Serious Adverse Event Report
1 July 2014 – 30 June 2015

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Category	Brief description	Main findings
Falls	Unwitnessed patient fall resulting in a fractured neck of femur (hip)	There were no clear gaps in care delivery identified, but there were a number of processes which could have been enhanced as part of a more rigorous falls risk management process, reduce falls risk and to better manage post falls care.

Recommendations	Progress on Implementation
Visual cues are in place that identify 'high falls risk' clients to every staff member on shift e.g. - On the board (coloured dots) - On the bedroom doors (coloured cards) - On the patient (coloured wrist bands)	Completed
Patient profiles are developed for every patient and accessible to all staff, to ensure the treatment plan and risk management strategies are known to all staff on all shifts - High risk patients – red tag	Completed
The Patient Profile is accessible to all staff and contains (at minimum) - Detailed profile of the patient - Current care plan (with specific strategies for falls prevention) - Medication information - Copy of last MDT review notes	Completed
The policy of one clinical files needs to be extended to include dementia care The patient medical file and Kahurangi file need to be amalgamated to ensure essential clinical information does not get overlooked	Implementation underway
The use of pressure mats / tether personal alarms / lowered beds will become standard practice for all patients identified as high falls risk	Completed

Development of flow chart and protocol to ensure all staff understand core requirements and safe handling needs post fall. - required observation prior to moving - safe processes/equipment to reduce risk of further injury - RMO timeline for review post fall	Implementation underway
Develop protocol for 24 hour monitoring post fall	Completed Ongoing monitoring
Nursing documentation will include comment of the effectiveness of as required medications - with attention to level of sedation	Completed Ongoing monitoring
Increased physiotherapy input - providing staff education regarding Strength & Balance, Stay on Your Feet exercises for dementia patients	Completed Ongoing monitoring
Implementation of exercise programme as part of the normal ward activity programme	Completed Tai Chi now up and running on the ward
Replace flooring in high risk areas (lounge and bedrooms). Additional CAPEX item for 2014-15	Implementation underway - CAPEX funding identified and agreed for completion prior to June 2016
Treatment planning processes need to be focused so that there is one current treatment plan that addresses falls risk, diversional therapy needs and other care. This plan is available to all and sits in the patient profile document	Implementation underway

Category	**Brief description**	**Main findings**
Clinical Processes	Baby diagnosed with Hypoxic Ischaemic Encephalopathy	The Review identified a failure to recognise and respond to an abnormal foetal heart rate and CTG monitoring not being undertaken. The Review however, reported, it is not possible to categorically state that the outcome for baby would have been altered significantly had the appropriate guidelines been followed. A number of recommendations for improvements were identified.

Recommendations	Progress on Implementation
Foetal Heart Rate monitoring has been identified as an ongoing concern, therefore: a. A specific audit of compliance with the WCDHB FHR monitoring guideline to be completed immediately. Thereafter quarterly audits to be completed	Completed Ongoing monitoring
Ensure education and familiarisation training in FHR surveillance continues to occur in line with CDHB practices for all WCDHB maternity staff on an annual basis. • A database of staff completing training is to be kept by the Clinical Nurse Manager Maternity for auditing purposes	Completed Ongoing monitoring
Implement and localise the Canterbury DHB Hypoxic Ischaemic Encephalopathy (HIE) form to the West Coast DHB clinical environment.	Completed
The Maternity Educator to identify staff who have not attended the WCDHB essential 'documentation made legal' training and: a) Ensure attendance is completed and a record of attendance documented b) Ensure the New Zealand College of Midwives 'documentation education' sessions occur on the West Coast as part of regular education for midwifery staff.	Completed Ongoing monitoring
The Head of Obstetrics and Gynaecology to identify all Senior and Registered Medical Officers who have not attended the WCDHB essential 'documentation made legal' training and a) Ensure attendance is completed and record of attendance documented b) Ensure all SMO/RMO are aware of and adhere to the Medical Protection Society (MPS) A Guide to Clinical Records c) Ensure all SMO/RMO and midwives utilise a stamp with their name, designation and registration number on all clinical documentation.	Implementation underway

Category	Brief description	Main findings
Clinical Processes	Post-partum haemorrhage (PPH) that required resuscitation and a transfer to CDHB for a period of intensive care	The Review identified the presence of inverted uterus, with postpartum haemorrhage was not clearly recognised, which meant the required emergency response did not occur in a timely fashion. The normal process for emergency admissions was not followed; gaps in care delivery processes which contributed to the patient arresting and subsequent resuscitation were identified for service improvement. The recommendations are identified below.

