

Serious Adverse Event Report

Capital, Coast and Hutt Valley

2023/2024



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Serious Adverse Events

An adverse event is an event in which a person receiving health care experiences harm.¹ This report summarises serious adverse events that occurred and were commissioned for review between 1 July 2023 and 30 June 2024 for hospital and community services at Health New Zealand | Te Whatu Ora Capital, Coast & Hutt Valley District (CCHV). This report does not include public health or mental health, addictions and intellectual disability service (MHAIDS).

CCHV had 104 confirmed SAC 1 and 2 adverse events from 1 July 2023 to 30 June 2024. Six events occurred in the previous reporting periods but were either not reported or not commissioned until this reporting year. Of the 104 serious adverse events for 2023/2024 there were a total of 19 SAC 1 events, and 85 SAC 2 events.

Each of these events involved a patient experiencing harm while in our care. We acknowledge the distress and grief that occurs as a result of health care related harm and sincerely apologise to those patients and whānau affected by the events in this report. CCHV is committed to improving how we learn from these experiences in order to better deliver our services. This report also includes a summary of work we are doing to improve our services as a result of the recommendations from reviews into SAC 1 and 2 events and other improvement projects.

Table 1: Total reported SAC 1 & 2 adverse events for the last three financial years (2021-24)

Category*	2021/2022	2022/2023	2023/2024
Clinical administration	11	6	2
Clinical process/procedure	63	84	58
Documentation	0	0	2
Healthcare associated infection (HAI)	1	3	1
Medication/intravenous (IV) fluids	9	7	7
Nutrition	0	0	3
Medical device/equipment	0	1	1
Behaviour	1	3	1
Falls	37**	31	24
Resources/organisational management	0	0	5
Total SAC 1 & 2 adverse events	122	135	104

Health Quality & Safety Commission. (2023). *Healing, learning and improving from harm: National adverse events policy.*

¹

** Categorisation is based on the Te Tāhū Hauora Health Quality & Safety Commission event codes derived from the World Health Organisation classifications for patient safety*

*** This includes 6 historic events that were identified by coding audit*

National Adverse Events Policy

This is the first reporting year under the new Healing, Learning and Improving from Harm: National Adverse Events policy (2023). We continue to adapt and align our processes to the new policy. We have already seen an impact in the number of fall with fracture events.

As part of the changes, we have a more robust triage process where events are scoped at the time of the event and taken for triaging with timely and up-to-date information, with the process including relevant services, where possible. This has led to better understanding of the nature of events, the extent of patient harm, and more informed decision making around commissioning of event reviews.

Severity Assessment Codes (SAC)

The adverse events in this report are categorised as Severity Assessment Code (SAC) 1 and 2, using the new National Adverse Events policy (2023). SAC 1 and 2 events are adverse events that result in permanent or severe harm, major loss of function, or death. All SAC 1 and 2 adverse events are reported to Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora HQSC).

We have commissioned fewer SAC 1 and 2 events in this reporting year compared to recent years however it is as yet unclear why there has been a decrease. It may be partially attributable to changes to our processes, including more robust triage process, as well as the re-grading of some events following completion of review during assessment through the Serious Event Review Committee (SERC) process. We will continue to monitor reporting numbers and look for trends and possible causes.

There were 17 'Always Report & Review' (ARR) events. ARR events are those that could result in serious harm or death but are preventable with strong clinical and organisational systems.² The ARR events are not reflected in the numbers as all had SAC ratings of 3 or 4, which are not included in this report.

Each SAC 1 or 2 event represents either the death of an individual, a person having a permanent disability or life impacting change, or a loss of function that may have impacted or prolonged their recovery. We extend our deepest condolences to patients and whānau

² HQSC. (2022). Always Report and Review list 2021-22.

impacted by these events and acknowledge the ongoing grief of those who have lost a loved relative or friend.

