Canterbury District Health Board Serious Adverse Events Report

1 July 2017 – 30 June 2018

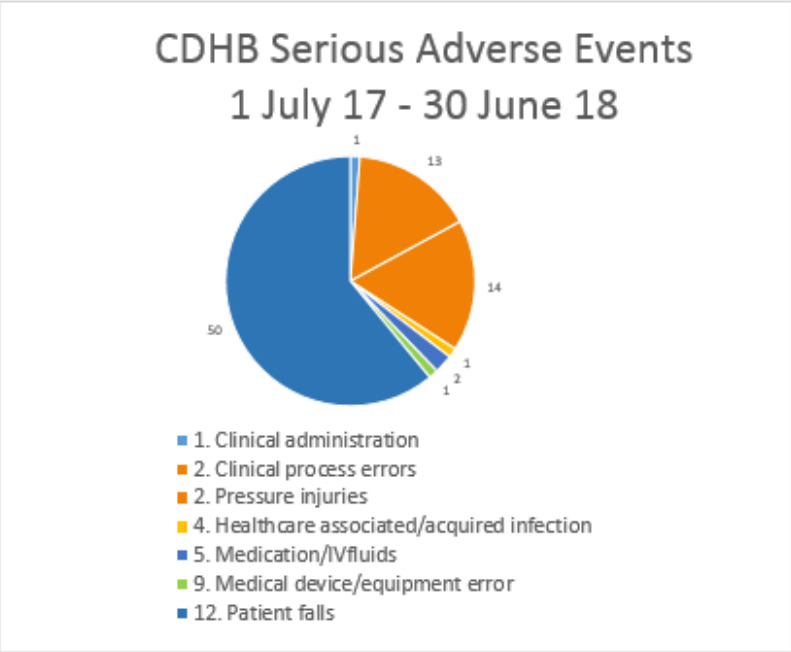
At Canterbury DHB our patient-focused, clinically-led culture supports our commitment to 'zero harm' and continuous quality improvement. All serious adverse events are reviewed through a formal process. The purpose of reviewing these is to provide sufficient feedback to patients and families so they are aware of contributing factors and causes of the event and how we intend to make our systems safer.

What is a serious adverse event?
A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

There were 82 serious adverse events reported out of the total of 14,353 incidents reported by the Canterbury District Health Board (CDHB) in the year from 1 July 2017 to 30 June 2018. Of the total serious adverse events reported, 50 were inpatient falls and 14 were hospital-acquired pressure injuries.

The events have been classified into six specific themes:

- Clinical administration – code 1
- Clinical process error (including pressure injuries) – code 2
- Healthcare associated/acquired infection – code 4
- Medicine/IV fluids error – code 5
- Medical device/equipment error – code 9
- Patient falls – code 12



Canterbury District Health Board Serious Adverse Events Report: 2017–2018

The report below summarises the findings and recommendations of the events reported. The recommendations/actions are in progress.

Note: Following investigation and findings, one Clinical Process Event has been withdrawn as a serious adverse event notification.

Event	Review Findings	Recommendations/Actions
Delayed follow up which may have contributed to loss of the right eye.	Vitrectomy surgery was outsourced for waiting list patients who were close to becoming overdue for their procedure. Not all outsourced patients were able to be accommodated within the expected timeframe for their subsequent follow-up appointment and the patient was seen approximately 7 weeks post-operatively (3–4 weeks overdue of generally accepted follow-up time).	Planning for outsourced contracts for Vitrectomy to include both day one post-operative follow up and the first outpatient appointment (usually at 2 weeks). If this is not the case then that would be by exception and recorded in the planning documentation for that contract.
Delayed follow-up which may have contributed to loss of the left eye.	The patient attended an outpatient clinic and was waitlisted for a 6 month follow-up appointment. The booking for the follow-up appointment was not completed within the expected timeframe. An 18 month delay to be seen resulted in reduced options for treatment for the eye condition. It was identified that lack of monitoring of scheduling processes combined with limited capacity/increased demand meant that the service did not see all patients in the expected timeframes. The service now monitors this to ensure patients are not waiting longer than 10% than actually intended. Individual cases are discussed with the Specialists to ensure any delays are clinically-acceptable or alternative solutions found to ensure patients are seen on time.	Service continues to identify any similar patients who are waiting longer than intended for their appointment. If not seen in the intended timeframe then are reviewed by the responsible Specialist for urgency and clinic scheduling is reviewed to ensure the patient is seen. The Department continues to implement improvements related to booking processes and works to continually make efficiencies across the Outpatient setting.
Retained swab during a procedure carried out in a non-theatre environment.	No established swab count process for procedures outside of the theatre environment resulted in a patient returning home with a retained swab and they subsequently developed sepsis.	A multidisciplinary group review of HQSC 'Open Book' document on retained swabs determined that additional measures were in place. Suture packs containing small gauze swabs were removed from the clinical area. This case and learnings were shared with clinical staff highlighting the safety measures such as safety tape visibility for internally inserted swab and system improvements such as swab and instrument count with documentation.

