Capital & Coast District Health Board
Clinical Serious Adverse Events Report: 2017-2018

During the period 1 July 2017 to 30 June 2018 Capital and Coast District Health Board (CCDHB) had **26** Clinical Serious Adverse Events (SAEs). These SAEs occurred in our hospital which meant that patients suffered harm or death whilst in our care. We sincerely apologise to the patients and family/whanau involved in these cases and acknowledge the distress and grief that occurs when things go wrong in healthcare.

Our practice is to communicate openly with patients and family/whanau at all times, including when adverse events occur, to acknowledge what has happened and to apologise. We listen to concerns, provide support, and involve patients and family/whanau in the review to the degree they prefer, and answer their questions and address any concerns that they have.

We rely on events being reported by the people involved and for this to occur we require a just culture that focuses on improving systems and not blaming individuals. We want our patients and their family/whanau, other health providers such as family doctors and primary health nurses, and our own staff to tell us when an incident has occurred and raise concerns, so that we can look into what has happened to try to minimise the chance of a similar event happening again. When reviews result in recommendations for changes and action, we ensure that these are followed up and implemented, thereby enabling a continually improving patient safety culture.

The 2017/18 SAEs are reported to the Health Quality and Safety Commission (HQSC) according to category. CCDHB's report excludes adverse events categorised as *behavioural*, as advised by the HQSC. For CCDHB the clinical serious adverse events are as follows:

CATEGORY	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Clinical Processes	9	17	9	5	**11**
Patient Falls	10	7	11	12	**14**
Medication/IV Fluids	2	2	1	1	**0**
Patient Accident	0	0	0	1	**0**
Medical Device	0	0	0	0	**1**
Total	21	26	21	19	**26**
Of the 26 events in this report *one is from the 2016/17 year*. This was not included in the 2016/17 report because their severity assessment rating was confirmed after the cut-off date. Since the date of reconciliation with the HQSC, the severity assessment code rating of one event was reviewed and was found not to be due to system or process failures.					

1

Event Summary: A patient was admitted to hospital after having fallen at home. Whilst they were on a ward the patient had an unwitnessed fall which resulted in a fracture of their femur. The fracture required surgical repair.

REVIEW

Key findings: The Review Team found that the patient was assessed as a falls risks and had a care plan in place which was reviewed daily. The patient had been moved several times in the two weeks since admission to hospital and had been moved to the new ward the same afternoon of the fall. At the time of the fall, the patient had been placed in a standard bedspace (not a 'high visibility' area). The Review Team found that at the time of the fall, there were insufficient staff available to monitor patient movements, in part because nursing handover was in progress. Whilst the nursing assessment and management plan for cognitive impairment and mobility concerns had been clearly documented in the clinical notes, this same information had not been transcribed into other clinical tools, including the TrendCare handover sheet.

Improvements Made: The ward where the event occurred has worked on implementing all of the recommendations from this review. This required a particular focus on ensuring that clinical information about each patient's risk of falls is communicated effectively between nursing staff, physiotherapists, and the patient/family. Clinical staff now correlate the falls information that is used on the electronic Whiteboard, TrendCare, progress notes, care plans, and signaling system. Nurses also regularly reassess each patient's risk of falling and the mobility equipment required. For patients who have fallen, the falls reassessment now includes assessment for low beds, sensor mats and placement in a high visibility area.

2.

Event Summary: Whilst being admitted to the hospital, a patient experienced delays in clinical assessment and treatment, and subsequently had a cardiac arrest and died.

REVIEW

Key findings: A patient was referred to the Emergency Department (ED) by a General Practitioner, due to the patient experiencing chest pain, and had an associated rise in a blood result. During the admission process there were communication failures, with key information either being delayed or not communicated effectively to the right people. The Review Team identified that both the patient's medical assessment and initiation of the treatment plan were delayed, and there were a number of factors that contributed to this delay.

Improvements Made: The Review Team made a number of recommendations to minimise ED overcrowding and improve acute flow, including development of effective referral processes, clinical policy and safe patient management pathways. CCDHB is implementing the Care Capacity and Demand Management programme, which focuses on quality patient care, best use of health resources, and developing a quality work environment. In practice this aims to make best use of staffing resources e.g. if ED is overcrowded then the Duty Nurse Manager uses TrendCare to identify wards that have positive variances in staffing. In these instances nurses will be 'gifted' to ED to provide help. Work is also underway educating external health providers to use Healthpoint Clinical & Referral Guidelines for all referrals.

