Adverse Event Report

Southern District Health Board

2017-2018

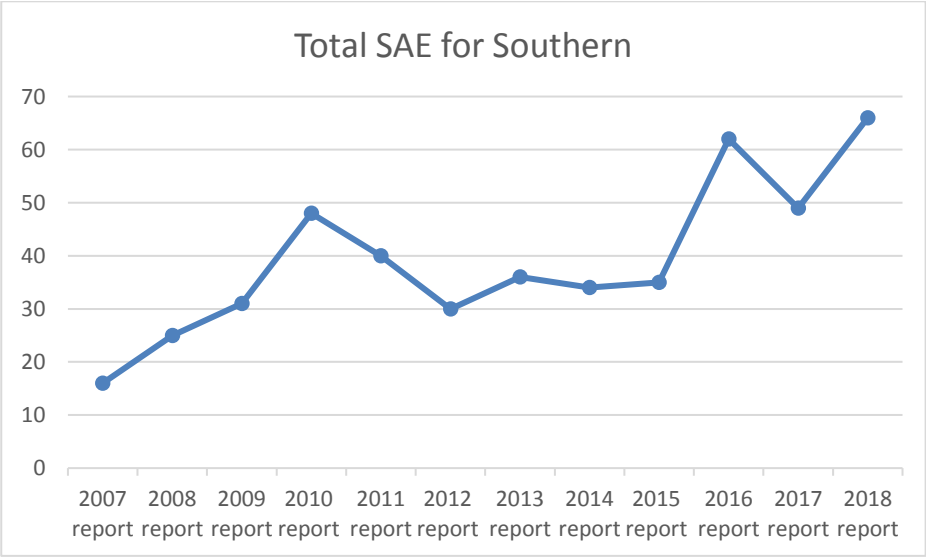
Adverse Events 2017 - 2018

Welcome to the adverse event report from Southern District Health Board for the period of 1 July 2017 - 30 June 2018.

It is recognised worldwide that health care is a complex process, has associated risks and that patients may become harmed when receiving care intended to help them. This report provides details of the serious adverse events that have occurred within Southern District Health Board (Southern DHB), the recommendations to make the care safer and our progress with implementing these safety measures. Some events are still being investigated at the time of release of this report, and recommendations from some events are still being implemented.

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report *"Learning from adverse events – adverse events reported to the Health Quality & Safety Commission"*; available at http://www.hqsc.govt.nz

Graph A



Graph A - In the 2017/18 year Southern DHB reported 66 events.

Southern DHB Annual Report: Quality and Performance Account provides analysis of the main groups of events and the district-wide improvement work being undertaken. A Quality Account summary will also be communicated to the wider public through community newspapers. Both publications are available on our website at http://www.southerndhb.govt.nz

What is an adverse event?

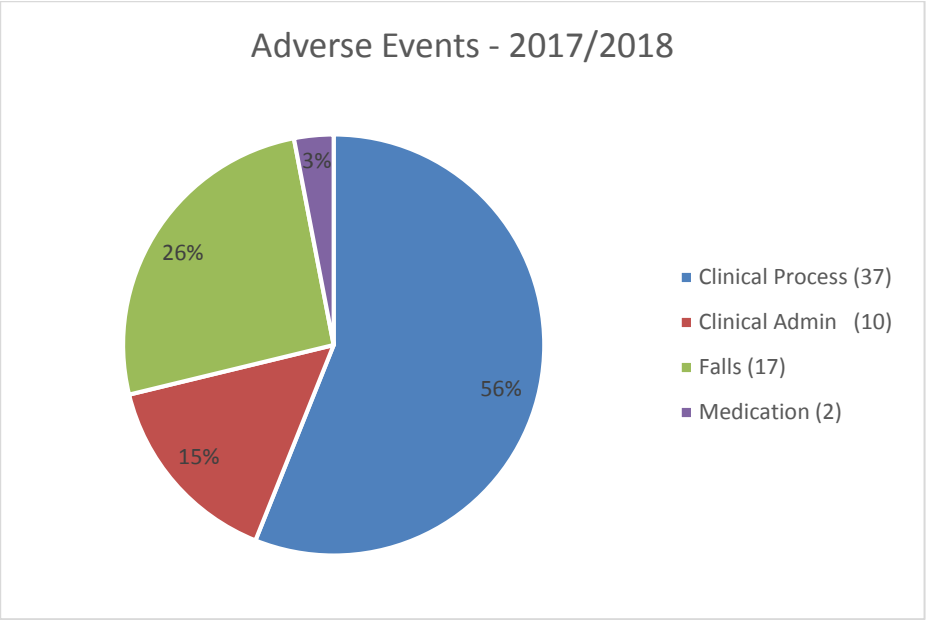
Adverse events are those that have the potential to, or have resulted in, harm to a consumer. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death. District Health Boards classify the severity of adverse events using the Severity Assessment Code (SAC). As a provider of health services we are required to report SAC 1 and SAC 2 adverse events to the Health Quality and Safety Commission.

Using adverse events to promote patient safety

All adverse events are investigated to learn what happened and how things can improve to avoid recurrence. Interventions are recommended to prevent the same or similar adverse events occurring in the future. It is not an exercise to blame individuals involved in the event.

A rise in the number of incidents can indicate a number of factors including better reporting practices or actual increase in events.