Recommendations	Progress on Implementation
All requests for ambulance transfer for 'complications in labour' are treated as emergency transfers. • Include in LMC education re emergency management	Completed
Emergency education sessions are adapted to include • the acute management of inverted uterus • estimation and appropriate management of blood loss	Completed
The DHB require all midwives (employed or self-employed) to use a standardised handover tool (ISBAR). This would be included in LMC education programme	Completed Ongoing monitoring
The DHB and St John develop a protocol requiring all Status 1 and Status 2 calls go directly to ED.	Completed Ongoing monitoring
St John Clinical Control are notified of the concerns identified in the review regarding a failure to use the RT40 system once Status One had been called.	Completed

Category	Brief description	Main findings: These will be posted on completion
Falls	Patient suffered Right Fractured Neck of Femur (hip) in witnessed fall.	The unidentified hazard of the door lip, along with the patient's poor eye sight, medication and the patients hands being occupied with 2 cups and a handbag were all identified in the Review as contributing factors in this fall. These factors, coupled with the contravention of the WCDHB Workplace Smoke Free Policy, resulted in the patient tripping whilst their hands were preoccupied, losing balance and falling to the floor with maximum impact resulting in a fractured neck of femur. As a result of the review a number of recommendations for service improvement were identified
Recommendations		**Progress on Implementation**
The Falls Committee to develop: • A standardised care plan and/or flow chart for patients following a fall. • A WCDHB post fall guideline, which will provide staff guidance on post falls assessment and appropriate care prior to moving the patient. • A training programme which should cover: o A full physical assessment o Baseline readings. o Pain assessment (Using an observational pain assessment tool for patients with dementia) o First aid management of fractures/potential fractures, if the RMO fails to attend • Once developed the Post Falls programme to become part of the WCDHB core training.		Post Falls documentation completed and ongoing Other recommendations in progress

• Adherence to legislative requirements for the storage and recording of medications was not followed by IPU staff:, therefore: o All Manaakitanga IPU staff to adhere to medication legislative compliance o Audit of compliance to be undertaken immediately and three monthly thereafter o Mental Health Quality Facilitator to be provided with a copy of the audit report and any corrective actions taken	IPU staff aware of legislation and medication compliance Audits initiated and ongoing monitoring Acting CNM and Pharmacy Manager hold regular meetings to review results and appropriate action as required
• That Hazards identified as having potential to cause harm and are dealt with immediately and ensure: • Hazards are mitigated with immediate effect • Manaakitanga IPU staff are conversant with the Hazard register. • Baseline Hazard audit and three monthly thereafter is undertaken	Completed Ongoing monitoring
A review of the current WCDHB Workplace Smoke-Free Policy to identify alternative strategies identified in respect of those patients with legally restricted movement (i.e. under the Mental Health Act) to be undertaken, and IPU staff adherence to the updated Policy monitored. • All Manaakitanga IPU staff to adhere to the policy	Review of Policy completed August 2015

Category	**Brief description**	**Main findings: These will be posted on completion**
Clinical Processes	Unanticipated complication of surgical procedure resulting in harm to patient	An ACC treatment injury was quickly identified by the treating doctor resulted with appropriate follow up care and ACC A45. Recommendations for service improvement were identified and are shown below.
Recommendations		**Progress on Implementation**

As soon possible after a treatment injury becomes known, all relevant ACC documentation is completed with the patient and the process is fully explained. A treatment injury pack is currently being developed and will be available in all clinical areas.	Completed, all areas of the DHB now have access to an ACC treatment injury pack.
The WCDHB Social Work team develop an information sheet detailing contact details for key Canterbury DHB personnel and support services that can be provided to family / whanau when a patient is to be transferred to the tertiary centre for further management.	Draft pack completed and in the process of being loaded onto the WCDHB patient information segment of documents for staff to access irrespective of the day, time or shift for patients and their family/whanau.
When an elective non-acute case is added to an already set theatre schedule, contingencies are considered as part of the planning for any unanticipated outcomes and appropriate timeframes are built in prior to the acceptance of that late addition to the list. Contingency planning to include availability of specialist staff.	Completed. Theatres are aware of the recommendation and implement when and where applicable

Category	Brief description	Main findings: These will be posted on completion
Clinical Administration	Lack of interagency awareness and communication in a patients care resulting in patient harm	Completion of review expected middle of December 2015
Clinical Processes	Physically unwell patient, escalating condition resulting with hospital admission and subsequent cardiac arrest	Completion of review expected middle of December 2015