External Review: The Health & Disability Commission reviewed the care CCDHB provided, and their findings and recommendations were consistent with those from CCDHB's internal review.

3.

Event Summary: The patient was admitted to hospital with back pain following a fall at home. During their hospital stay, the patient had a fall, which resulted in a fractured humerus that was conservatively managed.

REVIEW

Key findings: The patient was assessed as a falls risk on admission and had a care plan in place which was reviewed and updated daily. The review team found, however, that the patient had not been placed in a high visibility area. The patient had experienced periods of confusion and disorientation within an hour of the fall, but was easily directed back to bed both times. A call bell was in reach and the patient had generally used it appropriately, but not every time. The clinical notes and care plan clearly identified the specifications for mobility aids, assistance required and the need for regular ward rounds on the night shift to assess the patient.

Improvements Made: In response to this incident, the ward has developed and implemented 'intentional rounding' in 5 clinical areas. This process provides patients with greater accessibility to nursing staff during critical times e.g. at handover. New equipment has been piloted and the resources have been secured for purchasing sensor mats, visi-beams and low beds. Diversional therapy equipment (clocks, memory boards, twiddle mits) have been purchased for all wards, specifically to help confused, delirious or anxious patients.

4.

Event Summary: An infant died as result of birth trauma

REVIEW

A Coroner's review is in progress.

5.

Event Summary: A patient unexpectedly died due to medicine toxicity

Review in progress

6.

Event Summary: A patient had multiple admissions to the Emergency Department (ED) over a month. The patient was found to have toxic levels of a medicine, which had not been identified in previous hospital visits. This led to a prolonged period of debilitation and recovery.

REVIEW

Key findings: A patient had multiple admissions to the Emergency Department (ED) over a month, with seizures and deteriorating functioning and mobility. On the third admission the patient was found to have higher than the normal therapeutic range levels of a medicine. The medicine was ceased immediately and a thorough review and discussion was had with the Team. The Review Team found that the signs of medicine toxicity were apparent at the patient's second presentation to ED. These signs were not recognised at the time and an alternative diagnosis was made. The Review Team found no evidence that the guidelines were followed for the prescribing and monitoring of the medicine. The patient became toxic and this contributed to decreased functioning and mobility, and an increased length of hospital stay and recovery time.

Improvements Made: The findings of this report were presented to senior clinicians and staff in the hospital, so that lessons could be shared, and to inform practice. In addition, action plans were developed around providing further education to staff about appropriate monitoring of medicine levels as per guidelines. This promotes best practice and reduces the chances of a similar event from occurring.

7

Event Summary: A patient fell on a ward and sustained a fractured humerus and a skin laceration.

REVIEW

Key findings: The Review Team found that the patient was assessed as a falls risks on admission and had an appropriate care plan in place which was reviewed daily. The patient was in a high visibility area, and although staffing was appropriate, the nurses were busy with other patients at the time of the fall. The patient was being cared for in a low bed (to reduce the risk of the patient falling), but the bed had not been positioned correctly. The patient's call bell was within reach, although on investigation it was found that this was under-used. The Review Team found there was good planning and management of the identified risk of the patient falling, as evidenced in the clinical notes and nursing care plans. This included clear identification of required mobility aids, assistance required, and need to have a patient observation and engagement (POE) health care assistant (HCA) in attendance.

Improvements Made: The Review Team made recommendations in relation to staffing and management of 'at risk' patients. The ward has incorporated these into daily practice, and established that the high visibility room should be staffed by no less than one HCA and one registered nurse. Changes to practice have also included having a safety huddle every hour, which provides support to staff in the high visibility room, and provides the opportunity for the nurses to re-assess each patient's needs and re-evaluate the effectiveness of the care provided. Multi-Disciplinary Team members are now rostered to support staff allocated to this room. In response to this incident, focused teaching has been established for HCAs, and all HCAs now get one extra study day a year focussed on observation and engagement strategies to reduce the risk of falls, and how to safely manage delirium and confusion.

8

Event Summary: A patient experienced complications of a procedure. The patient subsequently died.

REVIEW

A Heath and Disability Commission complaint is in progress.

9

Event Summary: A patient fell in hospital and sustained a fractured femur. The fracture required surgical repair and rehabilitation over a prolonged period of time.

