Counties Manukau Health
Serious Adverse Events Report 2017-2018

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 2017) **Falls cases: 5**

Title	Findings	Recommendations	Follow up
Pulmonary embolism during an operation resulting in the death of a patient[1]	• Assessment of the patient's risk of thrombo-embolism was not documented at the time of admission or as the patient's clinical condition changed. • There were communication issues between services regarding roles in and responsibilities for the patient's care.	• The services will review their processes for ensuring venous thrombo-embolism (VTE) risk assessments are completed in a timely manner on admission or if a patient's clinical condition changes. • The services will audit the completion of VTE risk assessment and consider whether to adopt this as a key performance indicator (KPI). • Review guideline for the use of dabigatran (novel oral anti-coagulant) in the days before and after surgery. • Roles and responsibilities for the care of patients between the services will be clarified. • Notification of junior doctor absences through the organisation will be simplified and standardised. • The incident is to be discussed at departmental and organisational Grand Rounds	• The VTE prevention working group has supported surgical services to streamline and standardise VTE assessment and prophylaxis pathways in surgical services. The focus on elective orthopaedics has been associated with a sustained reduction in VTE cases. • First round of audits completed in January 2018. KPI development is still in progress. • Dabigatran guideline is currently under review. • Following extensive discussions through the departmental morbidity and mortality review process, roles and responsibilities have been clarified by the services. • The process of notification of junior doctor absences has been reviewed so that calls and messages to those absent are forwarded appropriately and can be acted upon without delay. • The incident has been presented at Plastic Surgery, Orthopaedic and hospital-wide Grand Rounds.

[1] This event occurred in the 2016/2017 reporting year but was not lodged with the HQSC until September 2017, after the reporting period had closed.

Title	Findings	Recommendations	Follow up
Central line associated bacteraemia (CLAB) following insertion of a central line[2]	• The patient had multiple admissions to CM Health and had a history of multiply resistant bacteria. • An attempt to insert a central line on the ward was not successful and took place in a room where there is no positive pressure flow[3]. • The intravenous (IV) antibiotics required when inserting a central line were not administered to the patient on the day of the procedure and were instead given the following day. • The central line was used on the ward for blood sampling which potentially contributed to the infection.	• The relevant clinical area to commence completion of the required CLAB forms for all central line insertions and manipulations. • The relevant team are notified of this change and copies of the CLAB forms are initially retained by the nurses for auditing purposes during the implementation. • Patient preparation checklists are to be completed by both the ward nurse and procedure nurse ensuring all questions are asked and patients are prepared appropriately. • IV antibiotics are to be administered prior to commencing central line insertions. • The recommended central line maintenance guidelines and techniques are carried out at all times when accessing central lines for blood sampling, dialysis, etc.	• The requirement to complete a CLAB form for all central line insertions and manipulations has been implemented in the relevant clinical area. • The relevant team has been notified of this change and copies of the CLAB forms were retained by the nurses for auditing purposes during the implementation. • Patient preparation checklists are being completed by staff ensuring all questions are asked and patients are prepared appropriately. • Intravenous antibiotics are being administered prior to commencing central line insertions as appropriate. • The recommended line maintenance guidelines and techniques are carried out at all times when accessing central lines.

[2] A central line, also called a central venous catheter, is a long, thin, flexible tube used to give medicines, fluids, nutrients, or blood products over a long period of time, usually several weeks or more. A catheter is often inserted in the arm or chest through the skin into a large vein.

[3] A positive pressure flow room lowers the risk of infection.

Title	Findings	Recommendations	Follow up
Central line-associated bloodstream infection (CLAB)	• Maintenance bundle form for CLAB insertions was not complete. • Septic episodes put the patient back in terms of their estimated discharge date.	• Although lack of complete documentation of the maintenance bundle form was not a contributing factor to this incident, a gap has been recognised in making sure all actions required in maintaining a central line are carried out. • Importance of ticking on the maintenance bundle form if a central line is/is not used on each shift to be highlighted. • Auditing will continue and, if identified in a timely way, individuals will be approached for targeted training.	• The requirement to tick whether a central line is accessed or not each shift has been highlighted with the relevant team.

