



Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Serious and Sentinel Events Report: 2013-2014

Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) have been working closely to improve the quality of care that we provide to our three communities. During the period 1 July 2013 to 30 June 2014 Wairarapa and Hutt Valley DHBs reported 15 Serious and Sentinel events (SSEs) and Capital and Coast DHB 21. These SSEs occurred in our hospitals and health services and were reported to the Health Quality and Safety Commission as required by national Reportable Events policy requirements.

Each of the reported events involves a patient suffering harm or death while in our care. We consider one event of this nature one too many, and apologise unreservedly to the patients and family/whanau involved in these cases. We acknowledge the distress and grief that occurs for patients and their families/whanau when things go wrong in healthcare.

We always seek to learn from these events and improve safety. Working together as a sub-region provides an opportunity to learn from each other and utilise our different areas of expertise to best support quality and safety issues. In order for this to happen, we depend on events being reported by the people involved. A strong safety culture means that patients and their family/whanau, other health providers such as family doctors and primary health nurses, and our own staff tell us when an incident has occurred and raise concerns, so that we can look into what has happened.

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

Our practice is to communicate openly with patients and family/whanau 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 family/whanau to the degree they prefer, and where possible answer their questions and address any concerns that they have.

When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented. In this way we aim to achieve our priority of Zero Patient Harm which forms part of our overall quality improvement and patient safety programme of work. This is one of six priorities linked directly to our Sub- Regional vision of "quality hospital care and complex care for those who need it", the Triple Aim outcome of "Improved quality, safety and experience of care" and the Government goal of "New Zealanders living longer, healthier more independent lives.

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Serious and Sentinel Events Report: 2013-2014

The top 3 SSE themes reported to the Health Quality and Safety Commission across the three DHB's are:

CATEGORY	WDHB	HVDHB	CCDHB
Clinical Processes	3	1	9
Patient Falls	1	5	10
Medication/IV Fluids	1	1	2

NB: 3 additional reviews for WDHB/HVDHB under separate categories.

Clinical Processes events reported this year include unexpected deterioration where the patient became suddenly and unexpectedly unwell, missed diagnoses where the patient's health condition had not been correctly recognised and treated, and a retained surgical item where a piece of surgical equipment was left in the patient and this was not identified immediately.

Patient Falls events include falls in hospital involving a fracture or other serious harm. We know that falls have a social, psychological, physical and economic impact on our patients and their family/whanau.

While it is not possible to stop every patient from falling when in hospital, many falls can be prevented. Our Falls Prevention Groups are actively working to reduce the number of patient falls and prevent the harm that can occur from a fall. Our ongoing work to prevent falls and harm from falls is aligned closely to the Health Quality and Safety Commission's national patient safety campaign "Open for Better Care". One focus of the campaign has been the prevention of harm from falls. The six Central Region DHBs trialled a falls signalling system and this is now part of an overall standardised falls prevention strategy in use across all adult inpatient areas.

Medication is very often an important part of a patient's therapy. However all medications carry risks and some have significant risk of patient harm, and must be prescribed, given, monitored and taken very carefully. Some of the events reported in this period relate to Warfarin, Fentanyl and Ketamine. We have a range of improvement work related to high risk medications and day to day medication safety in progress including; Warfarin safety, Opioid safety, Insulin safety and Safe prescribing. All of this improvement work is aimed at increasing the safe use of medications for our patients.

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



1.

Event Category: Clinical Process

Deceased: N

SAC Rating: 1

Event Summary: HDU: Review of level of service provision capability and staffing skill mix.

REVIEW - Key findings:

- Clinical leadership in and out of hours needed strengthening
- Reinforcement of escalation criteria and Early Warning Score (EWS) usage. EWS – patient deterioration warning system)
- Standardisation of documentation and handovers required
- Standardisation and alignment of policies/protocols required
- Staffing ratios, skill mix and competencies required to better match patient needs
- Training and education needs analysis required to match patient requirements
- Enhancement of planning for retrieval (Transfer) patients
- Need for standardisation of access and discharge criteria
- Strengthening of multi-disciplinary team approach required

Recommendations:

- Development of an action plan to address themes identified as findings in the HDU review

Recommendations progress (i.e. action plan):

Action plan has been developed and recommendation in progress:

- HDU clinical governance group implemented and meetings occur monthly and ad hoc as required for events/issues
- Dedicated senior doctor roster for both in and out of hours support in place
- Education and training needs analysis underway
- In and out of hours support and skill mix in progress

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



- Standardisation of policies and guidelines in progress
- Retrieval training and education session in progress
- Early warning scores education in progress
- Subregional 3DHB Critical Care Network formed to help with support with education, training and advice
- Pause on the complexity of patients that can be supported by the current HDU remains with transfers of complex patients to neighbouring hospitals continuing

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



2.

Event Category: Medication/IV Fluids

Deceased: N

SAC Rating: 2

EVENT SUMMARY: Patient in theatre, wrong medication administered. Patient became medically unstable and required further clinical management to stabilise.