Event	Review Findings	Recommendations/Actions
Baby born in poor condition.	Review not yet completed.	
Baby born in poor condition.	Review not yet completed.	
Postpartum haemorrhage following caesarean resulting in hysterectomy.	Review not yet completed.	
Baby sharing sleeping space with mother, neonatal death.	Review not yet completed.	
Perforated small bowel from suprapubic catheter insertion.	Review not yet completed.	
Head injury following patient handling transfer.	Palliative patient requiring use of a hoist to transfer from a chair to bed slid out of hoist due to incorrect use and insufficient training with hoist equipment.	Canterbury District Health Board establish best practice safe moving and handling policy, procedures and processes.
Concern with support for physical health care issues.	Report being drafted.	
Oral medication potentially aspirated with resultant cardiac arrest.	Report being drafted.	
Delay in treatment which may have contributed to an untreatable total retinal detachment.	Due to variation in practice, an independent service wide review was undertaken of the treatment and management of babies diagnosed with retinopathy of prematurity. Whilst it was not possible to be certain that variations in practice have directly led to this adverse outcome, opportunities for improvement have been identified including improved consultation and documentation within the local team regarding at-risk infants to ensure a better peer review process.	The Services are strengthening practice changes inclusive of; ➢ Retcam (a piece of technology that allows high definition, wide field, colour images to be captured of the backs of infants' eyes which can be viewed by Ophthalmologists for immediate diagnosis) is used for all high risk screening. ➢ Standardisation of treatment processes including access to post treatment photographs in different services to allow for peer review. ➢ Increase in frequency of screening clinics for follow up. ➢ Continue Audit screening, treatment outcomes and monitoring documentation.
Wrong site surgery performed.	Report being drafted.	
Medication omission at point of transfer.	Review underway.	

Event	Review Findings	Recommendations/Actions
Potential hospital acquired infection.	Review underway.	
Prescribed medication omitted.	The process for implementing a new thromboprophylaxis regime did not recognise the need to also amend the references to thromboprophylaxis in the Multidisciplinary Care Pathway. Incorrect information in the pathway led to fewer doses of Clexane® being prescribed on discharge than recommended for the risk factors. This contributed to the patient developing a cerebral venous sinus thrombosis and associated seizures.	The Multidisciplinary Care Pathway was modified. Associated documents are listed in the electronic Document Management System as a prompt for all related documents to be updated at the same time.
Prescribed medication interaction with an existing medication.	Report being drafted.	
Surgical placement of the wrong implant.	Report being drafted.	

FALLS

The Canterbury Health System is working together to reduce the harm caused by falls in our hospitals and reduce the incidence of falls in our communities. Older people who are injured as a result of a fall are more likely to lose confidence and independence, are at greater risk of falling again and may stay in hospital longer. The Canterbury District Health Board takes a fall in hospital very seriously as demonstrated by the strategies listed below.

Strategies

Canterbury DHB has a 'Whole of System approach to falls prevention'. The DHB is committed to achieving zero harm from falls and are focusing on the three key areas - falls prevention in the wider community, falls prevention in rest homes and falls prevention for older people receiving care in our hospitals.

In the community and rest homes

Falls Prevention has been a key focus for the health of older persons. Over 1650 people over 75 years benefited from the Canterbury Community Falls Prevention Programme in 2017/18. The Falls & Fragility Fracture Prevention Service Level Alliance was established in October 2017 as a time-limited (3 year) group to enhance and improve the falls and fragility fracture prevention work in Canterbury. Falls initiatives in 2017/18 included a partnership between the ACC, Sport Canterbury and the Canterbury Clinical Network to coordinate 12,000 places in community based strength and balance classes to further decrease older person's falls.

In our Facilities

From a total of 2,464 patient falls, 50 patient fall events were confirmed as resulting in serious harm in the 2017/18 year. Each serious harm fall has an independent file review to determine contributory factors and care management problems, with recommendations made and moderated by a multidisciplinary Review Panel.

