Counties Manukau Health
Serious Adverse Events Report 2013-2014

Introduction

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious Adverse Events.
Health Quality & Safety Commission | Serious Adverse Events Reports

In the 2013-2014 year, Counties Manukau Health (CM Health) reported forty six events that have caused serious harm or death. Thirty 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 is an incident where a patient is seriously harmed during medical treatment. 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 near misses, that is, where no patient harm was identified.

year	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
number of reports	**7**	**23**	**29**	**38**	**35**	**24**	**45**	**46**

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:

- 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

Summary	*Findings*	*Recommendations*	*Follow up*
Patient identification error resulting in patient having unnecessary x-ray procedure	• The patient's identification was not adequately verified • An interpreter should have been scheduled for this patient	• Further staff education of identification processes at various Radiology forums. Audit of compliance (initiative currently underway) • Stop and check process currently used in some areas in Radiology becomes mandatory • Scheduler guidelines to be reviewed and discussed at Radiology Operational Groups to establish pragmatic solutions	• Staff education has been completed and there are ongoing audits to ensure compliance • 'Stop and check' process has been implemented • Guidelines have been discussed and updated to ensure the appropriate use of interpreters in the clinical setting
Antibiotics were given to patient with known allergy resulting in a severe skin reaction	• Despite allergies being appropriately documented on the medication chart and in the clinical notes the patient was prescribed and administered the medication to which he was allergic for 8 days resulting in a severe rash	• Charge Nurse to lead reflective practice review • Case to be referred to the Medication Safety Service and the Allergy Group for review and teaching purposes • An electronic prescribing system that can prevent the prescribing of medications that are identified as causing reactions is recommended	• Completed • Completed • Electronic prescribing is being trialled as part of the national Health IT programme
Patient suffered two anaphylactic reactions prior to allergen being identified	• Two possible allergens were identified after first severe reaction – antibiotic or antiseptic • Whilst awaiting allergy investigation patient was admitted acutely to hospital and exposed unintentionally to antiseptic allergen on a second occasion and had severe reaction	• Raise awareness of presence of antiseptic in certain urinary catheter sets • Consider removal of antiseptic containing catheter lubricants from the hospital • Patients with new severe allergic reactions to possible allergens should have this allergy status documented formally until verified	• Removal of antiseptic containing catheter lubricants has occurred.

Summary	*Findings*	*Recommendations*	*Follow up*
Referral for colonoscopy from Emergency Department was not sent leading to a 10 month delay in referral and the need for more extensive surgery than may have been required if earlier referral had been acted upon	• The referral was not acted upon as it was entered into the wrong box in the electronic discharge summary (EDS) • Junior doctors were uncertain how to refer patients for colonoscopy using the EDS	• Simplification and back-up systems for the EDS referral /outpatient booking system are required • Train junior doctors to manage the complexity of EDS system	• iPMS (patient information system) upgrade is required before options can be considered • Training of junior doctors has been undertaken
Patient identification error leading to unplanned laser eye treatment	• Failure of positive identification process led to a patient receiving an unplanned but appropriate eye laser treatment	• Feedback to staff to re-inforce the requirement for positive identification of all patients • Consideration of the use of patient ID wristbands for all out-patient invasive procedures	• Feedback complete • Patient Identification group have recommended a renewed effort on positive identification of patients rather than extending passive methods of identification
Neonatal hypoxia and need for hysterectomy after delivery	• Equivocal fetal monitoring results were incorrectly interpreted as reassuring and the birth was not expedited • There was a delay in recognising the clinical signs of uterine rupture	• Undertake a review of the 'fetal monitoring in labour' guideline • Include uterine rupture as a topic for education of junior doctors and midwives in 2014	• Completed • Completed

Summary	*Findings*	*Recommendations*	*Follow up*
Community client with dementia walked away from a rest home and was found in a waterway with hypothermia and tachycardia	• A referral to Needs Assessment and Service Coordination (NASC) did not occur when the patient was admitted to residential care, which resulted in the patient being placed in an inappropriate level of care at the facility	• Meet with NASC team to confirm that completing a recent needs assessment prior to client entering a facility is required • When a level of care (LOC) is identified the client must be placed (or moved) to a facility that has that LOC available and not managed/monitored at a lower level • Work with staff to improve communication between services by sharing information / alerts/referrals for vulnerable clients • Follow-up with the residential care facility to discuss their policy and process around clients who have a Wanda Trak placed on them	• Completed. NASC policies have been updated. NASC team have had on-going education sessions with the NASC Professional Leader • The residential care facility has reviewed their process and notification to NASC when a Wanda Trak is to be used on a client
Unexpected death following elective joint replacement	• Patient had many chronic illnesses and went into multiple organ failure after the operation • Appropriate investigations and treatment were undertaken but patient's physical state continued to deteriorate	• Consider whether patients with complex physical health problems should be managed in the elective surgery centre • Review all acute transfers from elective surgery centre to Middlemore Hospital	• Review in progress

