Addington Hospital

Managing Clinical Adverse Events

Presented by:
Dr J Hurst – Hospital Manager
Mrs M Chinniah – Nursing & Quality Manager

19 January 2005
WHO World Alliance for Patients Safety Meeting
Durban
ADDINGTON HOSPITAL

VISION

To achieve a quality health service through innovative and dynamic healthcare leadership.

MISSION STATEMENT

Addington Hospital is committed to providing a safe, legal, ethical, quality patient focussed district and regional health service through the integration of the Batho Pele, Good Governance and Accreditation programmes, supported by information technology to achieve:

- optimal, cost-effective clinical outcomes for patients within the available resources and current provincial health policy;
- attraction and retention of talented staff by providing an exceptional work environment conducive to staff well being, participation, development, learning and research;
- enhanced customer satisfaction ensuring the dignity and rights of patients, staff and other customers;
- sound financial management;
- improved co-ordination and communication with stakeholders including the promotion of partnerships with the Community and the eThekwini District Health Office.

HOSPITAL MANAGER
CORE VALUES

INTEGRITY
TRUSTWORTHY
CO-OPERATIVE GOVERNANCE
SELF AWARENESS
TEAM WORK
COMPASSIONATE CARING
ACCOUNTABILITY
DEDICATION
ENTHUSIASM
APPROACHABILITY
Some Background Information

- Situated on Durban’s famous Golden Mile
- Built on present site in 1897 and has undergone many additions to the original complex
- KwaZulu Natal Public Sector Hospital
First Government Hospital
Durban - Bayside

1861
Addington Hospital, early 1900.
Some Background Information

Cont…..

2004

- Hospital Beds – 512
- Average Occupancy Rate – 94%
- Admissions p.a. – 31,630
- Outpatients p.a. – 350,083
- Staff - 2500
Some Background Information

Services offered by the Hospital:

- Obs/Gynae, Paediatrics, Dental
- General Surgery, Orthopaedics, Ophthalmology, ENT, Urology, Radiotherapy and Oncology, Critical Care Services
- **Rehabilitative Services**: Physiotherapy, Occupational Therapy, Speech Therapy
- **Support Services**: Radiology, Nuclear Medicine, Pharmacy, Anaesthetic, Laboratory, Social Work, Dietetics
- **Special programmes**: Prevention of Mother to Child Transmission, Voluntary Counselling and Testing, Antiretroviral rollout programme, HIV/AIDS Resource Centre, Advice Desk for Abused, Crisis Centre (Post Exposure Prophylaxis)
Path through Adverse Events
The Changing approach
First Phase
Path Through Adverse Events
First Phase

- Incident Reporting but on adhoc/crises intervention basis
- No structured, formalised process of collation, analysis and monitoring of trends for remediation
- Not integrated into Quality and Risk Management
- No “Buy-in“ – Casemix/Abstracting Module
Path through Adverse Events

The Changing approach

Second Phase
Path Through Adverse Events
Second Phase

- Re-entry into Accreditation Programme
- Quality Steering Committee
- In-house Risk Manager
- Case Manager
- Literature search for a model for Adverse Event Reporting and Monitoring
Path through Adverse Events
The Changing approach
Third Phase
Towards a Culture of Safety
Path Through Adverse Events
Third Phase

- Adapted and Adopted Adverse Event reporting and Monitoring Model

- Policies and Procedures:
  - Quality Management and Improvement Strategy and Programme
  - Risk Management Strategy and Programme
  - Adverse Event Reporting and Monitoring
Policy Statement:
Quality Management and improvement strategy and Programme – July 2003

PURPOSE: The provision of a framework for the Hospital and the leaders to provide \textbf{QUALITY} Patient Care in a \textbf{SAFE} well managed environment.

Prioritised focus for Clinical areas: Clinical audit including Adverse Events reporting and monitoring.
1. **PURPOSE:** The provision of a framework to Identify, Analyse and Evaluate risks so as to reduce the **frequency, severity and impact of all incidents, accidents and injuries.**

2. Definition of Risk: Risk is the presence of uncertainty and it is measured as the deviation from the expected outcome of a given situation or event.

