sling rather than an operation
- concluding upon review that, if a fall is not preventable, the event was not reported as a serious or sentinel event, irrespective of the injury resulting
- reporting all falls resulting in a significant injury as serious or sentinel, with the view that there is no such thing as an unpreventable fall.

In the case of some DHBs, the definition of a fall that causes harm (and is thus reported as a serious and sentinel event) is wide. This would include cases when patients, having fallen and struck their head, have X-rays taken (CT or MRI scan) because, to quote one DHB, the patient had sufferd a severe enough head injury to raise concerns about a brain haemorrhage.

To be sure of collecting information about all harmful falls, one DHB cross-references incident forms with ACC forms to ensure no incidents are missed. Even with this detailed approach to capturing data, this particular DHB has reported one of the lowest rates of falls.

Increase in reported falls

In previous reports, the year-to-year increase in falls has been put down to improved reporting. However, while the data on falls may not be complete or accurate, it is possible that falls with serious consequences for the patient may be increasing in frequency.

Possible causes could be more elderly patients being admitted, with increasingly complex illnesses, and increased workload on staff. Another factor could be the change in design of hospital wards to smaller bays and single or double rooms which, while improving privacy for patients, may result in the patients being less visible to nursing staff, thus at greater risk of falling.

A coordinated approach

In some ways it is perhaps unsurprising that DHBs have developed differing thresholds for reporting serious and sentinel events as, until now, there has been little feedback to DHBs on this issue.

While DHBs all have falls reduction programmes in place, the Commission recognises the need for a coordinated approach to reducing harm from falls. We have therefore supported a scoping study by DHBs to identify key stakeholders to be involved in a programme to reduce the number of falls, and harm from falls. The study will make recommendations to develop ways in which falls can be reduced.

Outpatient suicides

This year, unlike in previous years, cases involving the suicide of mental health clients within seven days of contact with a DHB mental health service (outpatients) have not been included in the serious and sentinel events report. This is because these incidents are quite different from the others reported.

The emphasis of this report has always been on incidents which have an identifiable cause and are, to some extent, preventable. For example, cases which involve wrong site surgery, medication administration errors, or lost referrals for further treatment. Conversely, identifying what might have prevented a patient in the community from taking his or her own life is extremely complex.

The Commission consulted senior mental health professionals, who advised:

- except in occasional instances of inpatient suicide, these cases of suicide cannot and should not be categorised as similar to the other events in this report
- root cause analysis is seldom the best approach to identifying ways of reducing suicide
- an alternative method of evaluating and reporting suicide should be developed.

The aim is to reduce harm and improve outcomes for patients, and close liaison will be needed with the agencies already engaged in reducing New Zealand's internationally high overall rate of suicide.

Thought will also have to be given to cases involving people who perhaps should have been seen by appropriate practitioners but weren't (these cases have never been included in serious and sentinel events reports).

The Commission will be working with mental health professionals (with consumer input) and other bodies such as the Coronial Office, the Director of Mental Health, the Health and Disability Commissioner and the Mental Health Commissioner to develop methods of evaluating and reporting which reflect the specific needs of people at risk of suicide.

The suicide of inpatients will continue to be included in this report.

The Future

There is still much work to be done in reducing harm from preventable adverse incidents.

This section of the report looks at some of the Commission's initiatives to improve safety. The Commission's role is to motivate, guide and support health and disability providers as they undertake quality improvement activities. Until now, we have mostly worked with DHBs, but this focus will be expanded to include other parts of the sector, including providers of disability services and community and aged care residential services.

Providers need to deliver services that are, first and foremost, safe. This can be challenging, because there are always competing demands on limited resources, and these resources vary – some DHBs are a tenth the size of others and many private providers much smaller again.

The Commission believes DHBs need to increase their collaboration, and develop more regional networks focussed on quality and safety. In this way, DHBs can learn from each other and maximise the value obtained from their combined resources. Wairarapa DHB, for example, one of the smallest DHBs in the country, has developed a system to integrate key staff into its own quality network, and this would work well in any DHB.

