Serious Adverse Event Report

Southern District Health Board

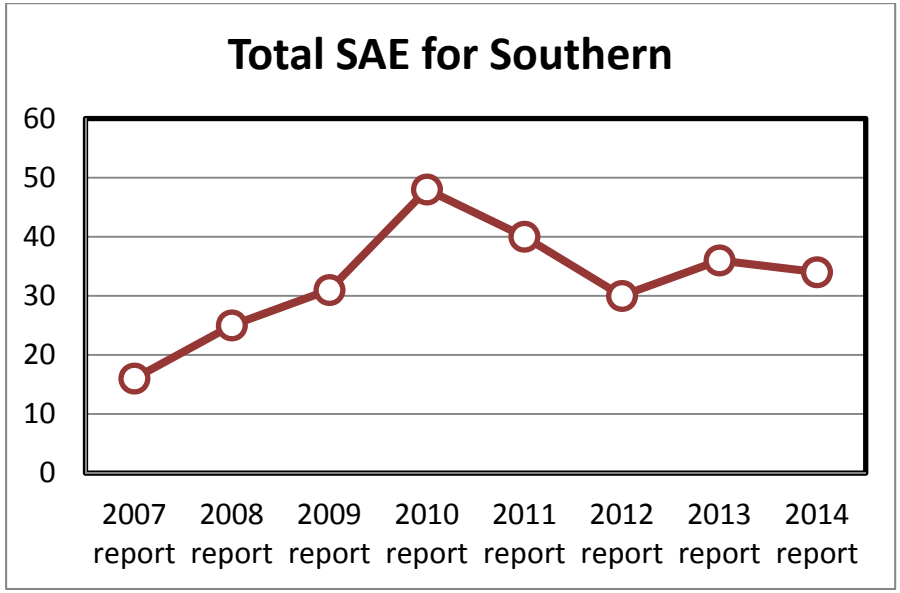
2013-2014

Serious Adverse Events 2013 - 2014

Welcome to the serious adverse event (SAE) report release for 1 July 2013 - 30 June 2014 from the Southern District Health Board.

It is recognised worldwide that health care is a complex process, has associated risks and that patients may become harmed when receiving care intended to help them. This report provides specific information regarding each patient's care and treatment without identifying individuals.
It includes recommendations to make improvements to the care we provide and our progress with implementing these improvements.

This report is released in conjunction with the Health Quality and Safety Commission National Report *Making our health and disability services safer*. (http://www.hqsc.govt.nz)



In the 2013/14 year Southern DHB reported 33 events that have caused serious harm or death and one event that nearly caused serious harm; a total of 34 events. Later in the year our *Quality Accounts* report will be released that will provide analysis of the main groups of events and the District wide improvement work being undertaken

What is a serious adverse event?

Serious adverse events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

Using Serious Adverse Events to promote Patient Safety & Prevent Harm

All serious adverse events are investigated to try to determine the major cause, or causes, that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future. The aim therefore is to enhance patient safety by learning from adverse events and near misses that occur in health and disability services.

Some incidents have not had their investigation completed at the time of release of this report. This means that the incident is still under investigation or that the recommendations are in the process of being finalised.

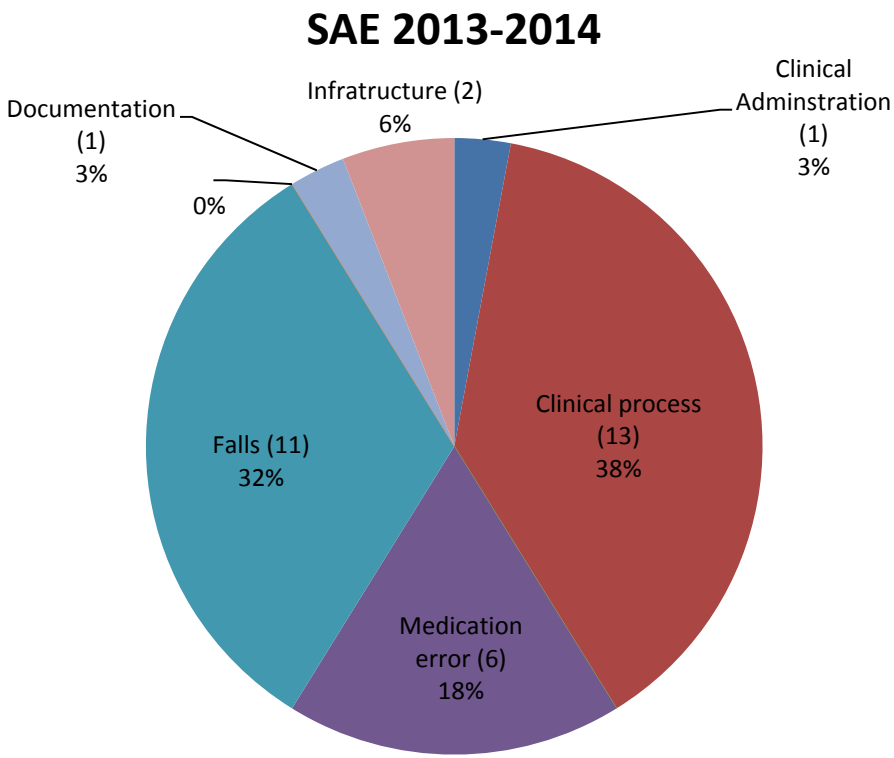
We have provided graphs to summarise the events that have occurred within Southern DHB. The rise and fall in the number of events can indicate a number of factors including changes in reporting rates as well as the actual frequency of events.

