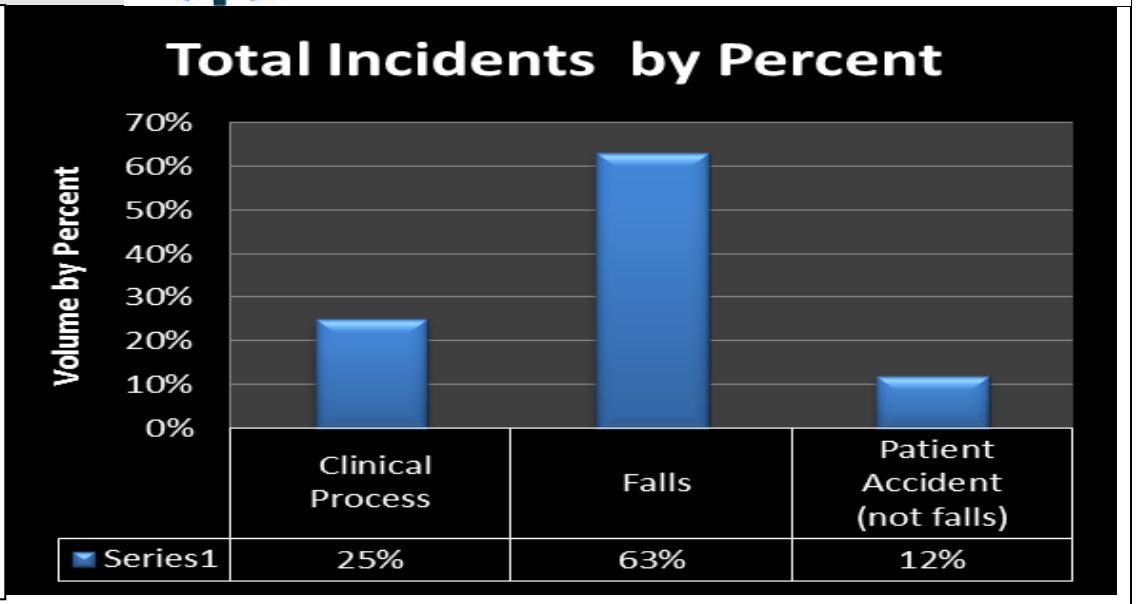
Serious and Adverse Event Report
01 July 2015 – 30 June 2016

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

There were a total of 8 reportable events covering the period of 01 July 2015 – 30 June 2016 for the WCDHB. Of these, the review of one event has been completed with implementation of recommendations. Review of a further 4 events continues to progress with implementation of recommendations, and 3 event reviews continue to progress toward completion.

Themes extracted from our Safety1st database indicate the following types of reportable incidents by percentage volume of occurrence (excluded in this count are mental health incidents):

- Code 02 = Clinical process error 25%
- Code 12 = Falls 63%
- Code 11 = Patient accident events (not cited as falls) 12%



Event Category	Brief Description	Recommendations	Progress on implementation
12	Fall resulting in fracture of hip x 2.	1. The process, policy and assessment for specialling be reviewed in relation to best practice and education around this ensues. 2. Falls risk assessments be completed in a timely	Implementation of recommendations underway.

		manner within 24 hours of admission. 3. This report (anonymised) to be used as an education tool for staff for the importance of communication and handover. 4. Falls group coalition to review post-fall procedure and implement in the clinical areas.	
Event Category	**Brief Description**	**Recommendations**	**Progress on implementation**
12	Fall resulting in fracture.	1. A quarterly falls risk audit to be completed on a random selection of patients. 2. A review of the post treatment appointment system to be undertaken to ensure patients are seen as and when scheduled.	Completed action. Completed action.
Event Category	**Brief description**	**Recommendations**	**Progress on implementation**
12	Unwitnessed fall of patient resulting in bilateral hip fracture. Patient subsequently passed away six days later from an acute event.	1. All staff adhere to the DHB Post- Fall Clinical Pathway and regular auditing is commenced on this documentation. 2. Provide evidence that TrendCare is being used effectively with appropriate allocation of patients to nursing staff in regard to acuity. 3. Patient story as an education tool for Modified Early Warning Score education and critical thinking, and the importance of completed documentation. 4. "Patient at a Glance" boards are completed and displayed at each patient's bedside. 5. That all patients (surgical and medical) who are monitored on telemetry have a daily ECG taken, which is then reviewed by the Registered Medical Officer (RMO).	Implementation of recommendations underway.

		6. Pathways are developed to ensure that all patients requiring referrals to relevant Clinical Nurse Specialists occurs within specific timeframes as agreed upon by the CNS team and CNM of each service. 7. That the Pharmacists undertake education sessions in the wards at regular intervals on the use and interaction of medicines commonly used in the wards, and the role of the nursing staff on with-holding medication until RMO review when adverse reactions could occur.	
Event Category	**Brief Description**	**Recommendations**	**Progress on implementation**
O2	Delayed diagnosis of Melanoma which advanced while under the care of two DHBs.	1. Recommend to the Major Skin Malignancies multidisciplinary meeting (MDM) that patients whose care requires a second presentation at an MDM are referred back to the MDM coordinator in a timely fashion. 2. To discuss with Department of Plastic Surgery an agreed follow up process to ensure that patients receive appropriate follow up following a diagnosis of high risk melanoma. 3 Implement a process to ensure that where specialist follow up is devolved to a general service or to primary care that patient specific or general recommendations for follow up are available. The following information will be included in all WCDHB orientation material for medical practitioners and in Health Pathways. 4. Implement a process to: • Ensure notification of primary care when a referral to secondary care is	Implementation of recommendations underway.

		declined and ensure that it is sighted • Provide advice to assist the primary care practitioner to manage the patient further 5. Ensure that supervision that meets College and Medical Council New Zealand (MCNZ) guidelines is available to GP trainees at all times. 6. Review the gatekeeper role of specialists to certain investigations (e.g. CT scans) by GPs to improve the timeliness of investigations. Introduce specific training so that the services are appropriately used. 7. Continue to review appropriate medical workforce requirements for Buller Medical Care to support the model of care.	
Event Category	**Brief Description**	**Recommendations**	**Progress on implementation**
11	Surgical injury during operation.	1. Where significant risk of surgical injury that cannot be readily treated at the patients local hospital base, patients is to be referred to a specialist tertiary hospital 2. That a framework is used to assess pre-operative risk. 3. Senior Medical Officers attend Serious Adverse Event Review core education to ensure that all incidents of serious harm are documented as directed in the Serious and Adverse Event Policy.	Implementation of recommendations underway.
Event Category	**Brief Description**	**Recommendations**	
02	missed referral form leading to delay in patient receiving treatment	Investigation progressing.	

Event Category	Brief Description	Recommendations	
12	Fall resulting in fracture.	Investigation progressing.	
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12	Fall resulting in fracture.	Investigation progressing.	