National reportable events policy

Since September 2008, the New Zealand health and disability sector has been guided by a draft national reportable events policy produced as part of the former National Quality Improvement Programme's role to introduce a national incident management system. During 2011, this draft policy has been revised and a final version developed. The health and disability sector has been consulted about the changes that have gone into the policy.

The new policy makes explicit the requirement for providers to have a process for managing reportable events. It provides clearer guidance on how this should be done. In particular, it emphasises the responsibility of the CEOs (or equivalent) of organisations to sign off the recommendations arising from root cause analyses. Another change is that the new policy requires providers to submit details of the outcomes of reviews into events.

The new policy ties the responsibility for responding to adverse events firmly to the people who are best placed to make decisions and allocate resources to ensure these analyses result in effective actions to actually change the system and make it safer. The policy is applicable to all providers – from large DHBs to small private hospitals, and will be available on the Commission's website.

Consumer engagement

Our health and disability services exist for the patients and consumers they serve. They must be patient- and consumer-focussed. No one is better placed to understand the experience of a service than the person receiving it. There is a huge opportunity to improve both the quality and the safety of our services through increasing the health literacy of New Zealanders and through greater emphasis on partnership and the role of patients and consumers in determining and contributing to the monitoring of their own care.

The Commission works towards the New Zealand Triple Aim for quality improvement:

- improved quality, safety and experience of care
- improved health and equity for all populations
- best value for public health system resources.

It therefore places the patient's experience as paramount in its objectives, and we are committed to ensuring all aspects of our work are consumer focused.

One of our major initiatives in the coming year seeks to increase consumer literacy – with an emphasis on the importance of choice – to ensure patients get the procedures they really need, and the Commission will be working with health professionals and patients to this end.

Many of the incidents described in this report have at their core a simple error, and in some cases this error could have been identified and addressed if the consumer partnerships had been stronger.

For example, failings in referral systems and when incorrect procedures are carried out, could perhaps have been identified early enough to avoid harm if the consumers concerned had been better placed to ask what was happening and why.

Engagement of patients in the pre-anaesthetic phase of the World Health Organization's Safe Surgery Checklist could identify that the wrong person was about to be operated on, or that the operation was not the one the patient was expecting. It could also provide an additional opportunity to alert all concerned to important allergies and medical conditions.

Similarly, patients would be more likely to take the right medications, and take them correctly, if they were fully informed about their treatment. In general, the more informed and involved patients are in their care, the safer that care is likely to be. Consumer literacy is partly a matter of what patients know and expect, but doctors and nurses have major responsibility in relation to what they tell their patients, and how they communicate.

The importance of communicating with grieving families

When an untimely and unnecessary death occurs in hospital, it is a tragedy for all concerned.

In April 2002, 91-year-old Mrs Eileen Anderson was taken to Palmerston North Hospital by her daughter Helen McKernan with what appeared to be a respiratory tract infection. She had been generally well for her age.

However a chart mix up and inadequate checking meant Mrs Anderson was given another patient's medication for four days – and not her regular medication. This led to a rapid deterioration in her health.

Though Helen and the wider family had concerns about the sudden and severe worsening of their mother's condition, they felt outside their comfort zone in seeking answers. They also felt some hospital staff seemed unresponsive.

"I began to realise there is a fine line between asking for necessary assistance and getting a reputation as a difficult family member," Helen says. "I felt like I was becoming a bother, and started questioning my own judgement."

When Mrs Anderson's condition became terminal, the family were not called in time to reach her bedside before she died, something they find hard to forgive. Nor did anyone prepare them for the upsetting presence of police officers in her room because the death was deemed 'suspicious'.

Despite this apparent lack of concern and basic communication, the family's response was initially generous.

"From the outset we accepted human error and realised the pressures staff were under," Helen says.

"We just wanted accountability and where doctors or nurses admitted their mistakes, we valued their honesty."

But when the family met with hospital staff they felt there was a lack of sensitivity towards their feelings and a reluctance to share information.

Helen says this just made the family more determined to push for answers and accountability. Frustrated at a lack of progress, they complained to the Health and Disability Commissioner in October 2002.

