Waitemata
District Health Board

Best Care for Everyone

Waitemata District Health Board

Serious Adverse Events Report (1 July 2016 to 20 June 2017)

What is a Serious Adverse Event?

Adverse events are events which have generally resulted in harm to patients. A serious adverse event is one which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function (http://www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/).

Serious Adverse Event Investigation at Waitemata DHB

All serious adverse events at Waitemata DHB are investigated by a team of clinicians (e.g. doctors, nurses, midwives, allied health) and quality team staff. To ensure that investigations are impartial, these staff will not have been involved in the event.

Adverse event investigations are undertaken according to the following principles:

- Establishing the facts: what happened, to whom, when, where, how and why
- Looking at systems and processes of care delivery with a view to improvements, rather than blaming individuals
- Establishing how to reduce or eliminate a recurrence of the same type of event
- Formulating recommendations and an action plan
- Providing a report as a record of the investigation process
- Providing a means for sharing lessons from the event

Each event report is then reviewed by the Adverse Event Committee (consisting of allied health staff, doctors, nurses, patient experience and quality staff) to ensure that the investigation has appropriately established the facts, addressed all issues and the recommendations and actions are robust. All actions are assigned to a responsible owner and tracked to completion, which is facilitated by the Quality and Risk Team.

NB: Please note that the events discussed in this report do not include Mental Health-related events; these are reported separately via the Office of the Director of Mental Health (Ministry of Health).

Reporting Serious Adverse Events

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious Adverse Events. Events are reported to the HQSC each year prior to an investigation having been completed; they are then confirmed with the HQSC when the investigation has been completed and the report approved by our Adverse Events Committee. Sometimes, the investigation will identify that the event was not as serious as first identified and will be downgraded (using an agreed HQSC rating matrix) and removed from the HQSC and DHB Serious Adverse Events data.

In 2016/17, we are reporting 44 completed adverse event investigations. In addition, there are some adverse events still under investigation. These will be reported in the 2017/18 adverse event report.

In the 2016/2017 financial year the HQSC reviewed the National Serious Adverse Events policy. As a result of this, we reviewed our internal adverse event management processes. We have subsequently made changes which will expedite our external notification process and the time it takes to complete our adverse event investigations. This will ensure that lessons are learned and improvements to the quality of care we offer are made at the earliest opportunity. It is likely that these process improvements will create the illusion of a 'spike' in the number of completed adverse event investigations reported in the 2017/18 report. However, this should not be seen as an increase in the number of adverse events in 2017/18.

Overview for 2016/2017 Serious Adverse Events

In the financial year 2016/2017, Waitemata DHB reported and completed **44** investigations that had caused or had the potential to cause serious harm or death (serious adverse events).

Financial Year	2006 /2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017
Number of events reported	22	11	20	17	29	29	50	51	48	42	44

We have reported **44** serious adverse events in 2016 -2017 a similar figure to the 2015/2016 figure. What we report and investigate has changed over time and we are 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. Each of the 44 adverse events were investigated using a systematic investigation protocol. Understanding where improvements need to be made so we can help staff keep patients safe are the main drivers for the investigation.

Injuries suffered by patients when they fall are the most common adverse event in any district health board. At Waitemata DHB **35** of the **44** serious adverse events related to falls; the injuries sustained in these falls included broken bones (fractures) and head injuries. Further details about the 2016/17 falls events are set out on **page 10** of this report.

The remaining **9** serious adverse events led to actual or potential serious patient injury. The table and report below outlines a summary of these 9 events, as well as the findings and recommendations that occurred in 2016/2017. These events have been classified into the following themes:

- Procedural injury (1)
- Delay / failure in follow up or treatment (1)
- Wrong or unnecessary procedure (1)
- Delay in escalation of treatment (2)
- Other (4)

Procedural Injury

Description of Event	Investigation Findings	Recommendations	Comments
A patient had a full thickness graft taken instead of a split thickness graft.	Equipment was assembled incorrectly and not thoroughly checked before use.	Guideline to be written: - – surgeon is responsible for loading the device – two people to double check the blade is loaded correctly before the aperture plate is screwed on – 'check box' added on the paperwork to indicate that the blade has been checked and communicated to relevant theatre staff.	Guideline has been completed. No other similar events have occurred. This event was reported to MedSafe.

