Counties Manukau Health
Serious Adverse Events Report 2015-2016

Introduction

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

Health Quality & Safety Commission | Serious Adverse Events Reports

In the 2015-2016 year, Counties Manukau Health (CM Health) reported 59 events that have caused serious harm or death. Thirty six 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 similar events recurring.

Injuries suffered by patients when they fall are the commonest ones in the hospital. Falls cause more minor, moderate and severe injuries than any other type of reported incident. In this year's report, 36 patients were injured after a fall. These injuries included significant head injuries, broken bones, and skin lacerations that required stitches. 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.

There were 23 other incidents leading to actual or potential serious patient injury. Five patients developed serious pressure injuries during their stay in our hospitals. Over the last 7 years there has been a drastic reduction in the number of patients with pressure injuries in CM Health as a result of a bundle of assessments and interventions. Now, every serious pressure injury that develops on our wards is thoroughly investigated and reported. In the last year we have invested in sharing the lessons learnt from all the incidents with staff in CM Health. 'Our Open Book' provides a summary of events with key learning points for staff to reflect on.

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 members 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.

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

Title	Findings	Recommendations	Follow up
Right and left heel pressure injuries	• Patient was admitted for elective surgery and as part of standard theatre preparation graduated compression (GC) stockings were applied. Documentation prior to surgery did not record patient's skin assessment. • After surgery and on admission to the ward no pressure area assessments were completed. • Ongoing pressure injury care was not followed including removing GC stockings prior to showers and documenting any findings.	• Patients identified as high risk and also wearing GC stockings should have these removed every shift for skin to be checked and documented. • Complete a skin integrity sticker for all patients with a surgery time of >3 hours and continue this on the ward. • Monthly pressure injury audit to include checking for the skin integrity sticker and its completion. • Develop a 'how to manage pressure injury guide' with clinical photography and follow-up once pressure injury identified.	• Educational sessions were completed in all areas in the July VTE (blood clot) awareness campaign. • The skin integrity sticker has been introduced across both theatre sites and is part of the theatre/ recovery handover. This has resulted in an increased identification of pressure injuries during surgery. • Auditing of the use of the sticker is under way. • The poster guide has been developed and tested. Awaiting approval and an action plan for implementation.

Title	Findings	Recommendations	Follow up
Failure to recognise a mother's deterioration after giving birth leading to delayed treatment and extended hospital stay	• Patient's deterioration as a result of infection was not recognised or acted upon by multiple health professionals when the patient's early warning scores indicated that there was deterioration in her clinical picture.	• Women's Health to provide continued further education in using MCIS (Maternity Clinical Information System) for clinical staff using the system. • Women's Health to review the MEWS (Maternity Early Warning Score) chart, assessing the appropriateness of the PUP (Physiologically Unstable Patient) scores. • Further education on the MEWS Chart specifically looking at the variations and action scores for clinical staff in Women's Health.	• A Clinical Midwife Specialist for Patient Information Management has been employed since March 2016. This role includes overseeing training and support for users of MCIS. Super users have been identified in each area and additional support provided. Individual feedback has been provided where required, and regular updates by email and other staff communication forums. • MEWS audit undertaken. A national group is reviewing the MEWS chart. A decision has been made to wait for the results of this national review. • MEWS education has been incorporated into one of the scenarios at the Midwifery Emergency day, a compulsory education day each midwife attends. Further, there is the online MEWS education module, accessible to all CM Health staff.

Title	Findings	Recommendations	Follow up
Retained drainage tube discovered three years after surgery	• Inadequate documentation of the length and placement of the Penrose drain meant staff and patient thought there were two small drains in place. • When the patient reported the drain had disappeared, although the wound was probed, no further investigations were made to find the drain at that time. • The drain caused repeated infections and remained undetected in the chest wall for three years as it was not visible on x-ray or ultrasound.	• Clear documentation of the type, placement and size of drain/s to be completed by the operating surgeon. • The service to consider a protocol for management of patients who have multiple presentations with the same infection. • Case to be considered for CM Health 'Our Open Book' publication.	• Perioperative documentation package is being reviewed and a section added to record size, length and number of drains inserted. • Service has considered that such a protocol is not necessary. • 'Our Open Book' case study was distributed in August 2016.