Title	Findings	Recommendations	Follow up
Unstageable hospital acquired pressure injury on right heel	• Unexplained dressing on patient's right heel, in combination with clinician instructions not to remove heel dressing, resulted in right heel not being assessed for 48 hours contributing to the pressure injury not being identified earlier. • Wound care chart and photographs were not completed when the pressure injury was identified which led to poor handover of presence of pressure injury. • The sliding sheets available were not an appropriate size which may have resulted in undue friction to the right heel when the patient was being moved up the bed increasing the risk of pressure injury development. • The layout of the current pressure injury risk assessment form means that some areas may be missed which may have contributed to an inaccurate assessment score and inadequate prevention measures being in place.	• Required process following identification of a pressure injury (i.e. wound care chart, photograph of injury, skin integrity sticker) to be reviewed and potential ways to improve the process identified. • Investigate possibility of using larger sized sliding sheets to move patients in bed. • Pressure Injury Group to consider layout of pressure injury risk assessment form and to see if the layout can be improved.	• Education package developed by Pressure Injury Group and discussed individually with each staff member. Pressure injury monthly audit process continues. • Larger sized sliding sheets are now in use. • Layout of pressure injury risk assessment form reviewed by Pressure Injury Group and no changes are able to be made to form while it is being upgraded for use on eVitals[4]. The Pressure Injury Group will review whether having the pressure injury risk assessment form in eVitals improves this issue.

[4] eVitals is the electronic observations platform that clinicians can record physical observations such as temperature, blood pressure, pulse and other assessments.

Title	Findings	Recommendations	Follow up
Inadequate assessment and management of a high risk pregnancy resulted in death of the baby before birth	• There was a lack of oversight and inadequate continuity of care by the multidisciplinary team which meant that the risk factors of the baby and mother were not fully recognised by staff throughout the pregnancy. • Both the number and complexity of maternity patients, coupled with the lack of doctors and midwives, contributed to the service being unable to provide the best standard of care outside of emergency situations. • There was lack of recognition of an unwell baby on pregnancy monitoring equipment which meant than an earlier caesarean section was not performed. • There was inadequate management of a woman with pre-eclampsia[5]. • The complexity of the electronic health record in use in the department hindered rapid access to the relevant clinical information.	• Review how continuity of care can best be implemented for women with complex pregnancies when requiring inpatient and outpatient care. • Review the optimum level of medical and midwifery staff required in the department. • Review the optimum number of beds required to provide the best standard of care for women. • Formalise the expected frequency for staff to complete updates and education on pregnancy monitoring assessments and reporting. • Increase awareness for all staff on the importance of completing and updating individualised management plans on the electronic health record in a standardised way.	• A Maternity Strategic Workforce and Capacity Planning Group has been established to review the optimum level of medical and midwifery staffing and bed numbers. • The review has been completed and presented to the Executive Leadership Team with recommendations for significant changes in September 2018. • A proposal for a new day assessment clinic has been approved by the Executive Leadership Team. • A change to the triage model of care trialled in October 2018. • Establishing the expected frequency of education regarding fetal surveillance is still in progress. • Ongoing education is being provided to staff about best practice documentation in the electronic record. This is being audited. • Ongoing meetings with software company to improve the functionality of the electronic health record.

[5] Pre-eclampsia is a condition in pregnancy characterised by high blood pressure, sometimes with fluid retention and protein in the urine.

