

Treatment Injuries and Wounds

Wednesday 15th November 2017





**Has your patient suffered a
treatment injury?**

Ministry of Health



ACC



ACC – Treatment Injury

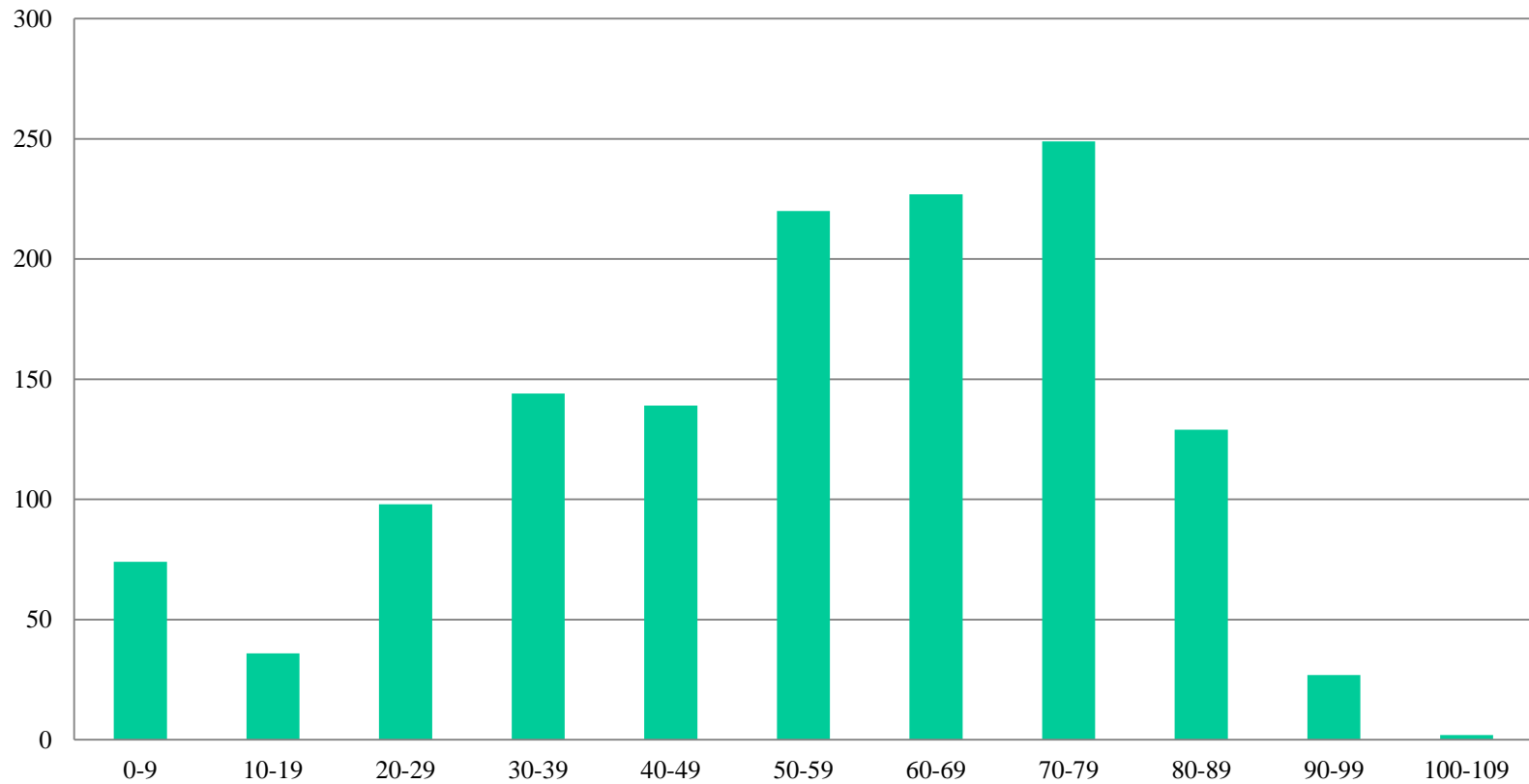
A personal injury caused by treatment that is neither:

- A necessary part of treatment
- Nor an ordinary consequence of treatment (high risk of occurring)

