Capital and Coast District Health Board
Clinical Serious Adverse Events Report: 2018-2019

This is Capital & Coast District Health Board's 2018/19 annual report on clinical adverse events. These events, in the interests of transparency and learning, have been reported and reviewed by our provider services and externally reported to the Health Quality & Safety Commission. The lessons learnt provide an opportunity to improve processes and systems to prevent patient harm and inform quality improvement.

We offer our sincere apologies to the patients and Whānau/family involved in each of the events described in this report.

Between 1 July 2018 and 30 June 2019 Capital & Coast District Health Board reported a total of 37 confirmed Severity Assessment Code (SAC) 1&2 clinical events. This total excludes suspected suicides.

Category	2016/2017	2017/2018	2018/2019
Patient Falls	12	14	10
Clinical Process	5	11	25
Medication	1	0	1
Resources	0	0	1
Patient Accident	1	0	0
Medical Device	0	1	0
TOTAL	***19***	***26***	***37***

Of the 37 clinical adverse events:

- One is from 2017/18 report and should not have been included
- Two were from previous years and reported late to the HQSC and, therefore counted in this year's report.

The number of clinical adverse events reported by CCDHB has increased from last year. An increase in reported events does not necessarily mean an increase in harm; it is more likely to be as a result of better systems to identify existing harm. Auditing has identified under-reporting of serious medication events and supports the organisation-wide planned future focus on medication safety.

CCDHB's QIPS team have placed greater emphasis on reporting of ethnicity data to ensure that we provide the most relevant information, and analysis, that is available to the DHB.

What this increased review of ethnicity data has shown is that Māori, Pacific and other ethnicities, as well as those with disabilities, are over-represented in poor health outcomes, and this has been reflected within the events described in this report.

Ethnicity	Number
NZ Māori	1
Pacific People	4
Indian	3
Chinese	2
Other Asian	2
NZ European / Other European	25

Clinical process events make up the majority (68%) of reported events. Events relating to delayed recognition of patient deterioration have increased this year, and we believe this is related to the increased alignment with the national policy's SAC criteria (HQSC, 2017) and implementation of the New Zealand adult and maternity Early Warning Scores across our hospitals.

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There has been a reduction in the number of reported harm from falls this year. This reduction is encouraging, but each fall resulting in harm is devastating for the patient and their family. The DHB will continue development of the multidisciplinary programme for falls prevention and management.

Thematic analysis identified that communication systems and the way clinicians share information, was a contributing factor in 25% of the clinical adverse events. The DHB recognises the importance of effective communication skills and handover processes between clinicians and continues to develop and deliver communication learning programmes.

The DHB understands how important it is to continuously grow a patient centred culture that prioritises patient safety and supports staff to report when things go wrong, to learn from each event and improve provision of care. The DHB's Supporting Safety Culture programme includes *Speaking up for Safety* presentations for all staff about how to raise patient and staff safety concerns. To date, over 80% of staff have attended. Staff are encouraged to report any events into the electronic reporting system.

The following report provides de-identified summaries of each event.

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1

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Cook Island Māori

Event Summary: The patient had an unwitnessed fall resulting in a fracture.

REVIEW
Key findings: The patient was at risk from falling because they had numerous medical conditions, including cognitive impairment. A mobility alert alarm was not effective. Nursing staff noted the patient mobilised unaccompanied on several occasions, however there was no formal plan implemented to supervise mobilising especially when needing to go to the toilet.

Improvements Made: This event occurred on the ward where regular ward multidisciplinary team discussions are now held that focus on providing patients with safe mobilisation plans. In addition, patients at risk are identified on nursing handover sheets to ensure this information is shared between staff when change of shift occurs. Learnings from this event have been communicated with staff and used for teaching purposes.

2.

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Chinese

Event Summary: A swab was left in the patient following a surgical procedure.

REVIEW
Key findings: After the patient reported discomfort, the health care worker located the retained swab and removed it. The review team identified that there had been no swab or instrument count before or after surgical treatment and documentation was not completed. The wrong type of swab was used which meant it was not easily visible.

Improvements Made: Two people must count the number of swabs used during this type of procedure to ensure that all the swabs are accounted for. After the final count, details must then be documented in the correct record document. In addition, educational posters have been displayed in clinical work areas to remind staff to adhere to the process.

3.

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: The patient had a fall which resulted in a fracture.

