Patient Serious Adverse Events (SAE) Report: July 2015-June 2016 – First released December 2016. Updated July 2018

	Description	Main Findings	Recommendations	Progress
1	Respiratory depression associated with opioid use.	No alert on the patients regarding Obstructive Sleep Apnoea (OSA). There is no policy or guidelines for patients with OSA who are scheduled for surgery. There is no specific and robust criteria for patients who deviate from the Total Hip Replacement pathway (THR). Bedside handover was not completed on day 2 post surgery despite patient still having Patient Controlled Analgesia (PCA) and Intravenous (IV) in situ.	Consider possibility of an alert to be attached to all patients' clinical records who have severe OSA. Develop guidelines around patients with OSA who are scheduled for planned surgery. Develop specific and robust guidelines with regard to variations for patients on a THR pathway. Institute bedside handover specifically for patients with PCA and IV fluids and document.	Complete. Complete. Complete. Complete.
2	Medication omission. Patient readmission.	Lack of clear plan for venous thromboembolism (VTE) prophylaxis. Apparent failure to provide adequate VTE prophylaxis perioperatively. Lack of clear evidence of continuing VTE prophylaxis post operatively	Ensure VTE risk and plan determined preoperatively. Confirm VTE plan at time of preoperative Surgical Safety Check. Ensure VTE prophylaxis continues in the ward and after discharge. The surgical service should be asked to review its audit process as above and Clinical Leader asked to review VTE prophylaxis in team meeting.	Complete. Complete. Complete.

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3	Delay in follow up. Admitted with vomiting and diarrhoea. Patient deceased.			Investigation report in draft.
4	Retained wound packing item with delayed removal.	No wound care management documentation which covers from operation (theatre) until wound healing occurs. Resulting in poor communication and suboptimal wound care management.	Working group formed (District Wound Care Documentation Pathway group) to develop a care pathway including end to end care plan documentation tool.	Complete.
		No overarching policy and guidelines for wound care management.	Working party to develop policy and guidelines for the district.	Complete.
		Real time operation notes not being completed.	Process for real time operation notes with template implemented.	Complete.
		No guidance or noting of number of pieces of foam inserted in wounds for Negative Pressure Wound Therapy dressings.	Negative Pressure Wound Therapy policy and guidelines updated to include the number and measured size of pieces of foam placed in wound.	Complete.
		Poor processes for written and verbal communication for wound care management between professional teams across the health care spectrum.	Develop implementation plan for care pathway developed by District Wound Care Documentation Pathway group including education, roll out to services involved in management.	Complete.