MidCentral DHB has since apologised to the family. It says Mrs Anderson did not receive an appropriate standard of care and agreed with the Health and Disability Commissioner that the procedures it had in place at the time were insufficient. The hospital's systems have since been reviewed and steps taken to prevent such an error occurring again.

Helen says she's now sure – 10 years later – that systems are much better; that there is more accountability and better processing of complaints so families in similar situations will not have to face the same frustrations.

"A family should be handled very carefully at a bewildering time like this and providers need to have procedures in place to be sure they communicate openly and with compassion. People are much more inclined to accept the tragedy of human error when there is accountability and genuine regret.

"That lack of openness and sensitivity led to a prolonged dispute that certainly took a heavy toll on us and on a good number of hospital staff as well."

Working with providers

In August 2011, the Commission appointed a senior advisor to oversee the reportable events process and is now seeking to appoint a clinical lead.

These roles include building on our relationships with DHBs and other providers, and helping develop adequate reporting and effective responses to adverse events and sharing the lessons learnt.

This will include helping DHBs to develop regional approaches to quality improvement through regional networks. For example, an incident may have taken place in a very specialised clinical area, and it may be difficult for the provider to find an appropriate clinical specialist to support the review. In another example, clinicians at a hospital may have had an event they had never experienced before, but which has occurred, and been analysed and addressed in another hospital.

In both these scenarios, the Commission aims to provide practical assistance, through having a wider view of the health and disability service, and a greater base of knowledge in relation to adverse events.

We believe that doctors and nurses do read the regular publications of their own organisations, and we are delighted that several of these organisations have embraced the idea of including case studies and other Commission communications in their newsletters, bulletins and the like.

Organisations that have already agreed to work with us include the Australian and New Zealand College of Anaesthetists, the Royal Australasian College of Physicians, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Central repository

The Commission now records on a database the details of all serious and sentinel events reported to it. This will become a valuable resource available to the wider health and disability sector to drive improvement.

Partnership with providers and other agencies

The Commission has a key role in collating information currently disseminated to various organisations. We are therefore working with other bodies that have responsibilities in relation to adverse incidents – ACC and the Health and Disability Commissioner's Office in particular.

While the primary roles of ACC, the Health and Disability Commissioner and the Commission differ, it is important the key messages emerging from the cases referred to each are collated nationally, so efforts to improve safety can be prioritised and coordinated. There will be important information that can be shared.

As this report shows, the number of serious and sentinel events reported has increased over past years. The Commission will assess how best to support providers, and what system to use, for the collation and synthesis of data from these events.

Education and training

While many providers have mature systems and processes to manage serious and sentinel events – in particular the review of those events – the Commission recognises they may need practical support to learn from adverse events.

During 2011/12, the Commission will look at the education and training providers require, particularly in relation to using root cause methodology in the review of more serious adverse events and to fully implementing the new national reportable events policy.

Open disclosure is now standard in DHBs across New Zealand, and is expected from all providers by the Health and Disability Commissioner. The Commission will help guide providers to develop appropriate open disclosure practices.

Improving Quality and Safety – Examples from DHBs

Small changes that make all the difference

A number of small changes made by Bay of Plenty DHB to reduce the harm from falls has transformed safety culture.

During 2009/10, Bay of Plenty DHB reported eight hospital falls resulting in serious harm, and one resulting in death. An April 2010 Health Roundtable[15] report to the DHB showed they had one of the highest rates of patient falls.

The DHB's Patient Safety Committee recognised reducing harm from falls as a top priority for 2011. A multidisciplinary project group, including medical staff and health care assistants as well as nurses, was established specifically to improve the existing falls prevention programme.

A literature review revealed that an evidence base for the prevention of falls in hospitals was lacking. However, there is evidence that multiple interventions can reduce the risk for older people in the community, so Quality and Patient Safety Manager, Debbie Brown, says they decided to make 'a whole lot of smaller changes' across the whole organisation.