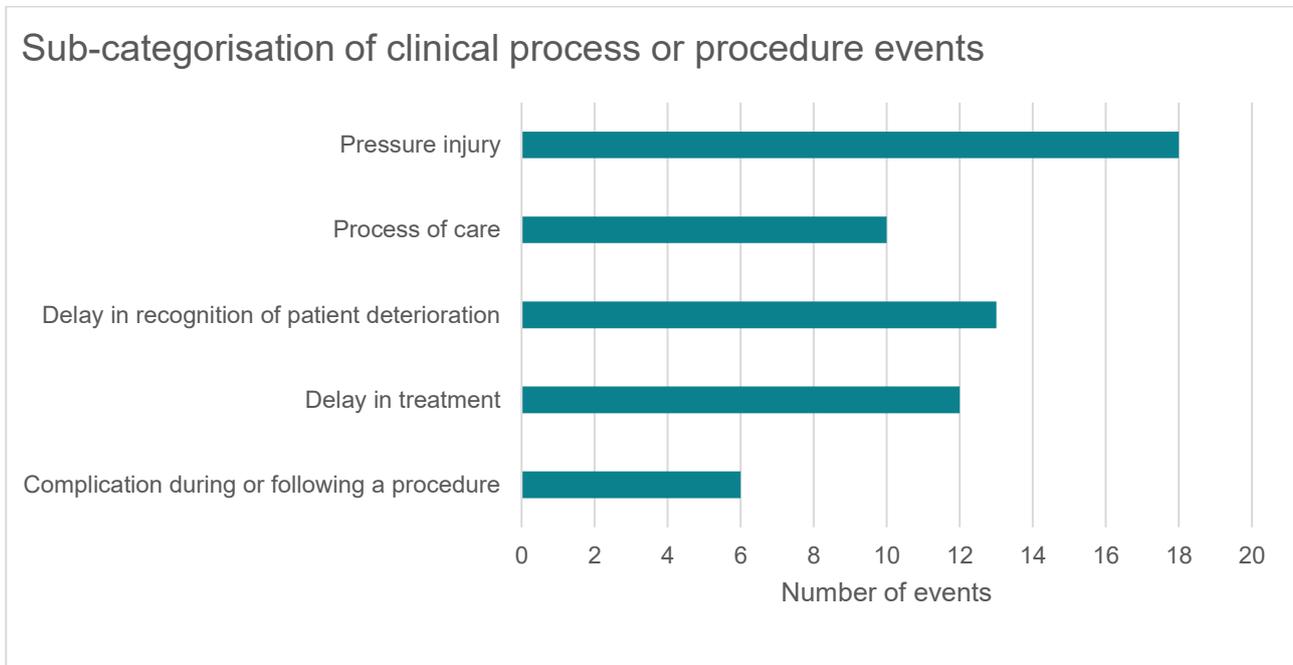
SAC 1 events

SAC 1 events represent those resulting in the most significant harm to patients. Of the 104 total events discussed in this report, there were 19 SAC 1 events. This is a significant decrease from the 37 events that occurred in the previous reporting year. ‘Clinical process/procedure’ events made up the majority of SAC 1 events (n=13). The most common sub-categories within this category were ‘process of care’ (n=5) and ‘delay in recognition of deterioration’ (n=5). The category with the next highest number of SAC 1 events was ‘resources/organisational /management’ (n=4).

Highest areas of harm

A total of 58 ‘clinical process or procedure’ events for CCHV were reviewed between 1 July 2023 and 30 June 2024 (SAC 1 events n=13, SAC 2 events n=45). ‘Clinical process or procedure’ events represent the majority of serious events (62 percent). These have been themed into sub-categories to provide more detail.

