Canterbury District Health Board Serious Adverse Events Report

1 July 2014 – 30 June 2015

There were 58 serious adverse events reported by the Canterbury District Health Board (CDHB) in the July 2014 to June 2015 year.

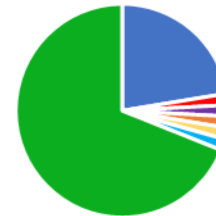
What is a serious adverse event?
A serious adverse event is one which has resulted in significant additional treatment, major loss of function, is life threatening or has led to an unexpected death.

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
- Documentation error
- Blood product error
- Medical Device/Equipment error
- Patient accident and
- Falls

CDHB Serious Adverse Events
1 July 14 - 30 June 15



Clinical process error
Clinical administration error
Documentation error
Blood product error
Medical Device/equipment error
Patient accident
Falls

Canterbury District Health Board Serious Adverse Events Report: 2014-2015

Clinical Process Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Complications following surgery	Rare progression of surgical complication, led to delay in diagnosis/treatment	Staff education. The system of ward rounds and obstetric medical assessments of women post-natally is reviewed	Completed
Complications related to birth	Incomplete assessment led to treatment delay	Staff education	In progress
Complications related to birth	Report underway		
Treatment delay	Report underway		
Treatment provided prior to final confirmation of investigation results	Report underway		
Patient deteriorated following medical treatment	Report underway		
Death subsequent to transfer of care	Treatment plan not followed	Staff education. ISBAR communication tool to be used for all verbal and written handover of patient care between hospitals	Completed
Intrauterine death	Investigation underway		
Complications following radiology contrast	Radiology Department protocols need updating	Radiology Department protocol for identifying patients at risk of renal injury prior to contrast scans is reviewed to meet current practice and RANZCR guidelines	Completed
Retained swab	Variation in the count processes may have contributed to the count being considered correct	Ensuring processes are standardised, changes to record keeping and to the way items are counted in and out of the body cavity.	In progress
Patient deteriorated acutely following presentation at ED	Investigation underway		
Incorrect radiation dose administered	Report underway		
Inpatient deteriorated acutely	Report underway		

Clinical Administration Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Referral not sent	Report underway		

Documentation Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Treatment delay	Treatment delay due to a misinterpretation of the waiting list categories	Staff education. One wait list for all endoscopy patients across the DHB	Completed

Blood product Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Incompatible transfusion causing acute renal failure with fatal outcome	Report underway		

Medical Device/Equipment Error			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Final Quality Assurance checks on a medical device were not completed prior to surgery	Report underway		

Patient Accident			
Description of Event	Review Findings	Recommendations/Actions	Implementation
Patient accident	The premorbid factors predisposing patient to injury when leg was knocked were likely dementia and delirium, frailty, and likely skin thinning secondary to prednisone. There is no single causal factor for this event.	No Recommendations	Completed

Falls

In our hospitals:

Patient falls in harm are the most frequently reported adverse event in hospital. Forty patients had a fall that resulted in a serious injury while an inpatient in our hospitals in the 2014-2015 year. Canterbury DHB has a ‘Whole of System approach to falls prevention’. We are committed to achieving zero harm 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.

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. The Hospital Falls Programme Steering Group meets regularly, providing oversight and direction across Canterbury hospitals for initiatives aimed at reducing falls in hospital and routine activities such as the annual Falls Awareness Campaign, reviewing policies, monitoring fall rates and progress on key projects.

In the 14-15 year, the new fall prevention visual cues were introduced across the hospitals. We have actively worked to ensure every patient has a safe mobility plan. This is displayed at the patient’s bedside, and those at risk wear a bracelet and any walking aids are tagged. They indicate to family and staff at a glance the level of assistance a patient requires when moving about.

The new standardised process for the care of patients following a fall was tested in Older Person’s Health and Rehab and the pathway has been refined. It will be rolled out to all other inpatient areas over the next four months.

In the community and rest homes:
In the past year, the Canterbury Community Falls Prevention Programme provided care to over 1600 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. If necessary, people are referred for supervision by a registered nurse, physiotherapist or qualified instructor, or to programmes aimed at improving strength and balance.

A recent evaluation exploring Canterbury’s integrated approach to falls found that from February 2012 to February 2015 there have been 1,083 fewer people presenting to the Christchurch Hospital Emergency Department due to falls, compared with expected volumes based on previous trends for people aged over 75. The evaluation also found that there have been 373 fewer than expected admissions for hip fractures. Compared with previous trends, there have also been 86 fewer deaths at 180 days discharge after treatment for fractured hips. This has saved around 27 hospital beds each year, a reduction of approximately one ward.