Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) continue to work closely to improve the quality of care that we provide to our three communities. During the period 1 July 2014 to 30 June 2015 Wairarapa DHB reported 9 Serious and Sentinel Events (SSEs), Hutt Valley DHB 7 SSEs, and Capital and Coast DHB 27 SSEs. These SSEs occurred in our hospitals which meant that patient’s suffered harm or death while in our care. We sincerely apologise to the patients and family/whanau involved in these cases and acknowledge the distress and grief that occurs when things go wrong in healthcare.

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 in the review to the degree they prefer, and where possible answer their questions and address any concerns that they have.

Working together as a sub-region enables us to learn from each other and utilise our different areas of expertise to improve the care we provide. We depend on events being reported by the people involved and for this to occur we rely on a just culture (balancing accountability of individuals and the organisation) that focuses on improving systems and not blaming individuals. We want our patients and their family/whanau, other health providers such as family doctors and primary health nurses, and our own staff to tell us when an incident has occurred and raise concerns, so that we can look into what has happened to try to minimise the chance of a similar event happening again.

When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented. This process assists us to achieve our 2014/15 priority of Zero Patient Harm, which forms part of our overall quality improvement and patient safety program of work.

The 2014/15 SSEs are reported to the Health Quality and Safety Commission according to category. For each DHB these were:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>2</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Processes</td>
<td>2</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Medication/IV Fluids</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Blood Products</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical Device</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>9</td>
<td>27</td>
</tr>
</tbody>
</table>

**NB: WDHB** – the number of events reported to HQSC (9) differs from the number in the above table (7) as the reports withdrawn were after the cut off date in September, 1 event was downgraded following review and 1 event will be reported in the Office of the Director of Mental Health’s report in December 2016.

**HVDHB** – the number of events reported (7) differs from the number in the above table (9) due to a reconciliation error.
Clinical Processes (assessment, diagnosis, treatment, general care)
These events have highlighted communication issues that have led to delays in treatment, allocation of care, surgical complications (wrong site surgery/retained items), test processing delays and interpretation. The three DHBs have focussed on improving communication and documentation through the use of communication tools, enhancing the early warning score (EWS) pathway that focuses on documentation and an early escalation of the deteriorating patient pathway. The Health Quality and Safety Commission’s Safe Surgery campaign for 2015/16 is aimed at improving communication and team work within Theatres, through the use of briefing and debriefing.

Patient Falls (includes falls in hospital involving a fracture or other serious harm)
These are still the leading category of harm nationally. For CCDHB patient falls have decreased and significantly there were no patient falls SSEs from December 2014 to May 2015. This is as a result of our ongoing work to prevent falls, which is aligned to the Health Quality and Safety Commission’s national patient safety campaign “Open for Better Care” that commenced in 2013. The CCDHB Falls Prevention Groups have implemented key system changes that have significantly reduced patient falls due to the practice change and engagement with the improvement focus owned by the clinical staff. As well as the successful implementation of the falls signalling system, we have improved staff engagement through real time auditing focussed on best practice (Point of Care Audits), and ward specific data on audit results/action and actual ward fall’s rate. Patient engagement in improving communication about falls risks (co-design), and a footwear campaign in April 2015 focussing on safe footwear to prevent falls.

Wairarapa DHB continues to work with Aged & Residential Care providers in promoting falls prevention. The Occupational Therapy (OT) team monitors and follows up on all falls presentations and discharges to Emergency Department to ensure patients have the resources to remain safe in their own homes. WDHB have focused on individualising patient care plans where falls risks are highlighted. The Assessment Treatment & Rehabilitation ward introduced non slip socks following a footwear campaign in April along with the falls signalling system and individual colour signs to encourage patients to use their call bells when mobilisation assistance is required.

Hutt Valley DHB has recently linked the Central Region Falls Signalling system to the Mobility Indicator in TrendCare (an electronic patient acuity and workload system) onto the patient electronic whiteboards in clinical areas (Self /Partial Assistance /Total Assistance – is a mandatory indicator in TrendCare). This means that the level of assistance required by a patient is automatically pulled across into the patient’s information, this results in an increased visibility of individuals mobility needs for all staff, improved compliance with falls assessments. The level of assistance required by an individual will adjust in line with the patient’s needs. The next step in this improvement is to have the falls assessments available in TrendCare. This will ensure that all assessments are standardised, accessible and more easily reportable. These actions are part of the falls prevention improvement work that is being undertaken to increase engagement with clinical staff and reduce the harm from falls in our hospital.

All three DHBs are actively engaged in the regional Integrated Falls Prevention Action Plan.

Medications
Medications are a very 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. CCDHB has focussed on ensuring those that prescribe and administer medications check the patient’s allergy status. Wairarapa DHB has had a focus on palliative care pain relief. Hutt Valley DHB are currently establishing medication safety groups in each clinical area with the aim of learning from errors as part of the continuation
for a culture of zero tolerance of medication errors. We have focused on the safe use of opioids and insulin, increasing the safe use of medications for patients.

**Blood Product**
The Wairarapa DHB event was related to an error in the checking process for blood transfusions. Wairarapa DHB has enhanced the education provided regarding the double checking process in relation to blood product administration by an Intravenous Nurse Educator.

**Medical Device**
The CCDHB event was related to a balloon becoming detached from a guide wire during stent placement. CCDHB has discontinued using this product and have notified Medsafe
**Event Category:** Blood/Blood Products
**Deceased?:** N
**SAC Rating:** 1

**Event Summary:** NZ Blood Service Audit identified a patient had received another patient’s blood product

**REVIEW**

**Key findings:**
- Case review undertaken which identified an error in the checking processes.
- No adverse outcome for patient as blood types were compatible.

