Canterbury District Health Board Serious Adverse Events Report

1 July 2018 – 30 June 2019

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

Canterbury DHB has a strong incident reporting culture, as evidenced by 17,671 incidents reported in the last financial year. Of these 14,655 were clinical. With the ratio of reported clinical Severity Assessment Code (SAC) 3-4 rated clinical harm /no-harm incidents compared to SAC 1-2 serious-harm events 142.3:1.

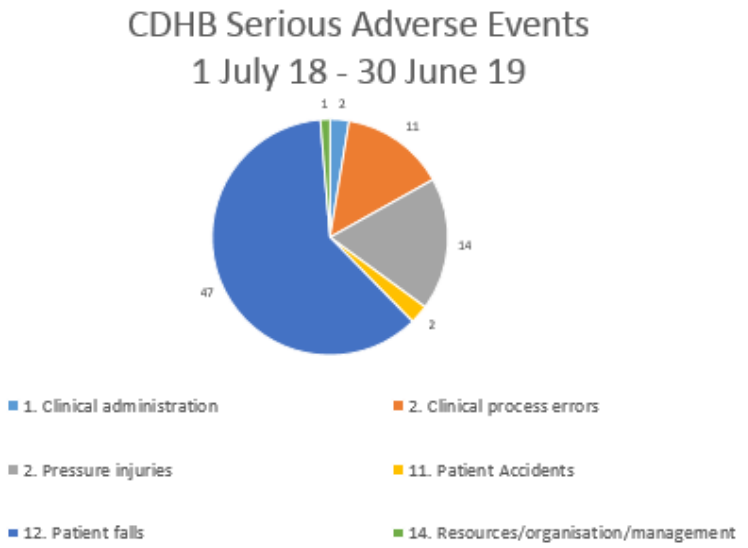
All serious adverse events are reviewed through a formal process. The purpose of reviewing these is to provide sufficient feedback to patients and families so they are aware of contributing factors and causes of the event and how we intend to make our systems safer.

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 77 serious adverse events reported out of the total of 14,373 incidents reported by the Canterbury District Health Board (CDHB) in the year from 1 July 2018 to 30 June 2019. Of the total serious adverse events reported, 47 were inpatient falls and 14 were Hospital-Acquired pressure injuries.

The events have been coded into six specific themes:

- Clinical administration – code 1
- Clinical process error – code 2
- Pressure Injury – code 2
- Patient Accidents (not falls) – code 11
- Patient Falls – code 12
- Resources/Organisation/Management – code 14



Canterbury District Health Board Serious Adverse Events Report: 2018-2019

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

Event	Review Findings	Recommendations/Actions
Delay in semi urgent CT colonography request being processed	Review underway.	
Delay in colonoscopy request being processed	Review underway.	

Event	Review Findings	Recommendations/Actions
Patient readmitted, septic and hypothermic, rapidly deteriorated.	Review underway.	
Patient with severe type 2 respiratory failure rapidly deteriorated.	Review underway.	
Baby born in poor condition and was unable to be resuscitated.	A non-symptomatic infection caused extensive pneumonia in fetal lungs. A previously normal Cardiotocography developed abnormal features which led to an insertion of an epidural soon after a significant fetal heart rate deceleration. Further abnormal features of the Cardiotocography were attributed to the effect of the epidural. This led to a delay in determining the need for further assessment and resulted in a delay in delivery. It was found that there was insufficient guidance around administering epidural analgesia. The on-call rostering model and practice around when to call the second on call Specialist Obstetrician meant a Specialist Obstetrician was managing a steadily busy Birthing Suite during the day and overnight	The on-call Specialist Obstetrician roster has been reviewed. The epidural Analgesia in Labour Guideline has been amended. The details of this case have been shared with the midwifery and obstetric teams for learning purposes.
Patient with misplaced long line, which delivered fluid to pericardial sac causing cardiac arrest.	Draft report completed	

