Serious Adverse Events Report

2012 - 2013

Introduction

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious and Sentinel Events. http://www.hqsc.govt.nz/our-programmes/reportable-events/news-and-events/news/1239/

In the 2012-2013 year CM Health reported forty five events that have caused serious harm or death. Thirty three of these events related to falls.

Because of the complex nature of health care, adverse events causing serious unintended harm to patients do occur and are truly regrettable. In reviewing each of these events, the focus is always on what we can learn and how we can improve care to prevent the likelihood of a similar event recurring.

What is a serious adverse event?

A serious adverse event has resulted in serious lasting disability or death, not related to the natural course of the patient's illness or underlying condition.

As part of CM Health's commitment to providing safer care for patients, we have in place a process for reviewing serious adverse events that occur in our organisation. The purpose of reviewing these is to determine the underlying causes of the event so that improvements can be made to the systems of care to reduce the likelihood of such events occurring again.

Serious adverse event reviews at CM Health are undertaken according to the following principles:

- Establish the facts: what happened, to whom, when, where, how and why
- To look for improvements in the system of care rather than apportion blame to individuals
- To establish how recurrence may be reduced or eliminated
- To formulate recommendations and an action plan
- To provide a report as a record of the review process
- To provide a means of sharing learning from the incident

Guide to Event Categories

Code Description

General classification of event	Event code
Clinical administration (eg handover, referral, discharge)	01
Clinical process (eg assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (eg, wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)	10
Patient accidents (not falls) (eg, burns, wounds not caused by falls)	11
Patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14

Event Category	Death Y / N	Case Précis	Review findings	Recommendations	Follow up
02	Y	A sick patient with severe injuries developed a sudden and unexplained serious clinical deterioration and had urgent blood tests taken. One of the blood test results showed an extremely low Blood Sugar level which was not immediately noticed leading to a delay in appropriate treatment. This delay was a contributing factor in the patient's eventual death.	The patient's deterioration was provisionally diagnosed as being the result of the initial respiratory injuries and a Blood gas was sent to the laboratory.. The treating team was therefore not immediately vigilant for other causes. The Laboratory procedure for telephoning extreme results did not work reliably for results from Blood Gas analyzers. The display of results with multiple "abnormals" all of which were in red, did not readily highlight extremely abnormal critical results.	Laboratory will review their systems for identifying extreme laboratory results and communicating these to medical staff. Laboratory will change the way extreme results for critical values are highlighted so that they are readily identifiable to medical staff.	Laboratory staff are now immediately alerted by all abnormal results that require urgent clinical intervention, including results from Blood gas analysers Extreme results for critical laboratory tests will be highlighted by appearing in white against a red background so that they stand out.
05	N	At the start of an emergency Caesarean Section the wrong medication was given which resulted in a difficult and delayed delivery with potential for harm to the baby.	There was not a standard approach in the anaesthetic checking process for medication administration. There was no process to determine who takes the lead in the immediate management for this type of emergency	Anaesthesia will review the process for checking high risk medications Anaesthesia will develop a process for dealing with this type of rare occurrence.	A formalised process for checking high risk medications has been implemented in anaesthesia Oxytocin alert label has been changed from white to pink A process has been developed to clearly identify responsibilities during an emergency

Event Category	Death Y / N	Case Précis	Review findings	Recommendations	Follow up
02	N	The ignition of chlorhexidine / alcohol antiseptic skin cleaner under the drapes during surgery resulted in a minor burn on the patient's thigh.	The use of alcohol based skin preparation in conjunction with the draping required for this type of surgery meant flammable vapour was trapped and was subsequently ignited by a spark from a diathermy machine.	Non-alcohol based antiseptic skin preparation will be used for this type of surgery	The Departments of Surgery and Women's Health are considering all alternatives available
02	N	The delay in timely treatment for a patient with an eye condition may have contributed to further visual impairment.	Due to the increasing number of patients in Eye Clinic exceeding the resources available, the patient was not scheduled in a timely manner for a check up.	A service action plan will be developed to meet the needs of the increasing number of patients with eye conditions. .	A Service Action Plan has been developed and a number of actions initiated: Review of the referral criteria Additional clinics for first specialist appointments. Increase in the number nursing & medical staff Certain procedures previously requiring inpatient care can now be done as an outpatient allowing increased access to care. Significant capital expenditure for ophthalmology examination and procedural equipment