Southern DHB is committed to improving patient safety in line with the HQSC programme of work; this forms part of the transparent process of identifying harm and working to learn from adverse events and improve our patient safety. Information is available at http://www.hqsc.govt.nz



Graph B Reporting Categories for 2017-2018 – total and percentage

Graph B indicates the number and type of reported SAC 1 & SAC 2 adverse events for the period. The largest group of adverse events relate to clinical processes 56% (assessment, diagnosis, treatment, general care), followed by clinical administration 10% (handover, referral, discharge), falls 17% (serious harm from falls e.g. broken hip), Resources/organisation, medication error 3% (dispensing, prescribing or administration of medications).

Themes, learning and improving in 2019

The main themes identified from our events often lead to organisation wide improvement programmes. This year we have identified a growing number of pressure injuries acquired while in hospital, and that our recognition and response to patients who are deteriorating needs to be better.

Pressure Injuries

In collaboration with the ACC treatment safety team, we have employed a pressure injury nurse for two years to focus on reducing pressure injuries across our District Health Board. This is an opportunity for Southern DHB to become an exemplar in pressure injury management.

Recognition and response for deteriorating patients

A targeted education programme for all clinical staff has commenced to improve our responses to deteriorating patients. A group of doctors and nurses highly experienced in spotting the early signs of a patients in trouble are touring our hospitals to upskill our staff.

Delays in patient diagnosis, treatment and follow up

This will be a new area of focus in 2019. An organisation-wide programme aimed at valuing patients' time commenced at the end of 2018. It will consider a range of administration processes and clinical practices to improve patient journeys through our health system.

Other themes have existing programmes that continue to aim for zero harm. This includes a focus on falls and on medication safety. These programmes continue to evolve as new information comes to light.

Report provided by:

Chris Fleming
Chief Executive Officer

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Chief Nursing and Midwifery Officer

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Chief Allied Health, Scientific and Technical Officer

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Falls				
	Description	**Main Findings**	**Recommendations**	**Progress**
1	Fall resulting in fracture. Neck of femur.	The root cause of the SAC 2 fall was a training and education issue related to bedrail use and appropriate bed use.	The Safe Use of Bedrails Policy and Clinical decision tool are rolled out through the educators and charge nurses to all of the inpatient areas.	Complete 23/11/2016.
			Charge Nurse Manager and Associate Charge Nurse Manager to continue monitoring bedrail use on a daily basis and using the daily huddles to feedback and educate the nursing team.	Ongoing.
			Random spot audits of bedrail use continue to be monitored through the patient safety group.	Complete 30/09/2018.
		It was found there are many patients who are suffering from confusion who are at high risk of of falls and the appropriate bed is not always available.	Understanding of organisational requirements for 'lo lo' beds is scoped and built into the capex process.	Complete 06/04/2018.
		A contributing factor this fall was that the patient was wearing socks.	Organisational decision is being made regarding non slip socks based on best practice evidence.	Complete 30/06/2018.

2	Fall resulting in fracture. Pelvis.	All appropriate falls prevention precautions were in place.	No recommendations.	Complete 29/03/2018.
3	Fall resulting in fracture. Right clavicle.	Patient fell despite all efforts in place including Falls watch.	No recommendations.	Complete 20/03/2018.
4	Fall resulting in fracture. Neck of femur.	All appropriate falls prevention precautions were in place.	No recommendations.	Complete 13/11/2017.
5	Fall resulting in fracture. Neck of femur. Patient has subsequently died.	Patient was an outlier in ward. No ongoing documentation of falls assessment within the clinical records from admission until after the fall with resulting injury. Fall due to patient independently mobilising with low walking frame from toilet.	Aim to repatriate patients as soon as practicable within admission. Reinforce the updating of all assessments as per Falls Prevention policy within the inpatient episode. Reinforce ongoing and current falls assessments completed and interventions implemented.	Planned 20/12/2018. Planned 20/12/2018. Planned 20/12/2018.
6	Fall resulting in fracture. Neck of femur. Left radius and ulna.	The patient did not wait for standby assistance with the walking frame to mobilise to the bathroom as identified in the nursing plan. Periods following team handover highlighted as a busy clinical time for all staff performing observations, admitting and discharging patients increasing patient risk for falls.	Staff reminded of the need for prompt response of call bells for toileting as delay encourages risk taking behaviour. Team leader to highlight patients identified as falls risk as part of the Falls Assessments & Bedside Handover. All staff to prioritise high risk patient needs and move these patients near the nursing station for closer observation and nursing response. Falls risk and mobility requirements to be highlighted on	Complete 27/04/2018. Complete 27/04/2018. Complete 27/04/2018.

			the Trendcare handover sheet, my care plan & the white board, highlighting patient status at a glance. Discuss with team the periods following handover and highlight that this is a busy clinical time for all staff performing their 4pm observations. Falls Champion to continue with monthly audits and feed back to managers. Associate Charge Nurse Managers to continue to monitor falls assessments daily via Trendcare assessments & feedback at the daily huddle meetings any patients, who need initial assessments or reassessments. Charge Nurse Manager to feedback the root causes and themes around falls at the monthly ward meeting.	Complete 27/04/2018. Complete 27/04/2018. Ongoing. Ongoing. Ongoing.
7	Fall with fracture. Probable contribution from secondary cancer in bone.	The fall was due to a momentary lapse of attention at a time when the patient was likely fatigued near the end of a rehabilitation session and it is unlikely that it could have been prevented.	No recommendations.	Complete 17/12/2017.