REVIEW

Key findings: On admission it was noted that the patient's mobility had recently changed from 'independently mobile' to 'requiring a walking frame'. However, the initial falls risk assessment tool and the daily care plans were not completed. The fall occurred when the patient's hand slipped on spilt water on the tray-table while standing next to the bed, resulting in a loss of balance and a fall onto the floor.

Improvements Made: Greater emphasis has been placed on timely completion of assessments upon admission, and audit results show an improvement from 72% compliance rate at the time of the event to over 90% currently. In addition, more consistent documentation of falls prevention strategies is evident both before and after patient falls occur.

4.

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Indian

Event Summary: A patient fell and sustained a fracture.

REVIEW

Key findings: The review team identified several factors which indicated the patient was at risk of falling. An initial falls risk assessment had been completed on admission to the hospital, however this had not been documented in the patient's electronic notes. The patient and family had been given information related to reducing risk of falls, however staff did not follow up on these recommendations and relied on the patient's family to supervise the patient. The patient normally used a walking frame which was available to use in the department, but it was not offered to the patient.

Improvements Made: A falls/mobility risk assessment has now been included as part of the initial patient assessment by adding a compulsory section specific to falls to the electronic notes system. Staff have received education around assessing whether patients use mobility aids, the importance of checking on patients regularly, not relying on families to assist with mobility and how to effectively assess falls risk and ensure patients are supported to achieve recommendations concerning safety.

5.

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Indian

Event Summary: A patient had an unwitnessed fall which resulted in a fracture.

REVIEW

Key findings: A patient who was at high risk of falling had a fall whilst rehabilitating in hospital, sustaining a fracture which required surgical repair. The patient had been given opioid pain relief and a sleeping tablet prior to the fall. There was no evidence that staff provided the patient with information regarding the expected sedative

effects of the medication, the duration of action of the medications, the potential impact on their balance and ability to walk safely, and the need to call for assistance if needing to mobilise.

Improvements Made: Ward refresher education now includes safe administration and monitoring the effect of medications in consultation with the patient, and is documented in the clinical record. All members of the ward multi-disciplinary team (MDT) receive falls prevention education so that patients are provided with a personalised mobilisation plan.

6.

Category: Patient Falls **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** European

Event Summary: The patient had an unwitnessed fall, hit their head and died a day later.

REVIEW
Key findings: A number of factors increased the likelihood that the patient might fall, and the impact of these was not fully recognised by staff. The patient had fallen previously during admission and was in a single room and therefore not easily in view.

Improvements Made: A multidisciplinary approach has been used to develop and implement individualised inpatient care plans for complex patients who are at risk of falls. Staff have been provided training on documentation requirements for care plans. There has been a refocus on the 'end of bed signalling' system to alert staff about how to safely mobilise each patient. The DHBs Falls Prevention Policy has been amended to include recommendations around increased monitoring of patients at risk.

7

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: The patient had a delayed diagnosis of malignancy.

REVIEW
Key findings: An inpatient had a Computerised Tomography (CT) scan to check for injuries which showed an incidental finding that required further investigation. The review team found that the incidental finding was not followed up during the time the patient was in hospital, or communicated for follow-up with their GP after the patient was discharged home.

Improvements Made: All incidental radiology findings are reported in hospital discharge summaries. The findings from this event were an agenda item at the radiology and morbidity meeting and are to be presented at the Clinical Governance Board meeting.

8

Category: Patient Falls **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** NZ Māori

Event Summary: The patient had an unwitnessed fall in hospital requiring emergency surgery from which the patient deteriorated. After discussion with the family, treatment was withdrawn and the patient subsequently died.

REVIEW
Key findings: The patient had been identified as a falls risk in the care plan, however the assessment was not completed. Following an unwitnessed fall, a CT scan showed a pre-existing haemorrhage had slightly increased, which led to worsening confusion for the patient and this may have contributed to the fall. The patient subsequently died.

Improvements Made: There is now regular education to all clinical staff about the importance of completing falls risk assessments and developing individualised care plans. The education focusses on documenting mobility/falls risk assessment and reflects the recently updated 'Reducing and Managing In-patient Falls' policy. Monthly audits of falls risk assessment documentation in the Patient Admission to Discharge Plan (PADP) are completed.

9

Category: Medication **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Other Asian

Event Summary: Incorrect connection of an epidural catheter which resulted in mild local toxicity to the patient.

