Serious Adverse Event Report: Nelson Marlborough Health

1 July 2016 to 30 June 2017

Introduction

Nelson Marlborough Health (the Nelson Marlborough District Health Board) reported 18 adverse events to the Health Quality & Safety Commission (HQSC) in the 2016/17 financial year. Of these, to date, eight events have been classified as serious adverse events under HQSC criteria.

This report provides a summary of our serious adverse events, findings, recommendations and actions completed within the year. We publish it in conjunction with the HQSC's annual *Learning from Adverse Events Report* available online:

https://www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/

What is a serious adverse event and how are they reported and investigated?

Nelson Marlborough Health (NMH) is dedicated to providing the very best in healthcare. While everything is done to ensure that safe and effective care is provided to all patients, sometimes things go wrong. We refer to these incidents as serious adverse events and we take them very seriously.

A serious adverse event is an unintended, negative consequence of care that has resulted in serious harm to a patient. The event may have led to a patient needing significant additional treatment, has been life threatening, or led to a major loss of function or unexpected death. Adverse events can arise due to a mistake in care or an unplanned complication of treatment such as a reaction to a medication or the development of a serious infection.

NMH acknowledges that serious adverse events are distressing for all involved. We would also like to reassure readers that the rate of these events is very low when compared to our rate of successful procedures and treatments. In this paper we report eight serious adverse event over twelve months while on an average day at NMH 128 people attend the emergency department, four babies are born, 28 people undergo surgery and 86 people are discharged from hospital.

At NMH we encourage the reporting of every adverse event or near miss. A reporting system records what happened and supports case review to identify opportunities for improvement. We intend to learn from every event and make changes to prevent similar events occurring.

During a case review, NMH works openly with patients, service users, staff and family/whanau to ensure their concerns and needs are addressed and supported. We encourage consumer engagement during the review process so they may share their experiences, help us identify any recommendations for change and find resolution of the event.

New Zealand district health boards (DHBs) classify the severity of adverse events using the HQSC's severity assessment code (SAC). The two major SAC classifications, SAC 1 and SAC 2, are called serious adverse events. A SAC 1 event is one that has led to an unexpected death of a patient or severe loss of function that is related to the process of our health care. A SAC 2 event is one that has caused permanent major or temporary severe loss of function that is related to the process of our healthcare.

NMH recognises that each serious adverse event involves a person suffering harm or death while in our care. We deeply regret all instances of patient harm and acknowledge the grief and distress they cause to all involved – patients, whanau, friends and our own staff.

Serious adverse event review

NMH had fewer SAC 1 and 2 events in the 2016/17 financial year (*Figure 1)* compared to 2015/16; the 2016/17 figure is closer to our long-term average.

Further development of information for our staff to accurately classify events within our 'Safety 1st' reporting system using the HQSC criteria, and a greater overview and triage of all logged incidents by our Clinical Governance Support Team has allowed our reporting to be more specific this year.

NMH supports a 'just culture' environment to build staff confidence and willingness to report events.

'Just culture' is a culture of transparency and an environment of openness and trust for the people who use our services. We recognise that in almost every adverse event a collection of circumstances have come together to allow it to happen. Our focus is therefore on improving our systems of care not blaming individuals who contributed to a small parts of the problem.

By encouraging reporting of all events including less severe and 'near misses' and by responding and acting on them, we hope to foster just culture. At the same time we hope to reduce the number of more severe events by implementing corrective actions.

Serious Adverse Events at Nelson Marlborough Health: 2011 – 2017

Figure 1: Adverse events reported to HQSC by NMH 2011-2017

Year	*2011-2012*	*2012-2013*	*2013-2014*	*2014-2015*	*2015-2016*	*2016-2017*
Number of events reported	**6**	**9**	**8**	**11**	**41**	**18**

Why our figure is different from the HQSC's *Annual Learning from Adverse Events* report?

Nelson Marlborough Health reported 18 serious adverse events to HQSC during the 2016/17 financial year (FY) but the HQSC's report lists eight serious adverse events.

Our figure is different as some events have been downgraded or amended since the publication of the HQSC report. Of the 18 events reported to HQSC:

- four were reclassified as not meeting SAC 1 or 2 criteria post-review and therefore downgraded to SAC 3
- six were reclassified as not meeting classification of a SAC event post-review as harm/death was not due to process of our healthcare eg serious decline in health/death was found to be due to the natural progression of a patient's illness rather than due to process of healthcare
- therefore 10 events in total were excluded from the HQSC figures for 2016/17.

