Canterbury District Health Board Serious Adverse Events Report

1 July 2019 – 30 June 2020

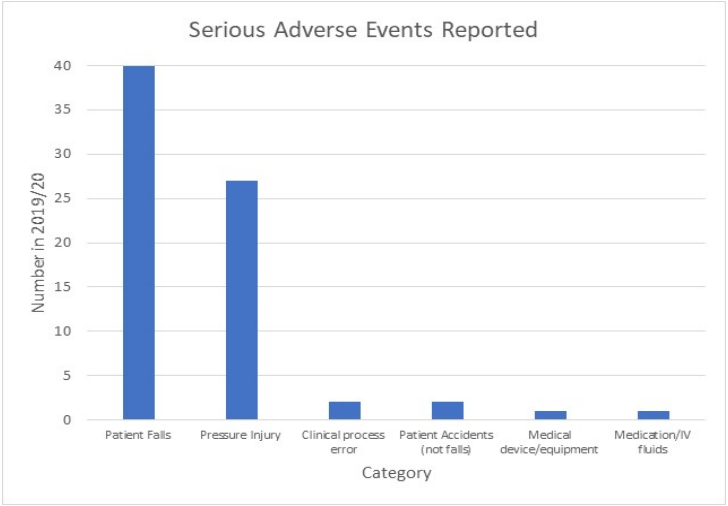
At Canterbury DHB our person-centred, clinically-led culture supports our commitment to 'zero harm' and continuous quality improvement.

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.

All serious adverse events are reviewed through a formal process. The purpose of reviewing these is to provide sufficient information to patients and families about the contributing factors and causes of the event and how we intend to make our systems safer.

There were 77 serious adverse events reported out of the total of 13680 incidents reported by the Canterbury District Health Board (CDHB) in the year from 1 July 2019 to 30 June 2020. Of the total serious adverse events reported, 40 were inpatient falls and 31 were healthcare acquired pressure injuries. Events are classified in specific categories:

Category	Number
Patient Falls	40
Pressure Injury	31
Clinical process error	2
Patient Accidents (not falls)	2
Medical device/equipment	1
Medication/IV fluids	1



Note: Suspected suicide reports are excluded from this report.

Canterbury DHB has a strong incident reporting culture, as evidenced by 16664 incidents reported in the last financial year. Of these 13680 were clinical. With the ratio of reported clinical Severity Assessment Code (SAC) 1-2 rated incidents compared to SAC 3-4 clinical harm to no harm events to serious harm events 1 SAC 1-2 events: 177 SAC 3-4 clinical events.

Canterbury District Health Board Serious Adverse Events Report: 2019-2020

The report below summarises the findings and recommendations of the events reported.

Clinical Process Error	Review Findings	Recommendations/Actions
Excessive medication resulting in irreversible renal dysfunction	Review Underway	
Patient deteriorated rapidly and died	Review Underway	

Medication/IV fluids Error	Review Findings	Recommendations/Actions
Improper dose of medication administered requiring resuscitation	Review Underway	

Medical device/equipment	Review Findings	Recommendations/Actions
Intraoperative surgical fire resulting in burns	Review Underway	

Patient Accidents (not falls)	Review Findings	Recommendations/Actions
Inpatient missing person injured by car, transferred to ICU	Not yet started	
Left shin pretibial laceration	Left shin hit against walking frame while sitting down and supervised, sustaining a large laceration with skin tear requiring surgical intervention. Walking frame did not have any sharp edges or points that may have contributed to this injury. There were no obvious care failures or avoidable causative factors that may have contributed to this event	No recommendations.

HOSPITAL ACQUIRED PRESSURE INJURIES

Canterbury DHB is committed to ensure all steps are taken to prevent pressure injuries from developing while people are in our care. Pressure injuries (PI) [also known as pressure ulcers or bed sores] can occur if care is not tailored to the person's risk factors. PIs are considered mainly as a preventable adverse event. These injuries usually affect 'bony' parts of the body and are due to sustained pressure or from shear and/or friction.

Canterbury DHB has been proactive in preventing PIs, both the hospitals and the community, taking a 'whole of system' approach to implementing improvements.

In our Facilities

In 2019/2020 we treated 120,074 patients, using 374,338 bed days. A total of 706 hospital acquired pressure injuries were reported across our facilities. Of these PIs, 292 were stage 1 (reddened area), 381 were stage 2 with partial loss of the top of the skin (dermis), and 31 were confirmed as a stage 3, 4, unstageable or deep tissue pressure injury. Each hospital acquired pressure injury stage 3 or greater has an independent file review to determine contributory factors and to identify if there were any care management problems. These reviews are moderated by a multidisciplinary expert Review Panel which includes a consumer, and recommendations were made.

