Serious adverse event report

1 July 2021 – 30 June 2022

Te Whatu Ora
Health New Zealand
Capital, Coast and Hutt Valley

Serious Adverse Event Report

1 July 2021 – 30 June 2022

This report describes serious adverse events that occurred and were commissioned for review between 1 July 2021 and 30 June 2022 at Te Whatu Ora Capital, Coast & Hutt Valley (CCHV). Each of these events involves a patient experiencing harm while in our care. We acknowledge the distress and grief that occurs as a result of each adverse event and sincerely apologise to the patients and whānau affected by these events. CCHV is committed to implementing the recommendations from each review.

CCHV reported 122 confirmed SAC 1 & 2 adverse events from 1 July 2021 to 30 June 2022. Of the 122 serious adverse events for 2021/2022 there were a total of 23 SAC 1 events, and 99 SAC 2 adverse events. Sadly, of the 23 SAC 1 events, 21 patients died. Of the 122 events included in this report 16 occurred in the previous reporting period but were either not reported or not commissioned until this reporting year. Six of these events were falls resulting in fractures that were identified from auditing of discharge coding data. Seven of the historical events included in the report were part of a group of reviews relating to delayed first breast screening appointments.

It is internationally recognised that in developed countries one in 10 patients are unintentionally harmed while receiving hospital care.[1] The harm can be caused by a range of adverse events and 50% of them are considered preventable.[2] CCHV is committed to providing high quality and safe care to our community through our shared values of manaakitanga, kotahitanga and rangatiratanga. Part of that commitment is ensuring openness and transparency when things have gone wrong.

When serious harm occurs we review what happened, reflect on the findings, and take action to reduce the chance of a similar event occurring again. The lessons learned from reviewing serious adverse events provide opportunities to improve processes and systems to reduce patient harm and inform quality improvement action. By understanding what has happened, we can seek to change and improve care for our patients.

Table 1: Total reported SAC 1 & 2 adverse events for the last three financial years (2019-22)

[1] World Health Organisation, 2019. *Patient Safety*. https://www.who.int/news-room/fact-sheets/detail/patient-safety
[2] World Health Organisation, 2019. *Patient Safety*. https://www.who.int/news-room/fact-sheets/detail/patient-safety

Category*	2019/2020**	2020/2021**	2021/2022
Clinical Administration	0	3	11
Clinical Process or Procedure	53	95	63
Healthcare Associated Infection (HAI)	0	0	1
Medication or IV Fluids	7	6	9
Behaviour	1	1	1
Falls with Serious Harm	21	19	37***
Resources or Organisational Management	0	1	0
Total	**82**	**124**	**122**

** Categorisation is based on the Health Quality & Safety Commission event codes derived from the World Health Organisation classifications for patient safety*

*** Combined total of CCDHB and HVDHB numbers*

**** This includes the 6 historic events that were identified by coding audit*

Highest areas of harm

The category with the highest number of reported SAC 1 and 2 events was 'falls with serious harm'. There were a total of 31 events classified as falls with serious harm, not including the six historical events. Twenty-nine of these were SAC 2 events and two were SAC 1 events where the fall was considered a contributory factor in the patient's death. The category with the next highest number of events was 'delay in treatment' a sub-category themed within 'clinical process or procedure'. There were 21 events themed under 'delay in treatment'. Of these, seven were classified as SAC 1 events where the delay in treatment was sadly, a contributory factor in the patient's death.

