# Taranaki District Health Board
# Learning from Adverse Events Report
# 1 July 2018 to 30 June 2019

www.tdhb.org.nz

This report has been written for the consumers, their whānau and communities of the Taranaki District. It provides a summary of the serious adverse events* that have occurred in our services in the 2018/19 year. This report is released in conjunction with the Health Quality and Safety Commission's (HQSC) *Learning from Adverse Events* annual report 2018/19.

Patient safety is a 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//whānau-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 whānau 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 undertook a significant review of our incident management system and implemented a new 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.
- Note: In 2019 the Health Quality and Safety Commission released a list of maternity examples to DHBs to assist the maternity sector to identify report and learn from adverse events. Taranaki DHB implemented this change within maternity services and these events have been included in this report for the first time.

Taranaki District Health Board reported eleven serious adverse events to the Health Quality and Safety Commission during the reporting period 1 July 2018 to 30 June 2019. 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. ie results in death or significant loss of function *(abridged)*

| Description of Event | Review Findings (abridged) | Recommendations/ Actions (abridged) | Progress |
|---|---|---|---|
| Stillbirth | The external review team identified the following contributing factors:<br><br>There were significant delays in the mother seeing key people early on in this pregnancy.<br><br>Service co-ordination and communication between teams within the hospital and tertiary services needed improvement.<br><br>Responsibilities between the Lead Maternity carer and hospital clinicians required more clarity. | There are a number of recommendations as an outcome of this review as follows:<br><br>Review staff education and resourcing for women with complexities in pregnancy.<br><br>Improve documentation.<br><br>Guideline/Protocol review.<br><br>Improve referral systems and processes.<br><br>Follow-up counselling and support. | <br><br>Underway<br><br>Ongoing<br><br>Underway<br><br>Completed<br><br>Completed |
| Inpatient sustained a significant pressure injury on one heel | A review was completed which identified the following contributing factors to the development of the pressure injury:<br><br>More assessments needed during admission, transfers between departments and when significant change in the patient's condition was noted.<br>The management and treatment plan implemented did not meet best practice. Initially there was varying documentation in regards to skin staging of pressure injury. | Present case review to the wards where the patient was during admission.<br><br>Ongoing education to ward staff on the importance of and completion of risk assessments, and their frequency, and documentation of the same and staging of pressure injuries.<br><br>Incorporate significant focus of pressure injury prevention and management into tissue viability study day.<br><br>Develop a turning schedule where skin checks can be documented.<br><br>Ensure the ward has access to all pressure relieving devices and adequate education around these. | All recommendations have been completed. |

| | | | |
|---|---|---|---|
| Unexpected death of a patient undergoing a cardiac procedure | A review was completed which identified the following contributing factors:<br><br>The patient was high risk. Although a full and thorough consent process and clinical assessment which weighed up the risks vs benefits was carried out, the patient's hypertension was significantly worse than previous tests had indicated. | All high risk patients referred for cardiac angiography will undergo further team assessment to further evaluate risk versus benefit. | The recommendation has been completed. |
| Inpatient fall in a ward resulting in a facial fracture | A review was completed which identified the following contributing factors:<br><br>The patient had a sleep disorder and fell out of a hospital bed narrower than his bed at home and in an unfamiliar environment.<br><br>Bed rails were not offered as an enabler. | Consider the use of a sensor mat.<br><br>Education of the use of bed rails as an enabler to provide safety for patients who are used to larger beds at home<br><br>Education re low beds and when they would be appropriate to use<br><br>REM sleep disorder education to staff. | All recommendations have been completed. |
| Newborn death | This review has not revealed the cause of baby's death or if the factors identified would have prevented baby's tragic outcome, however multiple factors have been highlighted for improvements in systems, processes and care provision across all services involved.<br><br>The reviewer identified the following contributing factors:<br>Separation of baby from the parents.<br><br>Difficult access to home and hospital.<br><br>The DHB policy and protocols relating to Neonatal death and Coronial processes do not have sections relating to the procedures expected when the Coroner is involved in Neonatal death, including the Police process, appeal process and volunteer baby loss services. | Work with the police and Coronial services to implement processes to prevent unnecessary separation of babies from parents/families.<br><br>Accesses to Homebirth destinations are assessed and evacuation procedures discussed antenatally for families intending a homebirth. All Lead Maternity Carers have appropriate access.<br><br>The DHB updates guidelines relating to cases reported to the Coroner; role of the coroner and police, the appeal processes and volunteer baby loss services. | Completed<br><br>Completed<br><br>Completed |