Title	Findings	Recommendations	Follow up
Breakdown in co-ordination of care resulting in the death of a baby	• Inadequate allocation to a senior doctor for clinical oversight and continuity of care meant that fetal and maternal risk factors were not fully recognised by staff leading to delays in a management plan. • Multiple systems and health professionals involved in the care made it difficult to coordinate. • Not having one set of clinical notes made it difficult for health professionals follow the management of cares. • When a woman presents to Birthing and Assessment (B&A) there is currently no triage process by a health professional. • Failure to understand the significance of ultrasound findings led to a lack of increased surveillance during the pregnancy. • Failure of the GROW programme[6] to function on the Maternity Clinical Information System (MCIS) at the 36.4 week clinic prevented the ability to accurately plot the growth of the baby and therefore identify slowing of growth. The opportunity to change the plan of care and bring forward the caesarean section slot was then missed. • The limited availability of elective caesarean slots prevented flexibility in changing pre-booked dates.	• The service to review the options for having senior doctor oversight, continuity and clinical responsibility for women with complex pregnancies. • Review the supply and allocation of elective caesarean slots to ensure this meets the demands of the service giving priority to women with high risk pregnancies. • Review and make recommendations for improving the co-ordination of care for women with complex pregnancies. • Consider writing a letter to the Ministry of Health in support of a single system of documentation between all health professionals involved in a woman's care. • Provide a model of care that includes a triage system in B&A. • Provide education to lead maternity care (LMC) midwives that if the complexity of a pregnancy changes, a referral can be made to the Women's Health Service to take over care. • Provide education to staff on the importance of communication with the LMC and documenting conversations and phone messages. • Provide education and up skilling on Small for Gestational Age guidelines. • Provide education to staff and LMCs that if the GROW programme within MCIS system is not functioning then a paper-based GROW chart should be completed	• The review has been completed and presented to the Executive Leadership Team with recommendations for significant changes in September 2018. • There is ongoing communication between clinical leaders and the Ministry regarding the integration of maternity clinical information services in primary and secondary care. • A change to the triage model of care is being trialled in October 2018 and further model of care work is being supported by Ko Awatea. • Neonatal Encephalopathy taskforce (funded through ACC) is developing a national educational program. • Ongoing education is being provided regarding best practice documentation in MCIS.

[6] The GROW programme is where the customized growth charts are generated in MCIS but this was not accessible due to a network failure.

Quarter 2 (October – December 2017) Falls cases: 4

Title	Findings	Recommendations	Follow up
Inadequate fetal surveillance of a severely growth restricted baby contributing to the death of the baby	• Inadequate fetal surveillance led to a growth restricted baby not being recognised and the Small for Gestational Age (SGA) Guideline recommendations not being adhered to, including the timing of birth around 38-39 weeks. • Staff made repeated efforts to contact the mother and followed the process in the Community Midwife Antenatal Care Plan and Schedule of Care Guideline. • At the woman's first presentation to Birthing and Assessment (B&A), the assessment was incomplete and did not consider documented risk factors (i.e. a previous SGA baby, smoking status and raised body mass index (BMI)). Fundal height measurement[7] and fetal heart beat monitoring (CTG) was not performed which resulted in the woman being discharged home to await the establishment of labour. • On the woman's second presentation to B&A, the CTG was abnormal. • There was no referral for a review prior to the woman being transferred from B&A to the birthing suite. If the CTG was reviewed prior to transfer, immediate transfer to the operating theatre may have been advised. • The NZ Maternal Fetal Medicine Network Guideline for the management of suspected SGA pregnancies is lengthy and not easily referred to in a clinical environment.	• Provide education for staff on risk factors for SGA and stillbirth, including history of non-attendance at antenatal appointments, raised BMI and admission CTG and appropriate referral to the obstetric team. • Professional follow up and education plan for one staff member regarding assessment, documentation and follow-up to ascertain whether a woman has attended recommended growth scans and the SGA guideline recommendations. • Professional follow up and education plan for one staff member regarding identifying risk factors, objective measurements of fundal height, monitoring of fetus in early labour and the SGA guideline recommendations. • Add an additional risk factor to CM Health's Fetal Heart Rate Monitoring in Labour Guideline that the history of a previous SGA baby requires consideration for an admission CTG. • Ensure there is timely referral to the B&A in-charge with any abnormal CTG findings for urgent escalation to the Obstetric team. • Develop a CM Health SGA guideline which aligns with The NZ Maternal Fetal Medicine Network Guideline for the Management of Suspected SGA Singleton Pregnancies and Infants after 34 Weeks Gestation using the two flow charts on the recommended management processes.	• The NZ Maternal Fetal Medicine national 'small for gestational age guideline' has been implemented in the organisation for at least two years. The guideline contains excellent summary pages and a simple to follow flow diagram which is routinely used in antenatal clinics. • Development of CM Health's concise document to complement the 29 page NZ Maternal Fetal Medicine Network Guideline for the management of suspected SGA pregnancies is underway and due to be completed in November 2018. • The SGA guideline is being updated to include a history of previous SGA baby as an additional indication for admission CTG. • Professional development plans have been developed and implemented for the staff noted in the report.