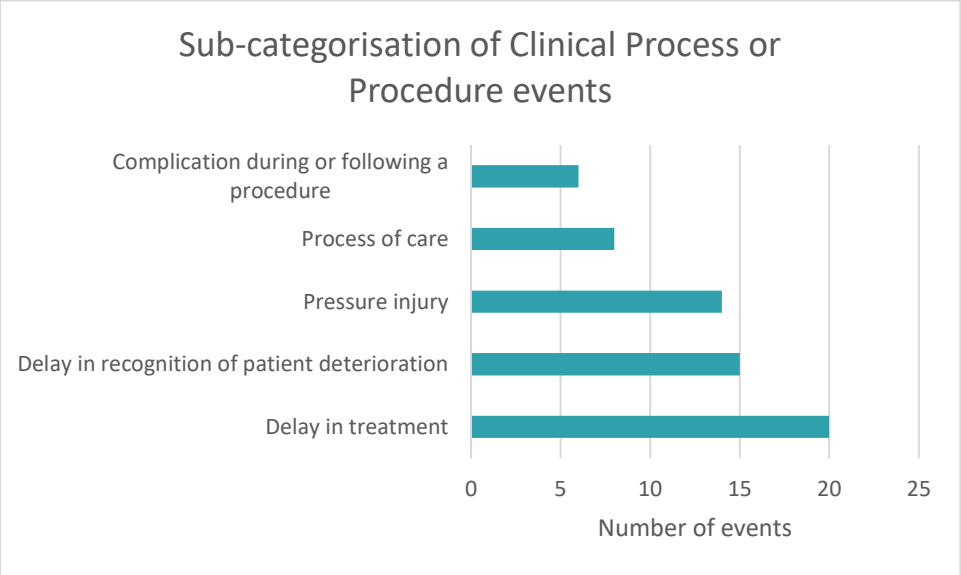
We recognise that physical harm is not the only type of harm that can occur. There are very real harms that affect people's mental, spiritual, cultural and emotional health. The Serious Adverse Event reporting system is based on a western, physical model however it is the current framework used by the Health Quality & Safety Commission New Zealand (HQSC) derived from the World Health Organisation (WHO) classifications for patient safety. We have escalated this issue to the HQSC and look forward to future improvement work in this area.

The following describes the health outcomes for all patients as a result of a SAC 1 or SAC 2 serious adverse event:

- 43 patients were conservatively managed
- 16 patients experienced a progression of disease
- 18 patients were transferred to a higher level of care
- 18 patients required surgical intervention
- 5 patients experienced permanent harm or loss of function
- 21 patients died
- 1 patient had an outcome classed as 'other'

A total of 63 Clinical Process or Procedure events for CCHV were reviewed between 1 July 2021 and 30 June 2022. The Clinical Process or Procedure classifications represent the majority of serious events (52%) and have been themed into sub-categories to provide more detail.

Figure 1: Sub-categorisation of Clinical Process or Procedure events



Te Tiriti o Waitangi

Te Whatu Ora Capital, Coast & Hutt Valley has particular responsibilities and accountabilities under Te Tiriti o Waitangi to improve health outcomes for Māori. The Quality and Patient Safety (QPS) team continues to work to improve responsiveness to Māori who experience serious harm. The Serious Event Review Committee (SERC) has specific Māori representation, teams reviewing events involving Māori patients include a Māori staff member, where possible and the Quality team continues to upskill in knowledge of Te Tiriti o Waitangi, tikanga and health equity, assisted by our Pou Tikanga.

Our Population

The CCHV region is a region diverse in cultures, ethnicities, abilities and geographic settings and it is changing. Our population is expected to grow, age and become more diverse[3].

Table 2: Total projected populations for CCHV District as at 30 June 20214

Ethnicity	Number	Percentage
Māori	65, 060	13.7%
Pacific Peoples	34,700	7.3%
Asian	72,250	15.2%
European	303,710	63.8%
Total	***475,720***	***100%***

Equity

Te Whatu Ora Capital, Coast & Hutt Valley is a pro-equity organisation that values kotahitanga. However, we recognise that we are not achieving equitable health outcomes for Māori, Pacific Peoples, people with disabilities, those with enduring mental illness and those who have fewer resources.

Māori and Pacific Peoples are proportionally over-represented in adverse events when compared with the District population. Māori make up approximately 14% of the total CCHV population but are over-represented, with 20 people (16%) affected by serious adverse events. Pacific peoples make up approximately 7% of the District population however Pacific peoples are over-represented, with 10 people (8%) affected by serious adverse events compared to 7% of the District population.

We acknowledge this points to inequities in our District in terms of Māori and Pacific Peoples being affected by serious events proportionally compared with other ethnicities. Te Whatu Ora Capital, Coast & Hutt Valley are working towards reducing inequities across our District, as a priority.

CCHV are committed to improving health outcomes and achieving equity through targeted quality improvement projects, particularly for Māori and Pacific Peoples. A key focus of the organisation is developing our Māori and Pacific workforce, including a specific plan for allied health careers.