Delay/Failure in follow up or treatment

Description of Event	Investigation Findings	Recommendations	Comments
Pulmonary embolus (blood clot in the lung) following orthopaedic surgery after a patient was discharged. The patient passed away.	The patient met the criteria for pharmacological thromboprophylaxis according to Waitemata DHB's Thromboprophylaxis Risk Assessment and Prescription Guideline. The patient should have been prescribed pharmacological thromboprophylaxis (blood thinning medication) once a high risk of bleeding had been excluded. There were missed opportunities to check and confirm whether pharmacological thromboprophylaxis was required and therefore prescribed.	Waitemata DHB's Thromboprophylaxis Risk Assessment and Prescription Guideline should be renamed 'Protocol' and resident medical officers (RMOs), Registrars and Senior Medical Officers (SMOs) instructed that they must complete the risk assessment and prescribe thromboprophylaxis when the risk criteria are met (ie if the criteria are met and there are no contraindications to prophylaxis, then thromboprophylaxis must be prescribed). If a decision is made not to follow the protocol ie not prescribe according to the prescription protocol, then the name of the decision maker and the reason for the decision not to follow the protocol must be documented. Medical staff should be encouraged to seek the advice of a haematologist (blood specialist) if there is any uncertainty about whether a patient meets the criteria for pharmacological thromboprophylaxis and/or how to prescribe. The primary medical team caring for the patient (eg orthopaedics, general surgery etc) is responsible for undertaking the thromboprophylaxis risk assessment and prescribing prophylaxis. Other team members should be encouraged to check and ask whether the patient requires thromboprophylaxis eg the anaesthetist and other theatre staff, ward pharmacist, ward nurses and allied health staff, however responsibility for assessment and prescribing remains with the primary medical team.	Changes to Waitemata DHB's "*Thromboprophylaxis Risk Assessment and Prescription Protocol*" has been completed and shared with the medical staff. No other similar events have occurred. A solution has been developed on the patient electronic record system which records whether a VTE risk assessment has occurred or not and whether thromboprophylaxis is required; with a link to the DHB's Thromboprophylaxis Risk Assessment and Prescription Protocol and a link to e-Prescribing (MedChart).

Description of Event	Investigation Findings	Recommendations	Comments
		There should be a standard place to document electronically the venous thrombo-embolic (VTE) risk assessment.	

Wrong or Unnecessary Procedure

Description of Event	Investigation Findings	Recommendations	Comments
Excision of a different skin lesion (under local anaesthesia) to that which was meant to occur.	It was unable to determine if a photograph of the skin lesion was received with the referral. The patient was not given the opportunity to visually identify that the surgical site was marked correctly.	There should be a photograph sent with every skin lesion referral. Skin lesion referrals without a photograph should not be accepted; they should be returned to the referrer and a request made to resend the referral with a photograph of the lesion attached. Ensure that photographs either from referral or clinic are readily available on day of surgery There should be an accurate, detailed specification of the site and location of all skin lesions, particularly patients with multiple skin lesions documented in the patient's clinical record. If the photograph sent with the referral is not sufficiently clear then a photograph should be taken in clinic and uploaded to Concerto for reference prior to surgery. Ensure accessibility of hand held mirrors for patients to check that pre-operative marking areas are appropriate and accurate At the time of surgery, if the skin lesion is no longer visible or there is any uncertainty about the location of the lesion, then the operation should not go ahead. The patient should be asked to return to their General Practitioner to mark the lesion if it reappears/becomes apparent.	Patient proceeded to have the correct lesion removed. The guideline for the acceptance of a skin lesion referral with a photograph is in place. The decline usually occurs at grading if there is not a photograph or biopsy. This guideline information for referral of skin lesions has been disseminated to General Practitioners (GPs) via newsletter and is available on Healthpoint*. **Healthpoint provides up-to-date DHB information about healthcare providers, referral expectations, services offered and common treatments.* No other similar events have occurred.

Delay in Escalation of Treatment

Description of Event	Investigation Findings	Recommendations	Comments
Delay in diagnosis and treatment of an infected skin flap of a patient at home.	Staff relied on the patient's assessment of her dressing and drain via telephone rather than visiting to make a visual assessment The patient was subsequently admitted to hospital with an infection	Professional lead to meet with staff and discuss case and how it could have been better managed. Completion of a specific policy outlining expectations of home visits and monitoring of patients post breast surgery.	Intravenous antibiotics successfully healed the infection and no surgery was required. New policy has been published and discussed with the entire home service. No other similar events have occurred.
Description of Event	**Investigation Findings**	**Recommendations**	**Comments**
A patient developed an E.Coli sepsis (serious infection) following a trans-urethral ultrasound biopsy.	A box on the laboratory interim report was not ticked; this box would indicate that this was not the full completed report. A full completed infection, prevention and control report contains more specific information related to the bacteria type. This resulted in the interim report being interpreted as the final completed report and the wrong antibiotic prophylaxis (preventative measure) being given.	Laboratory to review their report process to ensure that events of this type do not recur.	As a result of this event the laboratory has removed the tick box option and now only releases complete reports. This has reduced the risk of incorrect medication being prescribed due to incomplete information. No other similar events have occurred.