The number of events has been relatively stable after the "setting up years" of 2007 through to 2010, where improvements in reporting was the main reason in the apparent steady increase in events. Indeed, to paraphrase the words of the international safety expert, Dr Don Berwick, we appear to have a system that will consistently generate between 30 and 40 serious adverse events each year, about one third of these being falls. With the exception of falls, which have been stable for several years.

Overall, the adverse events here provide an indication of the risks affecting patient safety in any healthcare organisation. The number of events that result in harm to the patient (or in some cases, potential harm) is very small. As an indication of a well recognised international problem, reporting of serious adverse events shows that patient safety remains a concern, and the presence of a robust process to improve patient safety remains a priority.

The DHB, through the implementation of a new reporting system in 2015, will be able to undertake more extensive analysis of serious adverse events in the future.

The Southern DHB is committed to the *Open For Better Care* campaign developed through Health Quality and Safety Commission. This forms part of the transparent process of identifying harm and working to learn and improve patient safety.



The pie chart indicates the number and type of reported serious adverse events for the 2013/14 year.

Clinical process (e.g., assessment, diagnosis, treatment and general care) accounted for 38% (13) and patient ***falls*** 32% (11).
This year we have had six ***medication*** *events* (e.g., giving a patient the wrong medicine, or an incorrect dosage) at 18%.
Clinical administration events (e.g. handover, referral, discharge) account for 3% (1); and there were two cases of ***infrastructure*** issues (6%), and one case involving ***documentation*** (3%).

Refer Table 1 – SAE SDHB 1 July 2013 – 30 June 2014

Lexie O'Shea
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Details	Description	Main Findings	Recommendations	Progress
1. SAC2	Information Service computer Server Failure, resulting in missing images for mammography.	1. Failure to configure the medical security system monitoring service for the server. 2. Failure to configure the archiving function when application for breast screening imaging was installed. 3. Two hardware faults in server for breast imaging picture archiving and communication system (PACS).	1. Medical security system service to update District Health Board as required. 2. Medical security system service has corrected this error and is monitoring the current process. 3. Identify and correct	1. Complete. 2. Ongoing. 3. Corrected.
2. SAC1	Fall with head injury and subsequently deceased.	No root cause identified. 1. The frequency of nurses' rounding is unclear. It does not appear that all the ward nursing staff members have the same consistent and frequency pattern of rounding.	1. Intentional rounding programme to be implemented across Internal Medicine wards as soon as possible.	1. Intentional rounding programme implemented.

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		2. Miscommunication between teams regarding how busy the ward was. The correct paperwork for a Patient Watch had not been completed. 3. A level of consciousness assessment tool was used to assess the patient's level of confusion. 4. Lack of a designated ward Falls Champion role.	2. Clinical team to ensure there is improved communication within the team about Patient Watch and ward activity. 3. That best practice for measuring, recording and escalating confusion is reviewed and any necessary changes to be implemented at a ward level. 4. That a member of the team assumes this responsibility of Falls Champion.	2. New falls documentation has been updated to include prompts for Patient Watch documentation. 3. There is a delirium tool on electronic document system. A working party is updating the document. Education will support the implementation of the revised tool. 4. Complete.
3. SAC1	Retained swab.	• Lack of documented swab count. • Lack of formal process surrounding perineal repair. • Use of a swab that did not have an identifiable tail	1. Require a formal process around the repair of perineum with requirement for documented swab count. 2. Information regarding new process to be shared with	1. New document developed: Perineal Injury Procedural Record, made organisation wide. Only tailed, radio-opaque vaginal swabs in use from August 2013. 2. Education sessions completed.