[3] Capital & Coast District Health Board (2021). *Capital & Coast District Health Board Annual Report*. https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-2021-22-annual-plan-final.pdf

[4] Te Pou o te Whakaaro Nui (2018) *DHB population profiles 2018 -2028 2017 update.* https://www.tepou.co.nz/resources/dhb-population-profiles-2018-2028

District and national context

The impact of COVID-19 continued to present challenges throughout the 2021/2022 reporting period, with a further nationwide lock-down and additional Level 2 lockdown in Wellington. After the lockdowns, the District experienced an increase in patients requiring hospitalisation with COVID-19. Even without the complications of COVID-19, high occupancy and demand on services has meant the hospital is consistently working at near capacity or in some areas over capacity, in the context of the ongoing impacts of COVID-19 and a shortage of healthcare workers, both nationally and internationally.

CCHV recently underwent a certification audit which identified a High Corrective Action needed around providing a sufficient healthcare workforce to provide culturally and clinically safe services. The organisation has consistently been working at, or above, capacity. This is exacerbated by discharge delays due to a strained community health care setting and higher sick leave and vacancy rates. Despite an effective CCDM programme and managerial support for decision making around patient flow, staff placement and service management, workforce pressures remain a prominent concern. The audit findings acknowledged that the national workforce shortage is having a significant impact on the organisation's ability to adequately staff all service areas.

CCHV is progressing a range of strategies to address the pressures, including initiatives to retain staff by focusing on wellbeing, recruitment and retention, particularly of its largest workforce, nurses and midwives. Professional development opportunities and training to develop skills continue to be offered to our existing staff to further develop the knowledge, skills and experience of our workforce.

Severity Assessment Codes

The adverse events in this report are categorised as Severity Assessment Code (SAC) 1 and 2, using the SAC rating in the National Adverse Events Reporting Policy 2017[5]. SAC 1 and 2 events are adverse events that result in permanent or severe harm, temporary loss of function, or death. All SAC 1 and 2 adverse events are reported to the HQSC. This report does not include Mental Health, Addictions and Intellectual Disability Services (MHAIDS) events.

There were six 'Always Report & Review' (ARR) events. ARR events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems.[6] The ARRs are not reflected in the numbers as all had SAC ratings of 3 & 4, which are not included in this report.

The number of reported and commissioned serious adverse events has remained relatively static when taking into account the combined total of both the previous CCDHB & HVDHB totals for 2020/2021. However, there has been a downward trend in reporting, in the context of the ongoing impact of constrained staffing and pressure on the health system which is reflected in the decreased reporting numbers. Across the board, it will be a priority to

[5] Health Quality and Safety Commission (2017). National Adverse Events Reporting Policy 2017 New Zealand health and disability services. https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933/

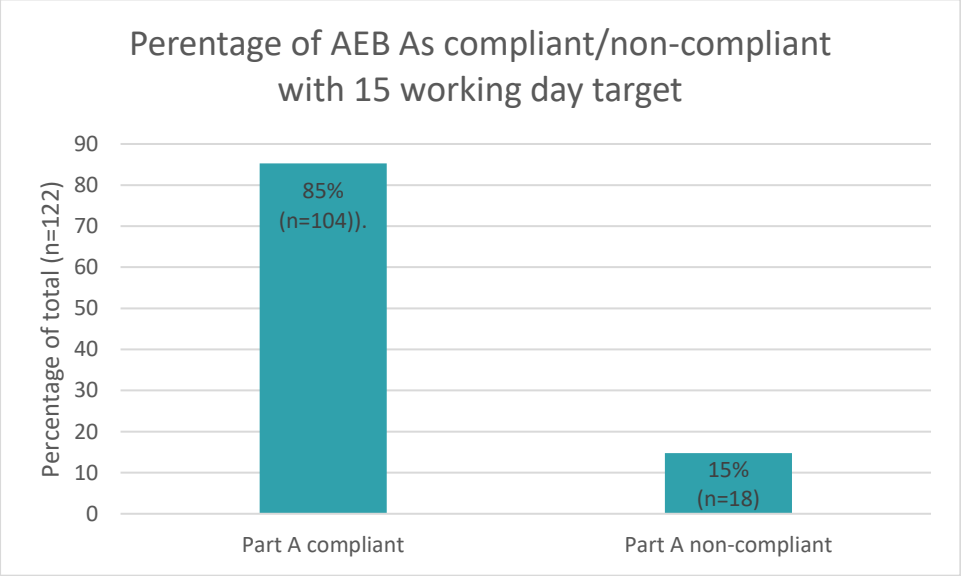
[6] Health Quality and Safety Commission (2022). Always Report and Review list 2021-22. https://www.hqsc.govt.nz/resources/resource-library/always-report-and-review-list-202122/

increase staff engagement with reporting events. This will happen District-wide with the support of the Quality and Patient Safety teams.

