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

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<thead>
<tr>
<th>CATEGORY</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
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<tbody>
<tr>
<td>Clinical Processes</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Patient Falls</td>
<td>1</td>
<td>5</td>
<td>10</td>
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<tr>
<td>Medication/IV Fluids</td>
<td>1</td>
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<td>2</td>
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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.
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
• 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
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
3. 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
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 (ie. action plan):**
- Not applicable
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 (ie. 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
### Event 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
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 (ie. 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