Taranaki District Health Board
Learning from Adverse Events Report: 2017-18

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This report is released in conjunction with the Health Quality & Safety Commission's (HQSC) *Learning from Adverse Events* annual report.

Patient safety is a top priority for the Taranaki District Health Board (DHB). We focus on a just patient safety culture, ensuring effective systems and processes are in place and we know that every day staff members strive to provide quality care that is safe and person and family/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. Therefore we are always looking for ways to improve services to make care as safe as possible for patients and of a high standard.

The National Adverse Events Reporting Policy 2017 requires every DHB to report serious adverse events to the HQSC. We rely on events being reported by the people involved and we require staff to report incidents. For every adverse event, significant review occurs and recommendations are planned, implemented and monitored. We communicate openly with affected patients and their families/whanau and share the outcomes of the review with them and with staff. 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. The emphasis is on improvement and reducing preventable harm in the future.

Taranaki DHB reported nine serious adverse events during the reporting period 1 July 2017 to 30 June 2018. We sincerely apologise to the patients and family/whanau involved and acknowledge the distress that occurs when things go wrong in healthcare.

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).

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Description of Event	Review Findings (abridged)	Recommendations/ Actions (abridged)	Progress
Patient fall resulting in a bleed in the brain that the patient did not survive	The review team identified the following contributing factors: • Falls Risk Assessment was not completed on admission to both the Intensive Care Unit and the ward. • Falls Risk Minimization Strategies were not implemented in ward. • Lack of documentation in clinical record of an explanation to the patient of the risk of using elevated cot sides and of consent from the patient to use cot sides. • Patient receiving triple therapy anticoagulation.	• Falls Risk Assessment and prevention education provided to all staff in the Intensive Care Unit and ward. • Falls Risk Protocol to be updated to include triggers for reassessment. • Unit based session developed and delivered to all staff on ward regarding the appropriate use of cot sides. • Review of the use of triple therapy anticoagulants in this instance.	All recommendations have been completed
Management of a pregnant woman exposed to an infectious disease while pregnant	The review team identified the following contributing factors: • A Parvovirus B19 Infection in Pregnancy Information Pack is available. There is however no recommendation to discuss all individual virus infections/exposure with patients. • Referral discussed with Obstetrician but no clinic review recommended. Parvovirus serology testing should have been arranged to assess the patient's immune status. This would have helped to counsel the patient and if appropriate, arrange for one to two weekly ultrasound monitoring if serology was positive. • Patient exposed to childhood viral illnesses at work.	• All referrals with viral exposure should be reviewed for serological testing where available and if (reliable testing does not exist for all viral illnesses) clinically indicated based on relevant clinical guidelines. • Antenatal clinic triage system assessing referrals should get second opinion if uncertain about advice given at the time. • Management in each case will be dictated by recognised guidelines. • In case of confirmed Parvovirus B19, one to two weekly ultrasound scan monitoring is also advised from 20 weeks. • Education for Midwifery and Medical Staff. • Copy of ASID "Management of Perinatal infections" to be kept in Antenatal clinic for reference.	All recommendations have been completed

Description of Event	Review Findings (abridged)	Recommendations/ Actions (abridged)	Progress
Patient with reduced mobility and pain developed a blood clot which resulted in his death	The review team identified the following contributing factors: • On admission the patient was not prescribed venous thromboembolism (VTE) prophylaxis, it was agreed that it was not the appropriate treatment at the time. • Documentation regarding the consideration of VTE prophylaxis is absent from the clinical record. • Mechanical VTE prophylaxis was not documented until two days after the patient was admitted to hospital. Documentation about the option of mechanical VTE prophylaxis was incomplete. • When signs and symptoms indicated a need, there was no request for ultrasound to exclude deep vein thrombosis (DVT).	• Review VTE prophylaxis best practice recommendations and discuss with medical teams. • Nursing education regarding signs and symptoms of deep vein thrombosis (DVT), nursing management and escalation of care. • Education for clinical staff relating to the importance of documentation. • Ensure that all medical and nursing staff members are mindful of the complexities of assessing, diagnosing and treating pain and its causes in at-risk patients.	Three recommendations have been completed One recommendation is due for completion in December 2018
Patient fall in a ward resulting in a fractured hip	The review team identified the following contributing factors: • Nursing documentation completed at Taranaki Base Hospital Emergency Department reflects that patient was unable to mobilise alone due to coordination difficulties. This, combined with her age and neurological condition, meant that she was at high risk for falls. • The patient fall occurred within 10 minutes of transfer between the Emergency Department and the ward.	• Education about falls risk screening for all nursing staff in Base and Hawera Emergency Departments. • Review nursing documentation policy and update nursing practice standards for falls and pressure injury (bundles of care). • Presentation of this case as a Case Study to all acute inpatient areas.	All recommendations have been completed

