Canterbury District Health Board Serious Adverse Events Report
1 July 2016 – 30 June 2017

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.

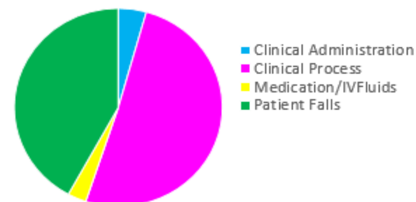
What is a serious adverse event?
A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

There were 73 serious adverse events reported by the Canterbury District Health Board (CDHB) in the July 2016 to June 2017 year. Following in-depth investigation it was established that 4 of the national reported events did not fall in the category of being a serious adverse event. Of the total serious adverse events reported, 29 were inpatient falls and 20 were Hospital Acquired pressure injuries

The report below outlines the summary, findings and recommendations of the events reported. The events have been classified into four specific themes:

- Clinical administration error
- Clinical process error
- Medicine/IV Fluids error
- Falls

CDHB Serious Adverse Events
1 July 16 - 30 June 17



Canterbury District Health Board Serious Adverse Events Report: 2016-2017

Clinical Administration Error (01)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Incorrect identification of patient led to unnecessary tests being undertaken	An incident review has been completed and a report is being drafted.		
Outpatient appointment not booked as intended	No closed loop process in place to capture if bookings are not made as intended. Possible false assumption that as the patient transferred to another facility prior to discharge the appointment would be made at that point.	A discharge checklist with request for follow-up has been developed and is now incorporated as part of the clinical documentation. To introduce a newly-developed electronic referral process that will allow for closed loop feedback.	Complete
Outpatient appointment not booked as intended	No closed loop process in place to capture if bookings are not made as intended Inconsistent application of processes for informing booking staff of the need for patient follow-up.	The process for post-operative follow up appointments is to be reviewed to eliminate the variation in practice and reduce opportunity for error to occur. A closed loop feedback process is to be developed to ensure that all post-operative patients have a booking made as intended. An audit is to be undertaken at 3 months post implementation to ensure that recommendation above are working as intended.	

Clinical Process Error (02)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Retention of a foreign body	Distraction of operator due to interruptions in a non-operating theatre environment. Poor global product design contributed to risk of the item being retained. No post-procedure reconciliation of all equipment was conducted.	Redesign of procedure to eliminate cause of distraction. Introduction of equipment check at end of procedure. There are currently no alternative product options available. Manufacturer has been informed of poor design for safety.	Complete

Delayed diagnosis	No process in place at the time to confirm results were read and acted upon. The test result showed other findings (incidental) which were not acted upon. No automated closed loop system to alert clinicians of an incidental finding.	Introduction of an automated closed electronic loop monitoring system for abnormal results to alert clinicians and trigger action/follow-up	
Post-procedure complication	Departmental protocol did not allow for deviation from normal referral process and as the patient was managed by a different speciality they were unaware that normally pre-procedural antibiotics were to be given. Patient factors may also have influenced outcome [sepsis].	Changes made to the departmental protocol to allow for planned variation from routine referral process.	Complete
Post-procedure complication	Absence of a clear pathway to aid pre-procedure planning for complex patients who are being cared for by multiple specialities.	Prompts to be developed within the electronic booking system for the procedure that links to the Hospital HealthPathways to provide guidance on similar complex patients, including pre-procedure antibiotics.	
Misdiagnosis	An incident review has been completed and a report is being drafted.		
Delayed treatment	An incident review has been completed and a report is being drafted.		
Missed diagnosis	An incident review has been completed and a report is being drafted.		
Delayed diagnosis	An incident review has been completed and a report is being drafted.		
Delayed diagnosis and treatment	Unfamiliarity with performing screening tests in primary care combined with unfamiliarity with performing screening tests at an age after which a diagnosis has usually been made and absence of a clinician-led triaging and prioritisation system led to the outcome in this case.	Information regarding this case was shared with primary care provider. Prioritisation/triaging, e-text reminder, appointment non-attendance and electronic ordering systems to be implemented in the department.	Complete
Baby born in poor condition	Scheduling of training and absence of available guidance for staff contributed to the outcome in this	Training schedules have been adjusted and a project is to be implemented to	Complete

	case.	review documentation, tools and processes.	
Baby born in poor condition	Ambiguous terminology used verbally and in clinical guidelines along with the design of documentation and communication processes between the clinicians contributed to this outcome.	Terminology in local and national guidelines is to be amended and review of documentation, tools and processes to be completed.	Complete
Baby born in poor condition	Review underway.		
Baby born in poor condition	Miscommunication between staff and patient and staff work practices led to the outcome in this case.	Changes made to documentation to highlight when English is a second language. Introduction of new tools to assist in communicating with patients for whom English is a second language. A change in work practice is introduced along with an amendment to a clinical guideline.	Complete
Retention of foreign body	Review underway.		
Incorrect treatment	Review underway.		