[7] Fundal height is a measure of the size of the uterus used to assess fetal growth and development during pregnancy. It is measured from the top of the mother's uterus to the top of the mother's pubic symphysis.

Title	Findings	Recommendations	Follow up
Neonatal death following premature delivery in Emergency Department (ED)	• An early medical review was required in light of the patient's level of pain and uncertainty over the length of pregnancy. • Delivery in the assessment area of the ED did not prompt an emergency call. • Based on its size, the baby was assessed as being not viable and resuscitation was not immediately performed.	• A higher degree of caution is required for patients who present to the ED with an uncertain length of pregnancy, vaginal bleeding and severe pain. • ED staff to contact Obstetrics for all patients who present in this manner. • Concurrent emergency calls to obstetrics and neonates are to be made for all babies delivered in assessment area of ED.	• Procedure updated and staff education provided regarding patients who present to ED with PV bleeding, severe abdominal cramps 10/10 severity, and pregnancy of unknown gestation. • Procedure updated and staff education provided for ED staff to contact O&G for advice / support for women presenting in ED with unknown gestations and prolonged vaginal bleeding, • Procedure updated and staff education provided that concurrent emergency calls to obstetric and neonatal teams should occur if a possibly viable baby is delivered in the ED.
Delayed recognition of a service user's deteriorating physical condition contributing to cause of death	• The patient experienced an infrequent but serious bowel complication associated with clozapine (antipsychotic medication). • Regular metabolic and bowel monitoring were not undertaken as expected.	• Review and implement updated clozapine monitoring guideline. • Review and implement physical health monitoring guideline for mental health service users. • Share findings of investigation with primary care and rest home providers	• Review of the clozapine monitoring guideline is nearing completion. • The broader physical health guideline is under review. • Findings of the investigation will be shared with rest home provider and primary care in the near future.

Quarter 3 (January – March 2018) **Falls cases: 7**

Title	Findings	Recommendations	Follow up
Iodine induced allergic reaction resulting in heart attack	• The process to fill in the checklist prior to the bladder investigation procedure was fragmented and not completed with all the members of the team present.	• The pre-procedure checklist is to be completed once all members of the team are present, similar to the 'time out' process used in the operating room prior to surgery. • The checklist is to be revised to include an alert that the solution used in the procedure contains iodine; the checklist to be completed with all staff in the room; and, any medication allergies to be reported to the doctor performing the procedure.	• Audit of procedure checklist to occur once procedure checklist has been in place for three months.
Unstageable hospital acquired pressure injury on left heel	• There was a lack of proper skin assessment done on the patient given the patient's decline in mobility and incontinence factors. • Not all interventions were put in place to ensure patient safety. • The frequency of position changes was not documented or monitored for a patient at high risk of developing a pressure injury. • There was inadequate and unclear nursing documentation around skin checks and what 'skin intact' means.	• In-service education sessions to be held with staff on how to complete and document physical assessments. • Increase frequency of pressure injury audit for a period of two months to review whether appropriate interventions are in place. • Discuss the utility of a 'turns' chart, as a possible method of documenting patient repositioning frequency, with the Pressure Injury Group.	• Education session was completed in the Ward. • Pressure injury audits are part of fundamentals of care. Audits occur monthly. • Global turn chart, a new process, is currently rolling out in all the wards.
Unstageable pressure injuries to both heels	• Accurate assessments of pressure injury risk and appropriate interventions were put in place. • Due to the patient's level of confusion and agitation, there was little cooperation with personal care instructions or turns.	• Discussion with pressure injury prevention steering group about how better to prevent pressure injuries in patients with high risk but low levels of cooperation and who are receiving end-of –life care	• A meeting with the wound care nurse specialist occurred in August. • New boots ("MaxxCare") are currently rolling out and are a better option for heel protection than current boots. • Global turn chart, a new process, is currently rolling out in all the wards • Clarification provided that PI prevention interventions are to remain in place if a patient is on a palliative pathway.