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		that remained visible as a reminder of its presence.	education about use and documentation for both core and Lead Maternity Care staff.	
4. SAC1	Medication error. Medication given to a patient with known sensitivity. Patient subsequently deceased.	1. The event is unrelated to the administration of the sedative medication. 2. There was no drug allergy noted on the medication chart and although the sedative allergy was noted in the clinical intranet and patient management system, these were not accessed prior to the anaesthetic. 3. Anaesthetic support for infants is an identified need.	1. The process of entering adverse drug reactions into the Clinical Intranet and Patient Management System needs review. The events should be properly evaluated by medical staff before entry and clearly documented using a standardised approach. 2. Good Practice Point: Clinicians need to check for alerts before providing care and treatment. A reminder to be sent. 3. Medical staff to continue to liaise closely between paediatrics and anaesthetics for difficult cases.	This report has recently been completed and the recommendations are yet to be implemented.

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			Anaesthesia department to consider having a core group of anaesthetists trained in providing anaesthesia to infants.	
5. SAC2	Unexpected abnormality noted on chest X-ray report not followed up as recommended.	1. An X-ray formally reported into the clinical intranet system by radiology services as potentially having a chest mass, was not noticed in the system by Emergency Department staff, and therefore not acted on. 2. Failure of the electronic results checking system to delete finished reports, produced a situation where the report was "buried" from the checking physician. This lead to a failure to action follow-up. 3. A copy of the report was sent to the GP who made several attempts to contact the patient by telephone and letter. The patient did not	1. The system failure in the clinical intranet, whereby acknowledged reports were not being deleted, requires review. 2. An additional feature is required, whereby reports that are not acknowledged within two weeks are redirected to a default clinician. 3. No recommendation	1 & 2. Acknowledged reports are now deleted. A new system is being looked into, to ensure tests results are reviewed daily. 3. No action required

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		respond and therefore a second opportunity for follow up was lost. 4. Plain film reporting is currently done by an outside provider, and while there are calls from them about abnormal films, they are not as frequent as when reporting was performed by in-house radiologists. This is another important layer of back up which has effectively been removed.	4. Contact should be made with the outside provider to share this case, and to determine if they could increase the reporting of abnormal films to the Emergency Department. This could be done via the provider sending a daily list of abnormal pathology to ED, to cross check if picked up.	4. This recommendation has recently been approved and is to be implemented.
6. SAC 2	Client fall on stairs resulting in fractured ankle	Fall on steps while going down and misjudging bottom step. New carpet installed by landlord was darker colour, which made bottom steps harder to identify. Lighting in the area was satisfactory and fully functional.	1. "Treadwell" product fitted to the stair edges, on advice of carpet installation company.	1. Complete.

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7. SAC2	Medication error. Patient given strong pain medication intravenously instead of orally.	1. An intravenous (IV) syringe was used to measure the volume of elixir and then taken to the bedside for administration.	1. Use of dedicated oral syringes for accurate oral medication measuring and administration.	1. Oral syringes and new feeding tubes are in use. However this recommendation will remain in a transitional stage while waiting for new international standards to be introduced. Procurement will purchase new systems when available.
			1a. Other oral medication elixirs should be administered in medication cups.	1a. Education has been delivered to staff.
		2. There was difficulty in communicating all the salient information about the patient's plan of care, to all the teams involved in both the outpatient and inpatient areas.	2. That policy and guideline documents be written for managing complex chronic pain patients in the acute setting. This will include:	2. Surgical Senior Leadership Team presently working with clinical staff.
			2a. An action plan for when the patient presents to hospital.	2a. Pending.
			2b. All plans and documents to be readily available on Intranet and in hard copy.	2b. Pending.
			2c. Protocol for the "blind	2c.Pending.

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			dosing" of analgesia (consent, prescribing and administration). 2d. An alert system for the community dispensers of controlled medication, to make them aware that the patient is in an acute in-patient setting and will not be requiring the community dose.	 2d. Pending
		3. There is a disconnect between the pain management in the inpatient and outpatient settings. 4. Team felt they needed the opportunity to debrief following the incident.	3. Complex chronic pain in-patients are to be reviewed by the chronic pain service at the first available opportunity. 4. Create an opportunity for teams who are involved in serious adverse events to have a debriefing session, both for psychological support and as a learning opportunity.	3. Surgical Senior Leadership Team presently working with clinical staff. 4. Staff to use Employee Assistance Programme and this can be organised by team leaders if appropriate.
8. SAC2	Fall with fracture.	No root cause for the fall identified. The patient's overall medical condition contributed to the fall.	No recommendation.	