8	Fall resulting in fracture. Neck of femur.	Falls screening and assessment: while the falls screening and assessment documentation was completed, further critical reasoning pertaining to this patient's clinical condition and history would have indicated that there was a falls risk.	Discuss the falls event with staff and feedback findings from investigation. Assistant Charge Nurse Manager, Educator and falls champion to audit falls documentation to ensure correct falls risk is recorded; and appropriate actions along with documentation occur. Continue to raise awareness of falls/clinical decision making with staff through discussion and case presentation.	Complete 17/04/2018.
		Incomplete documentation: Daily care plan not in use. Preventing falls leaflet not provided.	Daily care plan document and 'Preventing Falls in hospital' leaflet added to admission pack.	Complete 17/04/2018.
		Appropriate referrals.	Patients admitted to hospital who are dependent on mobility aids to assist with mobilisation must have a physiotherapy referral to assess safety and suitability of the aid completed within 24 hours of admission.	Complete 17/04/2018.
9	Fall resulting in fracture. Neck of femur.	Intentional rounding is not well integrated into ward practices. Although a patient watch was not deemed necessary it may have been prudent to undertake regular 15-30 minutes checks when managing patients with cognitive impairment.	Formalise and embed intentional rounding as part of ward practice. Ward working group to be established to review management of cognitively impaired patients within the ward. This needs to link to the work that is planned by the	Complete 30/09/2018. Complete 30/09/2018.

			Quality and Director of Nursing group around combined risk assessment for patients. This will include an extensive education programme that includes identifying appropriate care plans based on assessments, which are carried out every three days.	
10	Fall resulting in fracture. Femur. Patient has subsequently died.	Falls assessment complete. Observations need to be completed two hourly post fall. Documentation regarding next of kin needs to be improved.	No further action was needed. Post fall observation should be repeated two hourly. Staff will have reminders on huddle board. Associate Clinical Nurse Manager will follow up patients who have had a fall at morning hand over. Accurate and timely documentation is an expectation and a reminder will be provided on the huddle board.	Complete 11/06/2018. Complete 11/06/2018.
11	Fall resulting in fracture. Ankle.	Compression stockings were not listed as a risk factor, this could have been added to the patient's assessment.	All patients who are given compression stockings to be made aware of their slip risk. To be on My Care Plan as well as Falls care plan.	Complete 27/04/2018.
12	Fall resulting in fracture. Wrist and acetabulum.	All nursing assessments were up to date with a current falls assessment. Patient had not had a fall in the previous six months. This was an isolated fall for this patient. All falls prevention processes followed.	Continue with standard prevention to assess patients for falls risk. Participate in continuous falls prevention.	Complete 13/02/2018.
13	Fall. Patient has since died.	Falls reassessment was not completed post fall.	This will be put on huddle board for team members to ensure staff that they reassess patients post	Complete 21/02/2018.

			a fall and it is documented in the notes.	
14	Fall resulting in fracture. Coccyx and spinal cord compression.	Initially suspected spinal cord compression. However, the radiologist report stated no cord compression and treatment for this injury was therefore delayed. The patient should have been treated immediately as a spinal injury.	Suspected spinal injury – Spinal care patient training with staff. Education and training with Burwood spinal unit guidance and recommendations.	Complete 01/05/2018.
15	Discharge planning problem/Patient fall.			Investigation report in draft.
16	Fall. Fractured clavicle.	Patient fell in shower, the floor was wet. The patient had previously showered independently. Stood onto gutter frame and wheel slipped. Up-to-date falls care plan in place and implemented.	No recommendations.	Complete 30/07/2018.
17	Fall resulting in fracture. Right hip.	Falls prevention strategies were in place. Some clutter evident around bed space.	Reinforcement of the need to be extra vigilant in high falls risk patients who if they fall are likely to sustain a significant injury. All staff to ensure that as part of bedside safety checks that the environment is not cluttered (e.g. extra pillows, walker accessible but not in way of toilet entrance). Charge Nurse to do an environmental audit on bedside tidiness.	Complete 22/06/2018. Complete 31/07/2018. Complete 31/07/2018. Complete 31/07/2018.

		Formal Intentional rounding at night is undetermined. Communication with patient regarding "we have time to care and assist you". Electronic system did not reflect the care time taken post fall.	Education at huddles, ward meeting to raise awareness that we are not creating the perception that we are too busy to provide assistance to patients especially for toileting. Use the team based model to support this. Electronic system showed that there was a positive variance. On these occasions where staffing resource is evident the expectation of intentional rounding is in place. Nursing staff reminded to put in time when an emergency event occurs to record extra time spent with patient.	Complete 31/07/2018. Complete 31/07/2018.

Medication and Intravenous Fluids				
	Description	**Main Findings**	**Recommendations**	**Progress**
18	Incorrect medication administered. Cardiac arrhythmia.	Interruptions and distractions during medication administration is common. Variation in the preparation and process of medication administration within the Intensive Care Unit (ICU).	Develop agreed principles to embrace a 'patient quality/safety culture' in the ICU which supports development of uninterrupted medication administration practices in accordance with the IV policy. Develop a quality/safety sub-group that reviews IV medication including but not limited to audit,	Planned 20/12/2018. Planned 20/12/2018.

		There was no independent double check undertaken immediately prior to administration. Absence of labels and practices for differentiating between potentially lethal medications – provision of visual cue. During this time the admission rates were consistently high, with high acuity and challenges with nursing staff levels. Nurses were working more shifts to cover roster gaps with heavy workload. Potassium Dihydrogen Phosphate is the only IV medication available for Phosphate replacement.	resource review and orientation information. Standardise IV medication administration process and audit compliance. Consider the new ICU and how the change in environment will affect practices. Participation in Releasing Time to Care Medication Safety module to access relevant resources and information. Provide compulsory staff education on IV policy - all high-risk IV medications and fluids must be checked by two authorised/approved persons/staff at the bedside (including administration and syringe change) and audit compliance. Quality/safety group to consider trial and evaluation of corresponding coloured labels for IV syringes indicating different scales of medications (lethal, slow infusion or IV push over a few minutes). Review roster to ensure that shifts are rostered appropriately, and patterns provide most opportunity for rest. Staff survey. If staff agree to work an extra shift or overtime, develop a process to check the staff are not working excessive hours.	Planned 20/12/2018. Planned 20/12/2018. Planned 31/01/2019.