REVIEW

Key findings: The Review Team found the nursing staff had appropriately planned care for the patient that helped minimise disorientation, such as nursing the patient in a low bed, in a low stimulus room. Consideration had been given to placing the patient in a high visibility room, but it was agreed this would have increased the patient's agitation. The nursing risk assessment and care plan for falls had been completed as per policy guidelines and were appropriate to the patient's condition. After the fall there was a medical review and a multidisciplinary 'Safety Huddle' to review the event, although these were not documented in the patient's notes.

Improvements Made: As a result of this incident, Safety Huddles have been included in the 'Reducing and Managing in-patient Falls' policy. This policy is organisation-wide, which means that all adult inpatient areas will follow the same process. Safety Huddles improve teamwork and communication of clinical information specific to each patient, and help reduce the chances of falls from re-occurring. The process includes completing a sticker in the clinical notes following a fall and reviewing the effectiveness of the falls management plan. In addition, physiotherapists now document their mobility assessments in the care plan, which had previously been considered a nursing-only document. The nursing handover tool TrendCare was identified as an under-used resource, and the handovers notes are now used to help identify patients who have previously fallen.

10

Event Summary: A patient was admitted to hospital and within a few hours of being transferred to a ward, fell and sustained a fractured arm.

REVIEW

Key findings: The Review Team found a number of contributing factors led to the fall. In terms of the physical environment, the patient was in an unfamiliar environment and had been moved from ED to the ward and then to an isolation room within hours of the fall. The isolation room was not in a highly visible area and the fall occurred during nursing handover, a time when staff were pre-occupied with handover. The nursing assessment had identified the patient as at risk of falls on admission, however the risk assessment was inaccurate and did not have a plan to reduce the risk of falling. The Review Team also found that the nurse's workload was greater than they could provide, which may have contributed to poor planning and documentation of falls risk and mitigation planning.

Improvements Made: The Review Team recommended DHB-wide implementation of the 'Safety Huddle' when falls risk is identified, and that the 'Patient Admission to Discharge Plan' is updated to include space for subsequent falls risk assessments. A third recommendation was the nurse coordinator on duty must oversee patient load allocation and ensure it is appropriate. These recommendations have been implemented.

11

Event Summary: A patient was transferred between hospitals, with a severe headache and their diagnosis of a bleed was delayed. They had emergency surgery with a poor recovery. The patient was taken home, and passed away in the care of their family.

REVIEW

Key findings: The Review Team found there had been poor communication of the transfer, which was not phoned through to notify ED in advance of arrival. The ED was overcrowded and so the patient was initially placed in a corridor. The patient subsequently deteriorated and was then moved to a resuscitation room. The patient had emergency surgery and was transferred to ICU post-operatively. The Review Team found there were missed opportunities to identify the risk for the patient's rapid deterioration.

Improvements Made: The Review Team made a number of recommendations focussing on improving referral systems, overcrowding, acute flow and resourcing within ED. ED were also asked to continue development of a 'headache' pathway. In addition there were specific recommendations to the referring hospital to develop more comprehensive processes for acquiring patient information and transferring patients to ED. The ambulance service were provided a copy of this full report for learning.

The ED department has implemented a process for adding alerts to the ED electronic system and electronic health record for patients taking anticoagulant medicine. The headache pathway has been adapted and implemented. CCDHB is scoping a project to review processes for acute same-day referrals to ED from primary care and other sources, and the policy has been reviewed and updated. CCDHB are looking at options to manage the risk of patient harm due to delay in ED assessment as a result of ED resource being used to care for patients awaiting admission. This includes improving acute flow through ED, and one work stream is underway scoping the transfer of stable patients to the wards ahead of when a bed is available. ED are developing a protocol for 'caring for patients in emergency department corridors' to ensure those patients placed in corridors are appropriate, and are managed safely and effectively.

12

Event Summary: A woman experienced a prolonged labour and birth of baby with brain injury

REVIEW

Review in progress

13

Event Summary: An infant died as a result of co-sleeping

REVIEW
A Coroner's review is in progress.

14

Event Summary: A woman experienced increased bleeding after a routine caesarean section and birth of her baby. On investigation, the source of bleeding could not be found and the decision was made to proceed to hysterectomy. After the uterus had been removed, it became evident the source of bleeding was a vaginal tear, which was subsequently repaired and the bleeding stopped.

REVIEW
Key findings: The Review Team found there was a delay between the decision to perform a caesarean section and the woman undergoing the procedure. This meant the infant was further into the pelvis and may have made delivery of the head more difficult, and contributed to the woman sustaining injury. The Review Team believe the obstetric surgeon was unaware of the severity of the woman's condition while in recovery, and that communication of high doses of blood pressure medication could have been clearer between teams. The findings are in context of a busy shift where competing priorities made management complex.