Medication/IV fluids (05)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Incorrect dose of medication	Related to inconsistency of training, limited guidance material available and unclear prescribing practices.	One method to be taught to junior staff. Readily available guidance and clarity on prescribing requirements.	Complete
Incorrect dose of medication	Review underway.		

FALLS

Strategy

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 three key areas - falls prevention in the wider community, falls prevention in rest homes, and falls prevention for people receiving care in our hospitals.

In the community and rest homes

Over the past year, the Canterbury Community Falls Prevention Programme saw over 2,600 older people. Following an initial home visit from a physiotherapist or registered nurse, a home falls assessment and hazard check is completed, and a personal falls prevention programme is tailored to improve strength and balance and reduce the risk of falls.

Current evaluation for 2016/17 indicates that there is a decrease of 25% from expected volumes based on pre-intervention trends in the people over 75 years presenting to the Christchurch Hospital Emergency Department due to a fall. The evaluation also found that there has been 648 fewer-than-expected admissions for hip fractures and 222 fewer deaths post hip fracture than predicted due to a fall in the community since the programme began in 2012.

To further our ‘whole of system’ approach, we are now working closely with an ACC appointed lead agency to co-ordinate existing community strength and balance classes with the aim that 12,000 places will be available for older people in Canterbury over the next 3 years.

In our hospitals

29 patients had a fall resulting in serious harm while a patient in our hospitals during the 2016/17 year. 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 falls 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 which are incorporated into the bedside boards, inclusion of care planning for use of ensuites on bedside boards, monitoring and feedback of falls prevention results, Releasing Time to Care activities such as intentional rounding and bedside handover, the annual Falls Awareness Campaign, reviewing policies, and progressing key projects.

In the 2016-2017 year, the Access to Walking Aids project identified that some patient groups would benefit from using their own walking aids whilst in hospital. A non-slip sock audit took place and identified the need to reframe the use of non-slip socks to a temporary measure until appropriate footwear can be brought in. The findings from both these activities will be progressed with other similar work around ‘bringing in personal belongings’ (i.e. footwear, clothing and walking aides). The new purpose purpose-built facility for Older Persons Health (at Burwood Hospital) environment has also had a positive impact on reducing the number of falls, along with other falls prevention initiatives such as Bedside Boards (which now have a bathroom safety section, are bigger and positioned to encourage interaction with patients and their families), team based nursing, intentional rounding and bedside handover - all of these changes have contributed to the decreasing number of falls in Older Persons Health. A new Falls Assessment section was developed for junior staff use and is included in Hospital HealthPathways.

The electronic incident management system also continues to provide access to data to identify trends and focus future improvement work.

HOSPITAL ACQUIRED PRESSURE INJURIES

Strategy

Canterbury DHB is committed to ensure all steps are taken to prevent pressure injuries (PI) from developing while people are in our care. PI are considered to be largely preventable and are identified as an adverse event in health care delivery. Despite the implementation of evidence- based systems and guidelines for PI prevention and management, PI continue to occur. 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, use of appropriate pressure relieving equipment, repositioning and appropriate mobilisation of the patients/clients, promoting safe patient handling practise, and optimal nutrition and continence management.

The Canterbury Health Pressure Injury Advisory Group aims to improve clinical outcomes and standardize clinical practice across the District. The Group has been proactive in developing and implementing PI prevention strategies which range from the mattress replacement programme, 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.

In our hospitals

20 patients were reported to have developed a serious Pressure Injury whilst in a Canterbury DHB hospital in 2016/2017. Each case had an independent file review to determine contributory factors and care management problems, with recommendations made.

Across the Canterbury Health System

To further our ‘whole of system’ approach, we are working closely with ACC to strengthen of practice across the health community using their recently published guidelines aimed at Pressure Injury Prevention.