South Canterbury District Health Board Serious Adverse Events Report: 2016-2017

Fall			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
1. Fall with fracture	File review underway		
2. Fall with fracture	Serious Adverse Event (SAE) report completed	• Changes made that when falls assessments are completed, walking aids are recorded • Restraint minimisation training held annually to include discussion on unintentional restraint	Underway
3. Fall with fracture	SAE report completed	• A full multidisciplinary team falls review completed and documented for all people identified as a high falls risk	Underway
4. Fall with fracture	SAE report completed	• No recommendations	No further actions
Medical Device / Equipment			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
5. Cancellation of surgery	SAE report being drafted		
Medication & IV Therapy			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
6. Drug Storage / Management	SAE report being drafted		
Clinical Process / Procedure			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
7. Delayed diagnosis or treatment	SAE report being drafted		
8. Delayed diagnosis or treatment	Review underway		
9. Delayed diagnosis or treatment	File review underway		
10. Delayed diagnosis or treatment	SAE report completed	• A protocol developed for interns requesting medical imaging and laboratory services overnight • In-service provided to all Medical Ward nursing staff and interns with the focus on assessment and care of sick surgical patients • There is communication with an external provider around use of analgesia in patients presenting with abdominal pain	Underway (33% complete)

11. Delayed diagnosis or treatment	SAE report completed	• Patients leaving ED receive clearly outlined follow-up requirements • General Practices review their processes to ensure high priority referrals and results/reports are flagged and actively pursued • A review of ED process to ensure transfer of care arrangements are clearly documented on the electronic discharge summary • An external provider reviews their referral process for diagnostics • A review of ED processes for signing off results/reports	Underway (67% complete)
12. Delayed diagnosis or treatment	SAE report completed	• The OPD section in the ED Clinical Record becomes a mandatory field • General Practices review their processes to ensure high priority referrals and results/reports are flagged and actively pursued • A review of ED processes for signing off results/reports	Underway
13. Delayed diagnosis or treatment	SAE review to commence		
14. Complication	File review undertaken and report drafted		
15. Complication	SAE report completed	• Improve health clinicians recognition and reporting of relevant changes in patient's condition to medical staff within appropriate timeframes	Complete
16. Complication	SAE report being drafted		
Clinical Process			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
17. Incomplete consent	SAE report completed	• Formal induction package introduced for staff • Clinical handover using ISBAR introduced • Practice review for staff in ward • Review EWS and develop a tool for	Underway

		implementation	
Complaints			
Description of Event	**Review Findings**	**Recommendations / Actions**	**Implementation**
18. Miss diagnosis	SAE review completed	• Apology and information to patient • Imaging reviewed	Underway
19. Provision of Care	SAE review completed	• Apology to family/whanau	Underway
20. Provision of Care	SAE review completed	• Apology to family /whanau	Underway

Key	Explanation
File review	Review undertaken by a staff member from the patient's clinical file. Write a report and discuss with staff.
SAE Review	Multi-disciplinary group commissioned to review and investigate the event. To write a report and identify any learnings and recommendations