Title	Findings	Recommendations	Follow up
Patient died at home following treatment for nose bleed	• The Ear, Nose and Throat (ORL) acute pathway was not followed for patients who present to Emergency Department (ED) with active bleeding. • Staff underestimated the amount of blood the patient lost while in ED. • When patient returned to Acute ORL clinic after first discharge, the Registrar did not seek advice from a Consultant. • This case should have been referred to the Coroner. • Instructions regarding what to do if the bleeding started again were given verbally only and the patient's spouse had not fully understood them.	• ORL service to review and update the acute pathway for patients who present to ED with active bleeding. • Any unplanned acute admissions to Manukau site must be discussed with the Anaesthetist on duty. • Review and update patient handouts on nose bleeds and what to do if the bleeding starts again. • Present case to internal Morbidity and Mortality Grand Round. • Patient's spouse will participate in a patient experience video to be used in education sessions. • Case report to be shared with Ambulance and patient's GP.	• The review of the acute pathways is under way. • The patient information on nose bleeds is also under review. • A protocol on unplanned acute admissions to Manukau site is in development. • Case was presented at the July Morbidity and Mortality Grand Round. • The patient's spouse is not ready yet to assist with the video so this has been put on hold. • Case was shared with Ambulance and GP.

Title	Findings	Recommendations	Follow up
Delay in outpatient follow up may have contributed to vision loss in eye	• Due to a large number of high priority patients with reduced resources including staff vacancies, a follow up appointment was not able to be booked in an appropriate timeframe. • Steps taken to contact the patient were not documented. • Patients are not informed that there are delays which mean that they may not be seen within the recommended timeframe.	• Multiple strategies to meet demand are being considered for this service. • Improved documentation of attempts made to contact patients by the Referral Centre is required. • Patients are to be made aware of delays in service and encouraged to contact their GP if eyesight deteriorates whilst on waiting list.	• The Director of Hospital Services is prioritising action to meet the demands for urgent ophthalmology services. • Documentation has been improved. • A warning statement has been added to all correspondence to the patient and GP of the options available if the patient's eye sight deteriorates.
Delay in follow up of 10 months led to missed opportunities to prevent loss of vision	• Due to a large number of high priority patients with reduced resources including staff vacancies, a follow up appointment was not able to be booked in an appropriate timeframe. • Patients are not informed that there are delays which mean they may not be seen within the recommended timeframe.	• Multiple strategies to meet demand are being considered for this service. • Patients are to be made aware of delays in service and encouraged to contact GP if eyesight deteriorates whilst on waiting list.	• The Director of Hospital Services is prioritising action to meet the demands for urgent ophthalmology services. • Documentation has been improved. • A warning statement has been added to all correspondence to the patient and GP of the options available if the patient's eye sight deteriorates.

Title	Findings	Recommendations	Follow up
Hospital acquired pressure injury	• Inadequate skin checks under the patient's foot pumps. • Incorrect risk assessment score leading to inadequate preventative measures being put in place.	• Promote the use of skin integrity sticker for the documentation of skin assessments on admission. • Wound care coach ward resource staff to present a session to staff on accurate pressure injury risk assessment scoring. • Feedback the pressure injury incident finding to ward staff via the ward resource staff and charge nurse manager.	• The skin integrity sticker has been introduced across both theatre sites and is part of the theatre/ recovery handover. This has resulted in the early identification of pressure injuries during surgery. • The Pressure Injury Group are reviewing and updating the online educational package. • The pressure injury risk assessment tool is also under review. • Sessions were completed in all areas in the July 2016 VTE awareness campaign regarding daily hygiene and removal of foot pumps and graduated compression stockings for skin checks. • The poster guide has been developed and tested. Awaiting approval and an action plan for implementation.

Title	Findings	Recommendations	Follow up
Woman with a high risk of premature birth was discharged home with no planned follow up from specialist services. The woman later presented with severe infection leading to miscarriage.	• Discharge planning was inadequate. • Woman was not aware who to contact when she became unwell and this was a factor in her late presentation. • There was no protocol in place for management of care following insertion of a cervical stitch.	• Develop and implement clinical guideline for management of women with shortened cervix and history of premature labour. • Develop information package for women with premature ruptured membranes.	• The clinical guideline is under development. The draft for the guideline is complete with references and currently being formatted and will then be circulated for consultation. • Information package is also under development.
Foam dressing inadvertently left in wound	• Inadequate documentation of the dressing on transfer to the community team. • Inadequate investigation of wound when patient presented with signs of infection.	• Ensure dressing checklist is completed for each referral to the community team. • Raise awareness about retained foam dressing as a potential cause of wound infection. Consider this as a topic for CM Health 'Our Open Book' publication.	• A dressing checklist has been developed and is available via the wound care website. • 'Our Open Book' on retained foam dressing was completed in June 2016 and circulated organisational wide.

