Counties Manukau Health Adverse Event Report 2018-2019

What is a serious adverse event?

A serious adverse event is an incident where a patient is seriously harmed during medical treatment. Counties Manukau Health (CM Health) has worked hard to develop a culture in which staff feel safe to report adverse events. What we report and investigate has changed over time and CM Health is now also reporting events that have caused no long-lasting harm and events that are significant near misses, that is, where no actual patient harm was identified but the potential for future harm from recurrences was apparent.

As part of CM Health's commitment to providing safer care for patients, we have a process in place 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:

- To 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 lessons from the incident

Quarter 1 (July - September 2018) Falls cases: 3

Title	Findings	Recommendations	Follow up
Lack of coordination of antenatal care leading to a potentially avoidable stillborn baby	• Non-recognition by multiple healthcare professionals (General Practitioner, Birthing and Assessment Unit midwifery staff and Community Midwife) of the complexities surrounding a vulnerable woman presenting in the third trimester. This resulted in uncoordinated antenatal care and a potentially avoidable stillbirth. • High acuity and volumes in the community midwifery service led to the inability to provide appropriate antenatal care in a timely manner to the pregnant woman who was socially vulnerable. • Ultrasound scanning was not directly arranged for the pregnant woman and no health professional who provided her with a scan form followed up to see if the scan had been performed. • Antenatal grading requires urgent referral for antenatal care from >35/40 gestation • Community midwives don't have access to smart devices with internet access while undertaking visits outside of CM Health facilities. • There was insufficient supernumerary orientation to B&A North (Assessment) for a new graduate midwife.	• Review how Primary Care continuity of care can best be implemented for women with socially complex pregnancies when requiring inpatient and outpatient care. • Auckland Regional Health Pathways to include care of the woman presenting for the first time in the third trimester. • Remind GPs that there is a POAC pathway and guideline for Iron infusion. • Investigate increasing the numbers of Community Health Workers to support Community Midwives caring for women with complex social situations. Recruitment of Community Health Workers should be reflective of the ethnicities within the community served by CM Health. • Counties Manukau Health '*Care of the Unregistered Antenatal or Postnatal Woman Presenting to a Women's Health Facility*' Guideline to include arranging of POAC scan appointment or DHB scan appointment so that a woman is provided with her scan appointment details prior to leaving a clinic/facility/antenatal assessment. • Change the antenatal grading desk file to read urgent referral and allocation to a Community Midwife for women presenting at any time in the third trimester (i.e. 28/40 onwards). • Investigate internet connectivity for DHB community midwives while doing antenatal visits, especially to aid in booking POAC scans for women at the time of the antenatal appointment. • Graduate midwives should be given supernumerary orientation to B&A North (assessment) and be appropriately clinically supervised for a defined number of shifts.	• In progress

Quarter 2 (October – December 2018) Falls cases: 4

Title	Findings	Recommendations	Follow up
Evidence of harm from delayed eye clinic follow-up	• Three patients confirmed with compromised vision due to delayed follow-up • Ophthalmology continues to have difficulty meeting the demand for services	• Continue close monitoring via monthly report • Ophthalmology Service demand and patient risk to remain on the Risk Register • Clear advice to be given to patients about potential for delays and what to do if they notice worsening vision • Ongoing increased investment in additional clinics and extending existing clinic capacity • Senior doctor recruitment • Changes in practice to optimise treatment with Avastin.	• Monitoring via monthly report • Ophthalmology Service demand and patient risk on the Risk Register • Important Advice to Ophthalmology Patients: Communication provided to patients about the high demand for follow up appointments at Ophthalmology Clinics. • Advised patients to contact the service if they had concerns regarding eyesight or notice deterioration in your eyesight before your next appointment, • Increased clinic capacity to address the large volume of follow-ups. Extra clinics have been in place since mid- March 2019. These include evening and weekend clinics. Weekend 'mega' clinics have capacity to see 600 patients over the weekend. • Plans to expand capacity on Middlemore site. • New fulltime SMO recruited and 2 SMOs returning. • New treatment planning protocol in place for those receiving Avastin.