			Pharmacy to ascertain whether an alternative IV Phosphate medication is available.	Complete 02/11/2018.
19	Inappropriate prescription volume. Patient deceased.	Lack of awareness. No notification of restriction in place. No effective consistent electronic mechanism for alerting health practitioners that a restriction notice may be in place. Lack of integration between electronic systems. Lack of clinical pharmacist involvement within the hospital setting to identify patients' medications and challenges and to streamline the discharge process for complex patients.	The Ministry of Health be requested to undertake a full review and significant overhaul of the restriction notification system to ensure that notification of all restrictions is made electronically and includes electronic notifications to all health providers via the National Medical Warning System (linked to the patient's NHI). Consider the possibility that this restriction notice is also available for community pharmacies that dispense the medication. That the Southern DHB Chief Medical Officer facilitates the integration of electronic information systems so there is better communication transfer of patient information between primary and secondary care. That the Southern DHB Chief Executive Officer considers the possibility of additional pharmacist support be provided to all patients for Medicine Reconciliation, clinical review and discharge support across the hospital.	Complete 02/10/2018. Complete 02/10/2018. Complete 02/10/2018. Complete 02/10/2018.

Clinical Administration				
	Description	**Main Findings**	**Recommendations**	**Progress**
20	Delay in follow up. Loss in visual function.	Capacity issues.	Capacity issues addressed as per the ophthalmology review recommendations.	Complete 30/06/2018.
		Follow up appointment form not handed to administrative staff.	All patients clinic outcome checked by the administrative staff and follow up appointment made. A new protocol has been put in place ensuing that this occurs.	Complete 16/04/2019.
		Patients unaware of timeframe for follow up.	Consideration to giving patients written information at clinic when next appointment due.	Complete 16/04/2019.
		Eye patching was not consistent.	Parents are to be advised of all types of eye patches available and how to seek assistance if they encounter difficulties.	Complete 16/04/2019.
21	Delay in treatment. Loss in visual function.	Capacity issues.	Capacity issues addressed as per the ophthalmology review recommendations.	Complete 30/06/2018.
		Patient unsure of when follow up appointment due.	It is recommended that patients be given written information at clinic when next appointment due.	Complete 23/03/2018.
22	Delay in follow up. Loss in visual function.	Capacity issues.	Capacity issues addressed as per ophthalmology review recommendations.	Complete 30/06/2018.

		Patient enquiry regarding follow up appointment not acted on.	Ensure appointments prioritised as 'see today' are 'seen today'. There will be ongoing monitoring of this.	Ongoing.
23	Delay in referral. Loss in visual function.	Incorrect diagnosis.	Raise awareness of on call ophthalmology services.	Complete 29/08/2018.
24	Delay in follow up. Loss of visual function.	Follow up appointment cancelled and not rescheduled.	Capacity issues to address as per the ophthalmology review recommendations. All cancelled appointments are rescheduled at the time of cancellation. This should be addressed in the desk file for administration being developed.	Complete 30/06/2018. Complete 23/03/2018.
25	Communication/ Hand over failure. Incorrect procedure location.	Insufficient information on and with District Nursing referral form. Miscommunication between multi-professional health care teams and departments. Incomplete clinical records prior to discharge – no typed operation note or discharge summary.	A process will be put in place by the Wound Care Management Group to ensure that all referrals to District Nursing for wound management have a clear Plan of Care. Wound Care Management Group to develop a process whereby there is clear Plan of Care documented for post-operative patients prior to discharge from theatre. The surgical directorate develops a process to ensure that all clinical records that are dictated and typed are visible to staff across the organisation before discharge when referral to other service is required.	Planned 20/12/2018. Planned 20/12/2018. Planned 20/12/2018.
26	Delay in referral. CT scan.			This event has been reclassified as a SAC 3 and denotified to HQSC.

27	Delay in follow up. Loss in visual function.	Capacity issues. Appointment sent to wrong patient (patient's son). Hearing loss impacted or communication. Patient unsure of treatment plan.	Capacity issues addressed as per the ophthalmology review recommendations. Process for making appointments needs review with clearly documented process using the NHI to avoid error in sending the wrong patient appointments. Documentation of hearing loss and any other significant impairment in the patient management system. Written information for next appointment should be provided to ensure patient and next of kin are fully aware of plan.	Complete 30/06/2018. Complete 23/03/2018. Complete 23/03/2018. Complete 23/03/2018.
28	Failure to follow-up. Cardiac. Patient deceased.			Investigation report in draft.
29	Delay in diagnosis. Cancer.	Address overdue wait times for first specialist assessment. Set up one stop rectal bleeding clinic.	Review consultant surgeon FTE and outpatient space capacity. Look at the possibility of establishing this based on models used elsewhere and current space available. Would require additional nurse FTE.	Planned 20/12/2018. Planned 20/12/2018. Planned 20/12/2018.

		Feedback loop to GPs for patients waiting over their prioritised timeframe. Patient advice to be expanded if appointment outside timeframe.	Consider letter to GPs when timeframe expires asking GP to review patient. Patients to be advised in acknowledgement of referral letter to contact GP if over wait time or having problems.	Planned 20/12/2018.

