Serious Adverse Events: Nelson Marlborough Health

1 July 2017 to 30 June 2018

Nelson Marlborough District Health Board (Nelson Marlborough Health) reported 16 adverse events to the Health Quality & Safety Commission (HQSC) in the year 1 July 2017 to 30 June 2018. Of these, 7 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 available online:

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

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 District Health Board, things will sometime 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.

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 2017/18 year

In the year 1 July 2017 to 30 June 2018, a total of 16 adverse events at Nelson Marlborough Health were reported to HQSC. Of those 16 reported events, 11 have been withdrawn as a review of the event revealed that care was appropriate and harm was not due to process of our health care.

The 7 events have been categorized under the following headings:

- Clinical process
- Falls
- Resources/organisation/management

Description of Event	Review - Main Findings	Summary of Recommendations/Actions
Clinical Process		
Wrong site procedure (Always Review and Report) – no harm	There were a number of referral forms in the work space of MRI control room at the same time which resulted in the wrong form being picked up and magnetic resonance imaging (MRI) of wrong hip	Referral forms to be placed in an area where they cannot be mixed with next patient All referrals completed to be kept separate from any referrals still to be done MRI Technologists to verify the patient on the scan table correlates with the patient referral form
Delayed recognition of patient deterioration – patient died	Modification of Early Warning Score (EWS)[1] normalized abnormal vital signs Too much reliance on EWS as only method of escalation in this event – the tool is only one part in identifying patient deterioration	Ensure all staff and visiting temporary staff are familiar with and informed of Emergency Departments internal Early Warning Score (EWS) escalation system Case discussed/shared learnings to all clinicians highlighting appropriateness of modifications in acutely unwell patients and to adhere to the clear policy for modifications
Delay in diagnosis – patient died	Severity of underlying disease not recognized until late in the clinical course – it is unlikely that earlier recognition would have altered the outcome. Breakdown in communication between medical staff and nursing staff contributed to delay in recognizing patient's deteriorating condition. Discharge management plan not discussed with family.	Case discussed at Medical Mortality and Morbidity meeting Good communication is at the heart of medicine and medical teams have acknowledged some deficiencies and addressed these within the department

[1]An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. These scores are based on a set of physiological observations (parameters). In general, respiratory rate, heart rate, systolic blood pressure, temperature and level of consciousness are measured

Selection and timing of treatment in ED - patient died	Intensive Care Unit (ICU) level hands-on expertise was not available on site during the night. Available resources did not highlight the critical importance of commencing treatment for this particular life threatening medication overdose early, prior to onset of symptoms	Toxicology management to be handed over to the inpatient team. Plan to be initiated by emergency department physicians and can alter as the clinical situation changes Anesthetists to undergo regular training and updates in critical care skills Initiate activity to provide telemedicine link with appropriate national or local expertise 24 hours/7 days Improved resources for toxicology information and change the 'go to' resource for toxicology - Tertiary level ICU specialist recommendations when requested to be implemented immediately by secondary colleagues in any setting
Adverse cardiac/ respiratory event during procedure- patient died	Past medical history not widely known by team undertaking procedure Details of potential medical risks not written on consent form Dependent on patient to self-report medical history Policy regarding anesthetic involvement in this acute procedure not on intranet	Comprehensive risk assessment to be performed prior to procedure and review of safety check list Review procedure pathway documentation to include section to highlight relevant comorbidities ISBAR[2] handover from ward nurse to area nurse to be implemented in this setting Handover procedure for general surgery patients to be developed Printable summary of complex or vulnerable patients' medical history to be developed to sit within the electronic medical record – working group identified to address this Anaesthesia policy to be further developed to include provision for area staff to request anaesthetic assistance during procedure

[2] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information

Falls		
Fall resulting in head injury, periorbital fracture and fractured clavicle (collarbone)	Other physical features/comorbidities made patient high risk for falls. Patient not placed on Lo-Lo bed. Lo-Lo beds not historically used on surgical ward. Physiotherapy review not completed due to workload. Patient self-administered glyceryl trinitrate (GTN) immediately prior to fall.	Review of falls assessment and care plan tool. Assessment must clearly inform actions Advocate use of Lo-Lo beds on surgical wards. Assess impact/environmental factors with utilizing Lo-Lo beds within surgical wards Physiotherapy to review all patient within 24hrs of surgery Revision of Medicine Administration Policy and Patients Own Medication Policy to ensure information regarding self-administration is clear and aligned
Resources/organisation/management		
Delay in ophthalmology follow- up/delay in treatment resulting in visual loss	Increased demands for service. Availability of clinic appointments for follow ups leading to patients not receiving follow up appointments within recommended timeframes. There was a lack of interdepartmental coordination and communication did not happen reliably – clinician not informed of concerns and patient left with existing appointments. Clerical processes not followed	Business case presented Immediate implementation of improvements Review of all clerical staff processes Development of desk file Introduction of the acuity index tool Review of current operational coordination of the service and review of current booking system Alter follow up appointments booking process All avastin[3] follow up appointments (4 total) are now pre-booked at start of treatment including follow up

[3] Avastin is a drug for the treatment of a certain type of colorectal cancer but can also be used to treat certain eye conditions by being injected into the eye. Usually injections are performed at intervals of 4-6 weeks