West Coast District Health Board Serious Adverse Events Report

1 July 2019– 30 June 2020

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 to analyse our existing health practices and systems. The purpose of reviewing these is to provide sufficient feedback to patients and families and to allow the DHB to gain insight into any contributing factors and causes of the event.

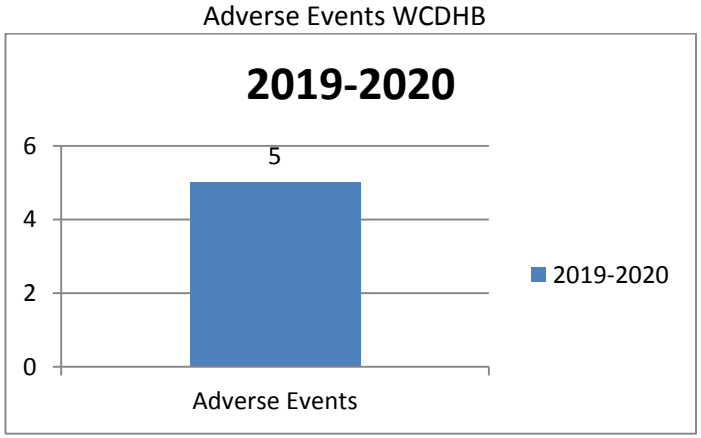
What is a serious adverse event?

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.

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

The Event Codes for the 5 events for the WCDHB are as follows.

Code 12 – Consumer/Patient Falls
Code 02 – Clinical Process
Code 01 - Clinical Administration



Event	Review Findings	Recommendations/Actions
Event Code: 2 Consumer presented to their General Practitioner with chest pain. The consumer was treated for indigestion. The consumer was admitted to tertiary level care 3 weeks later with a missed cardiac event.	The findings of the review showed opportunity for reviewing systems and processes that failed to meet health standards. That there were deficits in the care provided to the consumer and further training for staff was identified.	**1. All WCDHB practice nurses involved in the triaging process to undertake training in triage.** **2. A complete operational system review to be undertaken for DHB owned and operated general practices and report to executive management.** **3. Triage training to be embedded into the orientation package for DHB owned and operated general practices.** **4. Peer support networks established to provide peer review, support, and facilitate ongoing communication.**
Event Code: 12 Consumer with cognitive impairment was independently mobilising 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 WCDHB policies and procedures and the Health and Disability Services Standards. Incidentally there seemed to be some confusion picked up during the review regarding interpreting the word supervision and what that meant for patient care.	**1. Establish working definition and scope of the word supervision when being documented in care plans.**
Event Code 12: 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 fall's risk management did not comply with the DHB's Falls Prevention and Management Policy.	**1. Investigate adapting Trend Care to provide options for patients identified as cognitively impaired that are consistent with falls risk mitigation and best practice.** **2. Establish a falls and restraint champion to attend falls committee meetings, promote falls strategies and restraint guidelines congruent with current practice. Be the resource person for that location.**

		3. Pharmacy staff to attend event location and regularly review medication charts.
Event Code 1: Consumer with co-morbidities deteriorated with an acute condition and subsequently died after being transferred to a tertiary centre.	All aspects of care were not compliant with the WCDHB policies and procedures and the Health and Disability Services Standards. Delay in transfer to tertiary centre. Delay in recognition of the deteriorating patient. Poor communication.	**1. Criteria for adult admission from event location should be developed and show clear protocol to ensure adult patients presenting to the event location are managed collaboratively in the right place, right time, by the right people. These criteria should reflect clinical capability and experience of the multidisciplinary team. They should also take into consideration the limitations of the facility and the complexity of transport when transferring to higher level of care.** **2. The multidisciplinary team integration of service and nursing model of care in the event location should be reviewed to ensure that collaborative care decisions are optimized and documented to a high standard, and that continuity of care and accountability are prioritized.** **3. Evidence of regular interprofessional case review, peer support, and continuing education for all staff working in the event location to be provided to the credentialing officer (for doctors), Allied Health Manager (for AHP's) and Clinical Nurse Manager (for nurse's) to demonstrate that there is ongoing learning and development that meets the governing bodies standards of practice. This also includes evidence of progress with completed annual**

		success and development plans as per WCHDB policy. **4. Delivery of regular, tailored scenario-based training and de-briefing within the event location that will enable skill development around the rapid assessment of an acutely unwell adult, as well as enhancements to the integrated model of care.**
Event Code: 2 Consumer discharged without appropriate medication, readmitted with an acute condition.		**Review underway.**