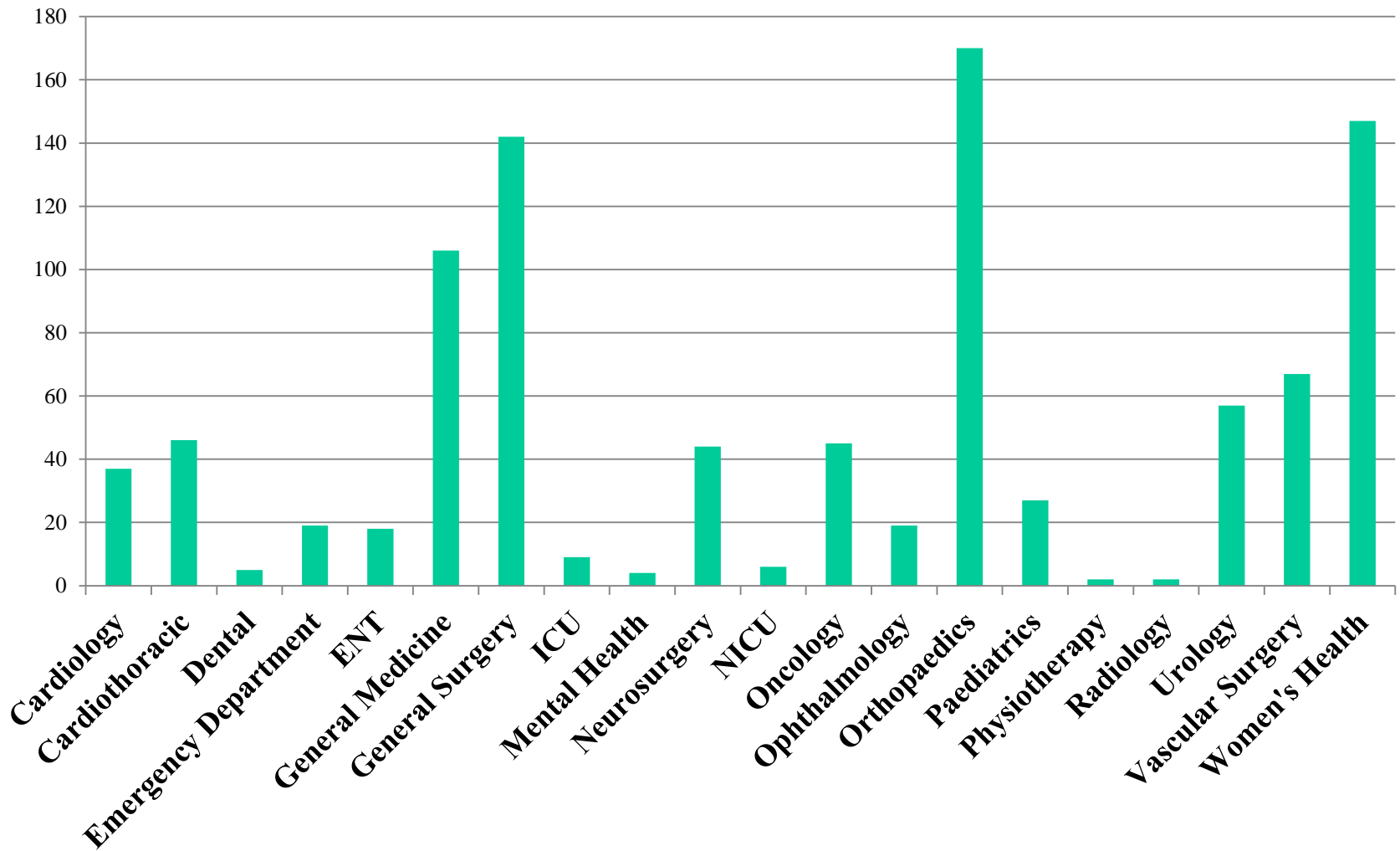
Even though an injury is a known risk of that treatment it is still a treatment injury