Reporting and review process

In the past year, serious adverse event processes have been standardised and aligned across the different hospitals. The QPS team continue to assess and improve the current review process at CCHV. Adverse Event Brief (AEB) Part A forms serve as formal notification of a serious event and must be sent to the HQSC within 15 working days from the date of internal notification that an event has occurred. The QPS team submits AEB Part B notifications of completed reviews to HQSC, aiming for the deadline of 70 working days.

Figure 2: Compliance in submission of AEB Part A notification forms within desired timeframe July 2021 – June 2022



A review is not considered complete until whānau have given their final feedback. The review is then signed off by SERC, which includes valuable input and perspectives from consumers. We recognise that timely completion of serious event reviews is really important. Not only to learn from what happened and mitigate risk of recurrence, but to go some way towards providing answers for patients and whānau.

A pilot of service led reviews has given ownership of reviews to appropriate departments within the hospital flow group with the intent being for services to take ownership of reviews with support from the QPS team. This system has worked well and supports greater engagement with clinical staff, and reduced timeframes for review completion due to increased efficiency. We will continue to develop this system and extrapolate it to other departments in 2023.

A note on ethnicity data

As part of the Serious Adverse Event reporting we collect ethnicity data in order to better plan, tailor and deliver policies and services[7]. We have used the following ethnicity groupings consistent with the Ministry of Health's ethnicity data protocols[8]: Māori, Pacific Peoples, Asian, Middle Eastern/Latin American/African (MELAA), Other and European. Where a patient identifies with multiple ethnicity groups we have used prioritised output reporting.

[7] Ministry of Health (2017) Ethnicity Data Protocols https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

[8] Ministry of Health (2017) Ethnicity Data Protocols https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

Clinical Administration Events

There were 11 events as a result of clinical administration errors. Nine of these events related to breast screening delays and were reviewed together with the help of an external panel of experts. More information on these reviews can be found in the BreastScreen Central General Report. The remaining two events involved the administration of appointments or procedures.

Patient ethnicity: Māori (n-2), Pacific peoples (n=1), Asian (n=2), MELAA (n=2), European (n=4)

Table 3: Clinical Administration

Event summary	
9	Nine patients had a diagnosis of advanced breast cancer following delay to screening*
1	One patient had surgery cancelled due to the COVID-19 Level 4 lockdown resulting in a progression of their disease
1	One patient was lost to follow-up, resulting in surgical intervention

What are we doing to further reduce clinical administration events?

- A planning process for managing breast screening appointments using all available data to plan service delivery on a daily basis has been implemented. This new approach maximises productivity and compliance with national targets.
- Funding was approved for two new fixed sites for breast screening clinics. This will increase screening capacity and improve service delivery for a population previously served by a mobile unit.
- Barriers to recruitment and retention of medical imaging technicians have been examined and initiatives to improve staffing will be explored.
- Education for surgeons to raise High Suspicion of Cancer (HSCan) alerts on patients' files for all patients referred for surgical removal of a suspected cancer.
- A Multi-Disciplinary Meeting (MDM) has been established for discussion of patients with a specific tumour type. MDMs are the national standard for cancer care - a regular meeting is held, where all involved specialists discuss individual patients, determine the best treatment options and coordinate with other specialties if needed.

*For further detail refer to the Breast Screen Central General Report

Clinical Process or Procedure Events

The number of adverse events attributed to a failure of clinical processes or procedures decreased from 95 (combined total of HVDHB and CCDHB) to 63 in the last financial year (2021-2022). This drop in the total number, compared with the last reporting period, likely reflects a decrease in staff lodging reportable events.

These events have been themed into five categories:

1. Delay in recognition of patient deterioration
2. Pressure injury
3. Delay in treatment
4. Complication during or following a procedure
5. Process of care

1. Delay in recognition of patient deterioration

Fifteen serious events occurred due to a delay in recognition of patient deterioration across a range of healthcare settings.