Other

Description of Event	Investigation Findings	Recommendations/Actions	Comments
Accidental dislodgement of a haemodialysis central line venous catheter during dialysis.	Dialysis catheters/lines should be secured as per the *"Commencing and discontinuing dialysis with a central venous catheter"* policy once connected to the patients tunnel line. How securing of the lines should happen had not been specified in the policy but is recognised by staff as best practice to either loop lines around and clamp onto patients shoulder or to tape to the arm of the chair. This did not appear to have been the case in this situation.	All central catheters/lines should be secured in a way that avoids any pulling on the catheter and does not leave lines hanging down where they could be caught or pulled. Specific instructions on how this procedure is to be undertaken is detailed within the policy *"Commencing and discontinuing dialysis with a central line venous catheter"* Haemodialysis unit staff to make their patients aware of the specific risks of any tension on the dialysis lines.	Actions have been completed No other similar events have occurred.
Description of Event	**Investigation Findings**	**Recommendations/Actions**	**Comments**
A patient required the retrieval of a partial dental plate from their throat following general anaesthesia.	The "*Airway*" question had been removed by the DHB theatre team from the WHO Safe Surgery Saves Lives (SSSL) checklist sign in and so the presence of dentures was not mentioned in the "sign " process Anaesthetist was aware of plate, but did not remove it either prior to the procedure, or once the patient was anaesthetised. It not been determined why usual procedure was not followed.	The "*Airway*" question should be replaced in the checklist sign in section, and state of dentition is mentioned by the anaesthetist at sign in. At "sign out" in response to the question on postoperative concerns, the anaesthetist should mention dentures, if relevant, and their disposition (in patient, in container) and any other prostheses (hearing aids, glasses etc)	Checklist has been updated and in use Discussion completed with anaesthetic team with regard to expectations in relation to the safe management of dentures/partial plates and other prostheses No other similar events have occurred.

Description of Event	Investigation Findings	Recommendations/Actions	Comments
A baby was born unresponsive following an emergency caesarean section for baby bradycardia (low heart rate); efforts to revive the baby were unsuccessful.	Sudden and unexpected death of a term infant in labour in an otherwise well mother Despite a possible maternal history of meconium[1] a Cardiotocography (CTG) [2] trace to establish fetal well-being was not undertaken on admission to the maternity unit. A fetal scalp electrode was later attached during labour for CTG tracing. Inspection of the CTG trace available from the fetal scalp electrode suggests that the heart rate recorded was maternal rather than baby. That, along with the meconium stained skin on the baby at birth suggests that the baby had possibly died prior to labour.	The *"Fetal Assessment in Labour "* guideline be updated to include the recommendation that continuous fetal monitoring is to be performed where there is a history of meconium stained liquor until clear liquor is established or meconium is confirmed. Midwives to be reminded that a history of meconium should be treated judiciously until proven otherwise.	This case has been put forward to the National Perinatal and Maternity Mortality Review Committee to review for further comment. Guideline updated. No similar events have occurred.

[1] **Meconium** is the dark green substance forming the first faeces of a newborn infant),

[2] **Cardiotocography (CTG)** is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM)

Description of Event	Investigation Findings	Recommendations/Actions	Comments
Displacement of a tracheostomy tube (internally) from the trachea (windpipe) resulting in cardiac arrest	Tracheostomy tube was well secured with sutures and tape. Tube likely dislodged when the patient's neck was extended during facilitation of a turning procedure (i.e. patient laid flat). This was undertaken with a dedicated airway nurse present. The patient had substantial soft tissue to the front of their neck which made initial diagnosis of the dislodgement difficult. Tube length and type may have been a contributory factor to the dislodgement in the patient's neck soft tissues. It is rare for a tracheostomy tube to dislodge internally. Because of the loss of the tube the patient was unable to receive adequate oxygen which contributed to the cardiac arrest.	Continue to support best practice of dedicated airway nurse in the intensive care unit (ICU)/high dependency unit (HDU) for all patients with an artificial airway, and supporting the head to maintain flexion rather than extension of the neck and trachea. Surgical tracheostomy in ICU patients should involve a discussion with an intensivist (ICU specialist) and surgeon as to what type of tracheostomy is required. Tracheostomy patients will be identified clearly as "high risk airway" within the ICU/HDU. Enhance familiarity with difficult airway scenarios and equipment required.	Patient recovered well following the event. Training on difficult airway scenarios are undertaken on a regular basis within the ICU/HDU Unit. No similar events have occurred.

Summary of falls causing patient harm

There were **35** adverse events related to falls reported to the Health and Safety Commission (HQSC) by Waitemata DHB in the year 1 July 2016 to 30 June 2017. This is an increase of one fall on the previous year (2015/2016) and two less falls than 2014/15.

29 of the injuries sustained were fractures and **six** patients sustained some form of head injury, i.e. bleeding in the brain, as a result of their fall.

Fractures sustained as a result of these falls are as follows:

Fracture	Number
Neck of Femurs (hips)	**10**
Pelvis	**2**
Lower leg	**1**
Upper Leg	**2**
Foot	**1**
Upper Arms	**4**
Elbow	**1**
Wrists	**4**
Thumb	**1**
Ribs	**1**
Spinal Vertebrae (Back)	**1**
Nose	**1**

What are we doing to reduce further falls and harm?

The Falls Prevention Steering Group continues to ensure that nurses and health care assistants are aware of falls prevention activities in day to day interactions with patients. This includes:

- falls risk assessment on admission [using e-vitals] and regularly thereafter
- assessment of moving and handling practices
- patient and family education
- assistance of patients who are unsteady
- assistance of patients with cognitive impairment impulsive actions
- use of appropriate support equipment e.g. floor line beds

A new campaign was launched in July 2017 called “Get up, Get Dressed, Get Going” to support patients who are identified as frail; getting patients up and sitting in chairs and walking reduces deconditioning, loss of function and core strength.