Title	Findings	Recommendations	Follow up
Unexpected death following a chest drain insertion	• Patient with severe lung problems on anticoagulation presented with a collection of fluid requiring drainage. • The timing of restarting anticoagulation post pleural procedures in a high risk patient may have contributed to the patient's deterioration. Patient was given Clexane (anticoagulant) 4 hours after the procedure due to concerns of embolic events causing his fluctuating level of consciousness. • The pleural procedure ideally should be done in earlier hours, and should be avoided after-hours unless in medical emergency. In this case it was delayed due to transferring the patient from a general medical ward to respiratory ward. **Additional Findings**: • Complex patient with multiple comorbidities and no English. Not managed in respiratory home ward initially.	• Patients with multiple comorbidities and anticoagulation need more intensive monitoring post pleural aspiration. • Review and update recommendation on anticoagulants for pleural procedures with Haematology consultation. • Anticoagulation can be restarted after 12-24 hours post procedure depending on haemostasis in high risk patients. **Additional Finding Recommendations**: • Avoid 'outliers' of sub-specialities in Medicine to General Medicine Wards but placement in own wards	• In progress • Review and update recommendation on anticoagulants for pleural procedures completed

Quarter 3 (January – March 2019) Falls cases: 10

Title	Findings	Recommendations	Follow up
Stage 3 pressure injury on both heels	• Incomplete assessment and communication about pressure injuries from theatre staff. • Inability of Intensive Care Unit staff to view the pressure injury. • Inconsistent communication between shifts resulted in delay in initial treatment and worsening of pressure injury to both heels. **Additional findings** • Wound care chart not used once pressure injury identified.	• Review process with theatre when a pressure injury is discovered, consider if ICU staff would be able to come to theatre to assess pressure injuries. • Develop burn pathway that incorporates appropriate wound care aspects for the burn injury patient.	• Review process with theatre when a pressure injury is discovered by 30/09/2019 • Burn pathway developed 31/07/2019.

Title	Findings	Recommendations	Follow up
Misplacement of central venous line into artery requiring chest surgery for removal	• It is not currently standard practice to use multiple methods to verify wire placement prior to dilatation of vessel in difficult or high risk line placement.	• In difficult or high risk line placements change current practice to ensure blood gas analysis and use of ultrasound to demonstrate correct position of wire prior to dilation of vessel during catheter insertion.	• Provide summary of event and discuss at Intensive Care Morbidity and Mortality meeting by 31 August 2019 • Incorporate practice change into RMO orientation handbooks

Quarter 4 (April – June 2019) Falls cases: 4

Title	Findings	Recommendations	Follow up
Stage 3 hospital acquired pressure injury	• Patient declining turns due to shortness of breath & left hip pain. • Patient medical problems, malnourished, reluctant to change position. • Lack of documentation.	• Pressure injury resource nurses to work closely with ward staff by monitoring assessments and interventions. Feedback to charge nurse and team at handovers / huddles on areas for improvement. • Resource nurses to check how staff monitor skin integrity assessments and documentation. Resource nurse to provide a chart of different stages of pressure injury so staff are aware what stage it is. • At staff handovers / huddles; staff will check e-vitals to ensure patients' skin integrity has been sighted and documented.	• Weekly Pressure Injury updates • Waterlow score to be completed on admission and when there are changes otherwise weekly • Weekly pressure injury in-service sessions to discuss Waterlow scores, assessments and interventions

Always report and review cases

The Always Report and Review cases are adverse events that are reported and reviewed in the same way as serious adverse events, irrespective of whether or not there was harm to the consumer/patient.