Improvements

Across the Canterbury Health System
Canterbury DHB is continuing to work closely with ACC to strengthen best practice across the health community through the implementation of a system wide Pressure Injury Prevention (PIP) Community of Practice which includes both Canterbury DHB and West Coast DHB.

The one-year PIP Link Nurse training programme was celebrated in December 2019 with a Pressure Injury showcase. Frontline nurses in any setting were trained to teach, promote, monitor/undertake surveillance, and support improvement processes with colleagues to deliver best practices in the prevention, assessment and management of pressure injuries. The Link Nurse Programme also taught quality improvement methods applied to pressure injury prevention. Over 30 nurses from both health systems participated.

The Canterbury and West Coast Pressure Injury Advisory Group meets regularly with the aim to improve clinical outcomes and standardise clinical best practice. This is achieved by producing clinical resources to use in practice across the sectors and districts utilising a 'it takes a team' approach to Pressure injury prevention.
There has been an upgrading of mattresses and full mattress replacement programme with mattresses able to be dual purpose pressure

HOSPITAL ACQUIRED PRESSURE INJURIES

reduction and the nurse adds a pump to the mattress it becomes pressure relieving. This means patients do not have to wait for a pressure relieving mattress or be transferred unnecessarily.

A Video - SSKIN and Positioning education was developed and has been shared with the Health Quality and Safety Commission.

The PIPE (Pressure Injury Protein Energy) Diet is being implemented across the facilities, led by the Medical Surgical Division commencing this diet for patients with PIs. This has been a joint project between Clinical Dietetics, the Canterbury and West Coast Pressure Injury Prevention Advisory Group and WellFood.

FALLS

Falls Prevention

Canterbury DHB has a 'Whole of System approach to falls prevention'. The DHB is committed to achieving zero harm as falls can have both a detrimental physical and psychological impact. Older people who 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 team take safe mobility and fall prevention very seriously, with focus on the following three key areas: (1) falls prevention in the wider community; (2) falls prevention in rest homes; and (3) falls prevention receiving care in our hospitals.

Strategies

In the community and rest homes

Falls Prevention is still a key focus for the health of older persons. In 2019/2020 1852 people aged 75+ or identified as a falls risk, have benefited from the Canterbury Community Falls Prevention Programme. The number of referrals received in this year has been impacted by COVID 19. The Falls & Fracture Service Level Alliance, which was established in October 2017 as a time-limited (3 year) group to

FALLS

enhance and improve the falls and fragility fracture prevention work in Canterbury has now concluded its workplan. Ongoing governance of this area will now pass to the Health of Older Persons Workstream.

As at the end of June 2020 11,785 places have been filled in community-based strength and balance classes aimed at further decreasing older person's falls. During lockdown, Sport Canterbury supported accredited providers to offer exercise opportunities to their participants, and 21 of the 40 accredited providers delivered online content during this period. Since lockdown has lifted, Sport Canterbury has re-engaged with some of the community groups who support culturally and linguistically diverse populations within Christchurch.

In our Facilities
In 2019/2020 we treated 120,074 patients using 374,338 bed days. From a total of 2,014 inpatient falls across all our hospital facilities, a quarter of patients were injured (544). There has been a reduction from 1.54 to 1.45 falls resulting in injury per 1000 inpatient bed days compared to the 18/19 year (40). This reduction has been sustained.

Of the fall events, 40 patient injuries were confirmed as resulting in a fracture or head injury (classified as serious harm) in the 2019/20 year. Each serious harm fall has an independent file review to determine contributory factors and identify if there are any care management problems. These reviews are moderated by a multidisciplinary Review Panel and recommendations are made as required.

There continues to be a focus on safe mobility, identifying risk factors and tailoring falls prevention strategies to meet the needs of individual patients while they are in hospital, and at home.
There is an ongoing focus of patients using appropriate footwear in hospital and bringing in their walking aides they are used to.

Partnering with the patient/whanau and empowering them to keep safe while in hospital continues to be an important part of our hospital falls prevention strategy. This includes discussions around the patient's potential risk of falling and prevention strategies as well as providing them with educational material.

Improvement activities include standardising process and practice such as the use of aides to indicate a patient's safe mobility level (e.g. wrist bracelet) and visible bedside safe mobility plans for all inpatients. Bedside handover and the use of Bedside Boards are examples of encouraging and enabling opportunities for patients and their whanau to be more involved.