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9. SAC2	Injury to a family member by the patient, within 24 hours of Emergency Department discharge.	• No care delivery problems were identified during the patient's ante natal care, delivery, post natal care or treatment in the Emergency Department. • The cultural background of individuals involved in clinical and social interactions leading up to the incident will have influenced communication, but no clear evidence was found that this affected the clinical outcomes. • There were no clear warning signs that clinical staff may have been able to detect, anticipate and prevent the traumatic events that took place. • No clinical competency issues were identified. Based on the information	1. Education on clinical symptoms and signs of post natal depression and self harm are reinforced among clinical staff. 2. Event to be discussed with clinical team and learning disseminated.	1. Complete. 2. Complete

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		available, this appears to be an unavoidable and unpredictable event. • Staff shortages were mentioned during the review, however no deficiency of care was identified. • There was not close communication with ED staff regarding the review of this event • Mandatory screening questions had not been completed.	3. A benchmarking exercise is to be carried out with comparable sized EDs to quantify the nature of any staffing shortage in this ED. 4. Review communication process following serious adverse events, and keep staff directly involved in critical incidents informed of media releases likely to affect their roles in the organisation. 5. Front line staff to complete and document screening for family violence and suicidal tendencies. Patients identified with mental health issues, require documented risk assessment to ensure safety on discharge.	3. Benchmarking has occurred and findings reviewed. Business cases are being developed regarding staffing levels. 4. Communication processes are to be reviewed. 5. Pending.

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			6. Regular audit of clinical notes can provide feedback to staff to encourage compliance.	6. An initial audit was carried out. Results are to be discussed with staff and a follow up audit is planned for October 2014.
10. SAC2	Medication given to the wrong patient.	1. Failure to adhere to the recognised standards of medication administration. 1a. Failure to correctly identify the patient. 1b. Failure to administer the correct drug to the correct patient. 2. Failure to follow policy and have a second person check at the patient's bedside.	1. Reinforce single-patient administration policy in Intravenous (IV) manual and other IV resources Southern-DHB wide. 2. Review compliance in the Emergency Department (ED) around required two nurse checks to the bedside for opioids. Review and reinforce structure around discarding IV opioid wastage.	1. Staff have had medication administration requirements reinforced at education days. Policy on this has been reviewed district-wide and education completed. Appropriate changes in practise are in place. 2. Two nurse checks to the bedside for opioids has been reviewed, and a change in practice has occurred. This will be monitored and reviewed again in the future. 2a. Education in ED regarding controlled drug requirements has occurred.

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		3. Potential knowledge deficit due to minimal orientation	3. Have a structured minimum-orientation checklist for the Emergency Department, that short term nursing staff members are required to complete.	3. Orientation checklist developed and implemented.
		4. Early Incident reporting would not have prevented this error. However it would have enabled early open disclosure and reduced patient anxiety.	4. Education on due process with incident reporting for staff.	4. Education completed.
11. SAC1	Unexpected death.	1. The resident medical officer involved had not yet achieved advanced competence in Paediatric assessment and recognition of the sick child.	1a. Ensure paediatric assessment topics are delivered during weekly ED teaching sessions on a regular basis.	1a. This is now a regular item at ED teaching sessions.
			1b. Ensure optimisation of on the job clinical training of junior staff, by utilising observed and supervised examination and role modelling by senior staff.	1b. This an identified discussion point and agenda item at senior medical officer (SMO) meetings
			1c. Provide supervision for all junior doctors appropriate to their level of competence	1c. This occurs currently.

