TARANAKI
District Health Board

Learning from Adverse Events Report

1 July 2019 to 30 June 2020

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This report has been written for the consumers, their whanau and communities of the Taranaki District. It provides a summary of the serious adverse events* that have occurred in our services in the 2019/20 year. This report is released in conjunction with the Health Quality and Safety Commission's (HQSC) *Learning from Adverse Events* information for the same period.

Patient safety is top priority for the Taranaki District Health Board. We expect and value a just patient safety culture and ensuring effective systems and processes are in place. We know that every day staff members strive to provide quality care that is safe and person/whanau-centred however we acknowledge that we don't always get it right. Incidents where patients are harmed do occasionally occur and are truly regrettable. We routinely undertake in-depth investigations into events where there has been an unexpected outcome that has resulted in serious harm to a patient. The purpose of such investigations is to find out what happened, why it happened and put measures in place to reduce the likelihood of a similar event occurring in the future.

We sincerely apologise to the patients and whanau involved in these serious events and acknowledge the distress and harm that occurred to them when they were under our care.

The National Adverse Events Reporting Policy requires DHBs to report serious adverse events to the Health Quality and Safety Commission. In 2019, Taranaki DHB introduced a new Clinical Governance framework to support patient safety which focusses on the following:

- The framework makes it clear that people who work in our health services have a professional, legal and moral duty to report incidents.
- When an event is reported an incident management process commences which is overseen by senior clinical leaders, managers and the Clinical Governance Support Unit team.
- For every serious adverse event, significant investigation occurs and agreed recommendations are implemented.
- We communicate openly and honestly with affected patients and their families/whanau and offer to share outcomes of the investigation with them and with involved staff.
- The emphasis is on improvement and reducing preventable harm and reoccurrence.
- In addition, there is a strong focus on sharing learning from such events with other health providers in order to reduce the risk of such events happening again.

Taranaki District Health Board reported 16 serious adverse events to the Health Quality and Safety Commission during the reporting period 1 July 2019 – 30 June 2020. A summary of the events, the investigation recommendations and the DHB's progress in implementing the recommendations follows in the table below.

*An adverse event is defined as an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned. In practice, this is most often understood as an event which results in harm or potential harm to a consumer. (*National Adverse Events Policy 2017)*
A serious adverse event is an incident where a patient is seriously harmed during medical treatment, i.e. results in death or significant loss of function. *(abridged)*

Description of Event	Review Findings (abridged)	Recommendations/ Actions (abridged)	Progress
Patient sustained pressure injury	Patient was high risk for pressure injury but the review concluded this occurrence was preventable. There was a lack of skin assessments required for a high risk patient and the clinical record does not accurately reflect the nursing actions that could have prevented this injury occurring. Nursing processes were not followed as required by pressure injury management protocols.	• Daily monitoring and regular audit of accurate and consistent reporting on the completion of patients on a wound care plan. • Relocate the '3 step skin check and patient movement chart' to the end of the bed/ in the room; provide education on same to all nursing staff. • Provide education and practice expectation around the record of patient positioning. • Intentional rounding to address pressure injury, falls and well being. • Icon on electronic whiteboard that flags intentional rounding and or moving and repositioning.	• Implemented, regular audit ongoing. • This action is completed. • This action is completed. • This action is completed. • In progress.
Complications with delivery	Fetal-maternal haemorrhage diagnosed and baby born via emergency level 1 Caesarean Section under general anaesthesia. Baby born with low heart rate at birth. Mother and baby later transferred to neonatal unit and then required out of region transfer for specialist care. The review found that the clinical diagnosis was timely and accurate and baby was treated accordingly. There were no identifiable risk factors to suspect this condition antenatally. It is not clear	• Review of reduced fetal movement guideline and consider implementation of the Kleihauer test. • Presentation of the case for learning. • Documentation - staff reminded re. use of the standard and documentation audit.	• Decreased Fetal Maternal guideline updated to include Kleihauer information; this is for endorsement at the next Governance meeting. • Learnings from case review presented. A whanau meeting has also taken place. • Documentation audit to be completed early 2021.