Patient ethnicity: Māori (n=4), Pacific Peoples (n=1) and European (n=10)

Table 4: Delay in recognition of patient deterioration

Delay in recognition of patient deterioration: event summary	
2	Two events where a patient's abnormal blood results were not acted on appropriately
5	Five patients had a deterioration that was not escalated or investigated in a timely manner
4	Four maternity events where there was a delayed recognition of foetal distress
1	One event where there was not an appropriate high dependency bed available for a patient
3	Three events where there was delayed recognition that a patient had suffered a cardiac event

What are we doing to improve our clinical processes for early recognition of patient deterioration?

- Regular simulation training, involving obstetrics and NICU, to improve management and communication during maternity emergencies.
- The Patient Deterioration Governance Group reviews all in-hospital cardiac arrest events. From next year, this group will become District-wide so learnings from events can be shared across all hospital sites. This serves to ensure appropriate governance of recognition and response to deteriorating patients.
- Goals of Care discussion and documenting continues to be supported District-wide.
- HQSC will be rolling out the new Paediatric Early Warning Score (PEWS) in 2023.
- Tracer audits encompass all aspects of the patient stay, following a patient's journey from admission to discharge, and capture a snapshot that helps identify gaps. Documentation of vital signs and EWS is included in tracer audits and continues to be monitored to identify areas for improvement.
- A survey was completed for clinical staff around understanding of early recognition and escalation.

2. Pressure injuries

Fourteen patients sustained a hospital acquired pressure injury rated as a SAC 2 event. Eleven of the 14 pressure injuries were sustained while patients were in hospital and the other three occurred while under outpatient care. Ten were classified as unstageable* pressure injuries. Consistent themes were lack of, or no risk assessment and documentation of care planning, particularly on admission. Contributing factors included staffing and resource shortages, wound care CNS resource constraints and reduced mobility of patients. Since the creation of the District-wide Patient Event Review Sub-Committee (PERS) there has been oversight of all pressure injury event reviews and formalised monitoring of the effects of subsequent recommendations (see below for more detail). This monitoring has since shown a sustained improvement in pressure injury prevention and management.

Patient ethnicity: Māori (n=2), European (n=12)

Table 5: Pressure injuries

Event summary	
6	Six patients developed unstageable* pressure injuries during their hospital stay
4	Four patients developed unstageable pressure injuries related to a cast or medical device
3	Three patients developed stage 3* pressure injuries
1	One patient developed a stage 3 pressure injury related to a medical device

What are we doing to further reduce pressure injuries?

- The Pressure Injury Prevention and Management Policy, developed as part of the ACC work programme, is now embedded as standard practice for preventive measures.
- PERS was established with the purpose of overseeing pressure injury and falls event processes in order to reduce patient harm by learning and improving from serious events across the District. PERS ensures all reviews are timely and of high quality with SMARTER and effective recommendations.
- There is continuous education for registered nurses across the District around preventive measures including dressings and management of pressure injuries.
- Tracer auditing specifically for pressure injuries continues. Education days around VAC dressings continue with the addition of online resources with more targeted teaching points about VAC dressings.
- There has been increased education about available pressure relieving equipment, including beds and Roho cushions.
- District-wide guidelines and strategies for prevention and management of pressure injuries are informed by broader specialist clinical groups such as the New Zealand Wound Care Society and the Pan Pacific Pressure Injury Alliance.

**Pressure Injury Classification:*
Deep tissue: There is no open wound but the tissue beneath the skin's surface has been damaged.
Stage 3: Subcutaneous fat may be visible, no exposed bone tendon/muscle.
Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle.
Unstageable: Depth unknown. Full thickness tissue loss and base of the pressure injury covered by slough and/or eschar.

3. Delay in treatment

Twenty serious events occurred due to delays in treatment. These were mainly due to a delay in diagnosis or transfer. Sadly, six of these events resulted in patient deaths. Events relating to a delay in diagnosis or treatment are in the context of tight staffing restrictions and services operating at capacity, and were due to a variety of issues including capacity and issues with scheduling appointments.