REVIEW-Key findings:

- Unlabelled syringes of medication
- Identical syringes
- Collocated syringes

Recommendations:

- Labelling of syringes as medication is drawn up, in line with best practice
- Review of medication administration policy and procedures, consider including syringe labelling as mandatory procedure
- Development of learning paper for staff education purposes

Recommendations progress (i.e. action plan):

- Learning paper disseminated
- Double checks of syringe/medication prior to administration
- Policy in the process of being updated

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



3.

Event Category: Patient Falls

Deceased: N

SAC Rating: 2

EVENT SUMMARY: Patient awoke and attempted to get out of bed, fell to floor and suffered a fractured neck of femur.

REVIEW - Key findings:

- High risk of falls identified
- Appropriate care plan in place

Recommendations:

- Updating of bed allocation procedure to include immediate post op patients with high falls risk
- Update high falls risk identifiers with new resources from the national falls signalling system
- Continuation of the national falls prevention programme

Recommendations progress (i.e. action plan):

- Complete, no further action

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



4.

Event Category: Clinical Process

Deceased: N

SAC Rating: 2

EVENT SUMMARY: Patient undergoing surgery. Small part of plastic implant device broke off and was retained, unable to be located for removal. The risk of harm in pursuing the location of the device was greater than leaving it in-situ.

REVIEW - Key findings:

- All appropriate actions were taken at the time of the event

Recommendations:

- Nil

Recommendations progress (i.e. action plan):

- Not applicable

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



5.

Event Category: Medical Device/Equipment **Deceased:** N

SAC Rating: 2

EVENT SUMMARY: Audit of compliance of sterilisation of equipment identified several areas of concern.

REVIEW - Key findings:

- Lack of clear leadership and oversight
- Lack of access to education and participation in education for staff
- Environmental concerns regarding space and storage facilities
- Sterilisation equipment requires upgrade

Recommendations:

- Appointment of Team Leader
- Purchase and install two new washer/disinfectors
- Improved clinical governance and oversight required

Recommendations progress (i.e. action plan):

- An action plan has been developed, recommendations are under way
- Team Leader appointed
- New washer/disinfectors have been purchased and a programme for installation begins 20 October 2014

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



6.

Event Category: Resource/Organisation/Management

Deceased: Y

SAC Rating: 1

EVENT SUMMARY: Concerns were raised regarding senior leadership in the care of an adult transferred to another facility

REVIEW - Key findings:

- Lack of awareness of technical preparation of patient for transfer to another hospital
- Poor documentation of findings and discussions with specialists
- Lack of awareness of access to Point of Care (POC) testing (Blood Gas Analyser) by Duty Nurse Managers
- Diagnostic delay due to differential diagnosis elimination

Recommendations:

- Development of a sepsis care pathway package
- Education meeting for staff highlighting “preparation of patient for transfer”
- Documentation and leadership discussed with staff involved
- Review of awareness of “Point of Care” testing after hours

Recommendations progress (i.e. action plan):

- Education and teaching sessions regarding the preparation of patients for transfer by transfer team is in progress
- Feedback to senior clinicians involved to help strengthen leadership and documentation
- Development of a communication to remind staff regarding the process and ability to access POC testing after hours is underway. Consideration for alternative access to POC testing is being explored
- A Sepsis Care pathway package is being implemented

Wairarapa District Health Board

Serious and Sentinel Events Report: 2013-2014



7.

Event Category: Clinical Process

Deceased: Y

SAC Rating: 1

EVENT SUMMARY: Patient returned to theatre following post-operative bleed and passed away in theatre.

Review - Key findings:

- Initial surgery conducted without difficulty or complication
- Post operatively patient deteriorated
- Delay in diagnosis regarding the patient's post-operative deterioration due to co-existing medical problems and a rare post-operative complication
- Escalation of increasing patient deterioration to general surgeon did not occur in timely manner because of above
- Documentation of latest results not on all required forms

Recommendations:

- Enhancement of Multi-Disciplinary Team relationships
- Enhancement of "Managing the Deteriorating Patient" pathway
- Review the Point of Care testing resources

Recommendations progress (i.e. action plan):

- Patient deterioration (EWS - Early Warning Score) training and ALERT (Acute life threatening event recognition and treatment) training is offered every month to staff. This includes effective communication strategies
- Review of the documentation process is underway to ensure a robust process is in place for ensuring up to date documentation is available.
- The surgical team have invited other Multi-Disciplinary Team members to participate in the weekly meetings
- Development of a communication to remind staff regarding the process and ability to access POC testing after hours is underway. Consideration for alternative access to POC testing is being explored

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



1.

Event Category: Patient Falls

Deceased: N

SAC Rating: 2

Event Summary: Patient fell in hospital, resulting in fracture.