Summary	*Findings*	*Recommendations*	*Follow up*
Patient required resuscitation after inadvertent administration of muscle relaxant	• Post-operative pain medication was administered through an IV line which had not been flushed and still had muscle relaxant in the line • The usual process of flushing the line after administration of muscle relaxant and removal of luer had not occurred	• Discuss case and lessons at anaesthesia department meeting • Formal communication to all theatre staff regarding the need to flush all IV lines • Add 'Handover of IV lines' to surgical safety checklist	• Completed
Hospital acquired pressure injury	• An inaccurate Waterlow (pressure injury) assessment failed to identify the patient's very high pressure injury risk and the documentation did not clearly identify or record the deterioration of the pressure areas • There was no evidence of a skin assessment being made each shift	• Improve accuracy of pressure injury risk assessment • Improve regularity of assessments • Improve preventative measures • Improve patient and family engagement • Clarification of recommendations for the use of T.E.D. (anti-clotting) stocking for surgical patients with peripheral vascular disease (PVD)	• Session with wound-care resource nurse on the Waterlow assessment completed • Ward staff are reminded that patients with high pressure injury risk require a skin check of pressure areas each shift regardless of whether patient is independent and this must be documented • Patient and family education about the care of pressure areas and smoking risk is essential for patient with PVD and Diabetes and any with high risk of pressure injury.. • T.E.D. stocking guideline is being developed

Summary	*Findings*	*Recommendations*	*Follow up*
Delayed identification of hospital acquired pressure injury	• Lack of initial assessment of pressure injury	• Establish and implement a systematic skin integrity assessment process using standardised documentation	• Skin integrity assessment sticker has been introduced in Division of Surgery and is now being rolled out to Medicine and Rehabilitation services.
Delay in cervical suture may have reduced its effect on preventing premature labour	• Due to a mismatch between demand and capacity during Xmas and New Year period, there was a delay in repeating the trans-vaginal scan	• The service will review the level of provision of ultrasound and Senior Medical Officer cover over the Xmas and New Year period. • Reinforcement with staff regarding the need to review and follow recommendations made from Perinatal Reviews • Recommendations made in the Perinatal Mortality Report and letters to women to be the same • The women's health ultrasound service to investigate process for telephone consults and decision making • Where time/resource insufficient then the patient is referred acutely.	• Reviewed and plan in place • Completed by Clinical Head of Service • Review undertaken by perinatal midwife specialist • Ultrasound service have developed a coordinator role to improve communication between Lead Maternity Carer and specialist services • Reviewed and in place
Woman with a history Pulmonary Embolus in a previous pregnancy developed a blood clot in her leg when blood-thinning medication was discontinued after the birth of her child	• Advice to stop blood-thinning medication prior to discharge was not in line with best practice • There was no documented process for seeking advice for such patients in maternity	• Revise the 'Venous Thrombo-embolism in pregnancy' guideline • Discuss at combined services meeting	• In progress

Summary	*Findings*	*Recommendations*	*Follow up*
Mix up in biopsy specimens one benign and one indicating cancer. No delay in treatment or unnecessary treatment occurred	• There was a six month delay in identifying the error by which time specimen pots had been discarded so it was not possible to make definitive conclusions • The usual process of separating same tissue specimens was not followed. • The process of working on one specimen (single piece workflow) at a time may not have been undertaken • The usual process of three way checking may not have been followed	• Improve communication between clinicians and laboratory where there is a mismatch between clinical findings and laboratory results • Improve adherence to same tissue sample separation • Implement single piece workflow system • Provide additional training for three way checking • Purchase barcode tracking system for the Histology Laboratory	• Completed • Completed • Completed • Completed • In progress
A patient developed a serious joint infection following an infected IV luer site	• Delay in initiating antibiotics due to initial impression that symptoms caused by gout • Communication and documentation issues resulted in confusion for family and patient	• Increase awareness of potential for IV luer site infections to spread and the need for prompt treatment • Head of Department of Orthopaedics to review case and consider documentation and communication issues	• Hospital acquired infections are now part of junior doctor orientation • In progress
Delayed diagnosis of cause of loss of vision (a side effect of medication)	• Cause of loss of vision was not correctly identified by eye specialist • Presence of cataracts made diagnosis more difficult	• Written information regarding side effects are to be given to patients at clinic • Patients to receive copies of clinic letter so information is available to specialists working in private	• Completed • Completed

Summary of falls causing patient harm

Of the 46 serious adverse events reported to the Health Quality & Safety Commission for the 2013-2014 year, 30 were related to falls.

This year CM Health has reported fewer falls than for the 2012-2013 year.

The falls which resulted in fractures included:

- 3 upper limb
- 3 pelvis or ribs
- 2 lower thigh or leg
- 8 hips
- 3 skull or face

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 continued 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 six hours of admission to the ward
- Ensuring every patient is reassessed regularly or when their condition changes
- 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
    - Hip-protectors
- Developing an organisational clinical equipment management system that allows staff to quickly and efficiently access falls prevention equipment e.g. Invisi-beam alarms and low beds.

Over the last year, delirium (confusion) has been identified as a significant cause of falls in the hospital. The Delirium Management Pathway has been developed and will be rolled out through the hospital in the next 12 months.