Serious Adverse Events: Whanganui District Health Board

1 July 2019 to 30 June 2020

Since 2011 the Whanganui District Health Board (WDHB) has been required to report serious adverse events to the Health Quality and Safety Commission (HQSC). Theses events are classified as severity event codes (SAC) 1 and 2. In the year 1 July 2029 to 30 June 2020 WDHB reported 12 serious adverse events to HQSC This report provides a summary of these events, investigation findings and actions taken. We publish this report in conjunction with the HQSC's annual "Learning from Adverse Events" report that is available online in November each year: https://www.hqsc.govt.nzour-programmes/adverse-events/projects/adverse-events-reports/

What Are Serious Adverse Events?

Serious adverse events are events that have resulted in serious harm to patients while they are in our care. These may result in additional monitoring or treatment, major loss of function or even death. We recognise that these events have a significant impact on our patients and their families and are committed to learning from each event and improving the care we provide. We apologise to patients and their families as soon as the event is notified and share our investigation findings with them.

How Are These Events Investigated?

We appoint a selected review team and work with patients, families and staff to identify why the events occurred and any measures that can be taken to prevent a similar event happening again.

Analysis of Events

Events classification

Event type	Number
Patient falls resulting in a fracture	5
Medication errors	1
Clinical process, assessment and treatment	2
Pressure injuries classified as stage 3 or above	4
Total	12

Gender

Male	8
Female	4

Ethnicity

New Zealand European	11
Maori	1

Maori are under-represented in these statistics which is consistent with the national data. HQSC is seeking to understand why this may be so.

Age Ranges

All serious adverse events reported occurred in patients over 60 years.

60 - 70	2
70 – 80	4
80 – 90	5
90+	1
Total	12

Recommendations and Activities That Have Taken Place as A Result of Reviews Undertaken Included the Following

- Increased visibility of falls indicators and risk on "Patient at A Glance" boards
- Reviewed high watch and close supportive observations procedure
- Improved the documentation of risk assessments and individualised care plans
- Refresher training in falls risk assessment and prevention
- Appointed falls champions for wards
- Reviewed restraint policy to include the use of bed alarms
- Staff completed the pressure injury prevention programme workbook
- Improved the documentation of skin assessment and sites of concern
- Reviewed the process for obtaining air mattresses
- Reviewed the use of compression stocking in the frail elderly
- Instructed that ECG's to be taken for all patients with a cardiac history
- Blood tests to be taken for diabetic patients with gastro-intestinal symptoms or signs of dehydration
- Implementation of Korero Mai – patient, family and whanau escalation
- Reviewed medication guideline for stroke and changed labelling on medication to ensure correct dosages are given