Serious Adverse Events: Nelson Marlborough Health

1 July 2015 to 30 June 2016

The Nelson Marlborough District Health Board (Nelson Marlborough Health) reported 41 adverse events to the Health Quality & Safety Commission (HQSC) in the 2015/16 financial year. Of these, 26 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 national report available at: http://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?

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.

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.*

DHBs are required to notify the HQSC about all SAC 1 and 2 events within 15 days of the event being reported. Each DHB will then investigate each event and assign a final SAC classification.

At Nelson Marlborough Health, we work openly with patients, service users, staff and family/whanau during our investigation process to ensure all concerns and needs are addressed.

Investigating what has occurred helps us recognise opportunities to improve our systems and make similar events less likely in the future. 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.

Why have reported events increased at Nelson Marlborough Health this year?

As shown in *Figure 1*, NMH had a noticeable increase in reported SAC 1 and 2 events in the 2015/16 financial year. This increase is primarily due to three factors:

i) *Figure 2* shows that our health services did not suddenly get worse on 1 March 2015, rather our reported events increased due to the introduction of the Safety 1st online reporting system and increased staff awareness about the importance of using it.

ii) What we report and investigate has changed over time. We now report events which may not cause long-lasting harm, as well as events that are 'near misses', ie where there was the risk of harm rather than harm actually occurring. We may also report events that have occurred outside our hospital settings, such as in a patient's home if they are still under our care.

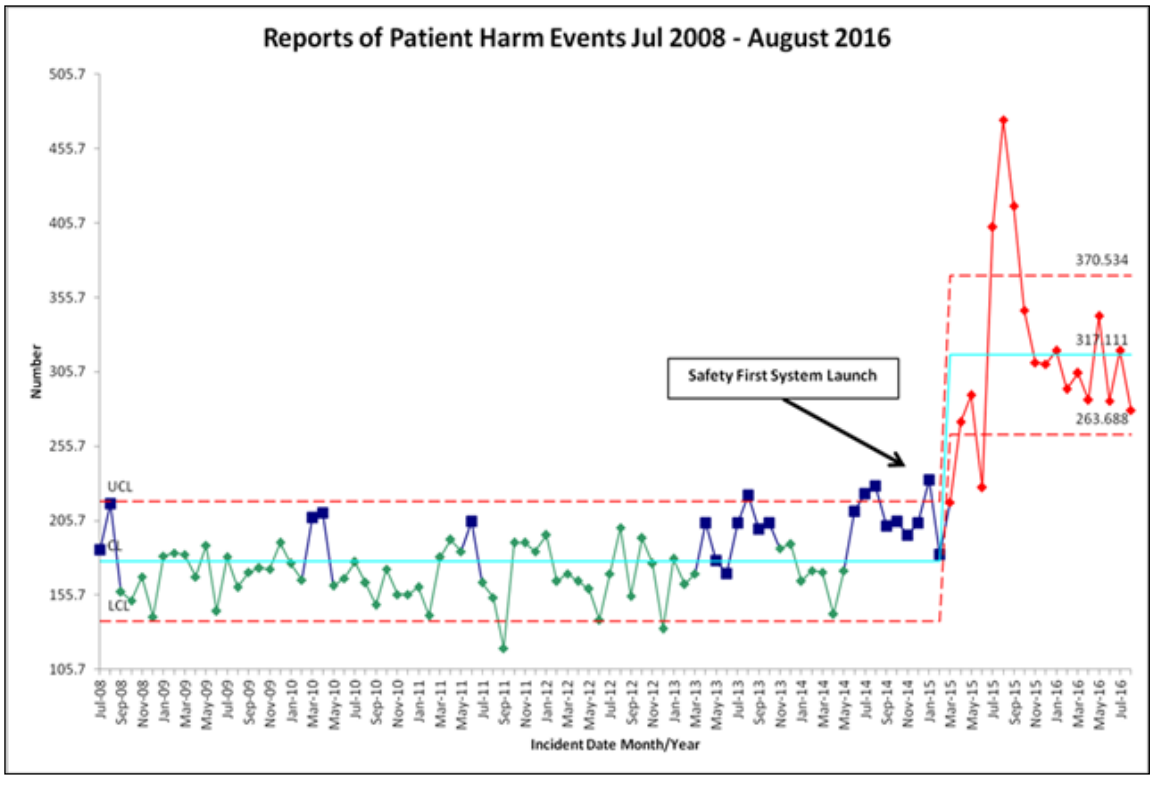
This has enabled us to have a greater overview of all incidents, regardless of their severity, to investigate the context and circumstances of an event, to recognise any recurring themes and provide opportunities to make improvements.

iii) NMH have embraced a culture of '*just culture'* that has increased confidence and the willingness of staff to report events. Open reporting of events contributes to a culture of transparency, an environment of openness and trust for the people who use our services. It also meets our NMH values of 'Respect, Innovation, Teamwork and Integrity'.