Baby born in poor condition	Draft report completed	
Child with pneumonia collapsed	Draft report completed	
Baby born in poor condition	Draft report completed	
Baby stillborn.	There was no formal admission process to prompt staff to ask if the patient had evidence of possible rupture of membranes. The relevant DHB clinical guideline did not contain information from the amniotic fluid testing product regarding appropriate use and potential for false negative results. Reliance was placed on the accuracy of the results of the amniotic fluid testing product and this overrode the history of ruptured membranes and meconium stained liquor provided by the patient. There was no process for producing a discharge letter following an antenatal admission to the birthing suite therefore creating a missed opportunity to ensure the presenting condition had been addressed. Incorrect information was entered onto the patient board that resulted in no further investigation of a possible diagnosis of ruptured membranes. A recognised framework for working through the two possible diagnoses was not in use which resulted in the patient being discharged with no diagnosis directly related to the presenting condition.	An 'admission assessment/triage record' is implemented. The Pre-labour Rupture of Membranes Guideline is amended. The amniotic fluid testing product has been immediately withdrawn from use from all of this DHB's facilities and a decision made whether to introduce an alternative product or cease using these tests. The documentation and communication process for patients being discharged from birthing suite is reviewed and revised as required. Staff are advised that clinical records remain the best source of information and not to rely on information on the patient board. Consideration is given to the implementation of the Clinical Excellence Commission 'Take 2 – Think, Do' framework.
Patient suffered a cardiac arrest following anaesthetic	Draft report completed	

Patient injury, un-displaced left femoral shaft fracture, sustained while practicing with physiotherapist.	The physiotherapy care plan was found to be appropriate and safe for patient however due to cognitive impairment, the physically able patient did not remember which leg to use to ascend and stepped using the wrong (left) leg before physiotherapist could advise which leg to use.	No Recommendations.
Suspected seizure	Review underway	

Event	Review Findings	Recommendations/Actions
Left scapular (shoulder) fracture	Review not yet completed – team formed	
Resident in Rural Hospital under GP care. Seizure in wheelchair. Left peri-prosthetic fracture	Draft report	

Event	Review Findings	Recommendations/Actions
Patient deterioration while awaiting surgery	The patient's neurological condition deteriorated whilst on the waiting list for spinal surgery. The patient sustained loss of function that could not be reversed with his subsequent surgery. There were no processes in place to inform patients waiting for spinal surgery of the possibility of serious complications that can occur and the need for urgent assessment. The service delivery model for patients waiting for Spinal Surgery was the same as for other Orthopaedic Surgery. Due to no agreed solution as to how to manage the increasing demand for acute spinal surgery without a corresponding plan to manage the elective surgery, surgeons were no longer being routinely informed when a patient made contact with the service. There was no alternative pathway for oversight of this group of patients.	That the pilot model (described below and currently underway) for managing access to acute and arranged surgery for spinal patients be continued until such a time as it becomes the new way of working, or an alternative model is put in place that manages the risks identified in this report. All patients who are placed on the waiting list for Spinal Surgery are informed verbally and in writing of the risks and signs and symptoms of developing cauda equina and the immediate action they are to take should this occur. This is to be documented in the patient's clinical record. The pilot model of service delivery for the acute spinal patient involves reallocation of the existing Orthopaedic theatre resources to allow for more to be allocated to spinal surgery. This has improved access to ensure that acute patients are accessing theatre in a timely manner and that operations are not having to be done out of hours. It was anticipated that these sessions would be used for the acutely

		injured spinal patient and for any of the elective patients that have been accepted onto the waitlist and posed a clinical risk of deterioration. This commenced on the 14th January 2019. To support coordination of this spinal patient activity, a spinal nurse coordination position was created for the pilot. A pathway is in place and known by staff to ensure that any information from a patient who has suspected symptoms of cauda equina is conveyed immediately to the responsible clinician. That the elective spinal service is closely monitored to ensure that planned additional resources are sufficient to match that of the demand.

FALLS

Falls Prevention

The Canterbury Health System is working to reduce the incidence of falls in our hospitals and reduce in our communities.

Strategies

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 effect. 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 team take a fall in hospital very seriously and are focusing on the 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.

In the community and rest homes

Falls Prevention is still a key focus for the health of older persons. In 2018/2019 1531 people over 75 years of age have benefited from the Canterbury Community Falls Prevention Programme. The Falls & Fracture 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. It continues to work in partnership with ACC and Sports Canterbury. As at the end of April 2019 18,485 places have been filled in community based strength and balance classes aimed at further decreasing older person's falls. Sports Canterbury has also worked on developing accredited classes for the culturally and linguistically diverse community; this group currently includes Maori, Pacifica, Indian and Muslim groups. Other initiatives that are currently ongoing include piloting an automatic referral process to the Community Falls Prevention Programme for those that have been discharged from hospital with a fracture of the humerus or a fractured neck of femur.