Title	Findings	Recommendations	Follow up
Blood stream infection related to intravenous cannula	• There was little documentation regarding the insertion or monitoring of intravenous line. • The line site became infected and the patient required 8 weeks of antibiotics as a result.	• Documentation of intravenous line monitoring to be completed in 'eVitals'. • Regular auditing of compliance to be completed in 'care compass'.	• Evitals is being rolled out across Surgical Services and IV insertion is part of the set of observations to be completed. • Auditing and reporting is being developed.
Blood stream infection related to intravenous cannula	• There was little documentation of the insertion or monitoring of the intravenous line. • The cannula remained in place 5 days longer than recommended. • The line site became infected ad the patient required 2 weeks of intravenous antibiotics.	• Documentation of intravenous line monitoring to be completed in 'eVitals'. • Regular auditing of compliance to be completed in 'care compass'.	• Evitals is being rolled out across Surgical Services and IV insertion is part of the set of observations to be completed. • Auditing and reporting is being developed.
Unstageable pressure injury on heel	• Inaccurate assessment of the risk of pressure injury resulted in inadequate interventions being put in place. • Delay in obtaining appropriate mobility equipment resulted in a further increase in risk of pressure injury	• Increased frequency of the audit of accuracy of pressure injury assessments • Audit use of 'plan of care' to identify patient needs and changes in functioning.	• Auditing was completed and the requirement to reassess the risk daily has been highlighted with the team. • 'Plan of care' audits are being undertaken.

Title	Findings	Recommendations	Follow up
Two patients became infected (cross transmission) with a carbapenem resistant organism (CRO)[8] during their hospital stay	• Cross transmission with CRO occurred in two patients while receiving care in three clinical areas within the hospital. • The incident investigation was unable to establish where exactly the cross contamination occurred. • The investigation found inadequate personal protective equipment usage, inappropriate containment of contaminated items (e.g. linen, equipment), inconsistent equipment cleaning practices and containment systems. • There was inconsistency in hand hygiene, patient handling and isolation practices between areas. • The number of current working Bioquell machines[9] was inadequate for the required CRO containment in the three areas. • Delays occurred in gaining access to a Bioquell machine resulting in an operating theatre being closed. • The Bioquell machine was unable to be used on certain clinical equipment.	• Review all standard personal protective equipment (PPE) used in the three clinical areas for effectiveness against CRO contamination, and source more suitable equipment (i.e. overshoes, masks, gowns and gloves). • Continue with infection prevention group meetings in the three clinical areas to ensure all sites are complying with best practice infection control standards. • Develop a Hand Hygiene workshop and training package specifically for staff in the areas involved. • Review the process of cleaning the operating theatre between surgical cases. • Investigate the possibility of a designated cleaning team for the operating theatre environment. • Investigate and prepare a business case for a larger Bioquell fleet. • As part of an enlarged Bioquell fleet, purchase dedicated devices for operating theatre area to eliminate theatre closures and downtime especially in specialist theatres (e.g. burns). • Continue to investigate how to safely decontaminate certain clinical machines without damaging them. • Review the patient isolation spaces available so they are more suitable for Bioquell.	• Review of PPE identified the need for better isolation gown. Procurement issues are being addressed. • Hand Hygiene improvement plan for the three services has been developed and implemented including the roll out of education sessions. • The process of operating theatre cleaning between cases has been reviewed and changes implemented. • A designated theatre cleaning team was considered but assessed as inefficient. Cleaning services have worked with theatre suite to develop more effective rosters. • Four new Bioquell machines have been operating since July 2018. • The need for a dedicated Bioquell machine for theatre will be assessed following a review of the usage of the new fleet. Bioquell machines are now used after every CRO case and routinely on a roster in each theatre. • Ongoing discussions are being held with equipment manufacturers regarding their products ability to withstand repeated hydrogen peroxide exposure. • A business case and capital request have been completed to reconfigure ICU bed spaces so that they may be more effectively decontaminated with Bioquell.