There continues to be a focus on identifying risk factors and tailoring falls prevention strategies to meet the needs of individual patients while they are in hospital, and for when they return home. The increased focus on involving the patient/family/ whanau in fall prevention planning, including discussions around their fall risk as well as providing them with educational material, also continues. Routine activities include the use of visual cues, safe mobility plans for all patients, monitoring and feeding back falls measures, Releasing Time to Care activity such as intentional rounding and bedside handover, the annual Falls Awareness Campaign, reviewing procedures and staff resources along with the patient/family information pamphlets to ensure they are appropriate.

In addition Canterbury DHB led the review of the South Island Generic Fall Prevention Self Learning Package for community and hospital staff in HealthLearn, reframing the use of non-slip socks for staff as a temporary measure until appropriate footwear can be brought in for a patient, and exploring options for operationalising the Safe Recovery Patient Education programme within Older Persons Health rehabilitation services. Improvements to the electronic incident management system fall event form have also been identified to help improve the data which is used to identify trends and focus future improvement work.

HOSPITAL ACQUIRED PRESSURE INJURIES

Pressure injuries (PI; also known as pressure ulcers or bed sores) are a major cause of preventable harm. These injuries usually develop over 'bony' parts of the body due to sustained pressure, or pressure combined with shear and/or friction. With the implementation of robust care systems and processes many PI can be avoided. The Canterbury District Health Board takes the development of a pressure injury in hospital very seriously.

Strategies

Canterbury DHB is committed to ensure all steps are taken to prevent pressure injuries (PI) from developing while people are in our care. Canterbury DHB has been proactive in both the DHB and the community by implementing multifaceted strategies to prevent PI from developing.

In our Hospitals

14 hospital acquired pressure injuries were confirmed in 2017/2018 as a stage 3, 4 or unstageable pressure injury. Each hospital acquired pressure injury stage 3 or greater has an independent file review to determine contributory factors and care management problems, with recommendations made and moderated by a multidisciplinary Review Panel.

Routine activities to prevent pressure injuries include use of standardised clinical skin and risk assessments undertaken by nursing staff to identify people at risk of developing a PI on admission and during care, the inclusion of PI prevention strategies into patient care plans, use of appropriate pressure relieving equipment, repositioning and appropriate mobilisation of the patients/clients, promoting safe patient handling practice, and optimal nutrition and continence management.

The Canterbury Pressure Injury Advisory Group aims to improve clinical outcomes and standardise clinical practice across the District. The Group has been proactive in developing and implementing PI prevention strategies which range from, survey of staff knowledge and confidence in identifying and staging injuries, point prevalence surveys, and improving professional development though a staff PI prevention e-learning package, updating the Canterbury DHB PI Policy and supporting documents, enhancing PIP communication across Canterbury by including community providers on the committee, sourcing and distributing PI staging lanyards, SSKINS posters/information and by holding numerous PI prevention activities for World Stop PI Day each November,

Across the Canterbury Health System

To further our 'whole of system' approach, we are working closely with ACC to strengthen practice across the health community through the implementation of a system wide PIP project.

Key initiatives aimed at reducing PI in the 2017/18 include the:

- Review of pressure injury resource requirements with a stock take of all PI resources and activity completed for the CDHB. A community stock take is currently underway.
- Development of a PIP Link Nurse (PIPLN) which is a frontline nurse in any setting who is trained to teach, promote, monitor/undertake surveillance, and support improvement processes with colleagues to deliver best practices in the prevention and management of pressure injuries.
- Development of a structured Community of Practice (CoP) to support and assist health professionals in all settings to share and develop knowledge and skills in pressure injury prevention and management. Specifically, the CoP will use social media to effectively mobilise and communicate PIPLN issues to engage health professionals in sharing PIP learning and resources.

HOSPITAL ACQUIRED PRESSURE INJURIES
• Work with community stakeholders in mutual areas of identified improvement. • A consumer survey on PI knowledge that will be used to help design PI resources for patients, residents, staff and the community. • Co-designing with the community, health education resources that will inform people how to prevent pressure injuries that: 1) during a temporary illness reduces activity; or 2) with long term functional impairment that limit physical activity. Once developed these resources will then be integrated within established information repositories and services. • Release of a PI dashboard that shows PI data across Canterbury DHB's inpatient services using coded data clinical records.