WEST COAST DISTRICT HEALTH BOARD SERIOUS ADVERSE EVENTS REPORT

1 July 2017 – 30 June 2018

The New Zealand Health Quality and Safety Commission identifies that Health Care is complex and that improving quality and safety in the 21st century is challenging. At the West Coast District Health Board (WCDHB) our commitment to patient focused continuous quality improvement supports our aim of 'zero-harm'. All serious adverse events are reviewed through a formal process in order to analyse our existing health practices and systems. The purpose of reviewing these is to provide sufficient feedback to patients and families so they are aware of any contributing factors and causes of the event and how the DHB intends to make our systems safer.

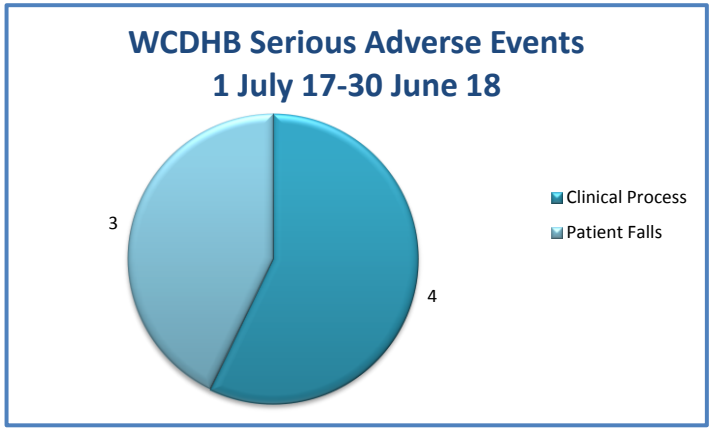
What is a serious adverse event?

A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

There were 7 serious adverse events reported out of a total of 1,375 incidents reported by the WCDHB in the year 1 July 2017 – 30 June 2018. Of the total serious events reported, 3 were inpatient falls.

The events have been classified into 2 specific themes:

- Clinical Process – code 1
- Patient Falls – code 2



The table below summarises the findings and recommendations of the events reported. The recommendations/actions are in progress.

EVENT	REVIEW FINDINGS	RECOMMENDATIONS/ACTIONS
Readmission to ED 8 hours following discharge	The DHB Emergency Chest Pain Pathway was not followed. This led to the failure to correctly identify and act on the changes evident in the presenting ECG.	• Ongoing education of RMO group regarding the chest pain pathway, including ECG interpretation on induction to working at the WCDHB.
Delayed detection of medical deterioration of an inpatient	There were missed opportunities for escalation of care by attending nursing and medical staff and a delay in transfer.	• To implement the national Early Warning Score and escalation options and response specific to the mental health service • The SMO responsible for the inpatient unit to include references to *'achieving equally well'* principles during RMO orientation. • The implementation of the EWS across the DHB is site specific.
Inappropriate inter hospital transfer	The lack of recognition of an unwell patient due to suboptimal assessments and documentation led to a delay in treatment.	• A clear decision making pathway is developed to determine the appropriate mode of transport that matches the acuity of all paediatric patients. • All Registered Nurses at the outlying facility to attend and complete the Emergency Nurses Paediatric Course (ENPC). • That all clinicians regularly undertake self audit of their clinical documentation utilising a validated audit tool.
Delay in 5 year colonoscopy surveillance	The communication process at the Clinic did not include a clear management plan for the patient, the electronic 'task' function was not used, ongoing management of the patient was complicated by staff turnover and the patient was not informed of the expected management of a 5 year surveillance screen.	• Implement a robust system for handover of ongoing patient management information and include the system in orientation material and guidelines made available to all staff. • The screening and recall process meets the RNZCGP Standard Indicator 25.

Inpatient Fall	There was incomplete nursing documentation and clinical practice regarding planning, assessment and evaluation of the management of this clinically unwell patient in the immediate post-operative period.	• That the MDT team prepare and present an education package of the complete documentation required for the full clinical assessment, management and treatment of the complex orthopaedic patient who sustained a fall. To be used for education purposes and as part of the orientation to surgical services. • That the MDT team prepare and present an education package highlighting clinical factors that impact on the Enhanced Recovery After Surgery process. To be used for education purposes and as part of the orientation to surgical services. • That real time feedback on the documentation is to be discussed with each specific clinician following the serious review of the event.
Inpatient Fall	Appropriate safety precautions were in place as per DHB Falls Prevention and Management Policy. At the time of the event, the ward was well staffed with a positive staff variance. Post falls management was immediately responsive and appropriate.	No recommendations from this review.
Inpatient Fall	Appropriate safety precautions were in place as per DHB Falls Prevention and Management Policy. At the time of the event, the ward was well staffed with a positive staff variance. Post falls management was immediately responsive and appropriate. The impulsivity and complexity of this patient's mental condition was a significant factor impacting on his cognitive ability to respond to instructions that would maintain his safety.	No recommendations from this review.