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		2. A lack of appreciation by the Emergency Department (ED) Consultant of the inexperience of ED resident medical officer and failure of ED Consultant to personally review patient.	2. Ensure good communication between ED senior staff members regarding the residential medical officers, and a well-developed departmental approach to providing an appropriate level of supervision and clinical teaching to ED residential medical officers.	2. All ED SMOs are responsible and this is a discussion point at SMO meetings. Ensure all resident doctors have a nominated supervisor, and comply with regular meetings and updates with their ED Supervisor.
		3. Nursing assessment not sought by ED medical staff and key information not shared between medical and nursing staff.	3. No ED patient should be discharged until there is discussion between nursing and medical staff. Ensure that communication between nursing and medical staff in ED is effective and highly valued at all times. The above should be included in regular ED clinical audit.	3. A memorandum has been completed and distributed regarding the discharge of paediatric patients.
		4. Decision to discharge was not challenged when independent nursing assessment suggested discharge may not be safe.	4. Initiate communication workshop with this focus – how to challenge appropriately, how to respond to challenge, how to promote a culture where appropriate challenge is valued.	4. This recommendation is being investigated as to who could provide this training.

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			4a. Develop written policy for discharge management of Paediatrics, to include follow up after discharge.	4a and 5. Written memo to be formulated to ensure all paediatric discharges of concern are followed up with a phone call from the paediatric assessment unit.
		5. No follow-up call arranged. Confusion as to routines for Paediatric follow- up calls. No written information given regarding expected course of illness and regarding when to return to ED.	5. Ensure there is clarity for all medical and nursing staff regarding indications and mechanisms for paediatric follow-up calls for children discharged from ED. Provide written information in the discharge summary (or a hand-out) regarding when to return to ED.	A new information pamphlet for patient's/family is in progress
		6. Options for further clinical assessment not taken up during the second presentation.	6. Patients re-presenting with ongoing symptoms related to the same illness, should be thoroughly assessed by a senior registrar or Consultant. There should be a low threshold for paediatric (or other specialist) referral for re-presenters.	6. This will be a minuted discussion point at staff meetings.
		7. The call for help by family to ED, was referred on because ED policy mandates	7. This policy is to be reviewed and a system set up, where calls for advice from recent presenters	7. Our current policy of referring to Health Line for advice is consistent with national

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		all phone calls for medical advice should be referred to Health Line.	are accepted (within a limited time period), when clinical progress is not as expected.	practice, and this would be outside of national guidelines to implement.
12. SAC2	Fall resulting in fractured lower leg.	1. Limited documentation of falls assessment due to confusing design of form and time and effort required to duplicate information. 2. The nurses find visual cues of a patient's risk of falling the most useful.	1. Redevelopment of falls risk assessment and care plan documentation. Add to the risk assessment and/or care plan: • Environmental assessment • Clear documentation of a patient watch needed and/or requested and the outcome of the request. 2. Development of signalling systems is required (visual cues). • Clear colour coded signage for patients and staff e.g. on Trendcare (nursing acuity system) handover sheet, in bed spaces and at doorways of patient rooms, on whiteboard in nursing stations. • Consideration of signage	1. Documentation completed and implemented. 2. The involved wards have an electronic white board with a visual cue for falls risk patients.  Head of bed patient plans of care are in the process of being developed and this will include the falls risk and possibly a modified traffic light system. This is going to be trialled as part

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			stuck to vinyl floors (e.g. High risk fall area, please ask for assistance).	of the model of care changes, bedside handovers and intentional rounding.
		3. The review identified there was limited evidence of critical thinking and translation of falls assessment into practical strategies to prevent falls.	3. Education on falls risk assessment, individualised fall reduction strategies and fall management to all staff including medical staff.	3. Complete.
		4. Highlight at every shift change and every ward round, those patients at risk of serious harm from falling, and then we will have a sub-group that we can manage more effectively.	4. This to be a pilot in one or several wards and the results audited. To understand that the identification of the patients that are at risk of falling, and those that are at risk of falling causing serious harm, is different and should be communicated and identified in different way.	4. Highlighted in handover and will be part of team huddles that will be implemented as part of the change of model of care. A start date of 4 November for the new model of care and audit will be done retrospectively.
		5. Time was also taken to think about a different review process for falls with serious harm.	5. Establish a post fall review process. This should be a standardised process across the DHB and be lead from the Quality and Patient Safety team.	5. A post fall process has been established. We are monitoring this work and being reactive to the needs of clinical services.

