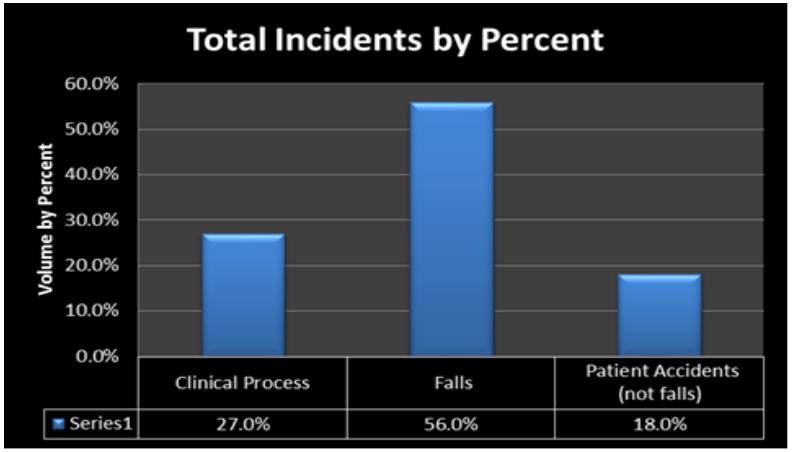
West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Serious Adverse Event Report
1 July 2016 – 30 June 2017



There were a total of 11 reportable events covering the period 01 July 2016 – 30 June 2017 for the West Coast District Health Board (WCDHB).

For this period 9 investigations have been completed with a further two still progressing. Themes extracted from our Safety1st incident reporting data-base indicate they are categorised into the following types of reportable incidents (excluded in this count are mental health incidents):

- Clinical process error 27%
- Falls 56%
- Patient accident events (not cited as falls) 18%

Event Category	Brief description	Recommendations	Progress on implementation
Patient Fall	**Fall resulting in fracture of hip**	**1. Documentation:** The completion of previous recommendations to integrate the physical and dementia care clinical assessments of all Dementia patients admitted to Aged Related Care Facilities, for the purpose of developing individual comprehensive clinical care pathways. **2. Clinical Records Documentation:** Daily documentation of the mobility status and associated risk strategies as required for all falls risk patients All Falls Risk Re-assessments are completed as per DHB Falls Prevention and Management Policy **3. Staff Education:** Specific education of addressing the aggressive/passive behaviours of the Dementia Patient to mitigate the risk of falls Specific education of a daily team approach to the management and associated responsibilities of managing falls risk patients each shift **4. Review Falls Prevention and Management Policy:** Clarify the requirement that within 6 hours post fall, a new Fall Risk Assessment Tool [FRAT] assessment is completed, signed and dated That Dementia patients are exempt from the wearing a red wrist / arm band	Implementation of recommendations is underway.

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Patient Fall	**Fall resulting in fracture of hip**	1) Nursing staff complete the West Coast District Health Board Post Fall Clinical Pathway and regular auditing is commenced on this documentation 2) Use Patient's story as an education tool for Modified Early Warning Score (MEWS) Education around critical thinking and the importance of completed documentation 3) 'Patient at a Glance' boards are completed and displayed at each patient's bedside 4) Admission to outlying WCDHB Hospitals should have a detailed discharge note on admission or clear plan documented by the Charge Nurse/Clinician-in-charge	Implementation of recommendations continues
Patient Fall	**Fall resulting fracture to knee and face**	1) That a Service Review is undertaken within the unit on the release of staff for meal breaks to maximise observation of, and maintain the safety of at-risk patients within the Dementia Service at all times 2) That work continues on changing the staffing model within the Dementia Service as per the project plan 3) That the garden maintenance is monitored by the facilities team to ensure pathways remain unimpeded within the walled garden, and that there is a review of the appropriateness of the steep footpath to bring it to a safe gradient that complies with current New Zealand Standards 4) Consider the installation of sensors on external doors to the walled gardens and/or a close circuit television (CCTV) that encompasses the garden areas	Completed
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Category			
Clinical Process	**Radiology printed scan reports not sighted by referrer**	1) The District Health Board (DHB) implements a closed loop Electronic Ordering and Sign off system for radiology results to mitigate the current level of risk to patients. This system to have an inherent escalation process to ensure results are acted upon in a timely manner 2) That the Vendor of any information system visits the client site after an agreed timeframe to ensure that the system is running as expected and that adequate audits are in place and generating reports to monitor operation 3) An independent overview of the testing and implementation processes on any information systems implemented used in patient care	Partial completion
Clinical Process	**Patient provided inaccurate information about their medical condition and use of equipment**	1) Accurate height and weight recordings are undertaken and documented on all patients on admission 2) Processes linked to the admission policy are reviewed in relation to patients who are: A) Prescribed and will use Continuous Positive Airway Pressure (CPAP) while inpatients B) Upskilling of the Ward Nurses with regard to patients' own CPAP machines C) Review of the accompanying documentation for recording CPAP 3) Clear criteria is formalised that ensures surgical patients are identified according to acuity, complexity and co-morbidity and referred to Tertiary Care in a timely manner	Implementation of recommendations continues
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Patient Accident [Not Falls]	**Still Birth**	1) All women presenting for Induction of Labour should be advised to present at the ward before 0800 hours 2) Consider a fluorescent sticker with the words **do not freeze** to go on all placental specimens 3) Verbal permission from the Obstetrician and the Midwife may initiate a Category 1 Caesarian Section Emergency Team response	Completed
Patient Accident [Not Falls]	**Unanticipated sudden death secondary to multi organ system failure**	1) A clear process is developed that guides decision-making, confirms individual Senior Medical Officer's (SMO) responsibility for each patient and includes an agreed process for handover between specialties 2) As part of the Health Quality Safety Commission (HQSC) Deteriorating Patient Programme an escalation of care process is developed to guide nursing staff and Resident Medical Officers' (RMOs) decision-making to ensure active early recognition and response to the deteriorating patient 3) This anonymised report is used as a teaching tool for the staff at the West Coast District Health Board. Education to focus on critical thinking, communication and documentation of changes in the deteriorating patient.	Completed
Event Category	**Brief description**	**Recommendations**	**Progress on implementation**
Fall	**Fall resulting in fracture hip**	Review still in progress	Pending
Clinical Process	**Patient self -medicating error**	Review still in progress	Pending