3. Definition of Risk Management: A planned Programme to prevent loss and control liability.

ANNEXURE C

ADDITIONAL HOSPITAL CLINICAL RISK MANAGEMENT MODEL

- Inpatient medical record review
- Emergency Unit record review
- Adverse event/clinical incident reports

Clinical Activities

Audits and reports

Issues raised by:
- Patient risk assessment tools
- Post mortem reports
- Media reports
- Consultative committees
- Patient complaint audits
- Insurers
- Literature reviews
- Provincial statistics

Clinical reviews

Adverse events

Detect risks

Analyze and prioritize risk probabilities, consequences and risk severity

Modify the risks

Accept risk (monitor)

Minor changes

System changes

Evaluate
ADDINGTON HOSPITAL CLINICAL MX MODEL

- Inpatient medical record review
- Emergency Unit record review
- Adverse event/clinical incident reports

- Pt risk assessment tools
- Post mortem reports
- Media reports
- Consultative committees
- Pt complaint audits
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- Literature reviews
- Provincial statistics

Clinical Activities

Audits and Reports

Clinical reviews

Adverse events

Detect risks
ADDINGTON HOSPITAL CLINICAL MX MODEL

Analyse and prioritise risk probabilities, consequences and risk severity

Modify the risk

Accept risk (monitor)

Minor changes

System changes

Evaluate
1. **Purpose:** As part of an integrated risk management programme that detects adverse events/incidents in the hospital; analyses their risk, and takes action to alter the rate of adverse events/incidents, procedures must be followed to report, analyse and learn from adverse events/incidents in order to improve the **safety** and **care** of patients.

2. **Definition of Adverse Event:** Any event or occurrence that could have or did lead to unintended or unexpected harm, loss or damage.

3. **Procedure and reporting channels:**
NOTIFICATION OF AN INCIDENT

(To be completed within 3 hours of occurrence)

Ward/department: _______________________

Date of incident: ________________________ Time of incident: ___________________________

Name of patient: ____________________________________________________________

File number: ____________________________

Diagnosis: _________________________________________________________________

Brief description of incident:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Doctor notified (if applicable) Yes No

Persons involved:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Notified by: ____________________________ Date: ____________________________

Please forward the notification to the office of the Hospital Manager during working hours, or to the office of the Duty Matron after hours.
INCIDENT REPORT

Instructions:
1. To be completed within one week of notification of the incident.
2. Attach the duplicate notification of the incident to this form.
3. Forward to the office of the Nursing Manager.

Diagnosis: ____________________________
Type of Incident: ____________________________
Date of Incident: ________________ Time of Incident: ________________
Hospital: ____________________________ Ward/Department: ____________________________

Report: ____________________________________________________________
__________________________________________________________
__________________________________________________________

Comments: ____________________________
__________________________________________________________
__________________________________________________________

Signature – Reporter: ____________________________ Date: ________________
Signature – Doctor if applicable: ____________________________
Signature – Unit Manager: ____________________________
Signature – Nursing Manager: ____________________________
Signature – Hospital Manager: ____________________________ Date: ________________
INCIIDENT INTERVENTION

Date of incident : ____________________________________________________________
Type of incident : ____________________________________________________________
Hospital : ____________________________________________________________
Intervention :
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Is adverse event/clinical incident risk assessment tool completed? Yes No

Signature – Nursing Manager: __________________________ Date:______________

Evaluation of Intervention:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Signature – Nursing Manager: __________________________ Date: _____________

Hospital Manager:___________________________ Date: ---------------
ADDINGTON HOSPITAL
Departmental Adverse Event/Clinical Incident Risk Assessment Tool

Date: ___________________________ Ward/dept: ___________________________

Reason for report: Please tick one of the following:

* Death
* Cardiac arrest
* Dispensing error
* Missed diagnosis
* Admission delays
* Medico-legal implications
* Other