Title	Findings	Recommendations	Follow up
Cut from a Dermatome blade that had been assembled incorrectly.	• The usual visual and verbal checks prior to turning on and using the Dermatome blade[1] were not adequately completed. • Members of the operating team were not aware of the inexperience of the person setting up the equipment. • The correct width of the guard and depth of the blade were not checked correctly resulting in a full thickness cut to the front of the patient's thigh requiring sutures. • Manufacturer was contacted regarding the Dermatome and was aware of the blade loading problems. A new model had been released and subsequently withdrawn, reason unknown.	• All theatre staff to be taught and assessed in setting up the Dermatome. This is to be checked prior to use by a registered nurse and operating surgeon. • Reinforce the use of the 'start of list briefing' which includes introducing themselves and their experience. • Theatre manager to follow up with manufacturer regarding safety of Dermatomes available and update team of any changes.	• A teaching package was already in place. An additional refresher was held with all theatre staff on an educational shutdown day in May 2016. • Briefings are in place. • Investigations continue to purchase an alternative Dermatome that will not allow blade to be fitted incorrectly.

[1] Dermatome blade is used to harvest skin for a skin graft.

Title	Findings	Recommendations	Follow up
Hospital acquired pressure injury	• Visual checks of pressure areas were not well documented and risk assessments were inaccurate. • Assessments were not undertaken when the patient was transferred to a different ward or when their condition changed.	• Education and training with staff on assessments and recording of checks. • Promote use of skin integrity sticker. • Streamline process of ordering and documentation of pressure relieving devices.	• Educational sessions were completed in all areas in the July 2016 VTE awareness campaign regarding daily hygiene and removal of foot pumps and graduated compression stockings for skin checks. • The skin integrity sticker has been introduced across both theatre sites and is part of the theatre / recovery handover. This has resulted in the early identification of pressure injuries during surgery. • The skin integrity sticker is in place in all Surgical areas. To be introduced in all Medical areas. • The process of ordering and documentation of pressure relieving devices has been streamlined and resources are available on the wound care website. • Auditing of the skin integrity sticker is under way. • The poster guide has been developed and tested. Awaiting approval and an action plan for implementation.

Title	Findings	Recommendations	Follow up
Hospital acquired pressure injury	• The absence of documentation of patient's medical history led to an incorrect pressure injury risk assessment on the ward and risk under-recognised. • Communication was inadequate to prevent the use of a graduated compression (GC) stocking during theatre. • No documentation of when (GC) stocking was removed or still in place following surgery.	• Use this case study to present to staff the importance of pressure injury risk assessment on admission, and re-assessment of risk during admission. • Teaching session to give an understanding to new staff on pressure injury risk assessment and to refresh existing staff on how best to risk assess properly. • Teaching session on the safe use of GC stockings and the importance of accurate documentation of skin condition when GC stocking removed.	• Educational sessions were completed in all areas in the July 2016 VTE awareness campaign regarding daily hygiene and removal of foot pumps and GC stockings for skin checks. • The skin integrity sticker has been introduced in all surgical areas. • Ongoing work to identify patients in theatre who don't need or should not have GC stockings applied. • Auditing of the skin integrity sticker is under way. • The poster guide has been developed and tested. Awaiting approval and an action plan for implementation. • The online pressure injury education package is currently being updated and made more relevant.

Title	Findings	Recommendations	Follow up
Delayed action on incidental abnormal X-ray finding	• A recommendation documented by Radiology to further investigate an incidental suspicious chest x-ray finding was acknowledged but not acted on by the team. • A series of internal process errors resulted in patient being discharged home without knowledge of the suspicious chest x-ray finding. • Variation in practice meant that the Radiology Alert system was not activated in response to the unexpected finding of a chest lesion. • The incidental finding of the chest lesion was dictated in the electronic operation notes but not handwritten in the clinical record or discharge summary.	• Present the case at the General Surgery Morbidity & Mortality (M&M) meeting. • Consider using this case as an CM Health 'Our Open Book' series. • Radiology to review the alerts system. • Radiology to consider posting significant abnormal findings in red (same as blood results) and see if the alert can be placed at the top of the report.	• Presentation planned at next M&M meeting. • 'Our Open Book' will cover this and previous delayed action on incidental x-ray findings. • Radiology review in progress.