Patient ethnicity: Māori (n=3), Pacific Peoples (n=3) and European (n=14)

Table 6: Delay in treatment

Event summary	
4	Four patients had delayed cancer treatment due to delayed investigations or specialist appointments
3	Three patients had a delay in transfer to the appropriate care area
4	Four patients had a delay in treatment due to a missed diagnosis
3	Three patients had a delay in assessment or investigation
3	Three patients had delayed treatment due to staffing or facility constraints
1	One patient had delayed treatment as the result of a lost laboratory specimen
1	One patient had delayed treatment due to an inappropriate prescription
1	One patient had a delay in treatment due to issues around designation of responsibility for their care

What are we doing to improve clinical processes that have contributed to delays in treatment?

- A respiratory clinic nurse has been appointed to reduce Faster Cancer Treatment (FCT) waiting times.
- CT scan criteria is being updated to have a lower threshold for scanning in elderly, frail patients who have experienced trauma.
- Increased weekend medical staffing for emergency departments.
- Updates to the electronic booking system for radiology requests, to improve communication with private providers.

4. Complication during or following a procedure

Healthcare is complex and all procedures carry a risk of complication. While steps can be taken to reduce the risk of adverse effects from interventions we acknowledge that not all complications are avoidable. Four patients developed a complication during a procedure and two following a procedure. Many patients in this group had complex health needs involving non-linear health journeys. A majority of the events involved known complications which were recognised in a timely manner and acted on appropriately, however in one event it was noted that there was a delay in detection of the complication. Two patients experienced permanent loss of function, and sadly, one patient died as a result of a complication.

Patient ethnicity: Māori (n=2), Pacific Peoples (n=1), Asian (n=1), MELAA (n=1) and European (n=1)

Table 7: Complication during or following a procedure

Event summary	
3	Three patients experienced a complication related to a surgical procedure during the post-operative period
2	Two patients developed a complication during a procedure
1	One patient experienced complications following the birth of their child

What are we doing to lower the risk of complications during or following a procedure?

- Reviews into a number of these events are currently in progress so recommendations have not yet been identified.
- A 'Human Factors Review' template for known complications during or following a procedure has been developed to streamline the review of these events and enhance learnings from them.
- Training around wound assessment and management continues, including additional online resources for VAC dressings. There continues to be a specialist wound care role to support nurses however, resource is limited. The organisation is working towards increasing staffing resource in this area.

5. Process of care

Process of care refers to actions or interventions performed during the delivery of patient care in accordance with evidence based best practice. There were eight process of care events, some due to issues during delivery of patient care. Sadly, four patients died as a result of these events.

Patient ethnicity: Pacific Peoples (n=2), European (n=6)

Table 8: Process of care

Event summary	
2	Two patients had issues related to medical devices requiring an increased level of care or surgical intervention
1	A patient sustained burns whilst receiving care in the hospital
4	There were four deaths related to delivery of patient care
1	A neonate died within hours of birth

What are we doing to improve our process of care?

- Reviews into a number of these events are currently in progress so recommendations have not yet been identified.
- The current Chest Drain Policy is being reviewed to include imaging post chest drain placement.

Healthcare Associated Infection (HAI)

There was one SAC 2 event related to a patient who developed an infection associated with their care.
Patient ethnicity: European (n=1)

Table 9: Healthcare Associated Infection (HAI)

Event summaries	
1	One event involved a patient with an infected intravenous line requiring an increased level of care

What are we doing to reduce the incidence of HAIs?

- The review into this event is currently in progress so recommendations are not yet final, however, HQSC have recently published guidance on the SAC rating of Healthcare Associated Infections (HAI). These will be promoted across the District to increase awareness of reporting requirements for HAI.
- A District-wide governance working group focused on sepsis management is in development, linking in with the work of the HQSC, to create an in-patient sepsis management pathway.
- A human factors template for HAIs is being developed and will be piloted in the coming year.

Medication and Intravenous (IV) Fluids

There were nine medication related events, all of which were categorised as SAC 2. This is an increase from a total of six medication events for the 2020/2021 reporting period. There were no events related to intravenous fluid administration.

Patient ethnicity: Māori (n=4), Asian (n=1) and European (n=4)

Table 10: Medication and Intravenous (IV) Fluids

Event summaries	
3	Three events involved an allergic reaction to an administered medication
4	Four events involved accumulation of a medication resulting in toxicity
1	One event involved the administration of an incorrect medication
1	One event involved a medication not being discontinued when indicated

What are we doing to reduce harm from medication and IV fluids?