No fault scheme

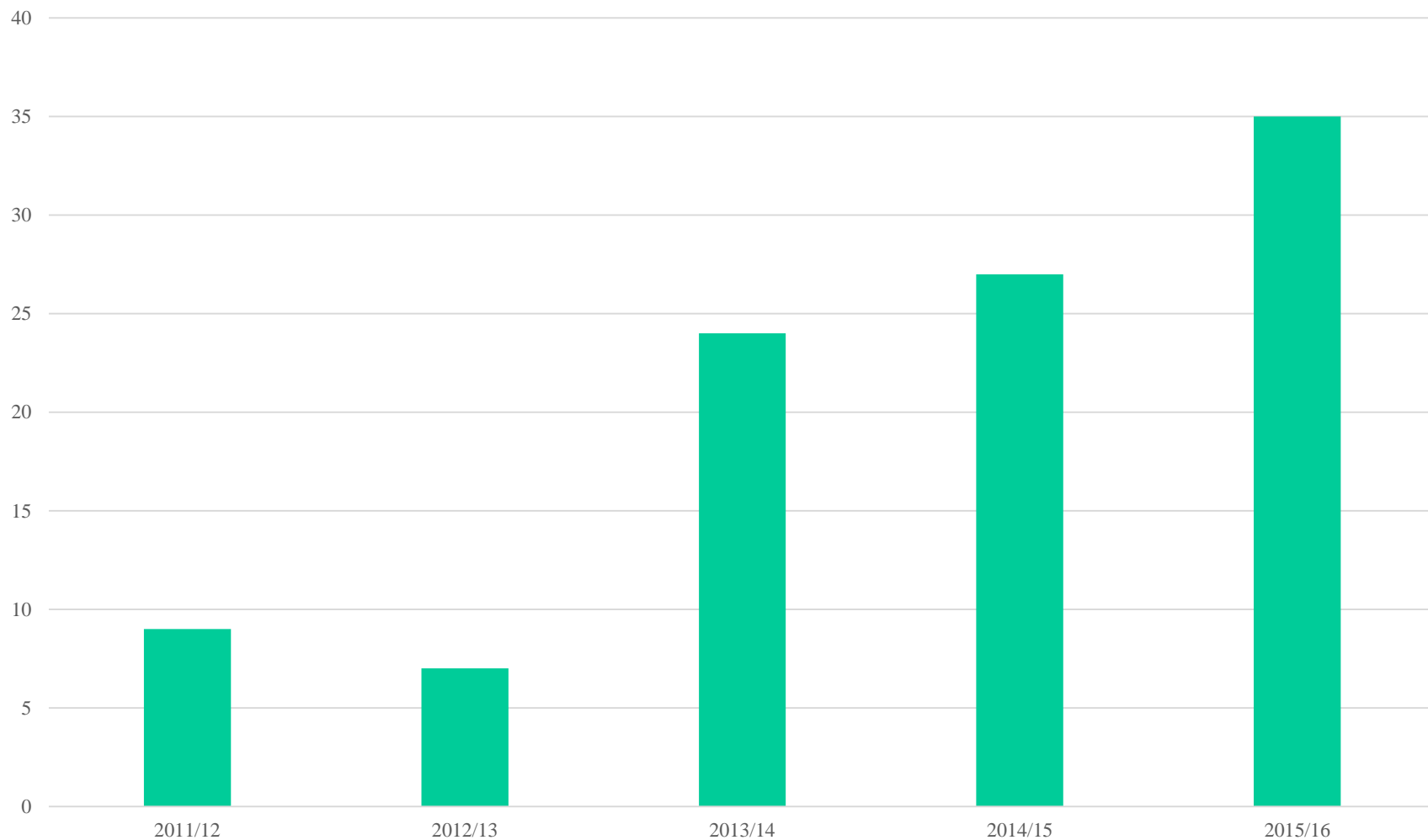
Treatment Injuries by age group for CCDHB



Injury location by service CCDHB



Accepted pressure injury claims for CCDHB



Data source - 'Supporting Patient Safety - April 2017' (ACC)

Accepted infections following surgery claims for CCDHB



Data source - 'Supporting Patient Safety - April 2017' (ACC)

**Post operative infections cost ACC
almost \$10 million for 2015/16
financial year**

**Pressure injuries cost ACC \$833K
for 2015/16 financial year**

Treatment Injury case study 1

85 yo man admitted with left 3rd toe cellulitis and osteomyelitis.

History of PVD, amputation of 4th and 5th toes, IHD, CHF, deconditioned in months leading up to admission

Braden scale 18 on day of admission = Low risk

Treatment Injury case study 1

Initial treatment – elevation and compression.

Amputation day 2.

No further risk assessment done

Developed left heel pressure injury by day 5 –
mattress ordered and pressure cares started.

How did ACC support this patient?

Treatment Injury case study 2

- 38yo female underwent abdominal rectopexy March 2011
- PE post op – Warfarin and Heparin
- Haematoma, infection and wound breakdown
- VAC therapy
- Incisional hernia 2013

Treatment Injury case study 2

Impact on the DHB:

- Missed revenue \$10,000 +

Impact on the patient:

- Denied access to financial support, home help, transport costs, child care, costs of GP visits.