Improvements Made: The Review Team recommended that triggers are developed for when an additional consultant must be called in to provide assistance; and anaesthetists to provide significant clinical information to the rest of the team during 'Sign Out' at completion of the surgical case. Recommendations were also made to develop postpartum haemorrhage triggers for consultant involvement when blood loss is estimated at over 1500mls, and for a postpartum haemorrhage kit on Delivery Suite to be regularly checked.

15

Event Summary: A patient fell on a ward which resulted in two fractures of their arm and bruising. The patient did not require surgery and was conservatively managed.

REVIEW
Key findings: The Review Team explored all aspects of the events surrounding the fall, including environmental, clinical, and patient-related factors. The Review Team found the nurses caring for the patient had accurately assessed the risk of falls, and that the care plan was appropriate and reviewed each day. The nurses regularly checked the patient during the night shift, although the patient was not moved to a high visibility area. The clinical notes and nursing care plan identified the need for mobility aids and a plan was in place that matched the identified need with additional assistance and observation. It was also clearly documented that the patient had a 'high falls risk status', owing to the medical status and intermittent confusion.

Improvements Made: The ward has focussed on observation and engagement, and at ensuring the appropriate levels of staffing and skill mix are in place, so that patients receive the most appropriate and safest care. Since this incident occurred, the Observation & Engagement working group has formed, which is responsible for

disseminating evidence-based practice for vulnerable patients at risk of falls or harm, or who need one-on-one observation. The ward is also working on using 'visual plans' at the bedside – these provide essential information about each patient's functionality e.g. walks with assistance to bathroom.

16

Event Summary: The patient experienced a fall as an inpatient, which resulted in a fractured humerus.

REVIEW

Key findings: The fall occurred after the patient had walked to an appointment in a different area of the hospital. Whilst the patient had a recent history of falls, and chronic health that affected touch and sight, the patient was not identified as a falls risk in the admission ward. The reason for this assessment is unclear.

Improvements Made: The Review Team recommended that falls risk assessments are done in all areas where patients are treated, not only in inpatient wards. Care plans derived from these assessments are to be aligned with patient's current condition and clear communication of these care plans between patient, family, and multi-disciplinary team. As a result of this event, the hospital has developed and piloted a new handover tool, specifically for confused patients. This has been used for inter and intra-hospital transfers and has been based on the ISOBAR communication tool. This has led to clearer communication between services.

17

Event Summary: A patient was admitted to Wellington hospital. Whilst on the ward the patient was witnessed to fall on the floor and sustained a fractured femur.

REVIEW

Key findings: The Review Team found that after the fall the patient was highly agitated and would not allow staff to conduct a physical examination or assessment. The immediate focus of care at this time was to minimise disorientation and agitation and promote comfort. The patient reported experiencing no pain throughout this event until the following day, when they were more lucid and able to tell staff about a new onset of acute hip pain.

Improvements Made: The Review Team found that at the time of the incident the fall was not documented in the medical notes. Corrective measures are being implemented for this cohort of patients at CCDHB. An inter-disciplinary working group has been formed, with expertise in mental health as well as physical health in the older adult patient group, to develop clear guidelines and protocols. This group meets every week in order to progress actions.

18

Event Summary: A patient had an unwitnessed fall resulting in a fractured femur. The fracture required surgical intervention.

REVIEW

Key findings: An initial falls risk assessment was undertaken and the patient was identified as being at risk of falls. The care plan reflected both mobility and functional ability as 'independent with supervision' and did not assess that mobility aids and assistance were required. Although the call bell was in reach, the patient had said that they felt it was not necessary to ask for assistance and had possibly stood up quickly, became dizzy, which led to loss of balance and subsequent fall.

Improvements Made: The Review Team have recommended comprehensive assessments regarding mobility, equipment and assistance needs; the introduction of mobility signage and the clear communication of the relevance of these to patient, family and all staff in the area. This has included the introduction of visual boards at bedsides to help orientate patients to the unfamiliar surroundings. New patient information leaflets have been developed, which educate patients and their family/whanau about their disorientation and associated risks.

19

Event Summary: A patient had a fall which resulted in a fractured femur and required surgical repair.

REVIEW

Key findings: The patient was in hospital for rehabilitation after a recent stroke and frequently walked to the bathroom with a stroller. The Review Team found that the nurses had appropriately identified the patient as a 'falls risk' in the nursing documentation. The nursing care plan reflected that the patient needed assistance with mobility and functional activities and an intensive multidisciplinary rehabilitation programme was in progress.

