Counties Manukau Health Adverse Event Report 2019-2020

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

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This report summarises all the Severity Assessment Code (SAC) 1 and 2 incidents included in the annual national release of Serious Adverse Events managed by the Health Quality & Safety Commission.

Quarter 1 (July - September 2019) **Falls cases: 7**			
Title	**Findings**	**Recommendations**	**Follow up**
Retained swab in left shoulder	• A dressing was used to stop bleeding during the treatment of a penetrating wound. • This was not detected during the washout and remained in place for 3 weeks until the repair of the shoulder fractures was undertaken. • The type of dressing used is not intended to be used as internal packing and does not have a radio-opaque marker (show on x-ray). • If a packing that contained a radio-opaque marker had been used, this retained dressing would have been identified earlier when radiological images were taken.	• Emergency Department to review the types of swabs and dressing held in the resuscitation rooms used for multi trauma and consider using products containing radio-opaque markers.	• Swab use was reviewed in the Emergency Department and radio-opaque swabs are now available in resuscitation area.

Title	Findings	Recommendations	Follow up
Patient at high risk of rheumatic fever with a positive test result did not receive early treatment	• Patient received an appropriate triage and nursing assessment but there was a delay in medical review due to low staff levels on that shift. The patient did not wait to be seen. • If the patient had been seen, given their history and presenting symptoms, a diagnosis of acute rheumatic fever was likely and the patient would have received appropriate antibiotic treatment. • A further opportunity to treat the patient early was lost when a positive result indicating the high risk of rheumatic fever did not lead to documented attempts to contact the patient. • CM Health policy 'Accepting Diagnostic Test Results and Signing Clinic Letters' (March 2019) only refers to Clinical Reports such as Histopathology and Radiology Reports must be viewed, accepted, actioned (where necessary) and signed off within 7 days.' There is no mention of an expected timeline for review, accepted and action of general blood requests or swabs.	• Medical staff will action or document response to positive results in future. • Consideration for an organisational standard for result sign off standard response times to potential high stakes results such as microbiology. • The emergency department will continue to allocate Senior Medical Officer (SMO) time to go through 'orphan' results. If a 7 day standard is adopted for such results then reprioritisation of resource may be needed to achieve this.	• Clinical Director to present case for addition of microbiology results to policy on December 8 2020.

Quarter 2 (October – December 2019) Falls cases: 6			
Title	**Findings**	**Recommendations**	**Follow up**
Peripheral line bacteraemia with thrombophlebitis	• Bacteraemia and thrombophlebitis associated with intravenous (IV) line, resulting in re-admission to hospital for 4 days and an extended course of IV antibiotics via peripherally inserted central catheter (PICC) line. • Lack of monitoring of the IV line site when in situ.	• Education and training for staff regarding the recommended observations and cares while IV line in place.	• Comprehensive peripheral IV line 'Choosing wisely' campaign currently being developed with Ko Awatea support staff to manage IV lines safely. ELT proposal to be presented on December 9 2020
Peripheral intravenous line associated bacteraemia leading to an aortic root abscess	• The patient had an infusion for an extended period using a peripheral intravenous line (PIVL). • There was no documentation when the line was inserted. • IVL checks and documentation were not adequately frequent or specific.	• A peripherally inserted central catheter (PICC) line could be considered if infusions are anticipated to be required for more than a few days, especially if multiple PIVL replacements are required. • Case to be discussed at Morbidity &Mortality (M&M) meeting. • Raise awareness of this complication of IV access. • Improve checks & documentation.	• Comprehensive peripheral IV line 'Choosing wisely' campaign currently being developed with Ko Awatea support staff to manage IV lines safely. ELT proposal to be presented on December 9 2020 • SAFETY II review underway on a General Medicine Ward in relation to the IV line management. Provisional findings due on December 11 2020.