<table>
<thead>
<tr>
<th>A. Grading of event: What was the harm to the patient? (Please tick one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) None : near miss</td>
</tr>
<tr>
<td>2) Minor : non-permanent harm</td>
</tr>
<tr>
<td>3) Moderate : semi-permanent harm</td>
</tr>
<tr>
<td>4) Major : major permanent harm</td>
</tr>
<tr>
<td>5) Catastrophic : Death/service closure/litigation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Likelihood of recurrence: (Please tick one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Can’t believe this will ever happen again</td>
</tr>
<tr>
<td>2) Could occur at some time</td>
</tr>
<tr>
<td>3) May occur occasionally</td>
</tr>
<tr>
<td>4) Will probably recur, but is not a persistent issue</td>
</tr>
<tr>
<td>5) Will definitely recur, possibly frequently.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. What action do you suggest should be taken to reduce the frequency of adverse events/clinical incidents? (Tick suggested actions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Changes to clinical and administrative protocols</td>
</tr>
<tr>
<td>b) Focused audits to investigate specific adverse events</td>
</tr>
<tr>
<td>c) Discussion with staff involved</td>
</tr>
<tr>
<td>d) Education at management and in-service training</td>
</tr>
<tr>
<td>e) Develop checklists for complex procedures</td>
</tr>
<tr>
<td>f) Increasing supervision of junior staff</td>
</tr>
<tr>
<td>g) Review of clinical protocols</td>
</tr>
<tr>
<td>h) Introduce patient assessment tools to predict risks of falls / pressure ulcers / deep vein thrombosis / wound sepsis</td>
</tr>
<tr>
<td>i) Regular feedback to clinical staff regarding these events and results of actions taken to reduce events and manage risks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Please hand in to Institutional Risk Manager: Charge Nurse D Pretorius who will calculate risk severity.</th>
</tr>
</thead>
</table>
### ADDINGTON HOSPITAL
### ADVERSE EVENTS ANALYSIS FORM

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>Impact (A)</th>
<th>Recurrence (B)</th>
<th>Risk severity (AxB)</th>
<th>Action taken (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly patient fell out of bed</td>
<td>4 Fracture neck of femur</td>
<td>4</td>
<td>16</td>
<td>c,d,f,h,i</td>
</tr>
</tbody>
</table>

Risk severity graded against total of 25
10 or <= Low grade / moderate = risk accepted
>10 = Serious
Risk severity: 16
Analysis: Injury in Hospital
ADDINGTON HOSPITAL
ADVERSE EVENTS ANALYSIS FORM
Cont……..

10 or < 10
Accepted and will be monitored

>10
Recommended relevant Action
1. Recircularisation & Education of P&P – cot side
2. Counselling of junior staff & supervisor for non-adherence to P&P

Risk Manager: __xx______ Date: __xx______ Signature: __xx_____

Forwarded to: 1. Quality Steering Committee √
2. Health and Safety Committee √
3. Unit Manager √
4.
## No of Adverse Events
### April – Nov 2004

<table>
<thead>
<tr>
<th>MONTH</th>
<th>CLINICAL</th>
<th>ADMIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>May</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>June</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>July</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Aug</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Sept</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Oct</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Nov</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
<td>55</td>
</tr>
</tbody>
</table>
Adverse Events
April – Nov 2004

No of Events

Clinical
Admin

April May June July Aug Sept Oct Nov
### Adverse Events

**Types of Events: April – Nov 2004 - Clinical**

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Delay</td>
<td>4</td>
</tr>
<tr>
<td>Medico Legal</td>
<td>5</td>
</tr>
<tr>
<td>Treatment Delay</td>
<td>12</td>
</tr>
<tr>
<td>Death</td>
<td>8</td>
</tr>
<tr>
<td>Dispensing Error</td>
<td>13</td>
</tr>
<tr>
<td>Missing Patients</td>
<td>8</td>
</tr>
<tr>
<td>Injury in Hospital</td>
<td>13</td>
</tr>
<tr>
<td>Delay transfer to another hospital</td>
<td>1</td>
</tr>
<tr>
<td>Transfer from ward to ICU</td>
<td>1</td>
</tr>
<tr>
<td>Booked for Theatre / Cancelled</td>
<td>2</td>
</tr>
<tr>
<td>Missed Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>
Adverse Events
Types of Events: April – Nov 2004

