Wairarapa District Health Board
Adverse Event Report: 2017-2018

There were nine serious adverse events reported by the Wairarapa District Health Board (WrDHB) during the period of 1 July, 2017 to 30 June, 2018. The following report outlines the summary and findings from reviewing six of those events and the changes that have been recommended and implemented with the aim of preventing such events happening again in the future. This report excludes three mental health events and one event that has since been downgraded and removed following reconciliation with the Health Quality and Safety Commission (HQSC).

The events reported are within the categories of:

- Healthcare associated/acquired infection
- Consumer/patient accidents
- Consumer/patient falls
- Behaviour

Any serious adverse event identified is reviewed by a team of relevant clinicians, supported by the quality team and overseen by the Clinical Event Review Group. The review explores what happened and why and develops recommendations for system improvements and future practice to prevent recurrence. The recommendations from the reviews are shared with the relevant staff within the organisation and added to the organisation's Corrective Action Plan, which is overseen by the Clinical Board to ensure implementation.

WrDHB encourages an open and honest patient-centred culture where we communicate openly with patients and their whānau/family. When an adverse event occurs we practise open disclosure, listen to the concerns of the patient, answer any questions transparently and provide support to the patient and their family/whānau. Reports and learnings are shared with the patient and whānau as part of this open communication process.

WrDHB wishes to sincerely apologise to the patients and their whānau/family involved in these events and acknowledges the distress that occurs when unexpected or unplanned outcomes occur. We thank them for allowing us to share their stories.

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What happened	What we found	What we are doing to prevent this happening again
Arthrodesis (joint fusion) following knee joint replacement as a result of on-going infection that did not respond to treatment.	On review the DHB found the care/management of the patient was appropriate. The review confirmed that the HQSC Quality Safety Markers for surgical site management were met for this procedure; that the DHB has robust wound management and infection control procedures; and that, overall, the DHB has very low surgical site infection numbers (supported by the HQSC Surgical Site Infection Programme results). Expert infectious disease advice confirmed that identification of the actual source of infection would be very difficult and, following the review, the DHB is confident that this infection was an isolated event. There is no evidence of a cluster of similar infections that would indicate a system failure.	To provide additional assurance around infection control procedures, an external review of infection control procedures in the operating theatre was commissioned. A number of minor recommendations are being implemented by the Surgical Services Group.
Use of diathermy resulted in a fire, causing burns around the patient's knee requiring subsequent surgery and skin grafting.	Alcohol-containing solutions should only be used for skin preparation pre-op and be allowed to dry completely before diathermy is used.	Skin preparation procedures have been modified and an education programme delivered to ensure : • Any alcohol-containing solutions are removed from theatre as soon as pre-operative skin preparation is completed. • Diathermy is not used in the presence of alcohol • Skin preparation is allowed to fully dry before the use of diathermy commences Regular audit of compliance to this practice has become part of the operating theatre standard audits.
Colonoscopy resulted in a perforation of the bowel	A frail elderly patient suffering from a variety of chronic health problems presented to the Emergency Department where they were referred for a gastroscopy and colonoscopy	A revised set of guidelines for open access referral for endoscopy have been developed.

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and the patient's subsequent death.	under the "open access" system. This system refers a patient directly for these procedures without requiring a prior clinic appointment. The patient underwent suitable bowel preparation and a flexible sigmoidoscopy was then performed. The review identified that, whilst the purpose of open access is to expedite the process, there are a number of patients (those with comorbidities and whose general state of health may require review) for whom prior clinic appointment is advisable before acceptance for investigative procedures such as colonoscopy and gastroscopy. This prior review would enable full and open discussion with patients regarding the appropriateness and risks of further investigation and whether treatment should take place given pre-existing state of health and comorbidities.	
Bowel perforation as a result colonoscopy that required transfer to tertiary hospital for further treatment.	The patient had a variety of health issues / comorbidities and was on anti-coagulant medication. During the colonoscopy multiple polyps of varying sizes were found and excised using combination of 'hot' and 'cold' snare. The patient subsequently represented and was diagnosed with a bowel perforation secondary to colonoscopy and biopsy and the patient was appropriately transferred urgently to a tertiary facility for further treatment. The review found that there was a need for a clear procedure around the management of patient on anti-coagulants who	Clear procedures and guidelines have been developed and implemented for: • management of patients undergoing colonoscopy who are on anti-coagulants • use of either 'hot' (with diathermy) or 'cold' (without diathermy) when performing polypectomy during colonoscopy • selecting the number and type of polyps to be biopsied for patients with multiple colonic polyps during each procedure

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	require colonoscopy, when 'hot' or 'cold' treatment of polypectomy is most appropriate, and how to best manage patients with multiple polyps.	A review was undertaken of the current diathermy equipment available at the DHB and a new ERBE endoscopy machine was purchased.
Bowel perforation following colonoscopy and biopsy, requiring transfer to tertiary hospital.	Patient was admitted for colonoscopy and polyps were removed with 'hot' snare, preceded by a saline injection, and the remaining polyps were removed with a 'cold' snare. The patient subsequently represented and was diagnosed with a bowel perforation secondary to colonoscopy and biopsy. Due to complications and the patient's comorbidities the patient was transferred in a timely and appropriate manner to tertiary facility for further treatment.	A guideline regarding the use of diathermy and techniques for this during colonoscopy has been developed and implemented.
Unwitnessed patient fall resulting a humeral fracture	Elderly patient with fractured left neck of femur was being treated conservatively and identified as a high falls risk, so was moved to a room that provided closer observation. Patient fell (unwitnessed) in the bathroom.	The review process for this incident is currently in progress. In the interim, the process for medical boarders is being reviewed. A falls education session will be added to core update days/orientation days to help communicate the learnings obtained from events.