Improvements Made: The Review Team promoted the continuation of appropriate care planning and recommended the continual vigilance of the patient's current condition and changing needs. At times this can be difficult to achieve, particularly when patients are encouraged to mobilise early and become more independent during their rehabilitation. The ward where this incident occurred have actively engaged in trying to achieve a balance between early rehabilitation and preventing patients from falling. The ward now includes daily reviews of each patient's individual needs, which includes clear documentation of agreed plans of care.

20

Event Summary: A patient fell and sustained a fractured femur whilst trying to mobilise.

REVIEW

Key findings: The patient reported that the mobility aid had slipped, which led to the fall. The Review Team noted that strategies had been discussed with the patient about mobility/falls risk, and that these may not have been internalised due to mild cognitive impairment. The Review Team found that the patient was appropriately assessed as a falls risks and had a nursing care plan in place which included daily mobility reviews.

Improvements Made: As a result of this incident, a key focus at CCDHB has been to improve access to mobility equipment out-of-hours. This has led to shared mobility resources that nursing and allied health staff can access 24/7; not just in daytime business hours. The Review Team recommended that comprehensive, appropriate care plans are instituted for the individual patients. Teaching has since been provided to nursing staff around how to individualise care plans. As a result of this incident the safety huddle has been developed from 'post-fall' to now include 'pre-fall'. Staff report that this change has decreased the likelihood of serious harm occurring, as the falls review process is more proactive and focuses on prevention.

21

Event Summary: A patient fell and sustained a fractured femur and hip whilst on a ward. The patient underwent surgical repair.

REVIEW

Key findings: The Review Team found that the patient had been appropriately identified as 'at risk of falls'. The care plan identified that the patient needed assistance with mobility and functional independence. However the care plan did not specify factors that were unique to the patient, such as known deconditioning, weakness and dementia with new delirium. The patient was placed in a high visibility area, but there were reduced levels of staffing when the incident occurred. The Review Team noted that the patient had not been placed on a low bed nor had a sensor mat in place, and these were considered to be contributing factors to the fall.

Improvements Made: In response to this event, CCDHB has continued to develop 'Intentional Rounding' as a core component of safe patient care. Targeted education has been provided to nursing and allied health staff (physiotherapists and occupational therapists) regarding individual care planning, documentation requirements, communication formats and equipment. The ward now has a particular focus on improving the care provided to older and frail patients. Resultant of this there have been three study days focussed on complex care of older and frail patients; and these sessions have enhanced practice and will continue as part of annual training for all clinical staff at CCDHB.

22

Event Summary: A patient underwent elective surgery. Following surgery the patient had a cardiac arrest and subsequently died.

REVIEW

Key findings: The patient underwent elective cardiac surgery which was complicated by intra-operative bleeding, cardiac arrhythmias, development of lactic acidosis and coagulopathy. Following surgery the patient was admitted to ICU where they developed several post-operative complications that reduced the patient's likelihood of a positive outcome of survival. Monitoring and management of the patient during and after surgery was as expected and the teams responded appropriately to the patient's condition.

Improvements Made: The Review Team recommended that changes be made to the information provided to family, following a patient's death; as well as to the Bereavement information. Feedback has also been provided to the clinical committee as an agenda item for action.

23

Event Summary: A patient had an unwitnessed fall, which resulted in a fractured femur.

REVIEW

Key findings: The patient got out of bed to go to the bathroom and used the over-table for support. The table (which has wheels) moved and the patient fell to the floor. The Review Team found that the patient was assessed as a falls risks and had a care plan in place which was reviewed daily and had identified the need for mobility aids and assistance with mobility. The clinical notes reported occasional urinary incontinence during the hospital stay, frequent toileting habits and the use of an

incontinence pad to reduce accidental wetting if unable to reach the bathroom in time. It does not appear that information about these toileting habits was translated into an overnight plan for this patient.

Improvements Made: At CCDHB all of the tables with wheels have been replaced with tables that have brakes. Patient toileting regimes have been established with continence training and individual plans of care. Improvement projects have helped streamline the continence products, which has standardised those available on the wards, which has led to more effective continence management.

24

Event Summary: A patient fell and sustained a fractured femur which required surgical repair.

Review in progress

25

Event Summary: A patient experienced a cardiac arrest post procedure, which resulted in brain damage.

Review in progress

26

Event Summary: A patient had undiagnosed and untreated syphilis in pregnancy.

Review in progress