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	when the initial concerns about reduced fetal movements were and whether this was a first presentation or a recurrence. Women are advised not to wait until the next day if concerned about reduced fetal movements.		
Inpatient fall resulting in a fractures	Patient was high risk for falls. Admitted due to concerns with overall wellbeing and decreased mobility. One-to-one monitoring of patient 'specials care' on admission. Later, the patient was assessed as more steady on their feet so specials care ceased. Patient experienced a fall whilst trying to mobilise suffering several fractures. The report noted that staff used the 'Close Care Guideline' (policy for watch/ specials) decision making tool to cease the watch/special appropriately. However, staff did not record the use of this tool and other factors considered in the decision to stop the watch/special.	• When there is any change to the nature of a watch/special, it is to be recorded in the clinical record.	• This action is completed. A special sticker has been developed and implemented to record any changes to the nature of a watch/special.
Delayed referral	The review found that the internal referrals and patient flow process was not standardised and therefore, was difficult to audit. The current Endoscopy service waitlist requires review.	• Establishment of a single, auditable electronic entry point that can be adapted for internal referrals to stop multiple referrals and reduce wasteful administration. • TDHB to prioritise the management of the Endoscopy waitlist and address the cancellations.	• Several initiatives in place to address waitlists; all are being actively managed by the Surgical Directorate. • Action closed; system in place since mid November 2020.
Delayed diagnosis of cancer	Referral misplaced after being printed from the clinical system. This resulted in a significant delay and re-referral from the patient's GP. The management of the internal referral process requires review.	• Paperless system of transferring referrals to the Booking Office is implemented. • Review current staffing (full-time equivalents FTE) and how it is utilised. • Review clerical workload and administrative tasks associated with	• Administrative staff FTE has been reviewed and increased by 0.6 to 1.6FTE.

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		endoscopy. • Orientate booking pool staff to endoscopy booking processes.	• TDHB is currently in the process of aligning the Endoscopy pre-admission service with the surgical pre-admission system. • A new Booking Office Manager with a pre-requisite clinical background has been appointed along with a new endoscopy booking administrator. All staff are now competent to work in multiple specialties.
Failure to recognise deteriorating patient's complex needs	Patient death due to multiple clinical concerns and failure of medical staff to recognise the deteriorating patient's needs.	• Work with the New Zealand Sepsis Trust and Health Quality and Safety Commission to implement learning programme for clinical staff. • Implement a Patient At Risk (PAR) nurse service. • Review the systems for responding to junior doctors and nurses when they escalate concerns. • Evaluate the purchase and implementation of a hospital wide electronic early warning score track and trigger system. • Provide a sepsis identification and treatment decision tool to junior medical staff. • Review systems and processes related to nursing and medical documentation in the emergency department.	• TDHB has partnered with NZ Sepsis Trust, ACC and HQSC to launch Sepsis Ready Programme; TDHB to become a pilot site for the programme. • PAR service has been established. • Completed to the level of house officers. In progress for other professions. • Application has been submitted for the approval of a trial of electronic early warning score track and trigger system at TDHB as of Nov 4, 2020. • NZ Sepsis Trust's sepsis identification and treatment decision tools are being rolled out as part of the pilot project. • ED CasCARD (Casualty Card – assessment and documentation) is undergoing extensive review, to be completed in early 2021.

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		• Review systems and processes for the certification of the deceased as soon as possible to facilitate timely, sensitive transfer from the intensive care unit. • Evaluate the implementation of a systematic, hospital-wide "speaking up for safety" type programme to empower junior nursing and medical staff to escalate clinical concerns.	• ICU is currently developing a pathway for nursing staff to improve care of the deceased patient. • In progress. Start date is anticipated in 2021; delayed due to COVID 19 and the need for trainers to visit from Australia.
Deteriorating patient after giving birth	Patient developed fluid overload resulting in pulmonary oedema, ICU care and treatment for acute kidney injury Issues identified were related to individual medical/nursing and midwifery staff knowledge of the patient's condition and not restricting fluid intake and the inconsistency of a midwife consult visit every shift while the patient was in ICU. There was delayed recognition of fluid overload, delayed recognition of the deteriorating patient and delayed escalation of the Maternal Early Warning System Vital Sign Chart (MEWS) score.	• Present case to HDU/ICU and Maternity clinicians. • Investigate care planning and care pathways for Maternity HDU/ICU patients. • Initiate the clinical bedside handover project.	• Case presentations completed. • Care pathways action still to be completed. • Bedside handover project still to be initiated; delayed as was part of hospital wide education programme now to be localised to individual areas. This is included in the pathways group work.
Patient sustained pressure injury	Complex health conditions meant this patient was at high risk of developing a pressure injury.	• Promote greater staff awareness of increased risk of pressure injuries in clinically complex patients. • Review stock of pressure relieving mattresses on the ward.	• The ICU nursing staff highlight barriers to pressure area care and completing incident reports as required. • A clinical equipment administrator has been employed who can track the appropriate allocation of mattresses. A mattress pool is now in place and it is too early to determine what effect this having as it is still