"In September 2011 we began a three-month pilot falls reduction programme in Ward 2A at Tauranga Hospital – a general medical ward managed under a kaupapa Maori philosophy. Changes included making hourly rounds, identifying falls hazards, increasing staff awareness, engaging with patients about their needs and improving risk assessment processes."

All staff complete a comprehensive report whenever there is a fall, and data about contributing factors are analysed for trends – such as the time of day at which most falls occur. Changes have been made, such as rostering on more staff and scheduling more rounds at those times, to reduce risk.

A new assessment tool is now used to screen patients for common factors associated with falls and the existing mobilisation risk identification tool has been made more user-friendly and efficient. Staff talk to the family and whānau of patients so they can support their loved ones to reduce falls, especially when they are elderly, and the falls information leaflet for patients is being improved.

Changes have also been made to reduce environmental hazards. These include ensuring patients always have safe and easy access to light switches and call buttons, making sure warning signs are in plain language, using floor-level beds for patients at particular risk, and having better guidelines around bed rail use. Bed rails can increase falls risk if they are in place when disoriented patients try to get up.

"We are looking forward to getting measured results when the pilot ends, but there is no doubt we've made good progress," says Debbie Brown, "and we'll keep finding ways to improve."

Maurice Chamberlain, Nurse Leader and Project Co-leader with Debbie Brown, says the big gain will be a shift towards not accepting 'falls will happen' as the norm.

"The changes we've made may have been small, but when implemented together they've transformed the 'safety culture' in the ward. A new awareness has helped us discover positive changes we could make in other areas as well."

The Health Roundtable ranks DHB performance using a traffic light system and the DHB is thrilled to have graduated from the 'stubborn red' category in the April 2010 report to 'yellow' in the October 2011 report.

Debbie Brown (left) with members of the project team, Ward 2A nursing staff and a patient at the September 2011 launch of the pilot falls reduction programme.

15 https://www.healthroundtable.org/

Dividing quality role brings hospital-wide benefits

A simple square of red duct tape on the floor of a busy ward at Wairarapa Hospital is helping to improve medication safety.

At Wairarapa DHB, when two nurses are standing inside the red square by the controlled drugs cabinet, it's a signal to their colleagues that they are not to be disturbed because they are totally focussed on checking controlled medication before it's given to a patient.

"Ideas like this work because they are generated so close to the clinical coalface,' says Cate Tyrer, Wairarapa DHB Director Quality, Safety & Risk. "My challenge was to create an environment where quality improvement ideas like this would multiply and flourish."

There was an opportunity to do just that when she chose to divide up a new quality leader role across nine key clinical areas, and instead of employing one person full time, split the role among some enthusiastic nursing staff with a passion for excellence and innovation.

Once a fortnight the nurse quality leaders have a dedicated day away from their usual role to focus full time on quality improvement, and it's been a great success.

"The amount of quality improvement and buy-in from clinical staff has far exceeded what could have been achieved by just adding an extra person to my team. While I might manage quality, the responsibility for it needs to come from within the clinical services teams.

"Everyone knows that every second Wednesday is that nurse's day to focus on quality improvement. It's protected quality time, paid from my budget. They don't wear their uniforms and they can't be pulled off their quality work just because the ward gets busy."

She says all the nurse quality leaders have worked in their respective areas for some time and have the respect of their colleagues, so their suggestions are listened to.

"And, of course, they are a catalyst for everyone to think about quality and safety more because they don't switch off from it on the other days of the week."

Complaints and negative patient satisfaction surveys are directed to the relevant quality leaders who look at what can be done to improve things.

Cate Tyrer and the quality leaders meet away from the hospital at the end of every fortnightly 'quality day' to discuss issues that have come up and improvement ideas. The red tape on the floor was just one of many ideas to come from the new approach.

"We'd been getting some drug errors in one of our wards – nothing that had caused harm to a patient, but things like missing signatures or other documentation errors. It's a very busy ward and it can be very difficult for staff to focus because of all the distractions and interruptions. Two nurses standing in the red square in front of the drugs cabinet is a simple but effective cue to everyone that they're not to be disturbed because they are double checking drugs."