Title	Findings	Recommendations	Follow up
Delay in epidural abscess treatment	• Despite a high clinical suspicion of an epidural abscess there was a delay in the diagnostic Magnetic Resonance Imaging (MRI) being performed by 24 hours as the patient remained stable and there were no signs of sepsis. • Communication from Senior Medical Officer (SMO) to SMO between the Acute Pain Service and Radiology may have meant that the appropriate investigation was performed in a more timely manner. • The removal of the epidural catheter was not documented nor were post removal observations • The Guideline (A219332) Post-operative management of epidural anaesthesia in adults – set-up, monitoring and nursing care requirements, catheter removal and management of adverse effects and complications – does not adequately outline the course of action to take for a suspected epidural infection	• Acute Pain Service to develop best practise guidelines for investigation of epidural abscess and to consider acute pain service SMO to radiology SMO discussion and referrals. • Nursing team on ward 34East to receive refresher education on management of epidural catheters. • Guideline (A219332) to be reviewed and updated.	• The Guideline (A219332) Post-operative management of epidural anaesthesia in adults has been reviewed and updated.
Severe pressure injury on patient's heel	• Lack of attention/assessment/communication of risk of pressure injury developing • Patient unable to engage and follow recommendations.	• Charge nurse/Clinical nurse specialist/Coordinator daily reviews of Wound Care Assessment plans. • Reminder to medical staff regarding reporting incidents – include in medical orientation. • Education update for staff regarding documentation/reviewing pressure injuries.	• Complete.

Quarter 3 (January – March 2020) **Falls cases: 6**			
Title	**Findings**	**Recommendations**	**Follow up**
Peripheral IV line associated bacteraemia	• On the admission day, the line was kept in with no indication for it as the patient's medication was oral. • Lack of documentation and observations in the clinical records. • CM Health does not have a guideline on the antibiotic management of IV-line-associated thrombophlebitis.	• Discussion with Ko Awatea (KA) for an improvement project: • Starter pack - allows standardisation of practice (disposable tourniquet, correct preselected consumables, labels) and promotes an aseptic field to work from. • Promotion of ANTT for insertions. • Site choice as per best practice not convenience. • Extension set on every line - there is an integrated model on the market which we have proposed, presented and recommended previously. • Mechanism for recording insertions in ED. • Promotion and reinforcement of documentation through e-vitals. • Raise awareness of this complication of IV access. • Improve checks & documentation. • Case to be discussed at M&M meeting.	• Comprehensive peripheral IV line 'Choosing wisely' campaign currently being developed with Ko Awatea support staff to manage IV lines safely. ELT proposal to be presented on December 9 2020. • SAFETY II review underway on a General Medicine Ward in relation to the IV line management. Provisional findings due on December 11 2020.
Healthcare Associated central line associated bacteraemia (CLAB)	• A patient requiring long term intravenous feeding via a central line developed a severe blood infection at home. • Despite investigation, it was unclear as to the source of this infection; it was possibly during the District Nurse clinic visit or at home during access for Total Parental Nutrition (TPN) administration. • Family member untrained in access techniques identified. • District nurses do not receive refresher updates on central line management.	• Trial of 'line locks' while central line is not being used to see if this reduces risk of contamination. • Offer made to patient to provide training to family.	• Complete

Quarter 4 (April – June 2020) **Falls cases: 4**			
Title	**Findings**	**Recommendations**	**Follow up**
Serious assault on members of staff by a patient	• There were barriers to accessing timely and appropriate services for the patient including the requirement to prove eligibility for health services in primary care. • The interface between the Emergency Department, Medicine and Mental Health teams is complex leading to uncertainty about clinical roles and responsibilities, communication and care planning. • There is no clinical pathway or decision making tool to support frontline staff manage patients with complex medical, mental health and risk issues. • Areas for improvement were identified in frontline staff safety awareness and response, equipment and communication tools for security staff and the composition of the team responding to an emergency call out relating to behavioural disturbance. • Acute services at Middlemore Hospital chronically work at the upper limit of their capacity restricting options for the care of patients with complex medical, mental health and risk issues.	• The DHB to consider a more pragmatic approach to proving eligibility in health across the district that does not limit access at time of highest need. • A documented model of care / clinical pathway agreed by MH, ED and Medicine will be developed to better provide care to patients with behavioural disturbance. This pathway will clarify access to and handover of information, development of management plans and clinical roles and responsibilities and police involvement. • Review the composition of the team to attend emergency callouts due to behavioural disturbance on inpatient wards in line with other metro Auckland DHBs. • Review the support and training available to frontline staff on dealing with behavioural disturbance and considered specific training for health care assistants who work as care partners for patients at risk. • Ensure the issues for security staff identified are addressed in the organisation wide 'Security review' currently underway. • Consider options for increased capacity to better manage patients with complex medical, mental health and risk issues at Middlemore Hospital.	• All actions to be completed by June 2021