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Patient fall in a ward resulting in a fractured hip	The review team identified the following contributing factors: • On the morning of the fall, the patient was assessed by the physiotherapist as mobilising independently with the aid of a walking stick. As she was assessed as walking at her usual level of functioning, she was discharged from the physiotherapy service. • Later that morning the primary nurse assisted the patient to the toilet. She was positioned in front of the toilet and had her hands on the toilet rails. The nurse lifted the patient's gown so she could sit directly on the toilet. The nurse left the bathroom to tidy the bed. Very shortly after the patient fell onto the floor. The nurse did not supervise the patient's transition from standing to sitting.	• Frequency of observations. • Education to nursing team about patient supervision in the bathroom. • Development of a pain relief/analgesia module for surgical/orthopaedic wards : assessment, treatment, evaluation and documentation of pain.	All recommendations have been completed
Patient fall in a ward resulting in a fractured hip	The review team identified the following contributing factors: • On admission the Falls Risk Assessment was completed. In this case four or more medications was the only risk criteria identified and the criterion of confusion was not identified at the time of this assessment. If it had been, the patient would have been identified as a falls risk and risk management measures would have been put in place. • In noting this on the morning of the fall the patient showered independently, was fully clothed including shoes and was mobilising independently using her super stroller.	• Education to all staff regarding completion of risk assessment documentation and associated care planning. Present case review findings to nursing team. • Roll-out of the nursing assessment and care planning documentation with defined care practice standards.	All recommendations have been completed

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Patient fall in a ward resulting in a fractured hip	The review team identified the following contributing factors: • Falls Risk Assessment identified the patient as a high falls risk. Falls precautions were in place. • The incident report indicated that the Registered Nurse caring for the patient attended to her hygiene and settled her to bed after which he tidied up in the sluice room. The patient was found 10 minutes later on the floor in the corridor and the fall was unwitnessed. • There is no evidence in the clinical file that the use a 'special' or sensor clip were considered.	• The use of a sensory clip be considered and the rationale and decision-making process documented for patients assessed as high falls risk. • Educate all nursing staff regarding the revised falls assessment and care bundle.	All recommendations have been completed
Patient sustained significant pressure injuries on both heels	The review team identified the following contributing factors: • On admission to the ward after surgery, risk assessments were partially completed. Pressure injuries were identified day three post-operatively. • From the chart review it is unclear as to how often the patient's pressure areas were assessed and the skin checks performed. • It is thought that the patient's condition after surgery, his limited mobility, friction bed exercises, absence of nursing skin checks and pressure injury prevention strategies all contributed towards the heel injuries. • The patient had reduced sensation to his feet which also would have impacted on his ability to feel and detect the pressure injuries.	• Education to ward staff regarding importance of and completion of pressure injury prevention risk assessments and daily skin assessments. • Education to staff about when to use and not use anti-thromboembolic stockings • Review of the critical pathway documentation related to Enhanced Recovery After Surgery (ERAS) Primary Total Hip Replacement. • Review of bed exercises and the reduction of friction equipment	All recommendations have been completed

Description of Event	Review Findings (abridged)	Recommendations/ Actions (abridged)	Progress
Maternity woman sustained a significant bleed after delivery	The review team identified the following contributing factors: • Early recognition of the trauma and volume of blood lost. • Access to leadership and the number of skilled practitioners to assist in a significant bleed sustained after delivery. • Timely transfer to the operating theatre to arrest blood loss and stabilise/minimise blood loss. • Recommendation to always consider use of vaginal packing for control of local trauma/bleeding.	• If ongoing significant bleed, transferring to theatre early, having a nominated leader/coordinator of the emergency, calling in a second specialist and staff to acuity to provide leadership. • Review contents of the relevant grab boxes. • Education on the process for alerting blood bank to execute the Massive Transfusion Protocol (MTP). • Education to maternity staff on the utilisation of the massive transfusion box. • Work Environment : List of staff contact phone numbers held by the Operator so that they can call the on-call in when tied up with an emergency. • Organisational Management : Ensure medical staff members are fully orientated to maternity.	All recommendations have been completed