Another innovation has been adding codes to theatre lists that show, for example, if patients have had their planned surgery cancelled before.

Nurses Ruth Parker (left) and Jan McEwen are checking medications inside the red square, indicating they are not to be disturbed.

"We're a small hospital with limited operating theatre space, and planned surgery sometimes has to be cancelled so urgent surgery can take place. While these numbers are less than five percent of all operations, the quality leaders worked with outpatient staff, who do the re-booking, and came up with the system. They now know at a glance which patients have had surgery cancelled before and they try to give them priority on the day and not cancel them again."

Other quality successes, which have also helped build relationships between different health teams, include:

- an operating theatre orientation programme for midwives
- a midwives education programme for theatre staff about procedures for storing umbilical cord blood
- working with the needs assessment service and coordination service to improve the discharge process.

Cate Tyrer says the latest project is printing information about quality and safety improvements on the hospital cafeteria's tray placemats as a novel way to keep staff, patients and visitors up-to-date with developments.

Improving the transfer of information between health practitioners

SBARR – Situation, Background, Assessment, Recommendations and Response – is improving communication at Bay of Plenty DHB.

Most patient care involves more than one professional discipline and the more a patient's care is transferred from one clinician to another, the greater the risk that important information isn't passed on.

Bay of Plenty DHB Quality and Patient Safety Manager, Debbie Brown, says not only is poor communication costly, it can also cause heartache, pain and suffering for patients and their families.

"Health care workers often experience many competing demands for their time. They are masters at multi-tasking and gather data and exchange information throughout their working day. However, sometimes critical pieces of information are inadvertently missed in discussion."

Debbie Brown says poor communication was a root cause of 75 percent of Bay of Plenty DHB's sentinel events, and the DHB is part way through a two-year programme to improve handover communication.

A standardised structure for concise, factual communication between clinicians, called SBARR, has now been implemented throughout the DHB following a successful pilot early in 2011. SBARR stands for Situation, Background, Assessment, Recommendations and Response.[16]

She says the SBARR structure ensures all priority information is related during patient care discussions and handovers, and that nothing critical is missed.

"SBARR condenses messages so they contain only concise and significant information about the patient, and allows the clinician to verbalise their assessment of the situation – what they think is happening and what recommendations or actions they think are needed to correct the problem."

Debbie Brown says SBARR makes sure urgent concerns are brought to the forefront and empowers staff to advocate on behalf of the patient.

"It also reduces any barriers to communication that may exist between health care professionals because of traditional hierarchy or interpersonal issues. SBARR is very flexible, can be used in any clinical handover situation, and has been well received by clinical staff."

Bay of Plenty DHB Medical Leader, Anaesthesia & Surgical Services, Dr Troy Browne, says SBARR is very useful in both emergency and non-emergency situations.

"It provides its own checks and balances. It allows people to communicate well even when they're stressed or under pressure, and even if they're not naturally a good communicator.

"If conversations aren't structured, you start thinking of questions to help you get a better idea of what's going on. That stops you listening, the person giving you the information gets distracted and errors can creep in.

"By using the SBARR structure, I can listen to the whole response, relay what I've heard, and the person doing the handover can confirm I've got it correct."

He says before the introduction of SBARR, he could be phoned at home at night about a patient, and wouldn't necessarily be told immediately if he was needed at the hospital, or whether he was just being phoned for advice.

Marama Tauranga, Clinical Nurse Manager and Dr Nazeef Malik, Senior House Officer Orthopaedics, using the SBARR method to communicate.

16 http://www.georgiahealth.edu/itss/edtoolbox/Scenarios/PatientSafety/SBARR/sbarrintro/SBARRintro.html

South Canterbury DHB Falls Prevention Project

Falls are the single largest cause of injury in New Zealand and account for more than a quarter of reported adverse events in hospitals. In 2010 the South Canterbury DHB launched a hospital-wide falls prevention and management project at Timaru Hospital which has significantly improved the assessment and care of patients at risk of falls.

