Canterbury District Health Board
1 July 2012 – 30 June 2013

Serious or Sentinel	Event code* (see codes below)	SAC	Description of Event	Review Findings	Recommendations/Actions	Follow up
Serious	2	2	Radiation overdose / geographic miss	Treatment calendar required modification and was incorrectly scheduled. There were a number of checks in place that failed to detect the error.	Protocols /guides updated and improved. More robust checks prior to treatment are in place. Radiotherapy treatment prescriptions have been simplified. Independent dose checking system has been designed for implementation.	Actions completed
Serious	2	2	Unplanned readmission to ICU.	Pressure on ICU beds may have influenced the decision for patient to be discharged.	Improvements to discharge and handover processes Critical care capacity to be reviewed.	Actions underway
Serious	1	1	Failure to communicate the plan for teeth removal to the Surgical Team.	Limited access to a patient information system resulted in a different outcome for the patient than what was recommended by another specialty.	Full access to the patient information system is now available to all relevant specialties.	Actions completed
Sentinel	2	1	Admitted with pneumonia – subsequently arrested and died	No causal factors identified	RCA report completed. No recommendations	Completed
Sentinel	2	1	Surgical complication leading to death	Root Cause Analysis underway.	RCA Report awaited	

Serious or Sentinel	Event code* (see codes below)	SAC	Description of Event	Review Findings	Recommendations/Actions	Follow up
Serious	11	2	Patient injury – not a fall	No care delivery problems identified.	Equipment modified to prevent reoccurrence.	Patient injury – not a fall
Serious	1	2	Delay in diagnosis and treatment.	Root Cause Analysis underway.	Organisation wide interim protocol disseminated relating to acknowledging internal referral. RCA report awaited.	
Serious	2	2	Delay in diagnosis and treatment.	Root Cause Analysis underway.	Organisation wide interim protocol disseminated relating to acknowledging internal referral. RCA report awaited	
Serious	2	2	Delay in diagnosis and treatment.	Root Cause Analysis underway.	Organisation wide interim protocol disseminated relating to acknowledging internal referral. RCA report awaited	
Serious	2	2	Radiotherapy target dose not achieved	Root Cause Analysis underway.	RCA Report awaited	
Sentinel	2	1	Death of baby after birth	Root Cause Analysis underway.	RCA Report awaited	
Serious	5	2	Respiratory arrest of woman during labour following administration of two types of analgesia; emergency caesarean section required	Clinical guideline availability and communication were contributory factors	RCA report completed. Clinical guideline more available and communication processes revised	Actions underway
Serious	5	2	Child suffered a seizure as a result of aminophylline toxicity	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	While undergoing outpatient procedure child suffered respiratory arrest; recovered	Root Cause Analysis underway.	RCA Report awaited	

Serious or Sentinel	Event code* (see codes below)	SAC	Description of Event	Review Findings	Recommendations/Actions	Follow up
Sentinel	2	1	Child admitted to Paediatric HDU with respiratory illness; cardiac arrest occurred and child later died	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	Umbilical vein catheter being used to administer Total Parental Nutrition to a child pierced liver	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	Term pregnancy with chorioamnionitis. Baby hypoxic on delivery requiring prolonged resuscitation. Cerebral injury occurred	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	Emergency caesarean section performed – baby diagnosed with cerebral injury	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	Pressure injury developed under Aspen Brace	The requirement for an Aspen Collar to be applied and maintained on a patient in a ward not familiar with their use contributed to development of a pressure injury	Develop & implement instructions for Aspen Collar placement and maintenance for use by ward staff. Develop a glossary of agreed terminology to ensure there is no confusion between the different types of collars available.. Ensure orthotics provide contact details to enable staff to know who to contact if brace or fit needs adjusting or for any issues which may arise.	Actions underway

Serious or Sentinel	Event code* (see codes below)	SAC	Description of Event	Review Findings	Recommendations/Actions	Follow up
Sentinel	2	1	Death of an inpatient	Root Cause Analysis underway.	RCA Report awaited	
Serious	2	2	Subdural haemorrhage identified post lumbar puncture procedure.	Subdural had chronic elements with no clear causal relationship to the lumbar puncture.	Protocol/checklist for elective lumbar puncture procedure developed & implemented to alert medical staff of patient contraindications.	Completed