Treatment Injury case study 3

- Vaginal prolapse repair
- Developed faecal discharge from vagina
- Diagnosed with abscess and ano-vaginal fistula
- OT – washout and laparoscopic formation of colostomy
- Treatment Injury claim lodged

Treatment Injury case study 3



When should we lodge a treatment injury claim?

Left hand side to be completed by patient

ACC46

Right hand side to be completed by clinician

ACC 46 ACC electronic input injury claim form

Patient NHI number: (Treatment provider to complete) A.B.C.1.2.3.4.

SECTION 1: PERSONAL AND EMPLOYMENT DETAILS *Patient to complete*

Family name: GREEN

First name(s): DIONTY

Date of birth: 01/01/1921 ☐ Male ☐ Female

Address: Street 42 ABC DRIVE Suburb WELLINGTON City + Postcode WELLINGTON

Daytime phone number: 012345678 Alternate phone number: 0

What is your ethnic background? This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.

☒ NZ European/Pakeha ☐ Cook Island Maori ☐ Fijian ☐ Indian ☐ Samoan ☐ Other European ☐ Tongan ☐ Other Pacific ☐ Other Asian ☐ Tokelauan ☐ NZ Maori ☐ Niuean ☐ South East Asian ☐ Chinese ☐ I'd prefer not to say ☐ Other ethnic group please specify _____

Employment status: ☐ Paid employment in NZ ☐ Self-employed in NZ ☐ Student or preschooler ☒ Retired, unemployed or other non-earner in NZ ☐ Overseas visitor

Occupation: _____

Usual work type? (Tick one box only) ☐ Sedentary (brief standing and walking) ☐ Light (frequent standing and walking) ☐ Medium (often lift small loads) ☐ Heavy (frequent lifting over 20kg) ☐ Very heavy (consistent lifting over 20kg)

Name of employer/trading name: _____

Location (or phone number): _____

SECTION 2: ACCIDENT DETAILS *(If needed, ask your treatment provider for help completing this section)*

Date of accident? 14/04/2014

Did the accident occur at work? ☐ Yes ☐ No

Did the accident involve a moving motor vehicle on a public road, driveway or beach? ☐ Yes ☐ No

Is this claim for a treatment injury? ☐ Yes ☐ No *(If yes, provider also fills in ACC152)*

What were you doing? eg. cleaning kitchen Patient fell while mobilising to bathroom.

What happened? eg. slipped on wet floor Patient fell while mobilising to bathroom.

How was the injury caused? eg. hit head on table

Accident scene (eg. home, place of work, road) _____ Accident location (eg. Toupou) _____

SECTION 3: PATIENT DECLARATION AND CONSENT

I have read and understood the important information, patient declaration and consent on the reverse of the patient copy of this form.

Patient to sign here or legal guardian or representative Green Date: 14/04/2014

Authorised representative's name: _____ Authorised representative's relationship to patient: _____

Treatment provider to complete
Note: ACC does not provide cover for illness or sickness

SECTION 4: INJURY DIAGNOSIS AND ASSISTANCE

Diagnosis coding used:

Diagnosis 1 _____

Diagnosis 2 _____

Diagnosis 3 _____

Additional injury comment Skin tear

☐ This is a work-related injury

Has the patient been admitted to hospital? ☐ Yes ☐ No

Is home help or other assistance required by the patient? ☐ Yes ☐ No

SECTION 5: FITNESS FOR WORK *(Registered medical practitioner only to complete this part. Maximum 14 days using this form)*

Is the patient fit to continue normal work? ☐ Yes (go to Section 6) ☐ No (continue)

FIT FOR SOME WORK

From DD MM YYYY to DD MM YYYY

the patient is fit to work _____ per day. The patient is fit for the following types of work:

☐ Sedentary (brief standing and walking) ☐ Light (mainly standing and walking) ☐ Medium (often lift 5kg plus) ☐ Heavy (often lift 9kg plus)

Additional restrictions (eg. No prolonged lifting) _____

FULLY UNFIT FOR WORK

The patient is fully unfit for work

from DD MM YYYY to DD MM YYYY

SECTION 6: TREATMENT PROVIDER DECLARATION

I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident or work-related gradual process. I also certify that the patient (or their representative) has signed the Patient Declaration and consent and has authorised me to lodge the claim on their behalf.