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13. SAC1	Fall with fractured shoulder and neck of femur.	1. Intentional rounding as a strategy is not commonly considered or discussed amongst staff. It does appear that the patient was reviewed regularly by nursing staff, however this is not well documented in the clinical record. 2. There are some areas where education may benefit staff knowledge and awareness of documentation and falls prevention strategies in the service.	1. The work on Intentional rounding that has been undertaken in the medical services, is discussed more widely with the view to full implementation. 2. Nursing staff education to ensure staff have the opportunity to reflect on this incident and incorporate the learning into the care delivered to patients in the area.	1. Intentional rounding team established. Education to nursing staff under way. 2. Education plan developed and delivered.
14. SAC2	Fall resulting in fractured hip.	1. Brakes were not applied on the bed, causing the bed to shift when the patient moved from sitting to standing; causing the patient to lose balance and fall. 2. Lack of appropriate individualised care planning on admission, with inadequate Falls Risk assessment plan.	1. Implementation of bedside handover to ensure staff are aware of the patient's immediate needs at time of handover, this will also include an environmental check. 2. Education for staff regarding completing Falls Risk document and Falls Risk plan, incorporated as part of the roll out for the new Falls documentation.	1. Bedside handover to be rolled out at the same time as intentional rounding in October 2014. 2. Implementation of intentional rounding in surgical ward is planned. This will support patients to be at the centre of care through a

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				standardised approach to monitoring and recording their status at regular intervals.
		3. No Red Falls Risk wrist band in situ at time of fall.	3. All patients who are categorised as a falls risk must wear a Red Falls Risk wrist bracelet.	3. Pending.
		4. Falls alarm not in-situ	4. Ensure falls alarms are considered and utilised appropriately, particularly for those patients with an altered cognitive state.	4. Pending.
15. SAC2	Fall resulting in fractured neck of femur (hip) and subsequent death.	• This patient was a very high falls risk which probably contributed to the loss of balance resulting in a fall resulting in a fractured hip. • The communication of falls risk in general was inadequate.	1. Monitoring and review of the investigations into all falls for the next 6 months. This audit should include if the falls risk assessment was completed and a falls care plan in place. 2. All adult medical wards to have a falls champion. 3. Following the 6 month review and collation of audit data, a Falls Meeting to be held.	Recommendations are in progress. 1. Pending. 2. Falls Champions identified. 3. Falls audits and being done regularly and results added to patient safety boards. 6 month

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			Any gaps will be identified and improvement measures put in place. Falls data will be presented on the ward patient safety board. 4. The Quality Improvement process would have a goal of decreasing injury falls by 20% without decreasing patient mobility. 5. Considering a colour coded system that has been adopted in other hospitals using a green, orange and red scheme that designates the level of risk each patient has for falling. 6. Adopt Functional Mobility Chart which is used in another ward for medical and surgery wards. 7. Periodic education for all team members including physicians in fall prevention in the hospital	review pending. 4. Pending. 5. Some areas do have colour coding. A system would cost the organisation to implement. A stock-take has just commenced to identify what we might be able to do internally as a standard. 6. Not supported as any change needs to align with District-wide Falls programme. 7. New individualised care boards to be reviewed each shift, are being trialled which has
		• No documentation that the raised toilet seat was to be used.		

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			setting and assessment.	patient mobility and aids. Education of all staff on this and on the new falls assessment form is ongoing.
			8. The executive team to coordinate other hospitals within the DHB to share interventional strategies that have proven effective in preventing falls.	8. Complete.
			9. Ask allied health and nursing services to consider whether grouping high risk fall patients in one or many rooms would be considered to be beneficial.	9. Under consideration.
			10. Wards to have enough equipment to safely mobilize patients. This should also include review of the equipment that is available and a regular maintenance schedule should be in place.	10. New high toilet frames have been ordered so that there is one per room.
			11. If fall plan requires supervision for toileting, the plan should anticipate patient needs	11. New individualised patient care boards above each bed, provide a visual cue about the

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				patient's mobilisation requirements and will aid in addressing this, as an addition to the care plans.
16. SAC1	Permanent severe loss of function due to surgery.	1. The 20 minute outpatient consultation timeframe allocated for this complex case, may have been insufficient to allow a thorough evaluation of all relevant material. 2. Not all relevant clinical information was available at the time of deciding to proceed with surgery. 3. The consent form used had insufficient space for full documentation of the	1. Sufficient time is made available for pre-operative evaluation of complex cases at specialist consultation appointments. 2a. Clinical administration processes should be reviewed to ensure that a copy of all clinical information generated from consultations held in the hospital service, are placed in the patient's clinical record. 2b. The process of ensuring how all clinical information from external consultations is placed in the patient's hospital record, should be reviewed. 3. The Service surgery consent form should be reviewed, to ensure all relevant information is	This report has recently been approved and some recommendations are yet to be implemented. 1. Audit of timeframes for appointment times is to be carried out. 2a. Pending 2b. Pending 3. Pending.

