Nelson Marlborough District Health Board Serious Adverse Events Report 2014-2015

Background

A Serious Adverse Event (previously known as serious and sentinel events) is one that has resulted in a need for further significant additional treatment, is life threatening or has led to an unexpected death or major loss of function.

The title has changed to signal a new direction, with a greater emphasis on learning from all events – not only the serious adverse events, but also near misses.

The emphasis is on improvement and reducing preventable harm in the future.

All reported events are allocated a Severity Assessment Code (SAC). See Severity Assessment Criteria Tables. For information on reporting Serious Adverse Events refer to Health Safety& Quality Commission.

Reporting Serious Adverse Events

Nelson Marlborough District Health Board (NMDHB) has robust systems in place to identify those patients who have been unintentionally harmed, including incident reporting by clinical staff.

Reporting of Serious Adverse Events contributes to a culture of transparency and an environment of trust for the people who use our services. It also supports our continuous quality improvement.

All reported Serious Adverse Events are investigated and analysed to discover the root cause of the event and to ensure steps are taken to prevent a recurrence.

Each of the reported events involves a person suffering harm or death while in our care. We acknowledge the distress and grief that occurs to family and whanau, and to the staff involved in the patient's care, when things go wrong in healthcare.

When events happen, Nelson Marlborough DHB works openly with patients, service users, staff and family/ whanau to ensure their concerns and needs are addressed and supported and that they are included in the review process.

There are more than 19964 admissions each year to the NMDHB. In 2014/2015 there were 11 Serious Adverse Events (compared with 8 in 2013/2014).

2014/2015 Serious Adverse Events			
Description of Event	Review Findings	Summary of Recommendations/Actions	Implementation
Complications related to pregnancy	Report Pending	-	-
Unwell newborn	Following review this event was rescored as a SAC3 event. Severity Assessment Criteria Tables		Completed
Unwell newborn	Newborn requiring significant intervention to stabilise condition prior to transfer to tertiary hospital.	Improve communication between units, increase awareness re emergency equipment location, and increase skill level of back up support staff.	Completed
Unexpected neonatal death	Report Pending	-	-
Chemotherapy related complications	Patient unwell with complex medical problems presented to Emergency Department. Treated and discharged. Patient deteriorated and died the following day.	Expand and improve information provided to chemotherapy patients that assists them and health care professionals to manage acute presentations.	Completed
Patient with multiple co-morbidities deteriorated acutely after fall in hospital and subsequently died.	Patient had multiple complex medical problems which contributed to delayed diagnosis of hip fracture.	Working group to discuss acute management of under 65 year-old patients who do not meet criteria for the nurse initiated Neck of Femur Fracture pathway. To develop a pathway of care for this group of patients until the ERAS Fractured Hip Patient Journey is fully established.	Completed
Death following post-operative complications	Report Pending	-	-

Patient deteriorated acutely and died following presentation at ED	This case has been appropriately managed and no fault found with the process and procedures described in the clinical record.	-	Completed
Unclear pathway of care between tertiary hospitals resulting in delayed diagnosis	Lack of co-ordination of care following discharge from tertiary provider and around subsequent diagnosis. The presentation was complex and difficult to diagnose which resulted in delay in the diagnosis.	The transfer of care document needs to include a list of all current and future planned service providers.	Completed
Delay in diagnosis	Report Pending	-	-
Death resulting from post-operative complications. Surgery performed by another provider	Report Pending	-	-