**Recommendations:**
- Education to be provided by IV Nurse Educator to staff regarding double checking process in relation to blood product administration.
- Policy review to ensure it is aligned with current best practice for blood transfusion.

**Recommendations progress (ie. action plan):**
- No change to policy or practice required.
- Education provided by IV Nurse Educator.
2. 10863

Event Category: Medication/IV Fluids
Deceased?: N
SAC Rating: 2

EVENT SUMMARY: Excessive medication charting for a patient with significant pain, resulting in patient delirium and drowsiness

Review:

Key findings:
- Lack of awareness by Prescriber in relation to different modes of narcotic use.
- Lack of liaison with the Palliative Care team regarding pain.

Recommendations:
- Education to clinical staff on different narcotic analgesics.
- Palliative team to be involved in all cases which need palliative care input.
- Palliative Care colleagues to give presentations at Clinical Society meeting (education meetings).

Recommendations progress (i.e. action plan):
- Education sessions on palliative care analgesics held.
- Nursing staff and doctors encouraged to involve palliative care team with all palliative care patients.
- Palliative Care team have presented at Clinical Society meeting.
Event Category: Clinical Process  Deceased?: N  SAC Rating: 2

**EVENT SUMMARY:** Patient did not receive CT scan in timely manner resulting in delayed diagnosis.

**Review:**

**Key findings:**
- ACC Head Injury protocol was not followed.
- A CT scan should have been given under general anaesthetic. The anaesthetist declined to anesthetise the patient due to the alcohol levels present at the time – this delayed the diagnosis.

**Recommendations:**
- Reinforce to all ED and Medical Staff the importance of following the ACC head injury protocol in the future.

**Recommendations progress (i.e. action plan):**
- Clinical Nurse Manager Acute Services and Chief Medical Officer confirmed that staff are aware of importance of using ACC head injury protocol.
- Anaesthetist involved no longer involved in clinical practice.
4. 11480

| Event Category: | Medication/IV Fluids | Deceased?: N | SAC Rating: 2 |

EVENT SUMMARY: Patient developed sudden onset of chest pain at end of procedure.

Review:

Key findings:
- Miscommunication between the anaesthetic team and the surgical team regarding the dose of local anaesthetic.
- Surgeon had asked for 200ml of local anaesthetic and was instead given 200mg.

Recommendations:
- Anaesthetists to write up a dosage algorithm to be prominently displayed in theatre.
- Anaesthetist will calculate the appropriate dosage of local anaesthetic and communicate this directly to the surgeon. This will be displayed on the theatre white board in mg of the drug and both the strength of the drug and the ml of the drug to be used. Nursing staff will display the ampoule/bag of anaesthetic drug to the surgeon before any is administered.
- Protocol received from Hutt Valley DHB for injecting local anaesthetic will be employed by all the orthopaedic surgeons.

Recommendations progress (i.e. action plan):
- Theatre Clinical Nurse Manager has notified all nursing staff of the changes.
- Hutt Valley DHB Protocol has been circulated to all the orthopaedic surgeons, and they have all been advised, and accepted, that it is the only process to use.
5. **11273**

<table>
<thead>
<tr>
<th>Event Category:</th>
<th>Patient Falls</th>
<th>Deceased?: N</th>
<th>SAC Rating: 2</th>
</tr>
</thead>
</table>

**EVENT SUMMARY:** Patient fell during night, sustaining a fracture which required surgery.

**Review:**

**Key findings:**
- Falls Risk Assessment was not completed adequately to identify that the patient mobilised with a walking stick, escalating the falls risk score.
- Inappropriate room allocated.

**Recommendations:**
- Ensure falls risk assessment is completed thoroughly noting any change in information and clinical status.
- Allocation to be reassessed as soon as it becomes apparent patient has increased risk and requires closer observation.
- Ensure appropriate room and team allocation for patients.

**Recommendations progress (ie. action plan):**
- Full fall analysis completed.
- Falls risk assessment and management planning audit completed.
- Falls risk intervention sheet for patients considered medium / high risk implemented.
Event Category: Clinical Process  Deceased?: N  SAC Rating: 2

**EVENT SUMMARY:** Three days post surgery following a complex bowel surgery it was identified that the wrong piece of bowel had been brought to the abdominal surface.

**Review:**

**Key findings:**
- The complication that occurred has been recognised as a potential complication of this procedure.
- There were no identifiable causal factors that contributed to the error.

**Recommendations:**
- Education within the department of this complication to be undertaken.

**Recommendations progress (i.e. action plan):**
- Education with involved clinicians included identifying causal factors, emphasis on the importance of identifying when these factors are present and strategies for minimising risk of repeat incidence.
Event Category: Patient Falls  
Deceased?: N  
SAC Rating: 2

EVENT SUMMARY: Patient had 3 falls post hip replacement and was unable to mobilise due to pain. CT scan showed fractures.

Review:

Key findings:
- Patient was noted as a high falls risk.
- Falls risk assessment and falls management plan completed.

Recommendations:
- Staff education to be enhanced on requirement to reassess patients following a fall to ensure any additional interventions are put in place to reduce risk.
- Staff education to be enhanced on documentation / care planning requirements in order for colleagues to be fully informed on mobilisation requirements.
- Ensure patient location is reassessed as soon as it becomes apparent the patient requires closer monitoring or observation.

Recommendations progress (i.e. action plan):
- Full falls analysis completed.
- Staff education undertaken.
- Falls risk assessment / management plan audit undertaken.