Canterbury District Health Board Serious Adverse Events Report

1 July 2015 – 30 June 2016

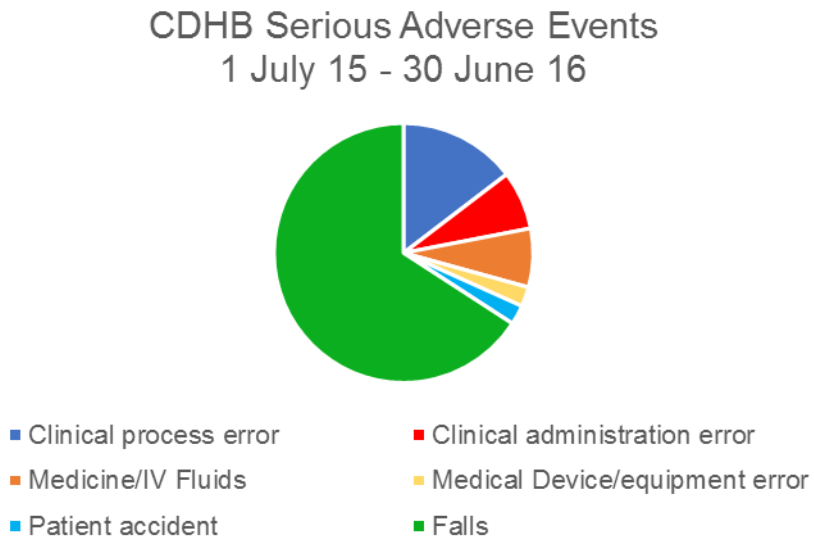
There were 43 serious adverse events reported by the Canterbury District Health Board (CDHB) in the July 2015 to June 2016 year.

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 process error
- Clinical administration error
- Medicine/IV Fluids error
- Medical Device/Equipment error
- Patient accident and
- Falls



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Clinical Administration Error (01)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Patient had a CT ordered and undertaken that was intended for another patient with the same surname.	A husband and wife attended separate speciality outpatient appointments on the same day. The wife required a CT scan and this was later found to have been ordered in her husbands name. The event was further complicated as both did require a scan but on different parts of the body. When the husband attended for his scan, he also received a 2nd scan on a different part of body. Despite intensive review and a number of hypotheses being tested; how this actually occurred remained unknown.	The incident review will be shared widely as there were a number of possible factors that may have contributed to the event occurring.	Meetings are scheduled for discussion of the case to occur in November.
Inability to provide timely treatment due to delayed transfer to Tertiary Centre	Report being drafted.		
Delayed follow-up and treatment	There was no clear and standardised format for medical staff to communicate follow up appointment timeframes to the booking clerk.	Improve follow-up appointment booking system and communication processes.	Complete

Clinical Process Error (02)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Complications from delay in diagnosis and treatment of condition	Review underway		
Retrieval of fetal scalp electrode two days after caesarean section	Report completed	Improve documentation and communication processes around the presence and removal of a fetal scalp electrode in operating theatre.	Complete
Intravenous nutrition into tissues due to migration of umbilical line	Review underway		
Unrecognised abnormal tests resulted in delayed treatment	Review underway		
Condition unrecognised resulted in delayed treatment	Review underway		

Consent to treatment not obtained	Report completed	Improve checking processes when electroconvulsive therapy is prescribed	Complete

Medication/IV fluids (05)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Unintentional administration of a residual anaesthetic agent	Report being drafted		
Narcosis symptoms developed and condition deteriorated following treatment	Report being drafted		
Anaphylactic reaction to medication	Report being drafted		

Medical Device/Equipment Error (09)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Perforation of 7 implantable ports in different patients over 4 months	Report completed	Cease use of port product and source an alternative. Review and enhance medical device evaluation processes	Complete To be commenced

Patient Accident (11)			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Left proximal femoral peri-prosthetic fracture following elective left total hip replacement.	Review underway		

Falls

FALLS

Strategy
Canterbury DHB has a 'Whole of System approach to falls prevention'. The DHB is 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 our hospitals.

***In the community and rest homes**:*
Over the past year, the Canterbury Community Falls Prevention Programme provided care to over 1900 older people. Following an initial home visit from a physiotherapist or registered nurse, a home falls assessment and hazard check is completed, and a personal falls prevention programme is tailored to improve strength and balance and reduce the risk of falls.

A recent evaluation found that from February 2012 to February 2016 there have been 1,533 fewer people over 75 years presenting to the Christchurch Hospital Emergency Department due to a fall, compared with expected volumes based on pre intervention trends. The evaluation also found that there has been 455 fewer than expected admissions for hip fractures, 191 fewer deaths post hip fracture than predicted and 800 fewer bed days occupied in hospital per year due to a fall in the community.

In our hospitals:
29 patients had a fall resulting in serious harm while an inpatient in our hospitals during the 2015-2016 year. There continues to be a focus on identifying risk factors and tailoring falls prevention strategies to meet the needs of individual patients while they are in hospital and for when they return home. Routine activities include the use of visual cues, safe mobility plans for all patients, monitoring and feeding back falls measures, Releasing Time to Care activity such as intentional rounding and bedside handover, the annual Falls Awareness Campaign, reviewing policies, and progress on key projects.

In the 2015-16 year, the new standardised process for the care of patients following a fall was finalised and implemented across the hospitals. A new look 'Reducing Your Risk of Falls While in Hospital' patient and family information pamphlet has been released. It now includes visual cues, which come in the form of a colour-coded bracelet or tag on equipment such as a walking aid. These cues indicate to family and staff at a glance the level of assistance a patient requires for safe mobility.

The implementation of the electronic incident management system has also provided access to data used to identify trends and focus future improvement work.