Falls

Case ID	Event Date	Serious or Sentinel	Event Code	SAC	Description of Event	Strategy
PMH68	04/07/2012	Serious	12	2	X-ray following fall revealed no injury. Patient complained of pain and subsequent MRI scan revealed Fractured Neck of Femur	*(Extract from 2011-12 report)*The Canterbury DHB is committed to '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. Key focus areas over the past 12 months include: *Designing and funding a Community-based Falls Prevention Programme that suits our local context, including:* • A modified version of the Otago Exercise Programme - a 12 month in-home exercise programme for the frail elderly which is delivered by DHB funded 'Community Falls Champions' who are either physiotherapists or nurses. • The 'Stay on Your Feet' Programme where trained volunteers provide a community programme for more active mobile older people (65+) either in their homes or in group settings. *Falls Prevention in aged residential care (rest homes)* Research suggests that Vitamin D supplementation for this group of older people significantly reduces falls and serious harm from falls. The Canterbury DHB is working in a collaborative way with rest homes and primary care providers to ensure that 75% of residents are receiving Vitamin D supplementation, through a Vitamin D Supplementation Programme in partnership with ACC. *Falls management in Canterbury DHB hospitals* The focus to date has been on raising awareness and reviewing what we currently do to help inform falls prevention strategies in our hospitals. Two of the key projects this year include: • April Falls' Awareness Campaign This campaign is designed to raise the awareness of the importance of preventing falls, not only in our hospitals but across the community. Information boards, a selection of posters and data on falls in our hospitals was prominently displayed during April in all of our hospitals.
PMH60	24/07/2012	Serious	12	2	Fell at bedside overnight whilst attempting to get out of bed to use urinal. Fractured wrist	
PMH61	15/08/2012	Serious	12	2	Patient fell in bathroom - fractured Neck of Femur	
PMH62	18/08/2012	Serious	12	2	Patient fell in bathroom - fractured Neck of Femur	
PMH63	07/09/2012	Serious	12	2	Attempting to stand up with gutter frame without assistance - fractured Neck of Femur	
PMH66	16/12/2012	Sentinel	12	1	Fracture to pubic rami; subsequent medical complications and died	
PMH65	18/01/2013	Serious	12	2	Fell in bedroom - fractured Neck of Femur	
PMH67	21/02/2013	Serious	12	2	- fracture of proximal humeral shaft	
PMH69	18/04/2013	Serious	12	2	Fell in bedroom - fractured Neck of Femur	
PMH70	03/08/2012	Serious	12	2	Fell in bedroom – fracture of Left Greater Trochanter	
ChCh162	23/07/2013	Serious	12	2	Fell returning from toilet - fractured Neck of Femur	
ChCh165	28/07/2013	Serious	12	2	Unwitnessed fall in lounge – fractured ribs	

Case ID	Event Date	Serious or Sentinel	Event Code	SAC	Description of Event	Strategy
ChCh166	29/08/2012	Serious	12	2	Fell whilst mobilizing - fractured Neck of Femur	• Real Time Falls Study in Hospital Setting Recent findings from our hospital falls study reinforces the need to pay close attention to the specific falls risk for each elderly patient while they are in Canterbury DHB care. In addition to addressing patient-specific factors, staff will undertake the following inpatient falls prevention actions (the essentials) if an older person is admitted to hospital: 1. Ask if they have suffered a fall at home over the last 12 months 2. Assess their risk of falling in a hospital environment 3. Ensure that appropriate falls risk management is in place for their hospital stay 4. Discuss the findings 5. Discuss with them and their family falls prevention strategies for when they return home. This may involve referral to a Community Falls Champion.
Chch168	31/08/2012	Serious	12	2	Fell whilst being assisted into bed - fractured Neck of Femur	
ChCh171	22/10/2012	Serious	12	2	Fell from stool – fractured clavicle	
ChCh173	18/11/2012	Serious	12	2	Unwitnessed fall at bedside - fractured Neck of Femur	
ChCh176	03/12/2012	Serious	12	2	Became dizzy whilst mobilizing and fell – fractured Neck of Femur	
Chch174	12/12/2012	Sentinel	12	1	Unwitnessed fall from commode at bedside. Laceration to head, subsequent seizures and death	
Chch178	19/01/2013	Sentinel	12	1	Patient attempting to stand; fell hitting back of head on the wall. Subsequent death from Subdural hemorrhage,	
ChCh179	20/02/2013	Serious	12	2	Fell at bedside - fractured Neck of Femur	
ChCh182	08/04/2013	Serious	12	2	Fell at bedside – fractured clavicle	
RURAL19	18/03/2013	Serious	12	2	Fell whilst mobilizing - fractured Neck of Femur	
RURAL20	09/04/2013	Serious	12	2	Found on floor - fractured Neck of Femur	
RURAL21	21/06/2013	Serious	12	2	Found on floor - fractured distal Femur	
BUR29	17/03/2013	Serious	12	2	Fell whilst mobilizing - fractured Neck of Femur	

Case ID	Event Date	Serious or Sentinel	Event Code	SAC	Description of Event	Strategy
BUR30	21/04/2013	Serious	12	2	Fell whilst mobilizing - spiral peri-prosthetic fracture.	

Event Codes:

General classification of event	Event code
Clinical administration (eg handover, referral, discharge)	01
Clinical process (eg assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (eg, wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)	10
Patient accidents (not falls) (eg, burns, wounds not caused by falls)	11
Patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14