Canterbury District Health Board Serious Adverse Events Report
1 July 2013 – 30 June 2014

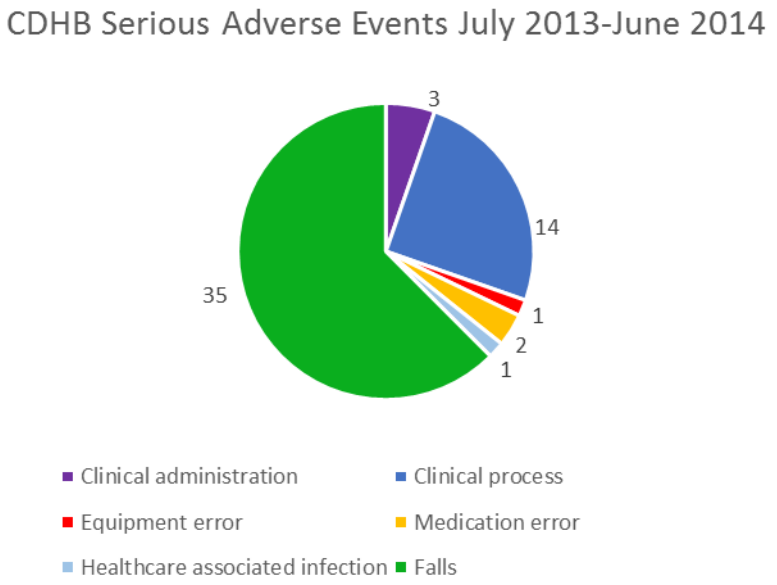
There were 56 serious adverse events reported by the Canterbury District Health Board (CDHB) in the July 2013 to June 2014 year.

What is a serious adverse event?
A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

At CDHB our patient focused, clinically led culture supports our commitment to 'zero harm' and continuous quality improvement. All serious adverse events are reviewed through a formal process that involves a multidisciplinary team. The purpose of reviewing these is to understand underlying causes of the event. By identifying problems and failures we can learn from them and make our systems safer.

The report below outlines a summary of events, findings and recommendations of the events which have occurred. The events have been classified into six specific themes:

- Clinical administration
- Clinical process
- Equipment error
- Medication error
- Healthcare associated infection and
- Falls



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Clinical Administration Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Internal referral not received.	Paper based referral system. Lost between services. No evidence of human error.	All internal referrals to be receipted on arrival with acknowledgement provided to sender. Sender to ensure receipt received.	In progress.
Referral not sent. Delay in treatment.	Referral form filed in the record but was not faxed.	Referral forms removed form clinic and referral letters now dictated and sent.	In progress.
Intrauterine death.	No care delivery issues identified.	Nil.	

Equipment Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Death while having procedure.	Under review. Report underway.	Under review.	

Healthcare Associated Infection			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Healthcare associated infection.	IV line inserted in medical emergency. Line dwell time less than 24 hours.	Re-education of staff. Stickers for insertion of intravenous devices be added to resuscitation trolleys.	In progress.

Clinical Process Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Patient deteriorated acutely. Delay in investigations.	Acute medical ward decanted to another hospital. Potential for patient to become high risk not evident at selection of admission site. Delay in investigations due to site configuration. Delay in inter-hospital transfer due to lack of knowledge of transfer protocols	Increase clarity of types of cases for decanted site. Clarify inter-hospital transfer protocols and display process flow sheets in prominent places. Make routine acute services available such as diagnostic tools easy to access.	Completed.