Clinical Process				
	Description	**Main Findings**	**Recommendations**	**Progress**
30	Behaviour leading to accidental harm.	The patient was found on the floor and later identified as unconscious. The patient was transferred to the Emergency Department.	That patients should not be permitted to sleep on the floor in the corridors of an inpatient unit.	Complete 01/03/2018.
			That staff are adequately trained to assess level of consciousness and provide appropriate care in managing an unconscious patient.	Complete 01/03/2018.
		Some aspects of nursing care was found to be below what is considered a reasonable standard of care.	That the Ward review its process around nursing notification of behavioural concerns to the treating medical staff.	Complete 01/03/2018.
		Serious gaps were identified in the chain of communication between the visit to the Emergency Department and his carers.	The Mental Health, Addictions and Intellectual Disability Directorate review its communication process around transfers of care in order that a consistent pattern of clinical communication can be established.	Complete 01/03/2018.

		Communication to the family was found to be inadequate.	That clarity be established regarding clinical responsibility for clients on leave from Wards. That responsible clinicians are identified appropriately in the electronic system for other DHB services to identify. That issues of medical concern be a part of each inpatient treatment discussion- including any new episodes of medical or surgical care. The Mental Health, Addictions and Intellectual Disability Directorate review medical input into physical health of patients on site. That families are kept regularly informed and updated during adverse events.	Complete 01/03/2018. Complete 01/03/2018. Complete 01/03/2018. Complete 01/03/2018.
31	Pressure injury. Inpatient acquired.	Inconsistency of documentation of staging of pressure injury by the wider health care team with a lack of evidence of a consistent plan of care for Wound management. Incomplete documentation of assessments throughout the patients' health care journey Pre operatively, Surgical Ward and Assessment, Treatment and Rehabilitation.	Education session provided to the clinical teams on pressure injury staging and pressure injury prevention. This will include the whole team involved in patient care, including Allied Health. Surgical ward and Assessment, Triage & Rehabilitation ward to embark on a Quality Improvement Process to audit pressure injury assessments with the aim to rapidly improve	Complete 30/06/2018. Complete 30/06/2018.

		No formal /written referral to Wound Care Clinical Nurse Specialist.	the documentation from baseline over an eight week period. Clinical Nurse Specialist to develop a formal referral pathway that electronically captures referrals. Electronic referral systems are being used by other specialist nurses and should be consistently implemented across the district.	This has been included in the ongoing pressure injury work plan.
32	Wrong side surgery. Decompression/ Discectomy.	Patient not marked on back.	Surgeon to confirm operative site and mark patients backs in day surgery on morning of surgery. This will be documented in the procedure policy.	Complete 17/04/2018.
33	Incorrect diagnosis. Multi-organ failure.	Missed diagnosis due to lack of familiarity and exposure to this type of presentation.	No recommendations.	Complete 27/09/2017.
34	Problems with coordinating rehabilitation. Hand function loss.	There is no clinical pathway, including training and development to support the treatment of patients requiring Specialist Hand Therapy input.	Development of a clinical pathway to support patients that may require Specialist Hand therapy input. Develop relevant patient education and written material to outline what the patient may expect post-operatively, to assist the patient in making decisions regarding their care.	Planned 20/12/2018. Complete 31/07/2018.
35	Delay in treatment. Triage.			Investigation report in draft.
36	Harm related to ophthalmology procedure.	Procedure of intra vitreal injection is inherently hazardous with risk of traumatic cataract.	No recommendations.	Complete 23/03/2018.

37	Harm related to ophthalmology procedure.	Procedure of intra vitreal injection is inherently hazardous with risk of traumatic cataract.	No recommendations.	Complete 23/03/2018.
38	Aspiration pneumonia resulting in death.	The investigators found no clinical pathway or intervention that could be amended to prevent such an incident in the future. The patient received attentive care at each stage of the clinical pathway. Appropriate actions were taken as clinical changes and signs appeared.	No recommendations.	Complete 26/10/2017.
39	Retained item. Delayed removal.	Needle detachment due to procedural difficulties. Prolonged delays for surgery in acute cholecystitis results in much more difficult surgery. Promote supportive team environment.	No recommendation made. A more timely way to manage these patients, who are often delayed, needs to be explored. Consideration to be given to formalising the existing informal support structure for both medical and nursing teams.	 Complete 02/05/2018. Complete 02/05/2018**.**
40	Deteriorating patient not escalated resulting in admission to Intensive Care unit.	The current SDHB observation chart and EWS scoring system fails to trigger in patients with deteriorating oxygen saturations and or ongoing supplemental oxygen use. Failure to use the current observation chart correctly led to an incomplete	Move to the new national observation chart. Wider fortnightly audit of observation charts to monitor nursing compliance with correct	Planned 2018-2019. Complete 31/12/2017.

		clinical picture of the patient's condition.	observations and actions being taken.	
			Relaunch of standardised education package for deteriorating patient including quick reference card, guideline, and use of ISBAR communication tool.	Complete 31/12/2017.
		Failure of medical and nursing teams to recognise and respond to patient deterioration due to lack of escalation and poor communication.	Follow education plan devised by deteriorating patient work group.	Complete 30/11/2017.
			Provide a teaching session using this case to ward staff outlining issues identified and learnings to be taken from this incident.	Complete 30/11/2018.
		No recorded medical examination or full patient review for three days post operation.	Each member of the team needs to be accountable for assessing the patient themselves and documenting findings based on this assessment. Communication to occur using recognised tools.	Complete 30/12/2017.
			Nurses that are responsible for students need to provide correct direction and delegation and appropriate supervision. Clinical leaders for all specialities to be made aware of this case.	Ongoing.
			Importance of timely clinical assessments, recognition of "at risk" patients, documentation and communication to be emphasised.	Complete 28/02/2018.

