West Coast District Health Board Serious Adverse Events Report

1 July 2018 – 30 June 2019

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 (West Coast DHB) 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 their families/whānau so they can gain insight into any contributing factors and causes of the event and understand how the DHB intends to make our systems safer.

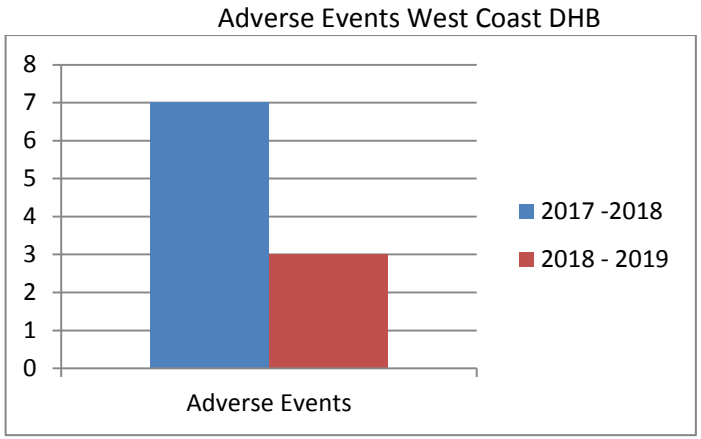
What is a serious adverse event?
A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

There were three serious adverse events reported out of the total 1284 incidents reported by the West Coast DHB in the year from 1 July 2018 to 30 June 2019. Of the total serious adverse events reported, all three were inpatient falls.

The Serious Adverse Events are allocated a code by the Health Quality Safety Commission of New Zealand.

The Event Codes for the three events for the West Coast DHB are as follows.

Code 12 – Consumer/Patient Falls



Consumer/Patient Falls (12)		
Event	**Review Findings**	**Recommendations/Actions**
Consumer attempted to mobilise unassisted with a walking frame and fell sustaining a fractured neck of femur.	The findings of this review established that pre and post falls risk assessment and management did not comply with the DHB's Falls Prevention and Management Policy.	This case was presented along with policies and procedures to staff for education.
Consumer with cognitive impairment stood up and lost balance and subsequently fell on to the floor leading to a fractured neck of femur.	All aspects of care both pre and post fall were compliant with West Coast DHB's policies and procedures and the Health and Disability Services Standards.	No recommendations came from this review.
Consumer with physical and cognitive issues mobilised independently and had an unwitnessed fall resulting in a fractured neck of femur.	The findings of this review identified clinical inadequacies in care and documentation but no single cause could be identified. Incidental findings provided prompts for recommendations. The pre and post falls risk management did not comply with the DHB's Falls Prevention and Management Policy.	1. Auditing to be conducted in to the Early Warning Score (EWS) pathway to establish staff compliance of use, escalation and activation response. 2. Establish barriers, contributing factors and enablers of the EWS system for staff and create appropriate action plan to facilitate compliance. 3. Present this event as an interactive case study to promote principles of interprofessional (collaborative) practice to the Allied, Medical, Nursing and non clinical members of the inpatient team. 4. Introduce interprofessional education related to falls risk management that supports staff to introduce interventions for falls prevention that are appropriate to people living with cognitive impairment.