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		discussion of potential complications and risks. 4. The case was not reviewed at a multidisciplinary meeting. 5. An expert specialist review was carried out. In the expert's opinion, the decision to perform laparoscopic surgery, given the information known to the surgeon at the time, was reasonable. 6. This was a technically difficult procedure. Bowel injury is a known but rare complication of laparoscopic surgery. There was delayed recognition of bowel injury post surgery. 7. There was no documentation of the informal review done by the	able to be fully documented. 4. Ensure there is a suitable forum for complex cases to be reviewed and senior medical officers should be encouraged to discuss complex cases at these meetings, as part of best practice. 5. Senior medical officers are reminded of the specialist College guidelines and assessment criteria for conducting laparoscopic procedures. 6. Senior medical officers are reminded of the constellation of signs that might suggest a problem if the recovery course following laparoscopy is not within expectations. 7. Any case which prompts review, should be documented by the clinician doing the review, as	4. Multidisciplinary meetings are scheduled and are occurring. 5. Discussed at multidisciplinary meeting. 6. Discussed at multidisciplinary meeting. 7. Discussed at multidisciplinary meeting.

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		clinical leader soon after the serious surgical complication was recognised. 8. The internal process of lodging a formal complaint was not followed, resulting in delays to investigation. 9. The operating surgeon didn't fully understand the purpose of different investigative processes for incidents and complaints.	per Southern DHB Incident Management Policies. 8. Review the pathways by which complaints are lodged, to ensure there is a consistent internal process to support timely investigation. 9. All senior medical officers involved in incident review processes or complaints, should be offered support from an independent colleague to ensure they are using a consistent system and process. 10. The senior medical officer orientation programme should be reviewed to ensure investigation processes are adequately covered.	8. Pending. 9. Pending. 10. Pending
17. SAC2	Fall resulting in peri-prosthetic fracture.			This report has recently been completed and is awaiting approval.

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18. SAC2	Fall resulting in fractured neck of femur (hip).	1. There was a lack of falls risk screening and assessment documentation. 2. The administration of intravenous medication may have caused dizziness.	1. Screening tools to assess risk for falls are introduced, as part of the documentation for patients being transferred to the Emergency Department Observation Unit.	Report recently completed and waiting for allocation of recommendation
19. SAC 2	Delayed action in response to referral- metastatic cancer.			Formal review in progress.
20. SAC2	Mislabelled breast biopsies.	1. A trusting relationship amongst experienced staff may result in a reliance on others to perform tasks correctly. 2. Additional labels are often printed during the assessment if the number of labels required is insufficient.	1. A "Time Out" process is to be established post collection of specimen to confirm patient identification and accurate labelling of specimen and pathology request forms. 2. Additional patient labels will be printed and placed in the patient biopsy assessment packet prior to commencement of cases to avoid the need to reprint labels mid procedure.	1. Complete 2. Complete

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		3. No Checklist procedure exists for tissue sampling. 4. The existing policy "Tissue Sampling – Breast Care Services" has very limited detail on patient identification or labelling specimen practices or requirements.	3. A tissue sampling checklist to be developed and implemented as part of a stringent process for specimen collection. 4. The policy "Tissue Sampling – Breast Care Services" to be reviewed to ensure there is a robust policy aligned to the new National Policy and Quality Standards (NPQS) for Breast Screen Aotearoa.	3. Checklist development completed and in use. 4. Policy reviewed and modified.
21. SAC2	Medication error			Formal review in progress, report in draft.
22. SAC 2	Delayed diagnosis of subdural bleed in an infant.			Formal review initiated, report in draft.
23. SAC2	Medication error. Patient received wrong medication.	1. Pump datasets have no intrinsic safety mechanisms to prevent inadvertent or excessively large drug boluses – despite this feature being easy to implement. 2. Human error (slip), leading to inadvertent bolus of the	1. Re-program main operating theatre infusion pumps to restrict drug doses to those that are clinically appropriate. 2. Dissemination of this case to clinicians as a reminder of	1. A reprogrammed syringe driver is currently being introduced into theatre environments, which has had the changes made to improve safety. Once in use in theatre, consideration may be given to Intensive Care Unit adopting a similar infusion pump dataset.