Title	Findings	Recommendations	Follow up
Delay in Ophthalmology treatment resulting in poor outcome	• Variation in practice across Auckland DHBs with COVID-19 Pandemic planning for patients undergoing Avastin treatment. • If CM Health had continued to see all Avastin patients, patient would have received timely treatment. • Patient (who was considered high priority due to vision in only one eye) was on a clinic list that was not reviewed as requested, resulting in not getting timely treatment. • There was no audit completed as requested following the identification of this patient harm case was notified to CM Health so it is unknown how many other patients may have been compromised.	• Standardise regional emergency planning measures for high risk patients. • Review events with SMO concerned. • Continue Avastin treatments on time during Level 3 and 4 Lockdown.	• All actions completed. • CM Health now follows regional agreements. • Avastin treatments continued during second lockdown period.

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
Wrong site incised for surgery	• Despite completing all appropriate pre-operative checks, a momentary lapse in attention (human error) resulted in local anaesthetic being given followed by a small incision being made to the wrong side of the upper jaw. • No evidence that open disclosure occurred with the patient	• Discussion in M&M meeting. • Ensure timely open disclosure occurs with affected patient even if no serious harm has occurred.	• Case discussed at M&M.
Wrong site incision	• Despite completing all appropriate pre-operative checks, a momentary lapse in attention (human error) resulted in local anaesthetic being given followed by a small incision being made to the wrong side of the upper jaw. • There is evidence of good documentation of the incident and open disclosure that occurred.	• Discussion at M&M meeting.	• Case discussed at M&M.
2x Retained surgical drain pieces in breast	• At some point during or after the original breast surgery in September 2017 – two small fragments of drain remained in place until identified incidentally on mammogram taken October 2019 and removed in November 2019 at another DHB. • Retained pieces were associated with ongoing irritation and discomfort until removed. • Drain pieces were discarded and would have been helpful to keep these until the investigation is completed.	• Share report with surgeons involved at the other DHB. • Keep any surgical retained objects until any investigation is completed.	• Report shared with surgeons at the other DHB.

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, 23 patients were seriously injured after a fall. These injuries included significant head injuries (one which contributed to death) 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 a continued approach to the review of falls which has identified areas for improvement including hand over, the electronic risk assessment form and interventions

Adverse event investigations in progress from 2019/2020

Service	Description of event
Surgery	Airway Obstruction leading to death

Adverse event investigations from previous year

Title	Findings	Recommendations	Follow up
Pressure Injury	• On admission it was identified that there was a stage 2 pressure injury on left ankle which progressed to a more severe pressure injury. • During the admission there was inconsistent pressure injury monitoring, management and documentation by nursing & medical staff. This was partially as a result of lack of wound assessment skills and knowledge of and application of pressure relieving devices e.g. heel protecting boot.	• Associate Charge Nurse to provide in-service education on pressure injury prevention and importance of documenting assessments and care by 6th August 2019. • Progress of each patient's pressure injuries will be discussed at handover with nursing staff and again at monthly ward quality meetings. • All patients arriving to the ward with pressure injuries will be followed up consistently each day by the Associate Charge Nurse and the allocated nurse to embed consistency for pressure injury care. • Medical team and wound resource nurse will review patient's wounds regularly.	• Education session completed as planned. • Changes to practice implemented.