Summary of events, findings and recommendations of the serious adverse events that have occurred in the 2016/17 financial year

The eight events have been categorised under the following headings:

- clinical process
- patient falls
- Resources/organisation/management

DESCRIPTION OF EVENT	REVIEW - MAIN FINDINGS	SUMMARY OF RECOMMENDATIONS/ACTIONS
CATEGORY 1: CLINICAL PROCESS		
Abdominal bleed following an emergency Caesarean section	Event has been investigated. The report is out for final amendments and approval by review team. We have improved the management and care of women who require high dependency care and/or are at risk of deteriorating.	Recommendations completed: Implementation of the Modified Obstetric Early Warning Score (MEOWS) System district-wide to assist staff to identify antenatal and postnatal women early if they deteriorate, and a pathway to get extra care. High-dependency postnatal mothers to be cared for in birthing suite to ensure higher ratio of care '1-2-1' Maternity staff education with extra focus on: • criteria around the use emergency call system • identification and management of the deteriorating patient
Unanticipated complications following surgical procedure	Under review - report pending	
Unexpected death of patient following	Patient presented with complex disease with high mortality	Further development of clinical guidelines for surgical conditions to indicate risks, observations and required responses,

admission with abdominal pain and complex multi-system disease	Incomplete fluid balance Handover/escalation of clinical concern/oversight of patients/communication pathways Staff feel able to voice issues within the team	including criteria for physician involvement in surgical care. Incorporation of the importance of cumulative fluid balance and clear documentation into the 'deteriorating patient' education programme. Fluid balance chart ward audit to be conducted on a regular basis. Development of pathway for junior staff with regards to escalation and notification to senior clinician if more than one review of patient required in an out-of-hours shift/pathway developed. All acute patients to be seen by consultant within 24hrs of admission. Staff to attend 'courageous conversations' study days for further development of communication skills and conflict management. Encourage staff confidence to 'speak up' and further foster mutual respectful behavior in the workplace.
Unexpected death of patient following computed tomography scan (CT)	Event has been investigated. The report awaiting final SAC classification/Centre for Adverse Reactions Monitoring (CaRMS) report radiology reporting to clarify when contrast is used.	Review formatting of the report at Radiology Service review meeting
Delay in treatment of sepsis (serious infection)	Event has been investigated. The report is out for final amendments and approval by review team Improve clinicians' skills in sepsis recognition and management and more timely detection and management of sepsis	Continue and add education sessions for Paediatric Early Warning Scoring Tool (PEWS) – alongside introduction of the fever screening tool to be added to Paediatric Observation Guideline – in progress Ongoing monthly audits to assess improvement in PEWS compliance and appropriate use of escalation pathways. Introduction of the Newborn Observation chart and Neonatal Early Warning Score (NEWS) to improve early recognition of unwell newborn babies.
Newborn baby born in unexpected poor	Report pending	In progress - planning for implementation of recommendations is underway including

condition		systems for managing high-priority referrals.
CATEGORY 2: PATIENT FALLS		
Patient fall in ward resulting in a fractured hip	Event has been investigated. The report is ready for sign off by Executive Leadership Team/Clinical Governance Support Group. Patient had difficult with weight bearing on legs and had reduced mobility prior to fall. Bed in low position and against wall sensor mat in place but was taken off watch. Patient more confused than normal and tried to walk on their own.	Falls risk assessments to be completed during In-patient admissions with appropriate actions put in place on the assessment. Falls assessment & intervention plan is integrated into the nursing care plan. Intervention plan is based on a clear pathway triggered by the individual assessment. Improve awareness of the nursing team re falls prevention strategies and preparation for the unexpected actions of patients.
CATEGORY 3: CLINICAL ADMINISTRATION (eg handover, referral, discharge)		
Delay in follow-up following newly diagnosed malignancy	Event has been investigated. The report is ready for sign off by Clinical Governance Support Group. Review findings: Lack of familiarity with the referral centre process, the referral letter was sent to the wrong place causing a delay in reaching NMH referral centre. Referrals triage process needs to be prioritised to manage incompletion without introducing delay. There was an absence of a formal method for confirming another DHB had received the referral leading to a delay.	Better information sharing about new processes. Investigate whether direct referrals can be established under a credentialing process smoothing the process of care. Development of a standard procedure for triaging referrals with sufficient time allocated for clinicians to complete this activity Continuing development of IT systems with e-triage, digital management of referral and processes to acknowledge all referrals.