Title	Findings	Recommendations	Follow up
Dispensing error led to 10 times overdose of medication for an infant resulting in admission to hospital	• Dispensing error by retail pharmacy led to a 10 times overdose of furosemide (heart failure treatment). • No hospital systems or process issues led to the dispensing error. • Opportunities to identify the dispensing error at an early stage were missed.	• Ward nurses to advise patients/caregivers that if medication is different from what they have been taught in the ward, they should speak with the pharmacist. • Home Care Nurses to routinely check medications with the caregiver. • Review the electronic prescription form and recommend development of a mandatory field for weight in paediatric patients. • Investigate medication reconciliation options for children with chronic and/or complex conditions.	• The Kidz First Nurse Educator is planning a train-the-trainer education approach for nurses providing information to patients/caregivers on medication administration. • The Clinical Nurse Director for Kidz First reviewed processes around medications in the home as part of the Home Care Nurses education half day.

Title	Findings	Recommendations	Follow up
Delay in emergency caesarean section	• There were delays in the decision to proceed to delivery whilst handover was completed to the next shift. • There was miscommunication in the category and urgency of the caesarean section. • Early warning signs of deterioration were not acted upon.	• Develop a standard/guideline on the classification and communication for caesarean section to ensure the principles of multidisciplinary communication underpin the smooth, safe and rapid transition to delivery. • Undertake an audit of emergency caesarean sections regarding the interval between the time of decision to time of delivery in comparison to the obstetric priority category. • Provide further education on the MEWS chart, specifically looking at the variations and action scores for clinical staff in Women's Health.	• The draft guideline is complete with references and is currently being formatted and will then be circulated for consultation. • MEWS education has been incorporated into one of the scenarios at the Midwifery Emergency day, a compulsory education day each midwife attends every year. Also there is the online MEWS module, accessible to all CM Health staff. • Correspondence was sent out on 23 May 2016 to all neonatal and Woman's Health staff reminding them of the process to procure emergency neonatal assistance.
Wrong sized nail used in hip surgery leading to longer operation and unplanned admission to Intensive Care following operation	• There was no consistent and clear implant checking process in theatre.	• Develop and introduce a clear implant checking process. • Share lessons learnt across all theatres at Counties Manukau Health.	• 'Implant Time Out' checklist introduced prior to opening implants. • Discussed at Theatre Quality Forum and Education shutdowns.

Title	Findings	Recommendations	Follow up
Superficial burn caused by lighted retractor [2]	• When in use for extended periods, and if the connection is not tight, the metal connection of the light source to the retractor gets hot enough to burn. • The retractor was placed on the patients' abdomen during the procedure resulting in a superficial burn.	• Discuss case at Plastics Morbidity & Mortality (M&M) meeting to remind all surgical staff of the importance of good surgery practice and safe handling of surgical equipment. • Biomedical Engineering to check the retractor to identify any safety issues. • Lighted retractors to be turned off when not in use and placed on a large swab in a kidney dish to prevent burns. • Investigate if safer LED light sources or alternative retractors are available with a purpose-built light source.	• Case was discussed in Plastics M & M meeting. • Biomedical Engineering completed testing and wrote a report on the light source and retractor. • Educational session and reminder given to theatre staff. • Investigations continue into an alternative retractor with cooler lighting. Quotes have been received.

[2] A retractor is a piece of surgical equipment which allows the surgeon to hold body tissue apart during an operation.