"It's unrealistic to think we will prevent all falls in hospitals, because it's important patients remain mobile, using their strength to aid their recovery," says Timaru Hospital's Director of Nursing, Midwifery and Allied Health, Sam Powell.

"But much can be done to identify and minimise the risks to patients, both while they are in hospital and when they are discharged home.

"All patients now receive a falls risk assessment when they are admitted and this is repeated if they are transferred to another service or if their health circumstances change. This helps formulate a plan to prevent that patient from falling while they are in hospital and on their discharge home."

Sam Powell says staff discuss the risk of falls with patients and their families, and advise them how to reduce that risk. Specific information – such as whether a patient should always be assisted when mobile or should only ever walk with a frame – is always present by the bed in a 'mobility flip chart'. This means any health professional dealing with the patient is well aware of their falls prevention needs.

At risk patients are also clearly identified with green wrist bands and they are specially identified to staff by green magnets on the patient board. Sometimes sensor mats are used in patients' rooms so nurses know when they get out of bed and can make sure they are safe.

"None of these innovations are all that radical or new,' says Sam Powell. 'But they all work together to ensure everyone – from orderlies, to nursing staff, to physios to family and friends – knows what the patient's particular needs are. There's not just one person holding the information."

To make sure the project stays on track and continues to improve, the DHB has also appointed a falls champions group. It includes representatives from all areas of Timaru Hospital along with a representative from Sports South Canterbury. The group meets quarterly to discuss the risk of falls and identifies key messages to feed back to staff. A pamphlet for patients, family and whānau, which explains the falls prevention project, is also being developed.

This initiative has been gradually implemented over the last 12 months across clinical areas and the DHB is seeing a noticeable improvement in assessment and planning and a reduction in the injury falls rate.

"We're also linking in with education for the patients' families and sharing information with community health professionals – like the patients' GPs and Sport South Canterbury's Stay on Your Feet Programme – so falls at home can be prevented as well," says Sam Powell.

"This has been a very positive initiative that is patient- and family-focused with the wider health care team all having a part to play in reducing harm from falls."

Nurse Robyn McDonald models the green bracelet worn by patients at risk of falling, and points to the green magnets on the 'Patient Status at a Glance' whiteboard which alert staff to a falls risk patient.

Red syringe plungers a simple way to increase patient safety

The use of red syringe plungers for administering relaxant medications is a simple, common sense approach to increasing patient safety at Waikato Hospital's Anaesthetic Services Department.

Relaxants paralyse the muscles in the body making it impossible to breathe unassisted, and are usually given after the patient has been sedated for an operation. It could be terrifying for the patient – and there is a risk of serious harm – if they are administered accidentally or at the wrong time.