Number of Events:
- Adm Delay
- Med Legal
- Rx Delay
- Death
- Disp Error
- Missing Pts
- Inj in Hosp
- T/F to ICU
- Theatre cancelled
- T/F to other hospital
- Md
### Adverse Events

#### Types of Events: April – Nov 2004

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft/Loss</td>
<td>7</td>
</tr>
<tr>
<td>Misconduct</td>
<td>8</td>
</tr>
<tr>
<td>Service Failure</td>
<td>11</td>
</tr>
<tr>
<td>Lack of Security</td>
<td>3</td>
</tr>
<tr>
<td>Invalid Consent</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>
Adverse Events
Types of Events: April – Nov 2004

- Theft/Loss
- Misconduct
- Service Failure
- Lack of Security
- Invalid Consent

Bar chart showing the number of events for each type.
Adverse Events
Grading/Severity: April – Nov 2004

No of Incidents

Grading/Severity

Clinical
Admin
## Clinical Adverse Events

### Grading/Severity: April – Nov 2004

5 Adverse Events > 10

<table>
<thead>
<tr>
<th>Grading</th>
<th>Adverse Event</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Admission Delay</td>
<td>Med Reg</td>
</tr>
<tr>
<td>15</td>
<td>Death</td>
<td>Theatre x 2</td>
</tr>
<tr>
<td>16</td>
<td>Misdiagnosis</td>
<td>A&amp;E</td>
</tr>
<tr>
<td>25</td>
<td>Death</td>
<td>Theatre</td>
</tr>
</tbody>
</table>
# Rates of Clinical Adverse Events

## April – Nov 2004

<table>
<thead>
<tr>
<th></th>
<th>No adverse events</th>
<th>No patients</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatients</strong></td>
<td>36</td>
<td>25257</td>
<td>0 (%)</td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>32</td>
<td>279444</td>
<td>0 (%)</td>
</tr>
</tbody>
</table>
Path through Adverse Events
The Changing approach
First Phase
Second phase
Third Phase
Way Forward
The adverse clinical incident ratings and risk severities are only done for the adverse clinical incidents reporting, therefore does not reflect the total adverse clinical incidents.

We need to apply incidence ratings and risk severities to our other methods of clinical adverse events detection.
ADDINGTON HOSPITAL CLINICAL MX MODEL

- Inpatient medical record review
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- Pt risk assessment tools
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- Pt complaint audits
- Insurers
- Literature reviews
- Provincial statistics
Challenges to optimise a systems approach to collection, analysis and actions to reduce Adverse Clinical Incident Rates

- **Inpatient medical record review**: Optimise our computerised Case Mix Abstracting Module which already has the ability to record Adverse Events.

- **Post Mortem Reports**: Reports, both forensic and reports to further determine the cause of death, to be channeled through the Risk Management to the Quality Steering Committee.

- **Insurers**: Case Manager to channel all clinical audits and complaints from Insurers to Risk Manager.

- **Literature Reviews**: More effort into Literature Reviews for benchmarking.

- **Provincial Statistics**: Not collected by Head Office currently; unable to benchmark. Challenge for Head Office.
Challenges to optimise a systems approach to collection, analysis and actions to reduce Adverse Clinical Incident Rates

- Ongoing in-servicing of staff on utilisation of Clinical Adverse Events reporting
- Organisation wide feedback on Adverse Events, as at this moment it is only to involved units
- Closer liaison between Risk Manager, Quality Manager, Case Manager, Infection Control Manager and Public Relation Officer to integrate data collection for analysis
- 6 Monthly comparative data evaluation to plot trends and patterns for remediation
ACKNOWLEDGEMENTS

Detecting and reducing Hospital Adverse Events: Outcomes of the Wimmera Clinical Risk Programme. MJA 2001; 174:621-625

Alan M Wolff
Jo Bourke
Ian A Campbell
David W Leembruggen

Appreciation to: Addington Hospital:
Informatics Team