Title	Findings	Recommendations	Follow up
Incorrect patient or incorrect procedure in Radiology department	• A series of cases in which patients received the incorrect radiological examinations with no adverse outcome • Themes identified in the case reviews included: • With electronic referrals there is no paper record to carry with the MRT to use as part of their identification checks – they only use a label. • Acute Radiology in ED's whiteboard only uses names and bed numbers. • The orderlies don't always check the patient's NHI when collecting a patient • Due to the high volumes of patients, the MRT staff get busy and distracted and can fail to follow the proper identification checks for a patient.	• MRT to trial the printing of referral form to use as part of the identification process of patients. • Trial the use of a tablet / slave monitor in the CT room to use the electronic referral to identify the patient. • Acute Radiology ED whiteboard to add in names, bed numbers as well as the patient's NHI for the orderly to use as an identifier. • Task manager can be used as a reminder to orderlies to check wristbands as part of the checking process when collecting patients. • To look at alternative options (Smartpage, barcode, smartphone scanning) in the wider organisation as part of patient identification • Orderlies to be trained on the use of AI2DET to ensure appropriate identification of patients.	• Label printer considered to be more efficient and change in process has occurred. • Use of tablet not considered feasible due to security. • Update in ED whiteboard to be considered.. • Limited functionality in Task Manager. • Smartpage trial in Radiology begins in December 2019. • Education and training has been rolled out to orderlies.

Title	Findings	Recommendations	Follow up
Device failure leading to a snare being retained after an endoscopic biopsy procedure	• There is no evidence that any processes followed by Gastroenterologist contributed to the failure of this device, resulting in a retained snare post procedure. **Additional findings:** • Training for this procedure and equipment is every two years and Gastroenterologist's next training us due in August 2019. The nursing staff get training from the company representatives • Staff are unaware of the faulty equipment process and how to report it. • Consent forms do not have sufficient information.	• Further training to be provided to the nursing staff • Company representatives to be available for the support for the next 5 procedures	• Nursing training refresher for the procedure was completed in February 2019. • Company representative attended further procedures (of which there has only been 1-2). • Review of consent forms completed and staff informed to make sure they don't use acronyms but write out the procedure in full when gaining consent.
Title	**Findings**	**Recommendations**	**Follow up**
Foreign object retained post procedure	• A retained abdominal swab remained undetected for 12 months following major abdominal, perineal and rectal surgery. • We have been unable to determine how the swab was left inside the patient's abdomen when all documentation indicates that proper processes were followed.	• Share report with surgical teams.	• Completed.

Harm related to falls

Injuries suffered by patients when they fall are the most common ones in the hospital. Falls cause more minor, moderate and severe injuries than any other type of reported incident. In this year's report, 21 patients were seriously injured after a fall. These injuries included significant head injuries and broken bones. Each of the incidents was reviewed to ensure that the comprehensive programme of falls prevention in place at CM Health had been followed. Understanding where improvements to the programme need to be made and how to better help staff keep patients safe are the main drivers for the review. Over the last year, there has been ongoing work to ensure accurate and timely assessment of falls risk including the recent addition of falls risk assessment to the electronic observations software.

Adverse event investigations in progress from 2018/2019

Service	Description of event
Women's Health	Intra-uterine fetal death associated with delay in treatment of maternal diabetes
Women's Health	Postpartum haemorrhage following elective caesarean section leading to maternal death
Surgery	Delay in treatment of skin cancer leading to progression of disease and the need for more extensive surgery and loss of function
Surgery (Always Report & Review)	2 cases where patients received intraocular injection into the incorrect eye.

Adverse event investigations from previous years

Title	Findings	Recommendations	Follow up
Delayed follow up and diagnosis of lung lesion	• An incidental ill-defined small opacity was identified on a chest x-ray in Dec 2017 with a suggestion of a 6-8 week follow-up image. No-one viewed and signed off on the results or followed this up resulting in a 6 month delay in diagnosis. • If the previous history of melanoma had been documented on the radiology referrals, this would have raised the pre-test probability of something more suspicious. This may not have been relevant on the chest x-ray that was investigating possible pneumonia. • A copy of the report was not sent to the GP resulting in a missed opportunity for a more timely follow-up. **Additional findings:** • Two staff member viewed the results and did not follow up on the abnormal result • Risk in Emergency Department of person assigned to sign off on 300 plus results at a time, that something potentially more serious will be missed with "sign off fatigue"	• Review alerts process and consider standardisation of alerts thresholds. • Discuss use of alerts process by Radiologists • Consider automatically sending results from all investigative radiology procedures to the GP	• Recommendations to be completed by 30 December 2019