REVIEW - Key findings:

- Falls assessment completed and falls risks identified
- Falls care plan implemented

Recommendations:

- That the DHB continue with the ongoing falls prevention improvement work related to reducing the incidence of falls in hospitals

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



2.

Event Category: Patient Falls

Deceased: N

SAC Rating: 2

Event Summary: Patient fell in hospital resulting in fracture.

REVIEW - Key findings:

- Complex patient presentation with communication issues led to a delay in diagnosis of fracture
- Falls assessment completed and falls risks identified
- Falls care plan implemented

Recommendations:

- Continue with Falls prevention programme strategies
- Staff education on patient presentation with complex mental health and cognitive issues

Recommendations progress (i.e. action plan):

- Education provided to the staff in the unit involved
- Continuation of falls prevention programme

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



3.

Event Category: Patient Falls

Deceased: N

SAC Rating: 2

Event Summary: Patient fell in hospital resulting in fracture.

REVIEW - Key findings:

- Patient with complex medical issues resulting in very high falls risk
- Falls risk assessment completed and falls care plan in place

Recommendations:

- Continue with Falls prevention programme strategies

Recommendations progress (i.e. action plan):

- Continuation of falls prevention programme

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



4.

Event Category: Fall

Deceased: N

SAC Rating: 2

Event Summary: Patient fell in hospital resulting in fracture.

REVIEW - Key findings:

- Falls risk assessment completed and falls care plan in place

Recommendations:

- Continue with Falls prevention programme strategies

Recommendations progress (i.e. action plan):

- Continuation of Falls prevention programme

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



5.

Event Category: Patient Falls

Deceased: N

SAC Rating: 2

Event Summary: Patient fell in hospital resulting in fracture.

REVIEW - Key findings:

- Falls risk was not identified and falls assessment not completed
- Patient 's medical condition contributed to fall

Recommendations:

- Falls prevention to be emphasised to staff daily
- Clinical Nurse Managers are to monitor compliance to the Falls prevention Programme
- Education to be provided to staff on the management of a suspected spinal injury
- Morning shift ward co-ordinator to be recruited

Recommendations progress (i.e. action plan):

- Quarterly audit of falls and compliance with actions required occurs within the hospital; this audit identifies any areas or gaps in the programme that require additional input regarding the falls prevention programme
- The Falls Focus Group reviewed the department's policy and implemented a new protocol addressing the importance of falls prevention work
- Falls risk assessments are now done within the first hour of arrival as per the national falls prevention protocol
- An electronic whiteboard in the department allows for easy identification of patients with a falls risk
- Teaching for staff in regards to management of a suspected spinal injury has occurred
- Recruitment of a morning shift ward co-ordinator has occurred

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



6.

Event Category: Medical Device/Equipment

Deceased: N

SAC Rating: 2

Event Summary: Incomplete surgical implant loan set from supplier, surgery rescheduled.

REVIEW - Key findings:

- Specialist equipment sourced from external provider was noted to be an incomplete set
- Provider of equipment informed

Recommendations:

- Nil

Recommendations progress (i.e. action plan):

- Not applicable

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



7.

Event Category: Medication/IV Fluids

Deceased: N

SAC Rating: 2

Event Summary: Patient received another patient's medication, along with their own (brought into Hospital with them) on discharge. Patient took all medications and required admission to hospital for additional treatment as a result.

REVIEW - Key findings:

- Incorrect medication provided to the patient on discharge
- Medication bag and patient's own medications were unlabelled

Recommendations:

- Store patient's own medication in new distinct coloured bags with patient's name clearly labelled
- Review medications with patient and family on discharge
- Develop a learning paper for staff regarding this event and the outcome for the patient

Recommendations progress (i.e. action plan):

- New "Patients Own" Medication bags implemented
- Labelling improved
- Learning paper under development

Hutt Valley District Health Board

Serious and Sentinel Events Report: 2013-2014



8.

Event Category: Clinical Process

Deceased: N

SAC Rating: 2

Event Summary: Suture needle unaccounted for at surgery completion. The patient was returned to theatre for the removal of the needle

REVIEW - Key findings:

- Needle had appeared to have flicked off the suture material on skin closure, thought not to have remained in the patient
- Lack of staff awareness that a portable x-ray machine could be made available for all theatres
- The patient should not have left the theatre without an x-ray as per the surgical count policy
- Anaesthetic team not aware that the needle continued to be missing at the end of surgery. Guidance could have been provided with regard to expected practice
- Senior clinicians should have been contacted earlier for support and guidance

Recommendations:

- All theatre staff to be made aware that the portable x-ray machine is available for use in and out of hours in all theatres
- Multi-disciplinary discussion regarding this case and further management to occur
- Review of the orientation of theatre staff to make sure that staff are directed to relevant policies and procedures

Recommendations progress (i.e. action plan):

- Review of the orientation of staff underway, and awareness of relevant policies and practices including the availability of portable x-ray for all theatres underway
- Multi-Disciplinary team discussion had about the case and learning's discussed