6. Preventing adverse events

Best care for older people in hospital

What is it?

An adverse event is an incident that results in harm to the patient. Adverse events commonly experienced in hospitals by patients over 70 include falls, medication errors, malnutrition, incontinence, and hospital-acquired pressure injuries and infections.

What we do or do not do to identify and respond to issues such as malnutrition, uncontrolled pain and unrecognised delirium can contribute to a patient experiencing an adverse event and, in turn, functional decline.

This factsheet will identify strategies you can use to minimise the risk of an adverse event.

Why is it important?

Physical and cognitive functional decline is often unrelated to the primary reason a person presents to hospital and can have a significant impact on a person's ability to perform activities of daily living.

- Older people are particularly vulnerable to experiencing adverse events due to inherent complexity in managing their care and a decline in physiological reserves. Approximately three in four older adults have complex multimorbidity[1], and one in two older people take over four medications.[2]
- Approximately one in 20 patients experience an adverse event while in hospital.[3]
- Patients with adverse events stay about ten days longer and have over seven times the risk of an in-hospital death than those without complications.[4]

How can you prevent an adverse event?

Adverse events can be prevented through screening and early identification of the factors that put older people at risk.[3,5]

Patients aged 70 years and over should be screened to determine the risks of adverse events, and undergo a comprehensive interdisciplinary assessment where risk is identified.

Effective communication with patients, their family, carers and other healthcare professionals is important in preventing adverse events for older people in hospital.[5] A lack of communication and collaboration between health professionals is a common factor in the majority of adverse events.[6]

All staff have a shared role in preventing harm to older patients.

Make sure you are familiar with your health service's official policy regarding the prevention of adverse events.

Screen and assess patients to minimise the risk of adverse events

- Use validated tools to screen for the risk of adverse events such as: falls, medication errors, malnutrition, continence, delirium and hospital-acquired pressure injuries.
- Ensure screening and assessment are undertaken at admission and transition to other areas in the health service.

Engage patients, families and carers in the care plan

- Encourage patients, family and carers to ask questions when you discuss risk factors and preventative measures:
  - Consider the patient's health literacy and their cultural and linguistic background.

  - Check the patient has all necessary aids such as glasses and hearing aids.
- Involve patients, family and carers in clinical handover processes and the care plan.
- Ensure patients, family and carers know how to identify and respond to clinical deterioration.

Respond to a patient who has a high risk of experiencing an adverse event

- Undertake a comprehensive geriatric assessment – with interdisciplinary team input – to ensure that risk is addressed and preventative strategies are included in the patient's care plan.
- Discuss preventative strategies (such as a medication review) with the patient and their family or carer and implement any changes to reduce the risk of an adverse event.
- Communicate adverse event risk factors to other staff involved in caring for the patient, for example by using alert symbols above patient beds, during team meetings and on clinical handover.
- Ensure that critical information, such as a medication list or falls history, is transferred, acted upon, and documented during clinical handover. Many health services use the framework ISBAR (identify, situation, background, assessment and recommendation) when transferring patient information during clinical handover.

Respond to a patient who has experienced an adverse event

- Provide the necessary care to address the impact of the adverse event on the patient.
- Inform and involve the patient and their family or carers of the adverse event and the strategies used to minimise risks.
- Review all preventative strategies and assessment procedures to minimise further adverse events occurring.
- Refer to the relevant specialist for best practice advice and management.
- Monitor and evaluate the outcomes of the ongoing care plan and adjust as necessary.

Monitor a patient's ongoing care

- Ensure you deliver person-centred care in agreement with the patient's monitoring plan, including documenting the type and frequency of observations to be recorded for the patient.
- Engage in intentional rounding (carrying out regular checks with the patient at set intervals) and assist the patient with eating, drinking, pain relief, ambulation, regular toileting and repositioning (as required).
- Escalate the care of a patient whose condition deteriorates.

The National Safety and Quality Health Service Standards provide a useful resource for hospital staff to prevent adverse events and harm to the patients.

Want to know more?

Older people in hospital
www.health.vic.gov.au/older-people-in-hospital

National Safety and Quality Health Service Standards, 2011, Australian Commission on Safety and Quality in Health Care. http://www.safetyandquality.gov.au/our-work/

See Factsheet 11. *References* for references cited in this factsheet.

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Available at www.health.vic.gov.au/older-people-in-hospital

Preventing adverse events for older people in hospital

Screen the patient for risk factors that may cause adverse events	**use** validated screening tools: – falls – medication issues – pressure injuries – malnutrition – continence – cognitive impairment
Document the patient's risk factors and put preventative strategies in place	**document** risk factors clearly **ensure** your health service's prevention and management protocols inform the patient's care plan
Communicate the patient's risk factors and preventative strategies to staff	**utilise** alert systems to notify staff of risk **ensure** risk factors are communicated to the treating team through structured clinical handover
Communicate the patient's risk factors and preventative strategies to the patient and their family and carers	**ensure** the patient has a good understanding of their risk factors and preventative strategies **seek** patient and carer input into risk factors and ask what preventative strategies work for the patient **encourage** ongoing patient, family and carer participation in managing risk
Decide what systems you will use to mitigate negative patient outcomes if harm does occur	**implement** evidence-based interventions – e.g. intentional rounding **reassess** patient risk factors **communicate** with patient and staff to keep everyone informed **review** all preventative strategies to minimise further adverse events occurring **engage** specialist input into management plan