AUCKLAND DISTRICT HEALTH BOARD
Communications
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ADHB Committed to Best Practice

Auckland District Health Board (ADHB) is committed to best practice in quality care, continually refining systems and processes to minimise any risk to patients, says Chief Medical Officer, Dr Margaret Wilsher.

Commenting on the release of the Health Quality and Safety Commission's consolidated report of New Zealand's Sentinel and Serious Events, Dr Wilsher said ADHB supports the work of the Commission toward decreasing adverse events in hospitals.

"ADHB welcomes any work to reduce adverse events in hospital care. I think we should strive for zero harm," said Dr Wilsher.

"ADHB has highly skilled and experienced professionals but healthcare has inherent risks and there will always be examples where, in hindsight, things could have been done differently.

"The purpose of the reporting system is to learn from incidents and improve patient safety, not to apportion blame."

Dr Wilsher said ADHB's report, between July 2009 and June 2010, showed some progress.

"This report signals ADHB has a healthy reporting culture which is aimed at identifying preventable errors and learning from them so that every best effort is made to try and avoid events such as these from occurring again," said Dr Wilsher.

"But despite some progress on last year, there is still room for improvement."

Dr Wilsher said any preventable error at the ADHB was unacceptable.

"ADHB takes adverse events extremely seriously. Every event is regrettable and we apologise to affected patients and their families for errors made.

"We will continue to work on system improvements toward best practice because quality care is our number one priority."

Dr Wilsher said ADHB had taken significant strides in improving how it responds and learns from adverse events. Recent examples of improvement include enhanced processes for mothers at high risk of birth complications, training for staff in event-review methods, and improved mental health risk assessment.

She said although the number of reported events from large hospitals were comparable due to heavy patient volumes, there was no room for complacency.

“We believe the right reporting mechanism is in place so that incidents are identified and learned from in a supportive environment and timely fashion, which ultimately results in greater improvements in public safety.”

The ADHB had 33 reported events. There were 12 sentinel events which included 8 deaths (4 directly attributable to the event, 4 where causation was uncertain), 2 severe injuries and 2 cases of retained surgical swabs.

Of the 33, 21 were serious events which resulted in 3 cases of permanent harm, 9 where there was no permanent harm, and 9 cases of falls in hospital causing fractures.

The report *Making our Hospitals Safer: Serious and Sentinel Events 2009/20*10, Health Quality & Safety Commission, is available at www.hqsc.govt.nz. A list of incidents from all DHBs is also available on this website.

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ADHB Summary of Serious and Sentinel Events Report 2009/10

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This document is available on the Health Quality & Safety Commission website www.hqsc.govt.nz

CODES USED TO CLASSIFY EVENTS

1 Wrong patient, site or procedure
2 Suicide of an inpatient
3 Retained instruments or swabs
4 Clinical management problem

Plus sub-code:

A Diagnosis (including delayed and misdiagnosis)
B Treatment (including delayed and inadequate)
C Monitoring/observations (not performed and/or actioned)
D Procedure associated incident or complication
E Investigation (delayed, not ordered or actioned)
F Discharge and transfer
G Other

5 Medication error
6 Falls
7 Blood transfusion reaction
8 AWOL patient
9 Physical assault on patient
10 Delays in transfer
11 Other
12 Hospital acquired infection

