Duke 31

Adverse Events Monitoring

The why, what and how of the new system

The Bristol story of a paediatric cardiac surgical service is not about bad people, people who did not care, nor of people who wilfully harmed patients.

The Ideal Health Care System

Everyone should have
access to
the right care delivered in
the right way,
safely, at
the right time, with the
best use of the available resources

Quality in Australian Health Care Study - cases per year

- Potentially preventable AEs 300,000
- Preventable permanent disability 50,000
- Preventable serious disability 15,000
- Potentially preventable death 12,000
- All injury and suicide deaths 6,000

- Wilson et al, MJA, 1995

The Likely Situation - Aus and US (NZ and UK)

- Potentially preventable AEs - 10% admission
- Potentially preventable cost - 5% of budget
- Deaths 50,000 pa - one every 10 minutes = US
- Two fully laden 747s every 1-2 days = US
- Two fully laden 747s every 2-3 weeks = Aus
- Six million dollars per day in Aus

Wilson et al, MJA, 1995

DEFINITIONS

- Incident - An event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage

DEFINITIONS

- Adverse Event – An incident in which harm resulted to a person receiving health care
- Near Miss – An adverse event or close call that did not lead to harm but could have

DEFINITIONS

- Sentinel Event – An undesired event that signals that something serious or sentinel has occurred and warrants in-depth investigation
- Root cause analysis – A systematic process whereby the underlying factors which contributed to a sentinel event are identified

OBJECTIVES

- Patient safety
- Systems focus – near misses
- No blame culture – negligence, wilful neglect
- Learning culture – prevent recurrence
- Would you be happy for your grandmother to be admitted to BBH ?

Aims of the new system

- To improve patient safety
- To identify system processes for improvement
- To improve the monitoring and evaluation of adverse events
- To increase the reliability of our reporting system and provide prompt feedback
- To ensure action is taken to address required improvements

Adverse Event Form & Minimum Dataset Forms

- Adverse Event Report form
- Sentinel Event Report form
- Falls Minimum Dataset form
- Pressure Ulcer Minimum Dataset form
- Occupational Exposure Questionnaire
- Security Report form

- (G:\QM\Risk Management\Adverse Event Monitoring)

What happens to the forms

- Complete all sections of the Adverse Event form
- Attach Minimum Dataset forms as appropriate
- Forward forms to your shift supervisor

Shift Supervisor's Responsibilities

- Check that all relevant details have been completed
- Outline any additional information about the adverse event or about the action taken
- Copy the report and retain a copy in the ward
- Forward original forms to the DQDSU

What DQDSU does next

- Date stamps and registers all reports
- Assesses the risk associated with the event
  - Low & Medium risks are monitored in trend reports
  - High, Very High & Extreme risks are sent to the relevant Director for investigation
- Forwards Minimum Data Se t forms to appropriate areas
- Trends and reports the data

Feedback

- Monthly reports will be sent to each area
- Additional trend reports will be distributed to relevant committees such as CSFs, HOD etc

Performance Indicators

- Adverse Event Report form received by DQDSU within 2 working days
- High, Very High & Extreme Adverse Events investigation completed within 10 working days
- All Adverse Events closed within 28 days

Remember to:

- Complete all sections & appropriate forms
- Be factual
  - establish sequence of events that led to the incident
  - describe what actually happened
  - identify what you did as a result of the incident
- Forward completed forms in a timely manner

Remember to:

- Report near-misses
- Feel you can make a difference

Patient/Visitor Adverse Events

- Complete the left hand column
- IMHS Clients refers to Mental Health clients
- Reporter Details - the person filling out the form
- Names of witnesses (if any) and how we can contact them if needed
- Current patient diagnosis/problems - is the reason the person is being treated by the Health Service (provisional diagnosis or othe rwise)

Patient/Visitor Adverse Events continued

- Adverse Event Type – key words to describe incident eg fall, pressure ulcer, medication error
- Next of kin/Medical Officer notified – include names of persons notified
- Open Disclosure section currently not completed

Staff Adverse Events

- Complete the right hand column
- Details relate to the staff member the event happened to <u>not</u> the reporter (although can be same person)
- Shift Type – fixed, standard, rotating
- Shift time - the intended start and finish time on the day the incident occurred (even if you did not complete the shift)

Staff Adverse Events

- Include names of witnesses (if any) and how we may contact them if needed
- Medical Officer notified – did you seek treatment through DEM, GP etc

Description of the Adverse Event

- The Description of the Adverse Event is the most important section
- State clearly what type of adverse event is being reported
- Be sure to include sufficient detail so that an appropriate risk assessment can be made
- Describe the event exactly – don't assume that certain details don't need to be recorded

Contributing Factors

- Indicate what may have contributed to this adverse event
- Think about the environment in which the event occurred
- Consider issues such as staffing, skill mix, other patients etc

Treatments/investigations

- Provide as much detail as possible, for example
  - What type of observations were ordered and for how long?
  - What blood tests/x-rays were ordered and why?
- Indicate whether the interventions ordered were as a direct result of the adverse event

Outcome of the Adverse Event

- All adverse events will have some impact on the people involved
- The impact may be physical, emotional, financial, psychological
- It may not necessarily impact on the subject of the adverse event
- The outcome may not always be obvious at the time of the event – any potential outcome may be listed for follow up during analysis if required

Prevention or Minimization of Outcomes

- This section helps us to identify where we might be able to make improvements to the systems we use
- Include details of how we can achieve these improvements, for example
  - If better communication could have prevented the event, what specifically needs to be done?
  - If practice or policy needs to be changed, what exactly are the changes required?

QH Defined Sentinel Events

- Procedures involving the wrong patient or the wrong body part
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Haemolytic blood transfusion reaction resulting in ABO incompatibility
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs

QH Defined Sentinel Events

- Infant discharged to wrong family
- Maternal death or serious morbidity associated with labour or delivery
- Intravascular gas embolism resulting in death or neurological damage
- Suicide of a patient in an inpatient unit
- Any serious and rare event

Any questions?