			Case provided to Resident Medical Officer unit to be used as an education opportunity.	Complete 15/01/2017.
41	Unanticipated complication of surgery/ Procedure.	Lack of documentation of handover arrangement in patient record. Fragmented and inconsistent consultant oversight.	Handover of consultant responsibility from one surgeon to another should be clearly documented in the notes. A simple to implement standard could be devised and brought to the attention of both departments. Patients as in this case should be handed over at the bedside, or at the very least seen by in-coming consultant, on the day of handover. The frequency of subsequent consultant visits and level of oversight then to follow the exact same principles as if the patient had been under the in-coming surgeon's care from the beginning.	Complete 01/03/2018. Complete 01/03/2018.
42	Delay in treatment. Cancer.	There was an unacceptably long waiting list for colonoscopy when the patient was accepted. Following referral to General Surgery the patient waited a further three months to be seen as a First Specialist Appointment, three weeks for urgent colonoscopy and a further four months until the patient received definitive surgery.	Ensure appropriate measures to keep the waiting times for colonoscopy consistent with the New Zealand Guidelines Group recommendations in terms of surveillance intervals, the National Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography and appropriate scheduling of staff and available lists.	Complete 15/06/2018. Complete 15/06/2018.

		From the referral for surgical excision, following the diagnostic colonoscopy, the patient received two further endoscopic procedures and two clinic appointments before having surgery.	Introduce a procedure where referrals directed to General Surgery can be re-directed to colonoscopy triage prior to an outpatient appointment.	
43	Life threatening Post-Partum Haemorrhage.			Investigation report in draft.
44	Delay in diagnosis. Lung cancer.			Investigation report in draft.
45	Unanticipated complications of surgery. Inadequate decompression C3-6.	The competency assessment (despite direct observation) did not identify that the surgeon had limitations in surgical technique. The recruitment process did not identify the extent of the gap in the technical expertise of the surgeon.	The department is to review the credentialing process for new surgeons who are overseas trained. The service needs to consider introducing a process of direct observation of surgical techniques for a defined number of procedures to assess competency. Referee checks must include a Senior Medical Officer who was involved in the supervision in the previous 12 months. Training log books for first time consultant posts to be reviewed and for more senior consultant log books for the past 2 years to be supplied.	Complete 01/10/2018. Complete 01/10/2018.

			SDHB should consider a section in the contract which explains that if credentialing cannot be achieved, there is a process to address this.	Complete 31/07/2018.
		The surgeon did not identify that they needed advice or support.	Job description to include a paragraph describing the type of supervision overseas trained Senior Medical Officers will be receive. Weekly clinical meetings to be reinstated.	Complete 01/10/2018.
		Orientation/induction plan was not verified as completed.	All new surgeons in the department to be instructed that it is their responsibility that the induction checklist is to be signed off (within the first 4 weeks).	Complete 31/08/2018.
		There is no documented evidence that the surgeon saw the elective patients pre-operatively or personally consented them.	Ensure checking of consent process at 'surgical timeout' is completed by the surgical operator (or equivalent). Audit signatures on consent documentation.	Complete 30/09/2018.
		Junior medical staff reported they felt unable to raise some concerns.	Consider copying all letters to patients to improve consenting process.	Complete 31/08/2018.
			Ensure that the 'Speak Up programme' for staff including resident medical staff has been introduced to the department. Ensure junior medical staff receive the registrar handbook	

			which outlines the importance of patient safety through good communication.	
46	Unanticipated complications of surgery. L3/4 decompression of cauda equina.	The competency assessment (despite direct observation) did not identify that the surgeon had limitations in surgical technique.	The Department is to review the credentialing process for new surgeons who are overseas trained. The service needs to consider introducing a process of direct observation of surgical techniques for a defined number of procedures to assess competency.	Complete 01/10/2018.
		The recruitment process did not identify the extent of the gap in the technical expertise of the surgeon.	Referee checks must include a Senior Medical Officer who was involved in the supervision in the previous 12 months. Training log books for first time consultant posts to be reviewed and for more senior consultant log books for the past 2 years to be supplied. SDHB should consider a section in the contract which explains that if credentialing cannot be achieved, there is a process to address this.	Complete 01/10/2018. Complete 31/07/2018.
		The surgeon did not identify that they needed advice or support.	Job description to include a paragraph describing the type of supervision overseas trained Senior Medical Officers will receive. Weekly clinical meetings to be reinstated.	Complete 01/10/2018.
		Orientation/induction plan was not verified as completed.	All new surgeons in the department to be instructed at	

		Junior medical staff reported they felt unable to raise some concerns.	orientation that it is their responsibility that the induction checklist is to be signed off (within the first 4 weeks). Ensure that the 'Speak Up programme' for staff including resident medical staff has been introduced to the department. Ensure junior medical staff receive the registrar handbook which outlines the importance of patient safety through good communication.	Complete 31/08/2018.
47	Delay in diagnosis. Myocardial infarction. Patient deceased.			Investigation report in draft.
48	Responding to deterioration problem.			Investigation initiated.
49	Pressure Injury.	Lack of education/knowledge regarding pressure injuries including documentation, staging and prevention.	Increased opportunities for pressure injury education and practice improvement. Pressure injury coordinator to consider education programme that promotes increased awareness of assessment, staging and prevention of pressure areas.	This has been included in the ongoing Pressure injury work plan.

