MEDIA STATEMENT

21 November 2019

Wairarapa District Health Board Adverse Event Report 2018-2019

Wairarapa District Health Board (DHB) has today published its annual adverse event report, in conjunction with the Health Quality & Safety Commission (HQSC)'s national data.

Three adverse events have been reported by Wairarapa DHB. One patient required additional surgery after a gauze swab was left unaccounted for following a surgical procedure. A second patient fell while in hospital and fractured their femur. The third event involved an undiagnosed breech birth that resulted in the death of a baby.

Findings of the review of the events is provided in a summary report published on the DHB's website.

While the DHB won't comment on individual cases, it has thanked the patients and their whānau for the opportunity to share their stories.

"Obviously we work hard to make sure adverse events don't happen, but when things do go wrong and people are harmed, we act swiftly to learn from those events and then share that learning to prevent it happening again," said Dr Shawn Sturland, Chief Medical Officer for Wairarapa DHB.

"We call these failures adverse events. But what we are really talking about is patient harm. There are people in the centre of these stories and, usually because of failures in systems or processes of some sort, they have been compromised."

"For that, we apologise, and from that, we learn," Dr Sturland said.

"We undertake a thorough review of all adverse events, which always includes consultation with the patient and their whānau and, where necessary, independent expert assessment. There is always something to learn."

"Even when a review has found the care to have been appropriate, we can usually discover things that we could have done differently that may have improved the patient's experience. Following a review, we implement process change and educate staff to ensure we deliver better care next time."

"We do apologise to these three patients, and we are grateful for the time they have spent with us assisting with the review of their care," Dr Sturland said.

The HQSC report, *Learning from Adverse Events*, includes national data relating to adverse events reported between 1 July 2018 and 30 June 2019. It has a theme of safety culture, and aims to assist DHBs, private surgical hospitals and emergency providers to strengthen the safety of their service through learning.

How does Wairarapa DHB manage adverse events?

Wairarapa District Health Board's Quality Team liaises closely with the Health Quality and Safety Commission (HQSC) to ensure robust and transparent review and reporting of serious adverse events. We encourage an open and honest reporting culture, and support staff to review and improve systems and processes whenever the opportunity arises.

Wairarapa DHB undertakes a thorough and inclusive review of serious adverse events; involving the patient, their whānau and external experts where necessary. The Clinical Event Review Group explores what happened, and why, and makes recommendations for change that are shared with staff and included in a Corrective Action Plan that is overseen by the Clinical Board.

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.

We remain committed to open communication and transparency, and publish an adverse events summary on our website annually.

How many adverse events have there been?

The Commission has published four years of adverse events data. This year, Wairarapa DHB has reported three adverse events. Last year, seven events were reported and eight the year before that.

What changes has Wairarapa DHB made as a result of this year's adverse events?

Wairarapa DHB has:

- re-educated staff on safe surgical policy, and included definitive timeframes for actions to occur as part of surgical procedures
- included policy familiarisation in orientation
- improved our operating theatre audit schedule
- introduced communication training with staff
- a full patient watch criteria applied for falls-risk patients
- introduced audit of compliance with policy

- developed guidelines and communication procedures
- improved support processes for bereaved parents and whānau, and follow-on care in the community post-discharge

How are staff involved in the adverse events affected?

Wairarapa DHB focuses strongly on system improvements, rather than on individual blame.

We have clear processes to support staff involved in adverse events, and have adopted systems to support staff to be involved in event reviews and recommendations.

The adverse events process provides an opportunity to review our service, and implement recommendations that will prevent such events reoccurring.

What does the DHB want to say to the patients involved?

Wairarapa DHB wishes to again sincerely apologise to the patients and their whānau/family involved in these events. We understand the distress caused when unexpected or unplanned outcomes occur.

We'd like to thank the patients and their whānau for allowing us to share their stories.

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