Wairarapa District Health Board
Adverse Event Report: 2018-2019

There were 5 serious adverse events reported by the Wairarapa District Health Board (WrDHB) during the period of 1 July, 2018 to 30 June, 2019. The following report outlines the summary and findings from reviewing these 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 any additional details regarding two suspected community suicides due to the potential identifiable nature of the events.

The events reported are within the categories of:

- Clinical Process/Procedure
- 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 again 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
Retained swab following surgical procedure, requiring an additional surgery for removal.	Surgical count did not occur in a timely manner and there was inadequate communication of this between team members, resulting in the completion of surgery before there was confirmation of surgical count having being completed. 'Sign out' following completion of surgery did not take place. Once the surgical count had been completed, the missing gauze was noted. The patient was informed, an x-ray was undertaken and the patient was returned to theatre while spinal block remained effective so minimal anaesthetic required and the gauze swab removed.	Re-education of existing staff regarding Surgical Count policy requirements, and the Safe Surgery policy has been updated to include a definitive time in which aspects need to occur. Sign off on policy familiarisation is now a standard part of staff orientation and all returning staff now receive a re-orientation. Audit of compliance to policies is now part of operating theatre audit schedule. Refresher in-service education sessions have been provided to all staff on communication.
What happened	What we found	What we are doing to prevent this happening again
Patient fall resulting in fractured right neck of femur requiring surgery.	Patient was placed in a close observation bed space having been identified as a high falls risk due to mild confusion The assessment made did not indicate that the patient required a full patient 'watch'. The patient's fall was an unfortunate outcome as a result of an unpredictable attempt to mobilise and existing assessments and care planning actions did not prevent injury. A patient 'watch' may have prevented this fall.	Wairarapa DHB continues the evaluation of falls risk at admission/presentation. All high risk patients are assessed for the requirement of a patient 'watch'. Appropriate actions and documentation is regularly audited to ensure compliance to falls management policy.

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What happened	What we found	What we are doing to prevent this happening again
Undiagnosed breech, until diagnosed in late stages of labour requiring transfer of care and vaginal breech delivery resulting in death of the infant.	This labour/delivery was managed within the expected guidelines for a baby believed to have been a cephalic presentation. On discovery of the breech presentation, appropriate management protocols were followed.	A review of this event found that best practice guidelines and DHB policy and procedures were followed. There were however some incidental findings that although would not have altered the outcome, some learnings were identified and shared, a number of recommendations made that have been implemented.