Date of consultation: 14/04/2014

Treatment provider's name (print) or stamp: John Lowe

ACC provider number: _____

Health practitioner index: ☐ Person (P/F/M) ☐ Organisation ☐ Facility

Treatment provider's signature: _____

Provider copy for _____

4. Correct code or detailed description of personal injury

6. Signature, date and print name

3. Must have patient consent

ACC2152

ACC
2152

Treatment Injury Claim

Treatment Providers use this form in addition to the ACC45 or the ACC42 (dental) when lodging a claim for injuries which occur in the context of treatment.



PART A: PATIENT DETAILS

| | |
|--|---|
| Patient's family name: <u>Green</u> | Patient's first name(s): <u>Dorothy</u> |
| Patient's date of birth: <u>01/01/21</u> | Patient's NHI number: <u>ABC1234</u> ACC45/ACC42 claim number: <u>JJ07178</u> |

PART B: TREATMENT INJURY DETAILS

| | |
|--|--|
| List the injury(ies) caused by the treatment: <u>Skin tear left thigh</u> | Diagnosis coding: <input type="checkbox"/> ICD10 <input type="checkbox"/> READ CODE <input type="checkbox"/> And reason (Dental) Diagnosis code(s) (if available): |
| List the signs and symptoms of the injury: <u>See medical records</u> | |
| Date which the patient first sought or received treatment for the injury: <u>14/4/2014</u> | |
| How does the injury affect the patient's daily activities? <u>Requires dressing</u> | |

PART C: TREATMENT (CLAIMED TO HAVE CAUSED THE INJURY)

| | |
|---|--|
| What treatment gave rise to the injury? (If the claimed injury resulted from failure to treat, please note.) <u>patient fell while moving to bathroom</u> | Diagnosis coding: <input type="checkbox"/> ICD10 <input type="checkbox"/> READ CODE <input type="checkbox"/> And reason (Dental) Diagnosis code(s) (if available): |
| Describe the events or circumstances which led to the injury. Include details of any medications and dates prescribed. (Please attach additional information if required.) <u>As above</u> | |
| Where was treatment provided? <input type="checkbox"/> Specialist rooms <input type="checkbox"/> GP/medical centre <input type="checkbox"/> Operating theatre <input type="checkbox"/> Emergency department <input type="checkbox"/> Ward/special unit <input type="checkbox"/> Pharmacy <input type="checkbox"/> Community clinic <input type="checkbox"/> Hospital outpatient clinic <input type="checkbox"/> Rest home/aged care <input type="checkbox"/> Home <input type="checkbox"/> Laboratory <input type="checkbox"/> Radiology <input type="checkbox"/> Other diagnostic/treatment area <input type="checkbox"/> Other - please specify: | |
| Name of the facility (if relevant): <u>Wellington Hospital</u> | |
| Outline the condition(s) being treated (with dates): | Diagnosis coding: <input type="checkbox"/> ICD10 <input type="checkbox"/> READ CODE <input type="checkbox"/> And reason (Dental) Diagnosis code(s) (if available): |

| |
|---|
| Outline all underlying health conditions and other relevant factors/treatment. (If the injury is a worsening of an existing condition, please note.) |
| Name and occupation of the health professional(s) who provided or directed treatment. (ACC may need to contact these people for more information.) <u>John Lowe RN</u> |
| Other information which may be relevant to this claim. (If there are related ACC claims, please note.) |

PART D: TREATMENT PROVIDER DECLARATION

| | |
|--|------------------------------|
| To be signed by the health professional completing this claim form. I certify that the information provided is accurate, to the best of my knowledge. | |
| ACC Provider number: | |
| Treatment provider name: <u>John Lowe</u> | Or Treatment provider stamp: |
| Occupation: <u>RN</u> | |
| Address: <u>CCDHS</u> | |
| Treatment provider signature: <u>[Signature]</u> | Date: <u>14/4/14</u> |
| Attach available relevant documents, for example copies of clinical records such as discharge summaries, clinic letters, operative report, radiology report, incident form. Don't delay lodging this claim if these documents are not immediately available. | |
| Lodging a treatment injury claim <ul style="list-style-type: none"> The ACC45 or ACC42 form can be lodged electronically or manually. Please email, fax or post the ACC2152 form and clinical notes to: ACC Treatment Injury Centre, PO Box 430, Dunedin 9054, Fax (04) 560 5361, email TIClaims@acc.co.nz Send your invoice to your ACC Service Centre (check www.acc.co.nz for contact and invoicing details) | |
| FOR HOSPITAL ADMINISTRATION USE ONLY | |

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.



**Has your patient suffered a
treatment injury?**