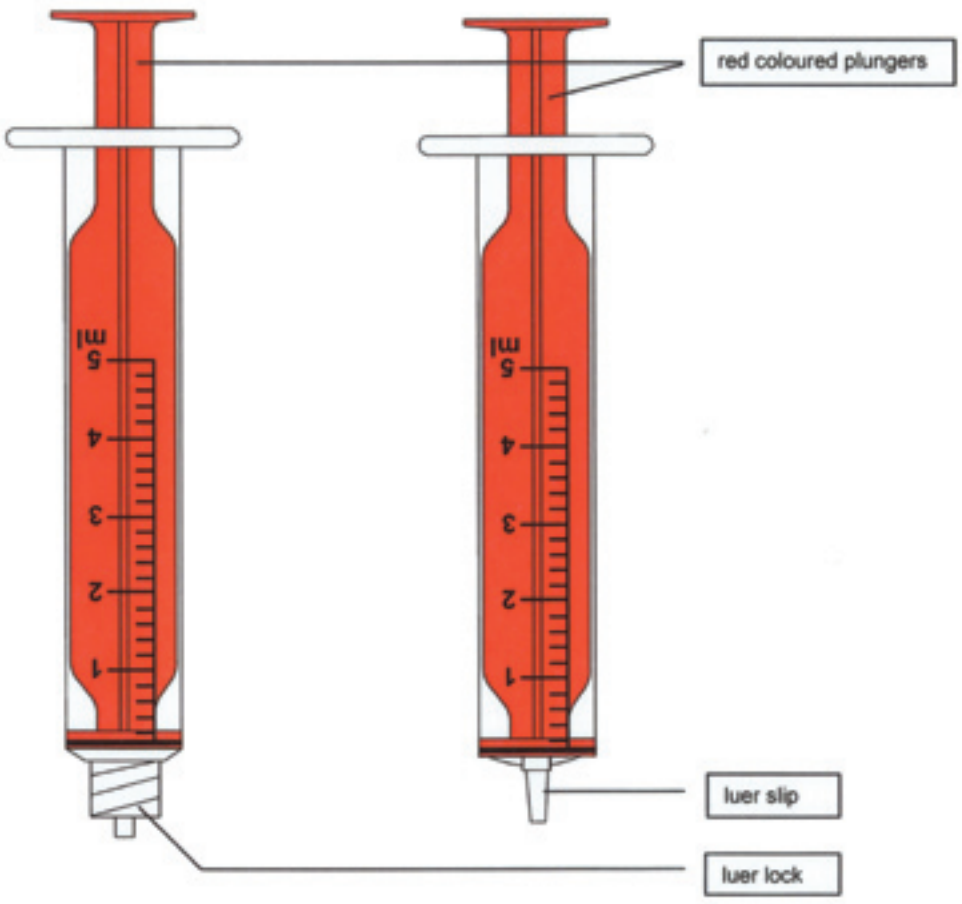
Red syringe plungers are easy to spot and make it much less likely this will occur. Red plungers for 5ml syringes have been sourced in New Zealand, and the team is also working to source similar plungers for 1ml syringes used for children.

Waikato DHB Chief Medical Advisor Dr Tom Watson says incidences of accidental 'awake paralysis' are not common, but the risk is taken seriously, because they are potentially fatal.

"We started with the red plungers idea about 10 years ago after discussions with a group of Australian anaesthetists who also wanted to reduce this risk. So far they've only been used in main theatre anaesthetics, but we're now planning to extend them to all Health Waikato departments that use relaxants."

While the red plunger initiative has not been formally evaluated, Dr Watson says anecdotal feedback shows it has been successful.

"Not only have incidences of awake paralysis been reduced, but staff drawing up the medications are now much less fearful of making a mistake."



Releasing time to care at Wellington Regional Hospital

The* Releasing Time to Care *initiative has resulted in staff on several wards at Wellington Regional Hospital spending more time with patients, and has seen real gains for the safety and wellbeing of patients

You might be surprised at how little of a nurse's or a therapist's time is spent directly caring for patients. In fact, with paperwork, handovers and having to walk back and forth between equipment rooms, they can spend as little as 20 percent of their day actually at patients' bedsides.

The *Releasing Time to Care – The Productive Ward* programme was developed under the UK's National Health Service in 2007/08 to help streamline internal processes at hospital wards and increase the time nurses and therapists spent with patients.

Results were dramatic – more patient care time, less waste, improved job satisfaction, and shorter hospital stays for patients.

In 2009 *Releasing Time to Care* was launched in New Zealand. It has already been embraced by 10 DHBs, involving more than 2275 staff, and results have been equally positive here – none more so than in several wards at Wellington Regional Hospital.

"*Releasing Time to Care* was a fresh opportunity for us to look at the way we were doing things," says Gayle Tristram, of Capital & Coast DHB's Quality and Risk Unit and project leader for the programme.

"We could see problem areas with new eyes, and then find practical ways to make things work better."

The programme consists of 11 self-directed modules. The first three are designed to gather information about what happens on the ward, establish baselines so future improvements can be measured, and equip ward leaders to guide staff towards safer, more dignified and more efficient care. The next eight modules help streamline systems and processes in key areas such as meal deliveries, shift handovers and medication safety.

For example, the well-organised ward module looks at where equipment is stored, how far nurses walk to get to it, and inefficiencies from things being lost or poorly labelled.

By marking off floor areas with tape and putting up pictures of the equipment to be stored there, wards were able to significantly save time and reduce equipment-related errors.