Figure 1 – Adverse Events reported to HQSC by Nelson Marlborough Health FY 2011-2016

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

Figure 2 – July 2008/2016 shows a significant increase in reported events following the introduction of Safety 1st in 2015.



Why are our figures different from the HQSC report?

We have put considerable effort into encouraging use of our Safety 1st online reporting system since it was introduced in March 2015.

Figure 2 shows that, with its introduction, reporting increased.

Reporting of events within Safety 1st is encouraged and welcomed. Correct categorisation of an event in Safety 1st; in line with HQSC matrix classification, can present a degree of uncertainty for staff however. Over the past year this has resulted in a number of events being reported to HQSC which, when subsequently reviewed in detail, did not meet the requirements for reporting.

This is what has happened this year: 41 serious adverse events were reported to the HQSC but only 26 of these could be classified as SAC 1 or 2 serious adverse events upon investigation. This is not captured in the HQSC report for the 2015-16 year because reviews occurred after the HQSC closing date prior to publication

We are currently developing better information to help staff to more accurately classify events using HQSC criteria.

Summary of events, findings and recommendations of the events that have occurred in the 2015/16 financial year

There were 41 adverse events reported by Nelson Marlborough Health to HQSC during the 2015/16 financial year. Of those 41 reported events, NMH identified 26 which met HQSC serious adverse criteria.

The 26 events have been categorised under the following headings:

- Clinical process
- Patient falls
- Resources/organisation/management

Summary of serious adverse events, findings, recommendations and actions completed within the 2015/16 financial year at Nelson Marlborough Health.

Description of Event	Review - Main Findings	Summary of Recommendations/Actions
Clinical Process		
Unexpected death following surgery	Information from pre-operative assessment, including the risk of cardiovascular collapse due to underlying heart disease, did not prevent this occurring.	It should always be clear who is caring for an individual patient. Medical Emergency Team to be developed as a 'flying squad' to support early intervention. Changes to Early Warning Score System

	Reponses to hypotension in the Intensive care unit did not result in low blood pressure being managed effectively.	where a single parameter like a low blood pressure can trigger an urgent response by staff with necessary skills and support. Preoperative (prior to operation) assessment process should be complete and determine a peri-operative (occurring or performed at or around the time of an operation) care plan which is clearly documented and followed by all those subsequently involved in care
Delay in diagnosis and treatment	Delay in blood results being processed Follow-up of blood results did not occur: there was a lack of system for follow-up of blood results Patient was not registered with a GP	Process put in place to enable diagnostic test results to be followed up after-hours. Patient sticker is kept on a list for the Senior Medical Officer to review any test results the following day. Process established for reviewing diagnostic tests post discharge when patient does not have a GP who can follow-up. Audit of actions by Clinical Governance Support Team
Unanticipated complications following surgical procedure	Case highlighted communication issues between the medical and nursing staff but these did not affect the patient's outcome Review of incident failed to identify a preventable reason for the complication during/following surgery Staff did not use pathways available to them (i.e. notify Duty Nurse Manager) to escalate their concerns which led to conflict in the interdisciplinary team	Staff to record each patient event/Dr visit/Dr examination in the notes as close to the event as possible Documentation workshop for all staff involved in the case Outline a clear escalation pathway for nurses to raise any concerns about a patient.
Delay in responding to deteriorating patient post operatively	Report Pending	Report pending
Unexpected inpatient death from aspiration pneumonia attributed to choking at place of residence	Contributory factors were significant in this case Patient communication and behavioural difficulties made	Development and implementation of a procedure for the monitoring of service users in their residence when they are physically unwell