Title	Findings	Recommendations	Follow up
Review of obstetric care following death of very premature baby	• The complexity of the mother's past obstetric history was not recognised early and referral to specialist services was delayed. • Scan reports were poorly worded and provided false reassurance. Opportunities to intervene were missed. • The severity of the mother's heart problem had not been recognised prior to labour. • There was uncertainty about whether to transfer the mother to the cardiac ward for closer monitoring.	• Develop and widely distribute a guideline for the management of women with previous mid-trimester pregnancy loss or preterm labour so that those at risk are identified early and referred at an appropriate time. • Develop agreed terminology with radiology providers regarding reports on cervical shortening. • Investigate telemetry options in Birthing and Assessment Unit.	• Guideline is being developed. • Regional discussion on agreed terminology for cervical shortening to be led by Clinical Head. • Technical aspects of providing telemetry in Birthing and Assessment Unit to be investigated with Clinical Engineering.
Central Line Associated Bacteraemia (CLAB)	• Patient was at high risk of developing this infection. • Elements of the maintenance bundle were not performed. • Documentation was incomplete.	• Charge nurse to lead the refresh of CLAB prevention training in the ward. • Reinforce need for consistent implementation of bundles of care.	• Training on the ward has been undertaken. • 'Our Open book' on CLAB is planned.

Title	Findings	Recommendations	Follow up
Retained drill bit following jaw surgery	• Use of a long drill bit with short drill guide (should have used long drill guide) and excessive bending of the drill led to drill bit snapping. • It was initially thought that the drill was flush with the bone but later review by a senior doctor identified the need to remove retained drill bit due to potential for damage to surrounding tissue.	• Supervision for junior doctors needs to be congruent with level of experience and capability. Service to review their decision making process for junior doctors to operate without direct senior doctor supervision. • Protocol to be developed regarding process to follow for any retained equipment/object.	• The service has reviewed the circumstances regarding this case and taken appropriate action. • A protocol regarding an x-ray in theatre for any retained equipment is under development.
Hospital acquired pressure injury	• Small unstageable pressure injury developed underneath a compression glove in a patient with a nerve injury. • No assessment of risk of pressure injury completed. • Regular checks of the skin area were not performed.	• Education and training with staff on assessment and recording of checks. • Promote use of skin integrity sticker. • Physiotherapists to formalise a communication plan for care of patients with reduced sensation.	• The skin integrity sticker was rolled out to the service involved. • Charge Nurses are working with physiotherapists to better use the patient status board (in each room) as a means of communication to all.

Title	Findings	Recommendations	Follow up
Delayed action on an incidental abnormal X ray finding	• Patient underwent routine CT scan for ongoing medical problem following a clinic appointment. • Radiology report identified highly suspicious lung lesion. • Report not read or acted upon until patient admitted with unrelated illness three months later.	• Presentation of case at M&M meeting. • Radiology to review effectiveness of alerts system. • Radiology to consider posting significant abnormal findings in red (same as blood results) and see if the alert can be placed at the top of the report. • Consider using this case as a CM Health 'Our Open Book' series.	• Presentation planned at next M&M meeting. • Radiology review in progress. • 'Our Open Book' will cover this and previous delayed action on incidental x-ray findings.
A community patient received the wrong medication leading to emergency admission to hospital	• Two blister packs of medication for patients with the same surname were in the same bag. • No duplicate name sticker was placed on the medication packs. • There was a high level of distraction in the house where the medication was being administered. • The nurses acted with haste when the patient agreed to take the medication after a period of hesitation.	• Review the process of transportation and administration of medication in the community. • Nurses to actively manage distractions such as mobile phones. • The 'five rights'[3] of medication administration are to be carried out at all times.	• Review in progress. • Nurses to ensure phones are on silent when at a patient's home. • The importance of the 'five rights' have been reinforced with the team.

[3] the five rights are the right person, the right medication, the right dose, the right time and the right route.

Summary of falls causing patient harm

Of the 59 serious adverse events reported to the Health Quality & Safety Commission for the 2015-2016 year, 36 were related to falls.

This year CM Health has reported a lower number of falls than for the 2014-2015 year. There was less than half the number of broken hips than last year. There has been a significant focus on identifying all harm from falls.

The falls which resulted in harm included:

- 10 patients had skin tears or lacerations.
- Six patients had a fractured hip or thigh.
- Six patients had fractures involving the upper limb or collar bone.
- Five patients had brain haemorrhages.
- Four patients had fractures involving the lower leg.
- Three patients had fractures involving the spine.
- One patient broke a tooth.
- One patient received partial thickness skin burn following a collapse whilst showering.

The falls prevention programme is continuing with 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
- Reliable and timely assessment for confusion
- 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
  - Developing an organisational clinical equipment management system that allows wards to quickly and efficiently access falls prevention equipment (examples include alarms, invisi-beams, ultra low beds)