[8] Carbapenem-resistant organisms are groups of bacteria that produce carbapenemases (chemicals). These chemicals can destroy antibiotics called carbapenems which makes the bacteria 'resistant' to the antibiotic.

[9] A Bioquell machine is a mobile Hydrogen Peroxide Vapour generator that can be connected to enclosures and equipment in a facility or used for room/zone decontamination.

Quarter 4 (April – June 2018) **Falls cases: 8**

Title	Findings	Recommendations	Follow up
Non-assessment of a women with reduced fetal movements	• There was a lack of capacity both in staffing and bed spaces in Maternity Services to assess the patient in a timely manner. • There is currently no formal triage system in Birthing and Assessment (B&A). This meant that staff did not have a clear overview of the status of the women waiting for assessment in the reception area. • The Decreased Fetal Movements Guideline was not implemented in practice due to potential resource concerns. • The escalation plan for Maternity Services was implemented but was unable to meet the demands. • There was no communication between B&A staff and the lead maternity care (LMC) midwife when the patient arrived or departed from B&A. • The fetal heart beat monitoring (CTG) was uninterpretable due to on-going fetal movements which caused a raised fetal heart rate. This meant that a true baseline was unable to be established. Ideally, the CTG should have been repeated or left on until a clear fetal heart baseline was identified.	• Review the optimum number of beds required to provide best practice inpatient care for women. • Review the optimum staffing levels utilizing external benchmarking. • Develop and provide a model of care that includes a triage system in B&A with clear pathways of communication that can stand up to the high demands on the service. As part of the triage system develop clear but flexible processes for communicating with referrers and include an understanding of opportunities for a regional approach to capacity management when B&A is full. • Institute the Decreased Fetal Movement Guideline, monitor the impact and address resource implications. • Formalise the expected frequency of fetal surveillance education required by the Women's Health Division to ensure that all staff providing care before and during birth have current certification. The expected frequency of training for certification to be formalised.	• A Maternity Strategic Workforce and Capacity Planning Group has been established to review the optimum level of medical and midwifery staffing and bed numbers. • The review has been completed and presented to the Executive Leadership Team with recommendations for significant changes in September 2018. • A change to the triage model of care trialled in October 2018. • The Decreased Fetal Movement Guideline has been implemented within the service. • Establishing the expected frequency of education regarding fetal surveillance is still in progress.