Auckland

Serious or sentinel	Event code* (see codes below)	Description of event	Review findings	Recommendations/actions	Follow-up
Serious	4A/C	Neonatal seizures possibly as a result of undetected low oxygen levels at delivery Long term outcome uncertain	Monitoring in labour difficult to interpret Lack of clear guidance regarding confirmatory diagnostic tests Incomplete handover	Provide education on low oxygen brain injury Specific guidelines for foetal scalp blood tests Update handover and transfer documentation	All completed
Serious	11	Unauthorised removal of baby from hospital	Adoption policy not followed Failure of social work triage, risk identification and alert processes Communication failures	Social work triage of new referrals Education of staff regarding social work alerts Update adoption policy	Established Completed Completed
Sentinel	4A/B/C	Delayed diagnosis and treatment of fatal meningococcal septicaemia	Initial emphasis on viral rather than bacterial infection No re-review when triage time exceeded Insufficient vital sign recordings delayed aggressive treatment		
Sentinel	4D	Air entered fluid tubing during brain X-ray, leading to a stroke	Flush fluid ran out Manual systems to check the bag Responsibility for checking fluid level not assigned Bag not clearly visible to staff members	Use 1000 ml bag Investigate high pressure infusion pumps Change site of infusion bags to more visible position Bag check responsibility of circulating nurse	1000 ml bags in use Infusion pumps being assessed Completed Completed
Serious	5	Respiratory arrest due to excess prescribed sedative in combination with self administered methadone No long term harm	No after-hours specialist advice on complex substance use Prescription unclear Baseline physical assessment not completed on admission	Establish access to senior on-call advice Assess competencies and provide training and support for practice improvement Staff development in physical assessment	Consultation strategy with alcohol and drug service Medication competency assessment developed Medical specialist nurse appointed

Serious or sentinel	Event code* (see codes below)	Description of event	Review findings	Recommendations/actions	Follow-up
Sentinel	2	Suicide after absconding from inpatient mental health unit	Ran away from staff while on an escorted break outside the building Preventability uncertain Suicide risk not fully identified May have been improved by more culturally directed approach and advanced risk assessment	Further development of cultural competent services Training in advanced risk assessment	Implementation in progress
Serious	4A/B	Delay in escalation of treatment for patient with respiratory deterioration Required ICU admission but no long term harm	Emergency escalation process not followed Poor communication between staff members	Further training on priority of medical emergency call system Strategies to improve handover and documentation	
Serious	11	Postoperative surgical patient attempted suicide No long term harm	Past history of suicide risk unknown to ward staff Post-operative delirium inadequately treated “Watch” requirements unclear	Delirium/psychosis clinical guideline Review of watch instructions every shift change	Completed but yet to be disseminated Not yet implemented
Serious	4A/B	Delay in diagnosis and treatment of heart attack in a young woman, possibly worsening severity of heart damage	Locum doctors failed to identify diagnostic heart tracing Competency for roles not confirmed Supervision inadequate	More specific assessment and documentation competency for locums	
Serious	1	Incorrect sperm used for donor insemination No pregnancy resulted	Unused sperm container not discarded from centrifuge Labelling not recognised as incorrect	End of shift discard of all samples Two staff to check all stages of sperm preparation	Implemented
Serious	4C/D	Grossly inadequate ventilation of an ICU patient during MRI scan Subsequent death was unrelated	Ventilator circuit incorrectly assembled in MRI room Significance of breathing monitor data not appreciated	Dedicated MRI ventilator circuits to be set up in ICU prior to transfer Add specific monitoring section to MRI training	Implemented

Serious or sentinel	Event code* (see codes below)	Description of event	Review findings	Recommendations/actions	Follow-up
Sentinel	4B/D	Death following cardiac injury during dialysis catheter extraction	Inadequate multidisciplinary planning No check of roles/risks/back-up prior to commencing No appropriate physical equipment/ facility available	External review of service Multidisciplinary forum for complex case planning Extend "safety checklist" concept to interventional radiology Business case for additional equipment	Completed In process In progress In process
Serious	3	Retained surgical swab after complex 14-hour procedure not identified until following day despite incorrect swab count being notified	Swab not identified on initial postoperative X-ray in intensive care	X-rays to be taken in operating room Operating surgeons to review any X-rays required for retained surgical items	
Serious	3	Retained surgical swab not identified for 5 days after operation Swab count was reported as being correct at the time of surgery	Interruptions and distractions during the count processes Poor communication between the team members regarding the swabs placed inside the patient		
Sentinel	11	Mother accidentally fell asleep (in parent room) with baby causing fatal suffocation	Bed/chair arrangements Limited opportunities for parental education No signs in room regarding safe sleeping practice	Dedicated breastfeeding chairs Review parental information package Add "safe sleeping" signs	All completed
Serious	4A	Delayed diagnosis of intra abdominal bleeding in woman on anticoagulant post caesarean section	Initial misdiagnosis confounded by poor handover Early post-operative anticoagulation may not have been indicated	Introduction of clinical midwife advisor role Review guidelines/teaching for perioperative anticoagulation	Completed In draft
Serious	5	Severe anaphylactic reaction to antibiotic with previously documented allergy No long term harm	Recent admissions had not documented the allergies noted earlier No allergy alerts for patients in the electronic record	Revise clinical alert system for patient allergies	Long term project linking with national system