REVIEW
Key findings: The patient had an epidural catheter placed for administration of patient controlled epidural anaesthesia (PCEA). The review team identified that the health care worker did not directly supervise the person connecting the PCEA and did not inspect the connection site prior to medication administration. The patient was followed up appropriately; the infusion was immediately stopped, the patient was medically reviewed and closely monitored. All investigations were normal and the patient's condition remained stable.

Improvements Made: Lessons learnt from this event have resulted in process changes so that when administering PCEA, the epidural tubing must be connected to the epidural catheter by an anaesthetist or anaesthetic registrar only. In order to reduce the risk of similar events occurring, the DHB is exploring changing the intravenous (IV) and epidural products to a new system that has different connectors for IV lines than for epidurals. This will mean that an IV line cannot be connected to an epidural catheter, and vice versa. Ongoing education is provided to health care professionals about management of epidurals when used for pain relief.

10

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

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Event Summary: A woman had a significant bleed after childbirth and was transferred by ambulance from a birthing unit to a tertiary facility. The patient deteriorated and required emergency surgery.

REVIEW
Key findings: The review team found that emergency transfer processes were not followed appropriately. Staff did not activate a call for emergency assistance which would have provided additional clinical support to prepare for safe transfer. Staff at the receiving hospital had not been told the patient had a significant bleed, or that the patient's condition had deteriorated during transfer. Communication between staff at the birthing unit and the receiving hospital did not facilitate optimal management.

Improvements Made: Following the review team's recommendations, there is ongoing education to staff working within maternity services to use the emergency system to initiate help when a patient is deteriorating. Staff attend an annual study day which focusses on simulation of emergency scenarios, aiming to improve communication, collaboration and clarify expectations of roles between health providers and ambulance staff. A standardised record checklist is now used when an ambulance transfer to a tertiary level hospital is required and there are now two intravenous infusion pumps available for use. A working group has been established with paramedics and staff from the DHB's Women's Health Service, focussed on improving the safety of women being transferred from birthing units.

11

Category: Resources **Deceased:** Y **SAC Rating: 1** **Ethnicity:** NZ European

Event Summary: A patient died whilst on a surgical waitlist.

REVIEW
Review in progress.

12

Category: Clinical Process **Deceased:** N **SAC Rating: 2** **Ethnicity:** Indian

Event Summary: Delay in hospital follow-up which contributed to progression of damage to patient's eye.

REVIEW
Review in progress.

13

Category: Clinical Process **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** NZ European

Event Summary: During a routine dialysis session, the dialysis catheter dislodged and the patient lost a large volume of blood. The patient died a week later.

REVIEW
Key findings: The review team identified that the patient's dialysis catheter was obscured during treatment. Staff regularly checked the patient's line, however blankets covered the patient, and the dialysis catheter and tubing were not clearly visible. When the line dislodged staff did not immediately see this had occurred, or that the patient was deteriorating.

Improvements Made: Changes have been made so that all dialysis patients have their line insertion site clearly visible at all times while treatment is in progress. A new protocol has been developed to ensure all dialysis lines are secured using standardised tape and checked at 30 minute intervals. In addition, new devices that detect fluid loss due to line dislodgement have been purchased, and are now routinely used for patients who are at risk of catheters dislodging. Staff have been trained to accurately assess cognitive function, as well as identify and respond to acute deterioration.

14

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: A patient was not provided counselling which resulted in an unnecessary procedure.

REVIEW
A Health and Disability Commission complaint is in progress.

15

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: An inpatient had ongoing high blood pressure which went untreated. Subsequently the patient had a haemorrhage which required surgical intervention.

REVIEW
Review in progress.

16

Category: Patient Falls **Deceased:** Y **SAC Rating:** 2 **Ethnicity:** Other European

Event Summary: A patient had a fall which resulted in a fracture requiring surgical repair.

Review in progress.

17

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: The patient developed a pressure injury whilst in hospital.

REVIEW
Key findings: The patient was admitted for surgical repair of a fracture. During rehabilitation on the ward, the review team noted that strategies to prevent pressure injuries were lacking in the patient's care plan. Assessments of the patient's skin integrity were performed and documented in the clinical notes. Although the development of a pressure injury had been identified, this was not documented or communicated effectively between clinicians.

Improvements Made: A Pressure Injury Prevention & Management plan has been recently been approved and implemented, aimed at reducing the development of pressure injuries. Education has been provided for nurses. There is now a requirement to identify patients at risk of pressure injury on both handover forms and in patient care plans.