- Changes to the layout of the medications on anaesthetic trolleys to standardise across theatres and off-site locations, such as Delivery Suite.
- Ongoing staff education about medication interactions and potential side effects including hospital-wide awareness campaigns on high risk medications.
- A Medications Alerts project has been undertaken by the District to improve the safety of medication alert management at all of our District's hospital sites. Progress so far includes the establishment of a working group for Medications Alerts and a District-wide patient alerts governance group.
- The Medications Alerts project will be a focus of the governance team with planned initiatives including: an implementation plan for new policies that support staff to safely change practice, development of a governance framework for patient alerts (beginning with medications), exploring options for a dedicated workforce for identifying and managing patient alerts in our hospital points of entry and continuing to advocate for ICT and national improvements, escalating through developing Te Whatu Ora governance structures as needed.

Behaviour

There was one behaviour-related SAC 2 event.

Patient ethnicity: Māori (n=1)

Table 11: Behaviour

Event Summary	
1	One event involved self-harm

What are we doing to address behaviour related events?

- The review into this event is in progress so recommendations are not yet final.
- Mental health services and security services are trained in de-escalation and have enhanced management plans in place to respond to emergent situations where patients are a risk to themselves or others. This includes Patient Observation and Engagement supports, where appropriate.
- Pre-planning by multi-disciplinary teams for individualised needs-based plans to support patients are in place for those deemed to be at high risk.

Falls with Serious Harm:
There were 31 falls causing serious harm in this reporting period. This does not include the 6 historic events found in audit. This is an increase from the 25 events reported across HVDHB & CCDHB during 2020/2021. Two of the fall events involved outpatients and the remaining 29 were among hospital inpatients. Twenty-nine of the falls resulted in the individual involved sustaining a fracture and two falls resulted in a head injury. Sadly, in two of the cases, the falls were considered to be a contributing factor in their death.

The falls primarily occurred amongst the older adult population across different hospital locations. A range of environmental, assessment, care planning, and process factors were found to have contributed. A number of falls occurred around handover time where there is decreased visibility of patients. Unfortunately, sometimes falls do occur despite safety huddles and appropriate falls assessment and management.

Patient ethnicity: Māori (n=2), Pacific peoples (n=2) and European (n=27)

Table 12: Falls with Serious Harm

Event summary	
29	29 patients sustained fractures following falls
2	Two patients sustained head injuries following a fall; one required surgery

What are we doing to further reduce falls?

- The District-wide PERS Committee was established with the purpose of overseeing pressure injury and falls event processes in order to reduce patient harm by learning and improving from serious events across the District. PERS ensures all reviews are timely and of high quality with SMARTER and effective recommendations.
- The current SAFE Falls Prevention Committee will become part of the Patient Safety Indication Committee which takes a holistic view of patient safety indicators such as falls, pressure injuries, safe mobility, continence and malnutrition.
- A District-wide Falls Prevention & Management policy is being implemented.
- Targeted improvements continue as a result of regular tracer audits.
- Collaboration with the Central Equipment Pool has meant improved availability and process for accessing and renewal of equipment such as Chair Raizers.
- The Fracture Liaison Service has been established to follow-up in the community with all patients that have had a fracture as a result of falls.
- Security Orderlies have processes in place for timely assistance and equipment when a patient falls and have regular training and simulation in safe handling practices.

Final Comment

While most patients that engage with our services do so without preventable harm occurring, the patients affected by the adverse events in this report have suffered serious harm or, in some cases, have died. Te Whatu Ora Capital, Coast & Hutt Valley reiterates that we consider even one event of this nature to be one too many, and we apologise unreservedly to the patients and whānau that have been affected by these events.

Robust reporting and review of these events is fundamental to enhancing patient safety. The learning from these events helps us identify areas for improvement and further development to assist our staff to deliver safe and effective care to our communities. In the future, our priorities will be focused on improvement activities such as:

- Encouraging and improving reporting behaviours to foster a culture that encourages our staff, across all levels, to speak up for patient safety
- Improving the serious adverse event review process to facilitate timely reporting for patients and whānau
- District-wide alignment of governance, processes and policies
- Improve processes to collect meaningful data from serious events to identify and improve equitable outcomes for patients
- To work with national stakeholders to enhance the current model to incorporate other areas of harm such as psychological, emotional, cultural and spiritual harm.