Event Category	Death Y / N	Case Précis	Review findings	Recommendations	Follow up
02	N	A chest x-ray with an abnormal finding was neither reviewed nor signed off for 7 months resulting in a delayed diagnosis of cancer.	There was an accumulation of unsigned reports due to a combination of high administrative and clinical workloads. This was further complicated by technical issues in the results systems. There was a lack of a clearly defined process of advising the referring senior doctor of any unexpected and significant findings in the x-ray.	Each service will review the administrative commitments of Senior Doctors and develop a plan to ensure that reports are signed off in a timely fashion. Radiology is to formalise an 'Alerts Protocol' to ensure that unexpected significant findings are promptly drawn to the attention of the responsible Senior Doctor.	The Alerts Protocol has been established which ensures that significant / unexpected findings are identified and checked daily. The referring clinician is then notified by email and If the referrer is a GP the report is faxed directly to the practice.
02	N	A patient sustained a ruptured oesophagus while undergoing a trans-oesophageal echocardiogram (TOE) for which she had a documented contra-indication in her notes.	The patient's pre-existing condition which is an absolute contra-indication for a TOE was not noted at any time during the admission or prior to the procedure. There was no prompt about contra-indications in the referral process to alert the receiving doctor. There was a lack of continuity of management for this patient due to staff illness. The consent form did not require the consenting doctor to exclude specific contra-indications for the procedure. There was no pictorial information sheet explaining the procedure. This meant the patient didn't fully comprehend what was going to	An electronic referral process is being developed and is to include a procedure check list to ensure any contra-indications are excluded. The Consent form is also to be re-designed to include this check list to ensure that each potential contra-indication / complication has been discussed. A patient information sheet will be developed in conjunction with the Patient & Family Centred Care Group. This information sheet has visual cues and appropriate language to ensure patient understanding The problem list is to be reinstated	Electronic referral process is yet to be implemented The consent form has been redesigned with a check list. A patient information sheet has been developed with appropriate pictorial images and language. The problem list has been reinstated

			happen and therefore didn't acknowledge any potential problems when questioned. There was no problem list in the clinical notes	as standard practice in Cardiology	
02	N	A delay in identifying a tear in the oesophagus after a difficult intubation led to an extended stay in the Critical Care Complex.	As this is a rare complication, the clinical signs were not immediately obvious to the attending medical staff.	The case will be presented to the speciality as a learning exercise.	Completed.
02	N	A patient who was referred for a colonoscopy had to wait for 10 months The colonoscopy revealed a cancer in an advanced state.	There has been an increasing demand for endoscopies placing the service under considerable pressure. The referral process which was paper-based was error prone and had insufficient safeguards	A comprehensive review of the Gastroenterology Service has been undertaken to ensure improvements in capacity and reliability of processes	Currently awaiting the final report and implementation plan for the recommendations.
02	N	A patient experienced a 7 month delay for a colonoscopy. A bowel cancer was subsequently diagnosed.	There has been an increasing demand for endoscopies placing the service under considerable pressure. The referral process which was paper-based was error prone and had insufficient safeguards	A comprehensive review of the Gastroenterology Service has been undertaken to ensure improvements in capacity, capability and reliability of processes	Currently awaiting the final report and implementation plan for the recommendations.

Event Category	Death Y / N	Case Précis	Review findings	Recommendations	Follow up
05	Y	A patient was prescribed a combination of medications that adversely affected his already compromised cardiac and renal function. He developed a perforated duodenal ulcer he subsequently had a cardiac arrest and died.	There was a failure to recognise potential serious adverse effects of the medication combination during the course of his medical management. By the time of the routine formal medication review, the patient was already severely affected by the combination of medications.	The events will be discussed at the Mortality and Morbidity clinical meeting The Pharmacy will prepare a campaign about the serious adverse effects of this medication combination.	Complete In development
02	N	The patient presented with a small cyst in the right nostril. Surgery was undertaken on the left side of her nose.	The policy and process for confirming and identifying the correct surgical site was not followed. As a result of a software upgrade error, the CT scan viewer displayed a mirror image of the nose which was not identified prior to surgery. The "Time out" step of the surgical safety checklist was not completed in line with CMH policy This resulted in the error not being identified before the patient left the operating theatre.	The event was discussed at the departmental meeting and the learning disseminated. The service will regularly audit the use of the Surgical Safety Checklist. Radiology is to confirm in writing the software upgrade error has been addressed to prevent a reoccurrence of the CT scan reversal.	In progress Completed
02	N	A cotton swab was left in place in situ after an assisted delivery which resulted in an infection.	The routine formal swab count that occurred after the delivery was incorrect.	The formal count process will be reviewed.	A third level of checking the swabs has been instigated.

Summary of Falls causing patient harm

Of the 45 serious adverse events reported to the Health Quality & Safety Commission for the 2012-2013 year, thirty three were related to falls. In three of these events, the fall contributed to the patient's death.

This year CMH has reported more falls than for the 2011-2012 year, however in this year's total we have included six falls that resulted in lacerations that required sutures that would not have previously been reported.

The remaining falls which resulted in fractures included:

- five fractures involving the upper limb,
- five involving the spine, pelvis or ribs
- two involving the lower thigh or leg.
- 10 patients had a fractured hip - one of the patients died following surgery to repair the fracture.
- 5 patients had a cerebral haemorrhage - two of these died.

The Falls prevention programme is continuing with the following strategies to reduce the risk of serious harm from a fall. Over the next year the focus will be on testing and improving the reliability of the following interventions across the whole organisation:

- All patients to have a falls risk assessment completed within 6 hours of admission to the ward.
- Ensuring appropriate interventions are put in place according to the assessed risk, including:
- Provision of non-slip socks
- Falls alert on room door
- Frequent nurse rounds (up to hourly)
- Nursed on low bed
- Walking frames and other stability supports
- Medication review to decrease use of medications likely to increase risk of falling
- Hip-protectors
- Ensuring every patient is reassessed regularly or when their condition changes
- Developing an organisational clinical equipment management system that allows wards to quickly and efficiently access falls prevention equipment (example alarms, Invisi-beams, high low beds as required by patients)