18

Category: Clinical Process **Deceased:** N **SAC Rating: 2** **Ethnicity:** Chinese

Event Summary: The patient lost sight in one eye, potentially related to delays in receiving follow-up care.

REVIEW
Review in progress.

19

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Indian

Event Summary: A newborn infant was born with a brain injury.

REVIEW
Review in progress.

20

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Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Tokelauan

Event Summary: A patient was removed from a surgical waitlist without an adequate plan for future review.

REVIEW
Review in progress.

21

Category: Clinical Process **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** European

Event Summary: The patient had a diagnostic test which was not reviewed. The patient later had a cardiac arrest and died.

REVIEW
Review in progress.

22

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** European

Event Summary: The patient developed maternal sepsis, resulting in the in-utero death of her infant.

REVIEW
Key findings: The review team found that collection of a mid-stream urine (MSU) sample within 24 hours, could have established the presence of existing infection. There was a lack of written antenatal information and resources provided on admission to the patient.

Improvements Made: The 'Management of Spontaneous Rupture of Membranes' policy will be amended to incorporate MSU screening as part of the initial clinical assessment for all women presenting with SROM, and repeating MSU screening at recommended intervals. Work is underway for more antenatal education, including information about foetal monitoring, plus other resources to be made available for women and their families.

23

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Samoan

Event Summary: The patient was prescribed and administered an overdose of medication in hospital, resulting in admission to the Intensive Care Unit (ICU).

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REVIEW
Review in progress.

24

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Other European

Event Summary: The patient had an unplanned removal of an ovary during surgery.

Review in progress.

25

Category: Clinical Process **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** NZ European

Event Summary: A patient died unexpectedly three days after sustaining trauma in an accident.

Review in progress.

26

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Other European

Event Summary: There was delayed recognition of a deteriorating patient which resulted in an unplanned transfer to the Intensive Care Unit (ICU).

Review in progress.

27

Category: Clinical Process **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** NZ European

Event Summary: The patient underwent surgery and died.

Review in progress.

28

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Other Asian

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Event Summary: Unexpected admission of a newborn infant to the Neonatal Intensive Care Unit (NICU).

Review in progress.

29

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** Cook Island

Event Summary: The patient required an organ transplant due to an error in medication management.

A Health and Disability Commission complaint is in progress.

30

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: Unexpected admission of an infant to the Neonatal Intensive Care Unit (NICU).

Review in progress.

31

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** European

Event Summary: A deteriorating patient required transfer to the Intensive Care Unit (ICU).

Review in progress.

32

Category: Clinical Process **Deceased:** Y **SAC Rating:** 1 **Ethnicity:** NZ European

Event Summary: A patient died from a complication sustained during a procedure.

Review in progress.

33

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Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: Poor placement of a vascular access catheter led to a second procedure to improve the positioning of the catheter.

Review in progress.

34

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: A patient had a fall and sustained a fracture.

Review in progress.

35

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: The patient had an unwitnessed fall resulting in a fracture.

REVIEW
Key findings: The patient had a fall at home and was admitted to hospital for rehabilitation. They had a subsequent fall in hospital resulting in a fracture. The review team found that the falls risk assessment in the Patient Admission to Discharge Plan (PADP) had been completed daily. At the time of the fall the patient was asleep without the bed rails up.

Improvements Made: In order to align recommendations with the falls committee quality improvement cycle, wider beds are being introduced into the rehabilitation wards. Guidelines are being formulated which describe the criteria and scope for the allocation of these beds so that the most vulnerable patients at risk of falls are prioritised.

36

Category: Patient Falls **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: A patient had a fall resulting in a joint dislocation and fracture.

REVIEW

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Key findings: The patient was admitted with a fracture after a fall at home, and required a period of rehabilitation. A subsequent fall in hospital occurred after the patient mobilised independently to use the toilet. The patient was assessed daily as being at risk of a fall due to impaired mobility status, and required supervision during mobilisation. No toileting or safe mobility plan had been made which would have reduced the risk of a fall.

Improvements Made: Education for staff about continence assessment and a learning package has been introduced to more readily identify patients at risk. Mobility status charts are now used at the bedside, and this information is transferred to the handover forms. Hourly rounding and discussion with patients around toilet breaks is now standard practice.

37

Category: Clinical Process **Deceased:** N **SAC Rating:** 2 **Ethnicity:** NZ European

Event Summary: A newborn infant was admitted to the Neonatal Intensive Care Unit (NICU) following pre-term birth.

Review in progress.