"The less time you spend looking for things or sorting out stock problems, the more time you have to be with people who need your care," Gayle Tristram says. She says another example is process mapping.

Gayle Tristram, Project Leader, Releasing Time to Care, *Wellington Regional Hospital.*

"Handovers were taking ages and work was often slowed due to frequent interruptions. The programme's communication module helped us record and analyse the reasons for the interruptions. The problem was then easily solved by putting the information people most often needed on the 'patients at a glance' board so they didn't need to ask others for it."

Releasing Time to Care is so successful because it encourages a culture of continuous improvement driven by staff themselves.

"Helping patients is why nurses and therapists come to work in the first place, so freeing up their time to do this more has been really great for morale," Ms Tristram says.

The programme has led to numerous improvements at Wellington Regional Hospital, and each ward working through it has increased direct patient care time by more than 7000 hours per year. Those completing the medication module typically halved their medication errors.

"Most of the changes *Releasing Time to Care* encourages are simple and inexpensive, but they translate into real gains for the safety and wellbeing of patients," Ms Tristram says.

Rotorua Hospital soap change increases patient safety

Sometimes the simplest change can significantly improve the quality of hospital care for patients. New soap dispensers in Rotorua Hospital's showers are just one example.

In July 2009 an elderly hip replacement patient at Lakes DHB's Orthopaedic Ward slipped off a chair while bending to pick up a bar of soap in the shower, and was seriously hurt. An investigation of the incident found inconsistencies in the way the showers were set up; especially in how soap was made available.

Rose Donovan, Quality and Risk Coordinator at Lakes DHB, was sure things could be done much better.

"The ward's clinical nurse manager, who was part of the investigation team, advised that wall-mounted liquid soap dispensers in showers would eliminate the need for patients to bend while washing and that made a lot of sense. It would reduce the likelihood of patients slipping over, and also seemed much more hygienic."

Rose Donovan (left) and Clinical Nurse Manager of the Orthopaedic Unit, Heather Schilt by one of the new wall-mounted soap dispensers.

In 2010 liquid soap dispensers were installed in all showers across the ward and Rose Donovan says the results have been noticeable.

"In the past year we have not had a single incident report relating to a fall in the shower as a result of picking up soap. We'll never eliminate shower falls completely, but we're confident now that both assisted and unassisted showering is safer for patients."

Meanwhile, Lakes DHB has been undergoing redevelopment, with stage one of the rebuild completed in July 2011. Known as Whakaue Rauoranga, the new building features much-improved modern facilities, including wall-mounted soap dispensers in all showers.

"Once we'd seen the good results in the Orthopaedic Ward, we contacted the building planners and insisted they be installed in every bathroom for patients. This will be an ongoing policy at Lakes DHB in the interests of patient safety," Rose Donovan says.

Appendix 1: Definitions

An **adverse event** is a health care event causing patient harm that is not related to the natural course of a patient's illness or underlying condition.

A **serious adverse event** requires significant additional treatment but is not life threatening and has not resulted in a major loss of function.

A **sentinel adverse event** is life threatening, or has led to an unanticipated death or major loss of function.

Open disclosure or **open communication** is the open discussion of adverse events with the affected parties, including the associated investigation and subsequent recommendations for improvement.

Preventable describes an event that could have been anticipated and prepared for, but that occurs because of an error or some other system failure.

Root cause analysis (RCA) or **RCA methodology** is a method to investigate an event to identify causes and contributing factors, and to recommend actions to prevent a recurrence.

Appendix 2: DHB Population Numbers

Source: Statistics NZ population projections, Sept 2007

DHBs	Population (000s)
Northland	154
Waitemata	516
Auckland	439
Counties Manukau	468
Waikato	355
Bay of Plenty	204
Lakes	102
Tairawhiti	45
Taranaki	107
Hawke's Bay	153
MidCentral	165
Whanganui	63
Hutt	141
Wairarapa	39
Capital and Coast	282
Nelson Marlborough	135
West Coast	32
Canterbury	491
South Canterbury	55
Southern	295
Total	**4241**

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