Serious Adverse Events: Nelson Marlborough Health

1 July 2018 to 30 June 2019

Nelson Marlborough Health (the trading name of the Nelson Marlborough District Health Board) reported 18 adverse events to the Health Quality & Safety Commission (HQSC) in the year 1 July 2018 to 30 June 2019. Of these, 9 events were 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 *Learnings from Adverse Events Report* that is available online: https://www.hqsc.govt.nz/our-programmes/adverse-events/projects/adverse-events-reports/

What are serious adverse events?

Serious adverse events are events that have resulted in serious harm to patients. 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.

In a service as large and complex as the Nelson Marlborough Health's (NMH), things will sometimes go wrong. When they do, the response should not be one of blame and punishment, but of learning that leads to improvements that reduces the risks to patients, visitors and staff. Care will never be risk-free, but by learning from our adverse events we can minimise these risks.

NMH would like to reassure readers that the rate of these events is very low when considered as a proportion of our successful procedures and treatments.

How are these events investigated?

All serious adverse events are investigated by a selected multidisciplinary review team. During a review, NMH works with patients, service users, staff and family/whanau to ensure their concerns and needs are addressed and supported. We encourage consumers to be engaged during the review process so they may share their experiences, help us identify any recommendations for change and find resolution of the event.

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.

Summary of events, findings and recommendations of the events that have occurred in the 2018/19 financial year at Nelson Marlborough Health.

In the year 1 July 2018 to 30 June 2019, a total of 18 adverse events at Nelson Marlborough Health were reported to the HQSC. Of those 18 reported events, six relate to mental health and have not been included in this report. Three have been withdrawn as a review of the event revealed that care was appropriate and the

harm was not due to the process of our health care. NMH identified nine which met HQSC serious adverse event SAC 1 – 2 and 'Always Review and Report' (ARR) criteria.

Please note that the events do not include mental health-related incidents; these are reported separately via the Director of Mental Health.

The events have been categorised under the following headings:

Event Type	NMDHB Number reported 1 Jul 2018- 30 Jun 2019	National Number
Mental health	6 events related to mental health	
Clinical process or procedure	5 events reported to HQSC relating to patient harm due to clinical process of healthcare	
Patient falls	3 events related to falls resulting in patient harm	
Medical device / equipment	1 event met criteria for ARR	
Event reported but withdrawn	3 events were withdrawn after review indicated that the outcome was not related to the process of health care.	
Total	18	

Recommendations and activities that have taken place as a result of reviews undertaken over 2018 to 2019 year included the following

1. Education, use and improved monitoring of early warning score charts
2. Introduction of Patient track (software to support monitoring of patients) with improved visibility of deteriorating patients across the hospital system
3. Improving guidelines for use and monitoring of emergency medications, foetal monitoring and obtaining second opinions
4. Escalation process education, encouragement and training for staff and for patients and families to ensure their concerns are addressed and they have a follow up plan
5. Review and updating of transfer documentation
6. Agreement and formalising of handover processes including the use of the ISBAR[1] tool

[1] ISBAR (Introduction, Situation, Background Assessment, and Recommendation) is such a tool. ISBAR organises a conversation into the essential elements in the transfer of information from one source to another

7. Ensuring care planning is developed in partnership with the client families/ whānau to address all concerns

8. Improved timeliness of decision-making following receipt of referrals into services and improving timeliness of communication back to referrers.

9. Updating of information sources used by clinicians to include important guidance on indications for and application of the *Mental Health Act.*

10. Additional tracking label ID process step prior to use of sterile instruments with accompanying education.

11. Further signage alerts in patient rooms for example:

    'Before you leave…
    - are you reassured?
    - do you have a follow-up care plan?

    If not – please tell your midwife or doctor.'

12. Reviewing requirements for regular refresher education topics for all professional groups and documenting when these have occurred

13. Improving falls risk assessments in preparation for transfers back to place of residence.

14. Piloting implementing a falls screen/bone health check on arrival to ED

15. Further development of 'falls champions' assigned to each ward.