| | | | |
|---|---|---|---|
| | Emergency directive procedure was not followed which caused a delay and improved communication was required within the interdisciplinary team.<br><br>Transportation of baby for return journey from the external mortuary services was below standard.<br><br>Set up of equipment required improvements.<br><br>End-of-life cares could have been enhanced.<br><br>information for parents about what to expect in relation to autopsy requires improvement | Education on correct emergency directive and the importance of closing the communication loop in emergency situations to prevent further reoccurrence.<br><br>External mortuary services informed re transportation of babies undergoing autopsy.<br><br>Ensure ventouse equipment is set up and ready to work with tubing attached and a spare handle.<br><br>Palliative care pathways discussed and initiated where agreed with parents for end of life cares. The DHB has Neonatal palliative care pathway implemented into the Palliative care protocol.<br><br>Information DVD for parents on considering autopsy be available for families on the ward lap tops. | Completed<br><br>Completed<br><br>Completed<br><br>To be progressed<br><br>Completed |
| Inpatient sustained a significant pressure injury on one heel | A review was completed which identified the following contributing factors to the development of the pressure injury:<br><br>Evidence of accurate skin assessment being carried out were not present. Areas of risk identified but not clarified until pressure injury present.<br><br>Documentation re skin integrity omitted from nursing notes. Documentation in wound care chart showed pressure injury present on admission, but was not included in ongoing clinical notes.<br><br>Lack of accuracy in use of the Braden Scale. | Discuss with individual staff involved and provide one to one education for pressure injury staging and management.<br><br>Standardised framework for documentation implemented across the organisation.<br><br>Education to ward staff about the Braden Scale tool, breaking down the assessment and covering each category individually. | All recommendations have been completed. |
| Inpatient sustained significant pressure injury in pelvic area. | A review was completed which identified the following contributing factors to the development of the pressure injury:<br><br>Escalation in ED when compromised skin integrity required. A specific pressure injury care bundle should have been | Education sessions in ED on assessment, staging and management of pressure injuries | All recommendations have been completed. |

| | | | |
|---|---|---|---|
| | implemented and pressure relieving surface arranged for ward.<br><br>Nursing process not followed as guided by pressure injury care bundles. | <br><br>Discuss with individual staff involved to establish their level of knowledge and insight on the importance of carrying out skin checks and thorough skin assessments, then establishing education based on learning needs assessed from this.<br><br>Present case to Practice Innovations Committee to empower nursing leaders with the knowledge to share with nursing staff with the aim to work towards improved assessment, intervention and evaluation of pressure injury management. | |
| Inpatient sustained significant pressure injury in pelvic area. | A review was completed which identified the following contributing factors to the development of the pressure injury:<br><br>Assessments being carried out during admission to acknowledge and identify risk not completed.<br><br>Implementation of the incorrect Pressure Injury Bundle where evidence of compromised skin integrity/pressure damage should have prompted a different bundle.<br><br>Varying documentation by nursing staff in regards to staging of each PI.<br><br>Delay in time to access pressure relieving mattress. | <br><br>Present case review, in particular to the wards where the patient was during admission.<br>Education to ward staff re importance of and completion of risk assessments, their frequency, and documentation of the same.<br><br>Ongoing education for ward staff so they are able to stage pressure injuries accurately. Ensure ward staff have accurate education on how to implement bundles.<br><br>Implement education around turning schedule once final draft signed off by forms committee.<br><br>Ensure the ward has access to all pressure relieving devices and adequate education around these. | All recommendations have been completed. |
| Unexpected hysterectomy-during childbirth. | The reviewer identified the following factors:<br><br>This patient had risk factors that were not identified and not communicated. | A complete and thorough history should be taken and documented accordingly and risks stratified. | Completed |

| | | | |
|---|---|---|---|
| | Written consent form did not include hysterectomy.<br><br>Appropriate care was provided. | | |
| Patient fall in a ward resulting in a toe fracture | The review identified the following findings:<br><br>The patient was mobilising wearing a leg brace and was being cared for by a nurse. Unfortunately her toe got caught in her super stroller. She was then carefully assisted to the floor by the nurse to prevent further injury. Full assessments and appropriate care was provided. | Discuss this patient event and present case study at a staff meeting to highlight that when a patient has a leg brace on he/she will need closer supervision. | Completed |
| Newborn death | This review has not revealed the root cause of baby's death or if the factors identified would have prevented this outcome. A significant issue was the distance from home to the secondary hospital and availability of patient transport which led to a delay.<br><br>The following factors have been highlighted for improvements in systems, processes and care provision:<br><br>Maternity records not available for admission.<br><br>Factors identified in delivery of care.<br><br>Improved leadership in an emergency required.<br><br>Paper work created confusion in regard to stillborn versus Neonatal death. | Have tracking cards in place for records that are not available to easily identify where they can be accessed.<br><br>Education on scenario training for newborn, life support, obstetric emergencies, requesting an ambulance in an emergency, and coronial processes.<br><br>Duty manager and ward staff roles need to be initiated for variance response management to support in high acuity and emergencies where documentation and family support is required.<br><br>Documentation rectified to indicate stillbirth rather than neonatal death. | All recommendations have been completed. |