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			being embedded in the hospital and delayed by COVID 19.
Patient sustained pressure injury	Patient considered at high risk for developing a pressure injury; appropriate advice offered to patient to avoid an injury occurring. All nursing care was deemed appropriate by the reviewer. There were no recommendations from this review.	*The investigation determined there were no recommendations to address.*	
Patient had an unwitnessed fall	Patient experienced a fall when moving out of bed to stand up. The patient then fell experiencing a hip injury. Patient not considered medium risk for falls and was considered independently mobile.	• Rounding and bedside handover at 11pm to ensure following for all patients - basic bed linen tidy particularly at night for patients who are independent; check the environment is clear of hazards, safe and adequately lit. • Consider greater support from HCAs in ensuring the abovementioned checks are completed.	• This action is completed. Documentation of hourly intentional rounding audits is maintained by Clinical Manager, Hawera Hospital. • This was discussed at the team meeting. HCAs support above action.
Delayed diagnosis of cancer	The patient waited outside of the recommended guidelines for an endoscopy.	• Reduction of the wait time for semi urgent endoscopies to within the guidelines. • Introduction of the E-referral system.	• This is being reduced and actively managed by the Surgical Directorate. • System introduced in November 2020.
Cancer diagnosis not reported following CT/ ultrasound	Presence of malignancy not reported on CT and ultrasound.	• Develop standard operating procedures specifying the number and type of reports that can be undertaken in a session. • Clinical audit of current process against the SOPs to be undertaken. • Audit reports of the Radiologists.	• Review of current practise underway including the introduction of Standard Operating Procedures. • Random audit of 118 scans, commissioned by Chief Medical Advisor, undertaken by an external reviewer completed August 2020. • Clinicians are actively encouraged to attend the Radiology Advisory Group (RAG) meetings.

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		• Encourage a better practise culture where referring clinicians can discuss results/reports with a Radiologist. • Duty Radiologist, doing the hot desk (acute) reports, fields enquiries and is available for second opinions.	• The allocation of a duty Radiologist planned for once unit is fully recruited.
Unexpected death of baby	The review considered the very tragic death of a baby following initial presentation at ED and treatment and care recommendations from the Child Health service. The review determined significant concerns regarding the inability to engage effectively with parents who held different health views. All staff actions in the review were deemed to be appropriate.	• Develop a new framework and policy for calling urgent case reviews when crucial medical advice is declined (for complex or high risk paediatric patients). • Ensure the framework/policy includes all relevant agencies and staff. Also ensure the assigning of responsibilities including the Lead Person & Lead Agency for following up and considering legal advice.	• Report recommendations endorsed very recently. • Actions to be taken forward by Child and Maternal Health Directorate in early 2021.
Stillbirth	Baby delivered still born at term. A review of this case is underway and recommendations will be reported in due course.	*Any recommendations from the review will be considered by the Serious Incident Review Committee in due course.*	
Patient fall	Patient had a fall while mobilising resulting in head injury and fractured left hip. The patient deteriorated and later died.	• Review and update the falls risk assessment process. • All clinical staff involved to complete the falls training. • Viewing panels to be installed in two to three side rooms doors to allow better visibility of patients when these side rooms are used for infection isolation. • Documentation audit to be completed on the following to check compliance: o falls assessment o anticoagulate medication trigger higher falls risk o early discharge from TBH as re-admission 39 hours post discharge	• This action is completed. • This action is completed. • Engineering requisition has been completed. Work pending. • This action is completed.

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		• Purchase more sensor clips for Hawera Inpatient Unit. • Review and update the criteria checklist for discharge and transfer to South Taranaki include a reminder for Taranaki Base Hospital staff to guide families to use the Urgent Pharmacy in New Plymouth to fill scripts (as there is no afterhours pharmacy in South Taranaki) – Clinical Governance Support Unit to liaise with relevant teams to support this action.	• This action is completed. • Consultation with ward staff, nursing and pharmacy leadership and community pharmacies across Taranaki region took place. A medicines pamphlet is developed for launch in January 2021 to inform patients about after-hours pharmacy options.
Patient sustained pressure injury	Nursing documentation regarding frequent positon changes and attempt to get a pressure relieving mattress indicate appropriate interventions were implemented. Ongoing, regular thorough checks were not documented in accordance with policy.	• Previous review noted that the hospital has sufficient stock. However, regular reassessments of mattress stocks are required to ensure these are freed up from patients that no longer require them. • Escalation pathway for pressure relieving mattress supply. • Consideration of a rapid access equipment supply.	• A clinical equipment administrator has been employed who can track the appropriate allocation of mattresses. A mattress pool is now in place and it is too early to determine what effect this having as it is still being embedded in the hospital and delayed by COVID 19. • A mattress pool is now in place and it is too early to determine what effect this having as it is still being embedded in the hospital after being delayed by COVID 19. • Initiative already in place.