	assessment and diagnosis of patient in Emergency Department (ED) challenging Limited onsite staff with clinical experience to monitor the service user's condition, led to a delay in recognising the onset of aspiration pneumonia Roster pattern did not allow any time within a shift for handover period	Communication between Disability Support Services and ED managers and clinicians to establish a common goal of ensuring the best outcomes for the service users when they journey through the hospital system Consider the appointment of a registered nurse onto the DSS team to provide co-ordination of physical health needs for residents Documentation policies to be reviewed/updated to include time of an event as well as the date
Delay in treatment of cancer	Correctly triaged as requiring 'faster cancer treatment' but incorrectly annotated as requiring an 'urgent' rather than 'ASAP' appointment Anomaly not questioned by administrative staff although noted to be outside expectations for their role. Inconsistent time-related response to the word 'ASAP' when used after triaging in different departments across the organisation 'Faster cancer treatment' category boxes present on the triage forms are not taken into consideration by administration staff when managing triage forms No wider multidisciplinary team oncology input automatically occurs for in-patients with cancer	Review triage process Issue addressed with administration staff Regular Urology and Oncology Multidisciplinary team meetings established
Two events relate to Delay in assessment and treatment	Reports Pending	Reports pending
Pressure injury – Unstageable (Depth of injury unknown)	Unclear format of Waterlow tool within nursing care plan. Risk not calculated correctly Lack of clear DHB/unit standards	Develop guideline for Waterlow assessment Reformat Waterlow tool within nursing care

	Pre-existing patient morbidity Insufficient pressure relieving device used in initial stages of pressure injury development	plan Education around Waterlow tool and correct score Audit of implementation of new tool to ensure risk assessment completed
Post-operative complications requiring Intensive care Unit (ICU) admission	Review findings - case was appropriately managed – patient's journey was appropriate and transfers to higher level of care undertaken appropriately	
Wrong size surgical implant, corrected during the same operating session	Report pending	Report pending
Unexpected inpatient death from cardiac arrest	Report pending	Report pending
Patient falls		
Five events related to falls resulting in harm Injuries sustained included: Fracture to right ankle, hip fracture, a head laceration, reduced level of consciousness as a result of a fall and an outpatient sustained fractured right femur following fall in hospital grounds One event remains open – report pending	Falls risk assessment and care plan did not get reviewed following one of the falls Bed position, bed type, sensor mat, close observation area, delay in post fall actions and implementation of universal precautions One patient had been identified as high risk but patient removed sensor mat alarm prior to getting up and fell in bathroom Staffing and patient complexity and high acuity	HQSC video on effects of falls viewed during staff reflection of falls and impact on patients Reinforce to staff involved accepted standard of care provision around fall assessments Restraint and enabler audit of all inpatient areas in Nelson Hospital Education provided to ward staff and static display on Lo Lo beds by Essential Health Care Team around falls prevention Education provided to ward Staff on falls assessment, falls care plans and documentation Nursing care plan and risk assessment timelines, policy review Outpatient appointment cards have a statement saying to phone the OPD if patient requires assistance with mobility once at the hospital Informal audit of current mobility parks and their usage and availability undertaken

		Signage indicating the location of wheelchairs for public use is sited at the main entrance. NMH have implemented a number of actions to identify people at risk of falls and to minimise the risk of inpatient and outpatient falls.
Resources/organisation/management		
Eleven ophthalmology events were reported to HQSC Nine events involved delay in ophthalmology follow-up/delay in treatment resulting in visual loss Two events did not meet criteria for SAC 2 classification	Follow-ups are being routinely delayed in order to manage new patients in a timely manner as required by MoH and because the number of patients needing to be seen has increased by 25% over past 5 years with no parallel increase in resource Planned follow-up time frames could not be adhered to Increase in demand (especially in Outpatient department) due to 1. New drugs (Avastin) for treatment of macular degeneration requiring specialised administration and follow-up and 2. increasing retinopathy screening Growth has not seen a commensurate increase in resources to meet these demands Patients were not monitored by any other means when their planned Senior Medical Officer follow-up could not be provided on time Patients were not offered any other form of monitoring when their follow-up became overdue Ophthalmology Department has sought innovative ways to manage workload but initiatives require additional funding which is not available	Develop monitoring report for overdue follow-ups to allow a regular reporting feedback loop to the service Virtual file review of all people on the overdue appointments list. Ophthalmology service improvement (remedial recovery plan) in place 1 Oct 2016 Development of new pathways for care, involving optometrists and addressing the emerging increase in treatable macular degeneration. Funding for a clinical nurse specialist approved. Letters of advice gone to patients where their follow-up is more than 50% overdue to explain the situation and to encourage people to obtain a review of their condition by an optometrist if they feel it is deteriorating. Additional clinic room now available. A piece of building work completed to enable this.