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		wrong medication	importance of clear drug labelling and proper drug identification. Explanation to staff of the drug labelling system, and a warning to not solely use label colour to identify syringes.	2. Pending
24. SAC2	Medication error. Aspirin given through wrong route.			Formal review in progress.
25. SAC1	Major Information Technology (IT) outage affecting multiple applications	1. Errors in monitoring configuration. 2. Insufficient administrative monitoring. 3. Specialist support and review of critical storage area network (SAN)s	1. Review storage area network (SAN) monitoring configurations. 2. Dedicated time and resources for daily monitoring. 3. Third party Support & Maintenance Agreements under negotiation.	1. Complete. 2. Ongoing. Partially completed with strict "morning checks" in place. Work still required on ensuring sufficient staff resourcing. 3. Ongoing.
26. SAC2	Mislabelled documentation resulting in privacy breach.	1. Incomplete documentation for invoicing purposes, at the time of treatment.	1. Full patient details including national health index identifier need to be completed on the invoicing spreadsheet, by the same staff member carrying out the procedure.	1. Staff are aware of this event, and are more vigilant regarding documentation.

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Details	Description	Main Findings	Recommendations	Progress
		2. Entering the partner's name on the invoicing spreadsheet, resulted in the wrong name being entered on the final invoice. 3. Inadequate checking of patient identification during the invoicing process.	2. Partner's names should not be entered into the spreadsheet. 3. Electronic patient management system should be checked at the time of invoice preparation, to verify the correct address and patient details including NHI number.	2. Partner's names are now not entered. 3. The electronic patient management system is now cross referenced for accuracy.
27. SAC 2	Contra-indicated epidural inserted post heparin treatment.			Formal review initiated, report in draft.
28. SAC 2	Wrong procedure performed.	1. The surgeon typically operates on the left side first as a matter of routine but did not in this case. 2. Despite time-out and writing the surgical plan on the whiteboard, during surgery the operative team did not take note that after completing the first resection,	1 & 2. Institute a Time Out procedure for strabismus eye surgery between every muscle, to ensure correct laterality, location and measurement.	1. Time Out procedure between each muscle has been implemented, written procedure pending.

Details	Description	Main Findings	Recommendations	Progress
		that it was the wrong resection that required surgery.		
29. SAC 2	Peri-prosthetic fracture as result of fall.			Formal review initiated.
30. SAC 2	Possible delayed diagnosis of neurological disorder.	Lack of a clear system for referral and follow up of patients who present multiple times with unclear diagnoses. Contributing factors: • the atypical presentation of the condition in this case. • lack of a formal system of handover for allied health staff involved. • a relatively recent change in the provision of neurology services, which some staff may not have been aware of.	• Develop a formal guideline for referral/follow up for patients who have unclear diagnoses, and who present more than twice within ten days to the Emergency Department (ED). • Audit patients with recurrent presentations to the ED with a view to identifying ultimate diagnosis and follow up. • Formal handover of patients seen by allied health staff in ED and recording of allied staff findings on emergency department information system. • To improve referral practices, establish a process for the	This report has recently been approved and recommendations are yet to be implemented.

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			publication of a list of subspecialties and outpatient clinics.	
31. SAC2	Patient choked on food and subsequently died.	1. As a result of this incident a knowledge gap has been identified amongst clinicians, about the increased risk of choking for people with mental illness. 2. The patient was noted to have some psychomotor deficiencies but this did not appear to have affected their eating. None of the clinicians interviewed had considered that this patient was at an increased risk of choking prior to this event. 3. Access to the treatment room is with key only – some staff reported this was problematic and believed it would be quicker if access was via swipe card.	1. Incorporate education for staff about the increased risk of choking in patients with mental illness. 2. Share the findings from the review of the literature with the speech language therapists to ensure they are aware of the links between mental illness and the increased risk of choking. 3. Explore options around swipe card access to the treatment room to enable getting equipment faster.	1. Appointment of Dietician to the service who will engage with staff. 2. A plan to incorporate this information in the physical health workshops throughout the year. In-service sessions have been provided. 3. The difference in time taken between using a key compared to a swipe card is minimal and would not have made any difference to the outcome in this situation. At this time there will not be an application to change the access.

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Details	Description	Main Findings	Recommendations	Progress
32. SAC2	Controlled fall resulting in fractured hip.			Formal review in progress, report in draft.
33. SAC1	Communication and misinterpretation resulting in a delayed transfer from Lakes District Hospital to Dunedin ICU. Patient subsequently died.			Report complete, pending authorisation.
34. SAC2	Patient death after surgery, possibly due to lack of bed availability in ICU.			Since reporting this event to Health Quality and Safety Commission, a review has determined this event is not a serious adverse event.