In our Facilities

From a total of 2,315 patient falls across all our inpatient facilities, a quarter of patients are injured and 47 patient fall events were confirmed as resulting in a fracture or head injury (classified as serious harm) in the 2018/19 year. Each serious harm fall has an independent file review to determine contributory factors and identify if there were any care management problems. These reviews were moderated by a multidisciplinary Review Panel and recommendations were made.

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 at home. Partnering with the patient/whanau to keep them safe while in hospital continues to be an important part of our hospital falls prevention strategy. This includes discussions around the patient's potential falls risk and prevention strategies as well as providing them with educational material. Routine activities include standardising process and practice such as the use of visual cues to indicate falls risk and bedside safe mobility plans for all inpatients. Empowering patient family/whānau is a key focus. The introduction of Bedside handover and the use of Bedside Boards are examples of encouraging and enabling opportunities for patients and their whānau to be more involved and in the centre of care.

There has been a 5% reduction in Falls resulting in injury per 1000 inpatient bed days compared to the 2017/2018 year.
As per 18 November 2019, 36 Falls reviews are completed out of the 47 reported.

HOSPITAL ACQUIRED PRESSURE INJURIES

Pressure injuries occurring during care (also known as pressure ulcers or bed sores) are considered preventable. These injuries usually effect 'bony' parts of the body due to sustained pressure, or pressure combined with shear, when there is a pulling of the skin across the bones which damages the skin and/or friction.

Strategies

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

Across the Canterbury Health System

The Canterbury Pressure Injury Advisory Group (CPIAG) aims to improve clinical outcomes and standardise clinical practice across the District. The Group has been proactive in developing and implementing Pressure Injury Prevention (PIP) 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 pressure injury prevention e-learning package, updating the Canterbury DHB PI Policy and supporting documents, enhancing pressure injury prevention communication across Canterbury by including community providers on the committee, sourcing and distributing staging lanyards, SSKINS posters/information and by holding numerous pressure injury prevention activities for World Stop Day each November.

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 Community of Project which includes both Canterbury DHB and West Coast DHB.

Key initiatives aimed at reducing pressure injuries in the 2018/19 are inclusive but not limited to

- Completed stocktake of pressure injury resource requirements and activity for Canterbury DHB and community and Aged Residential Care on West Coast and Canterbury Community, with plans now to standardise resources, allocate central repositories and update distributions lists and channels.
- Pressure Injury Prevention Link Nurse programme has commenced which is frontline nurses in any setting being 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 is teaching quality improvement methods applied to pressure injury prevention. There are more than 40 nurses from both District systems participating.
- HealthLearn Community of Practice online forum to support and assist health professionals in all settings to share and develop knowledge and skills in pressure injury prevention and management.
- Consistent messaging by updating and improving online resources i.e. HealthInfo and HealthPathways Information, including consumer health information media, i.e. WellNow Canterbury DHB community magazine and other health consumer publications online i.e. Eldernet website, St John, Corrections Newsletters and developing ongoing prevention communication plan.
- National learning package for non-regulated and regulated workers, currently in final draft with technical writing to begin next
- Equity of Access to Pressure Reduction Equipment completing as stocktake hospital and community wide and a needs assessment with recommendations for improved practice.

HOSPITAL ACQUIRED PRESSURE INJURIES

- Mattress replacement programme is being rolled out.

In addition, in Canterbury DHB facilities
Routine activities to prevent pressure injuries include use of comprehensive assessment, including past history of a pressure injury, skin condition, to identify risk factors such incontinence, nutrition issues, mobility problems, devices (e.g. catheter) pressing on skin, during care. The inclusion of prevention strategies into patient care plans such as the 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 are helping reduce pressure injuries.

14 hospital acquired pressure injuries were confirmed in 2018/19 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 were moderated by a multidisciplinary Review Panel and recommendations were made.

As per 18 November 2019, 12 Pressure Injury reviews are completed out of the 14 reported.