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
Delayed removal of retained vaginal pack with no physical harm experienced	• There was a lack of staff familiarity with the new 'PV Pack In Situ' process as well as a lack of documentation in the required fields of the Maternity Clinical Information System (MCIS) and operation note (Concerto). • The vaginal pack did not have a 'tail' left outside the vagina and secured to the patient's leg as had been communicated to staff as part of the introduction of the 'PV Pack In Situ' process. • There was a breakdown in communication in operating theatre with the insertion of the pack. This led to aspects of the documentation process not being followed or completed.	• Develop a working group to review the process of insertion and removal of a PV (vaginal) pack. • Re-educate all medical, nursing and midwifery staff involved in the care of women who may require insertion of a PV pack. • Standardise the PV pack used by Women's Health and operating theatre and agree to use one type of PV pack. • Educate staff that a 'tail' of the PV pack should be left outside the vaginal opening and attached to the woman's leg. • Review the operation note fields in Concerto. • Continue with pink 'PV Pack In Situ' sticker and wristband as per 'PV Pack In Situ' process.	• Working group established in January 2018 to review the process of insertion and removal of a vaginal pack • Criteria to audit use of PV pack developed for operating theatre and maternity wards. • Re-education for all medical, nursing and midwifery staff involved in the care of women who may require insertion of a PV pack (November 2018).
Retained vaginal pack with no physical harm experienced	• Lack of staff familiarity with the previously circulated 'PV Pack In Situ' process. • Lack of documentation in the required fields of the Maternity Clinical Information System (MCIS). • Lack of formal education and roll out of the 'PV Pack In Situ' process resulting in variable knowledge levels of staff knowledge of the process.	• Develop the 'PV Pack In Situ' procedure including a customised flow chart specific to each area involved. • Develop a system to ensure all relevant staff are educated on the 'PV Pack In Situ' Procedure. • Audit of compliance with new procedure as part of post-implementation review.	• New flowchart developed and in place • Staff education planned for November 2018 • Audit to commence March 2019

Title	Findings	Recommendations	Follow up
Furosemide[10] overdose with no physical harm experienced	• The patient's medication chart was not faxed to the pharmacy for the details of the prescribed medication to be added into Pyxis[11]. • The override facility was used on Pyxis to access medication prior to pharmacist review of the prescription. • The '5 Rs' of medication administration (right patient, right drug, right dose, right route, and right time) were not followed. • The staff member was distracted and having a conversation with someone else while they were selecting the medication.	• All medication charts to be faxed for review by pharmacy and then added to Pyxis. • If the override facility is used on Pyxis, a double check must occur with a second person checking the medication, as per the Pyxis Medication Management policy and procedure. • Ensure the '5Rs' are embedded in daily practice. • Create a clearly marked quiet zone for medication preparation in the treatment room.	• An audit was completed by the ward for 2 months. Charts were consistently faxed to Pharmacy for profiling and validation. Pharmacy has since changed its process from faxing medication charts to scanning medication charts. • An education session on the 5 rights was booked by the Nurse Educator for the ward staff to attend. • Yellow and black hazard tape has been placed around the Pyxis machine as a visual 'quiet zone' without disruptions. A follow up survey with staff will assess if this is effective.

[10] Furosemide is a diuretic (water pill) that is used to eliminate water and salt from the body.

[11] Pyxis™ is an automated medication dispensing system that supports medication management with various features for safety and efficiency. The system helps accurately dispense medication, while supporting pharmacy workflows.

Title	Findings	Recommendations	Follow up
Wrong side nerve block[12] with no permanent harm	• A pause was not completed immediately before the nerve block was inserted. • There were distractions in the operating theatre which meant that staff failed to notice the pre-block pause was not completed. • Some staff were distressed following an event affecting the team. • A team debrief did not occur after the incident. • Due to the predicted difficulties gaining intravenous (IV) access of a vein, the pre-surgery delay may have been avoided if the patient had been admitted the day before surgery for IV access, or IV access had been completed prior to entering the operating theatre.	• Case to be discussed at Anaesthetic meeting. • Case to be discussed at operating theatre shutdown day as an educational opportunity. • Case to be discussed at Anaesthetic Technician staff meeting. • Team debriefings to be encouraged/implemented after incidents.	• Case has been discussed at Anaesthetic complications meeting and with operating theatre staff and anaesthetic technicians. • Team debriefings are now supported when required.

Summary of falls causing patient harm:

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, 25 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 platform.

Over the last three years, there has been a large reduction in the number of falls leading to broken hips. Prior to November 2015, in-hospital falls leading to broken hips were occurring once per month, this has reduced to an average of once every three months.

[12] A nerve block is a procedure in which an anaesthetic agent is injected directly near a nerve to block pain. A nerve block is a form of regional anaesthesia.