		Multiple areas required to document pressure injuries lead to apathy and complacency. Lack of consultation with Wound Care Nurse Specialist.	Consideration of more streamlined documentation to reduce duplication. Clear process for notifying Wound Care Nurse Specialist when pressure injury discovered.	This has been included in the ongoing pressure injury work plan. This has been included in the ongoing pressure injury work plan.
50	Deterioration of symptoms after neck decompression surgery.	The competency assessment (despite direct observation) did not identify that the surgeon had limitations in surgical technique. The recruitment process did not identify the extent of the gap in the lack of technical expertise of the surgeon. The surgeon was did not identify that they needed advice or support.	The department is to review the credentialing process for new surgeons who are overseas trained. The service needs to consider introducing a process of direct observation of surgical techniques for a defined number of procedures to assess competency. Referee checks must include a Senior Medical Officer who was involved in the supervision in the previous 12 months. Training log books for first time consultant posts to be reviewed and for more senior consultant log books for the past 2 years to be supplied. SDHB should consider a section in the contract which explains that if credentialing cannot be achieved, there is a process to address this. Job description to include a paragraph describing the type of supervision overseas trained	Complete 01/10/2018. Complete 01/10/2018. Complete 31/07/2018. Complete 01/10/2018.

		Orientation/induction plan was not verified as completed. There is no documented evidence that the surgeon saw the elective patients pre-operatively or personally consented them. Junior medical staff reported they felt unable to raise some concerns	Senior Medical Officers will receive. Weekly clinical meetings to be reinstated. All new surgeons in the department to be instructed at orientation that it is their responsibility that the induction checklist is to be signed off (within the first 4 weeks). Ensure checking of consent process at 'surgical timeout' is completed by the surgical operator (or equivalent). Audit signatures on consent documentation. Consider copying all letters to surgery patients to improve consenting process. Ensure that the 'Speak Up programme' for staff including resident medical staff has been introduced to the department. Ensure junior medical staff receive the registrar handbook which outlines the importance of patient safety through good communication.	Complete 31/08/2018. Complete 30/09/2018. Complete 31/08/2018.
51	Malposition of subdural drain causing intracerebral bleed.	The competency assessment (despite direct) observation did not identify that the surgeon had limitations in surgical technique.	The department is to review the credentialing process for new surgeons who are overseas trained. The service needs to consider introducing a process of	Complete 01/10/2018.

			direct observation of surgical techniques for a defined number of procedures to assess competency.	Complete 01/10/2018.
		The recruitment process did not identify the extent of the gap in the technical expertise of the surgeon.	Referee checks must include a Senior Medical Officer who was involved in the supervision in the previous 12 months. Training log books for first time consultant posts to be reviewed and for more senior consultant log books for the past 2 years to be supplied.	Complete 31/07/2018.
			SDHB should consider a section in the contract which explains that if credentialing cannot be achieved, there is a process to address this.	Complete 01/10/2018.
		The surgeon did not identify that they needed advice or support.	Job description to include a paragraph describing the type of supervision overseas trained Senior Medical Officers will be receive. Weekly clinical meetings to be reinstated.	Complete 01/10/2018.
		Orientation/induction plan was not verified as completed.	All new surgeons in the department are to be instructed at orientation that it is their responsibility that the induction checklist is to be signed off (within the first 4 weeks).	
		Junior medical staff reported they felt unable to raise some concerns	Ensure that the 'Speak Up programme' for staff including resident medical staff has been introduced to the department.	

52	Fracture unknown cause. Femur.	Intensive Care Unit (ICU) trial bed not suitable to be used for patients that require floor hoist transfers. For patients such as a quadriplegic with no muscle tone, and poor bone density need precautionary measures when transferring (e.g. ensuring legs have adequate support when being moved in hoist or bed).	Increase staff awareness that Linet trial bed does not allow for hoist to fit underneath it. ICU physiotherapist to review manual handling best practice for patients at risk with long term co-morbidities.	Complete 31/08/2018. Planned 20/12/2018.
53	Pressure Injury. Inpatient.	Documented as pressure area care required, times undertaken not documented. No documentation as to integrity of skin as moisturiser cream being required. No documentation on day of transfer and ISBAR used. Pressure area assessment completed 48 hours after arrival in ward. Braden risk assessment not sensitive to all risks, staff need to use clinical over ride.	Arrange education session on using the Braden tool and documentation.	Complete 19/07/2018.
54	Delay in diagnosis. Intracranial tumour. Patient deceased.			Investigation report in draft.
55	Delay in diagnosis.			Investigation report in draft.

	Patient deceased.			
56	Pressure Injury. Inpatient.	Pressure injury from plaster that was necessary for conservative management of fractured right proximal humerous.	Recommendation that there is earlier documentation of pressure area/wound documentation that is specific – wound chart.	Complete 30/04/2018
57	Delay in diagnosis. Patient deceased.			Investigation initiated.
58	Pressure Injury. Inpatient.	Patient was at very high risk of developing a pressure injury secondary to his advanced peripheral vascular disease. The Braden score was not sensitive to this and even when scoring a 1 for sensory perception it still scored his risk out as low. There needed to be critical clinical override treating him as high risk despite the Braden assessment and instigate pressure prevention strategies at admission. The patient had many risk factors for pressure injury including PVD, poor nutrition and post-operative incapacity and reluctance to use prevention strategies such as foam boot and pillows to off load and relieve pressure. Some inconsistency found as to where to document wound care in clinical notes. Although the information was there it was in multiple places such as wound care chart, clinical progress notes. There was not good descriptions of the wound status and care plan making it difficult to gauge wound healing progress.	All patients admitted with vascular compromise should be identified as high risk for developing pressure injuries. Pressure injury prevention strategies should be instigated on admission with close reassessment daily to identify early any pressure injury development.	Complete 03/08/2018. Complete 03/08/2018. Complete 03/08/2018. Complete 03/08/2018