	which also contributed to delay in ambulance arrival.		
Delay in diagnosis and treatment.	On review subtle abnormality noted on CT. CT report not filed in clinical record. Clinical notes incorrect - CT noted as NAD. CT not viewed by treating team. CT not reported in discharge summary.	Radiology initial investigation impressions to be identified as such and followed up. All radiologic scans to be discussed at MDT. Electronic sign off of all radiology results. All results to go on electronic discharge summary to GP Team.	In progress.
Antibiotics were not prescribed for asymptomatic urinary tract infection	A general lack of awareness of the importance of treating all urinary tract infections/ colonisation in pregnant patients. The lack of information relating to the Lead Maternity Carer (LMC) for the patient resulted in the LMC not being copied into investigation results or receiving a copy of the discharge summary. This resulted in a lost opportunity for the LMC to provide treatment based on the positive urine result.	Promulgating the importance of treating all urinary tract infections/colonisation in pregnant patients. All investigation results and discharge summaries of pregnant patients to be copied to the patient's Lead Maternity Carer as well as General Practitioner. A process to refer pregnant patients admitted other than under an obstetric service to an obstetrician upon admission.	In progress.
Intraoperative injury.	Report completed.	Mortality and Morbidity report to be shared.	
Bilateral eye injury.	Incomplete assessment on admission.	Staff re-education. Review of assessment document proformas.	In progress.
Delay in diagnosis.	Report underway.	Under review.	
Left ventricular perforation at line insertion.	Report at final sign off stage.	Under review.	
Cardiac arrest 12 days after operation.	Report underway.	Under review.	
Sudden death at home 12 days after attending ED.	Under review. Report underway.	Under review.	
Brain injury.	Unanticipated complication with no guideline	Develop clinical guideline. Revise role	In progress.

	available. Unclear communication between team members regarding workload management. Unawareness of role in escalation process. Delay in requesting support.	descriptions, orientation programme and escalation process. Review communication methods/tools/processes.	
Death subsequent to transfer of care.	Under review. Report underway.	Under review.	
IV fluids went into arm tissue.	Under review. Report underway.	Under review.	
Brain injury.	Under review.	Under review.	
Cardiac event while undergoing procedure.	Under review.	Under review.	

Medication Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Inappropriate dose and route of medicine injection.	Patient experiencing an increasing allergic reaction to medication. Clinician administered all therapies including adrenalin IV. Patient experienced tachycardia and nausea. Recovered from all symptoms and discharged.	Standardisation of storage of Emergency Medications. CPR Training in the Outpatient setting. Call bell system in the Outpatient setting.	Completed.
Allergic reaction to medicine.	Inadequate checking of adverse drug reactions at point of care. Multiple interruptions. Delay in identification of adverse reaction.	Review and strengthen CDHB processes for displaying past adverse reactions at point of care. Review prescribing environment to reduce interruptions. Identify and manage work-loads.	In progress.

Falls

Thirty five patients had a serious fall while an inpatient in our hospitals in the 2013-2014 year. CDHB has a 'Whole of System approach to falls prevention'. We are committed to achieving zero harm from falls and are focusing on the three key areas - falls prevention in the wider community, falls prevention in rest homes and falls prevention for older people receiving care in Canterbury DHB hospitals.

In the community and rest homes:
The Canterbury Community Falls Prevention Programme, which enabled over 3000 older people to be seen in their own homes, has been reviewed and improved. Clients will now have access to a more responsive, clinically- led falls programme, no matter their level of frailty. All of these people will receive an initial visit including a home hazard check and the most appropriate falls prevention programme will then be delivered.
The Canterbury DHB is working with rest homes and primary care providers to ensure that at least 75 percent of residents over 65 years are receiving Vitamin D supplementation. Research suggests Vitamin D supplementation for this group of older people significantly reduces falls and serious harm from falls.

In our hospitals:
We continue to focus on patient assessment and tailoring falls prevention strategies to meet the needs of individual patients while they are in hospital and for when they return home. In August 2013 a Steering Group was introduced to provide oversight and direction across hospitals for the Hospital Falls Prevention Programme. This programme aims to reduce falls in hospital and includes routine activities such as the annual Falls Awareness Campaign, reviewing policies, monitoring falls and patient's assessments as well as key projects. Two current projects are:

- Standardising the falls prevention visual cues across hospitals and care of patients following a fall. Visual cues can be displayed at the patient's bedside, worn as a bracelet or tagged to patient equipment. They indicate to family and staff at a glance the level of assistance a patient requires in moving about.
- Ensuring patients have access to appropriate walking aids, this involves identifying the barriers to patients bringing their own walking aids to hospitals as well as looking at the availability of walking aids in hospital.