Serious or sentinel	Event code* (see codes below)	Description of event	Review findings	Recommendations/actions	Follow-up
Sentinel	1	Patient incorrectly received cardiac biopsy in addition to his scheduled procedure with serious complications. Patient subsequently died 3 months later.	Informal cardiac biopsy referral process Incorrect patient sticker for referral Inadequate patient information and consent process	Add cardiac biopsy to current referral form Review cardiology referral, consent and patient identification processes Consider electronic referral system	Completed In process Awaiting DHB-wide process
Sentinel	4E	Delayed in follow-up of investigations of complications of pregnancy Foetal death before specialist appointment	Referred non-urgently to clinic rather than hospital admission, possibly as a result of lack of role clarity		N/A
Sentinel	2	Suicide of community patient with daily visits			
Serious	4D	Oral medication given via intravenous line instead of via stomach/bowel tube No long term harm	Intravenous syringe used as bowel tube had intravenous connector Misunderstanding at nursing handover	Clear labelling of tubes Implement comprehensive enteral tube medication system Improve access to previous care plans	Labelling process implemented Partially implemented System in place
Sentinel	4A/B	Pressure ulcer leading to multiple complications, eventually fatal	High risk of pressure areas scored appropriately, but institution of preventative measures was delayed	Still under review	N/A
Sentinel	4B	Delay in response to low blood pressure Treatment ineffective, patient died	Preventability of death uncertain Emergency escalation process not followed		
Serious	6	Inpatient fall causing fractured neck of femur requiring surgery	Unwitnessed fall Non-English speaking patient		
Serious	6	Inpatient fall causing fractured neck of femur requiring surgery	Initial risk factors identified but an unwitnessed fall the previous day had not led to a documented change in mobility status	Staff training Falls risk assessment in every patient's file	Completed Implemented

Serious or sentinel	Event code* (see codes below)	Description of event	Review findings	Recommendations/actions	Follow-up
Serious	6	Inpatient fall causing fractured right hip requiring surgery	Witnessed fall Patient cognitive and behavioural factors Poor documentation and handover of risk factors	Risk falls assessment within first 24 hours of admission Standardise abbreviations in clinical record Review scoring of falls risk assessment Develop physiotherapy handover sheet	
Serious	6	Inpatient fall causing dislocated hip replacement requiring surgery	Unwitnessed fall while walking to the bathroom Patient behavioural and cognitive factors Poor English – patient's third language Documentation standards not met	Review of documentation, care map and terminology review, handover sheet for physiotherapy, comprehensive nursing assessment that include falls assessment	
Serious	6	Inpatient fall causing fractured neck of femur requiring surgery	Patient instructed to ring bell for assistance as required; however patient chose to toilet independently	Nil	Nil
Serious	6	Inpatient fall causing fractured neck of femur requiring surgery	Nursing assessment did not incorporate all needs and requirements No formal physiotherapy handover sheet	Improve documentation between allied health and nursing Ward to purchase cordless phone	
Serious	6	Inpatient fall causing fractured wrist requiring reduction and cast	Patient mobilised to toilet unattended		
Serious	6	Inpatient fall causing fractured hip requiring surgery	Confused patient on peritoneal dialysis accidentally dislodged tubing; slipped on wet floor A "watch" was used the previous evening but had been discontinued		
Serious	6	Inpatient fall causing fractured wrist requiring reduction and cast	Patient tried to mobilise independently		