		Staff awareness and high level vigilance for patients with prolonged theatre time in which vascular circulation is compromised intra operatively are high risk for pressure injury. Awareness that narcotic and epidural pain relief may further mask the developing pressure injury. If a pressure injury progresses it should be restaged, if greater than stage II then an Adverse Event (AE) SAC 2 notification should occur with the instigation of an investigation commenced at this time. Treatment injury forms to be completed as soon as a pressure injury is discovered.	If a pressure injury is identified strict documentation is required including detailed description (side, size, exudate & visual description) supplemented by drawings, measurements and photos to record the nature of the injury and to track progress - using the Silhouette system for any stage III pressure injuries. Raise staff awareness via staff education session on Pressure Injuries. Raise staff awareness in theatre via staff education session on pressure injury prevention while undergoing surgery. Use this case to demonstrate risk. Education session for staff.	Complete 03/08/2018.
59	Delay in diagnosis. Subluxed/ dislocated hip.			Investigation initiated.
60	Pressure Injury. Inpatient.	Assessment and planning for pressure injury prevention is not well integrated into care pathways/ care plans. This includes recognition of the acutely confused patients and nutrition/ hydration as key issues. Communication between shifts/ clinical teams regarding patients at risk of pressure injury and documentation is needs to be improved	Link to the work that is planned by the Quality and Director of Nursing group around combined risk assessment for patients. This will include an extensive education programme that identifies appropriate care plans based on assessments every three days.	Complete 27/05/2018. Complete 31/08/2018.

		The use of SSKIN as a framework for intervention and pressure injury prevention is not well understood or utilised as it could be. Nutrition and hydration are not well addressed or documented. Device related Pressure Injury is often not considered.	SSKIN is the framework that should be used for assessment, and planning. This will include nutrition and hydration and documenting these. A small working group to look at device related issues on skin care should be established.	Complete 31/08/2018.
61	Pressure Injury. Inpatient.	The Braden Scores were too low and not sensitive enough to trigger a response plan, and intervention strategies alone. Clinical practice variation and poor documentation. Nurses using National Pressure Ulcer Advisory Panel Classification Systems and Pressure Injury scales in silos.	Whole of system approach to pressure injury prevention, evaluation, monitoring and treatment options in line with best practice. Joint Education, Pressure Injury Audits and communication pathways.	Planned 20/12/2018. Planned 20/12/2018.
62	Delay in treatment. Tracheostomy problem.	Gaps in knowledge around the deteriorating patient and neurosurgery.	Education plan nursing staff including: Education review to understand actual vs ideal level of specialty neurosurgical skill required on the ward; Education plan for nursing staff to attend deteriorating patient study days (which include Early Warning Score response pathways and use of ISBAR communication tool);	Planned 20/12/2018

			Associate Charge Nurse Managers (ACNM) education plan identified including attending Advanced Core Level 6 Course within the next 6 months; Addition of Clinical Facilitator role, to use clinical teaching/coaching to support clinical decision making in practice, to help reinstall knowledge, and provide clinical support for complex and deteriorating patients in the ward environment alongside nursing staff and clinical leadership.	
		ACNM role consumed with logistics and bed management.	Understand leadership requirements to fulfil team based model of care (both team leaders and ACNM levels) and provide support where required; Peer coaching/mentoring programme for ACNM group. Leadership programme for Team Leaders.	Planned 20/12/2018
		Lack of discharge/admission processes from the High Dependency Unit to the ward. Communication documented by medical teams.	Development of Admission/Re-admission/Discharge criteria for Neuro High Dependency Unit patients. Clearly documented medical plans of care in the notes, and clear High Dependency Unit discharge plans.	Planned 20/12/2018 Complete 26/10/2018

		Inconsistent House Officer medical cover. Senior medical staff unavailable for junior covering medical staff to contact.	Ensure House Officer cover for the specialty service is a priority for the RMO Unit. Service Clinical Leads to define process for secondary escalation.	Complete 26/10/2018 Planned 20/12/2018
63	Procedural complication during chest drain insertion. Patient has since died.			Investigation initiated.
64	Pressure Injury. Inpatient.	Assessment and planning for pressure injury prevention is not well integrated into care pathways/ care plans. This includes recognition of the acutely confused patient and nutrition/ hydration as key issues. Communication between shifts/ clinical teams regarding patients at risk of pressure injury is poorly documented. The use of Braden as a tool does not always identify patients at risk. The use of SSKIN as a framework for intervention and pressure injury prevention is not well understood or utilised.	To link to the work that is planned by Quality and the Director of Nursing group around combined risk assessment for patients. This will include an extensive education programme that identifies appropriate care plans based on assessments which are carried out every three days. SSKIN is the framework that should be used for assessment and planning. This will include nutrition and hydration both of which are issues that are not addressed or documented well.	Planned 20/12/2018. Planned 20/12/2018.
65	Unexpected death.			Investigation report in draft.
66	Delay in diagnosis. Cancer.	Review registrar information in regard to Prostate Specific Antigen (PSA) protocols.	Ensure PSA treatment guidelines are included in Resident Medical Officer orientation information.	Planned 20/12/2018.