Figure 1: Sub-categorisation of clinical process or procedure events (1 July 2023 – 30 June 2024)



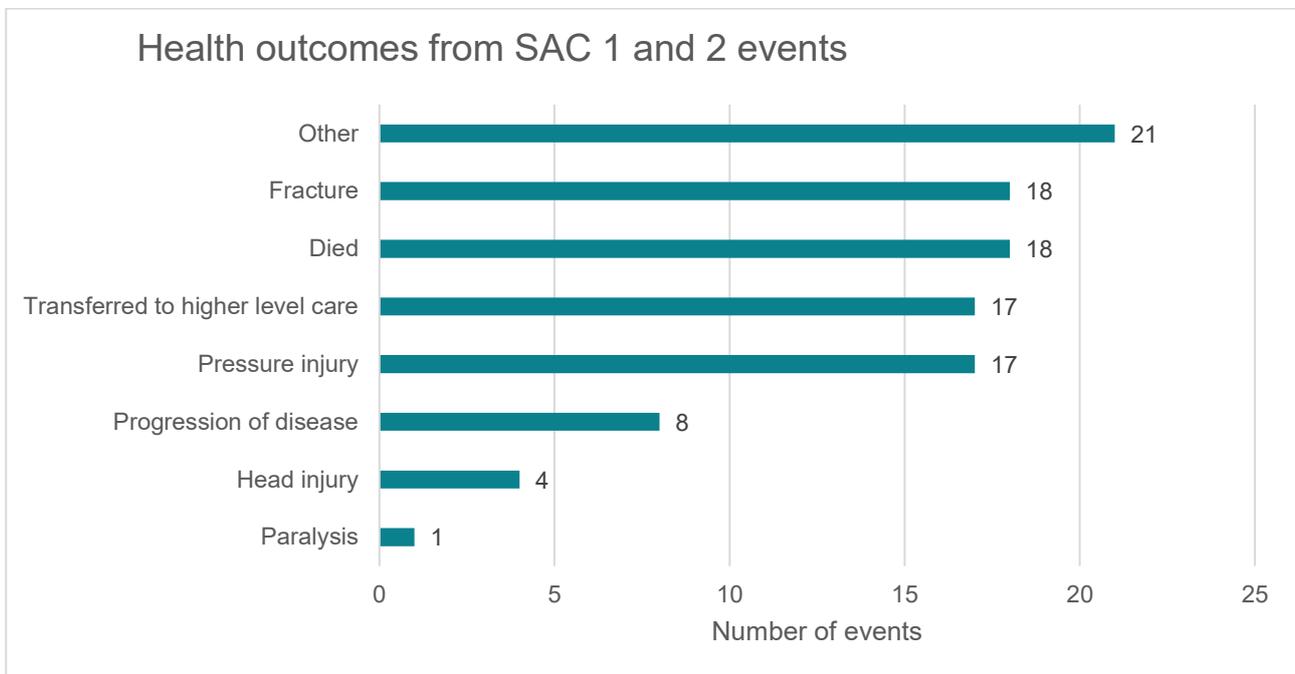
The category with the next highest number of events was ‘falls with serious harm’. There were 24 events themed under this category. Of these, one was classified as a SAC 1 event where the fall was sadly, a contributory factor in the patient’s death.

Under the previous policy, events were rated based on physical harm only. The new national policy recognises that healthcare related harm can be more than just physical: a person may experience psychological, cultural or spiritual harm. This report includes some events where there has been harm other than physical. As part of the implementation we are working to improve how we recognise and report other types of harm that people may have experienced while interacting with our healthcare services.

Health outcomes of SAC 1 and 2 events

The following chart describes the health outcomes for patients who experienced either a SAC 1 or SAC 2 adverse event:

Figure 2: Health outcomes of all SAC 1 and 2 events (1 July 2023 – 30 June 2024)



In some cases, it may not be possible to determine whether different or earlier treatment would have resulted in a different outcome for patients. However, review of these events can still provide us with information on how best to improve our services to provide the best care possible to patients and their whānau.

Te Tiriti o Waitangi

Health NZ has responsibilities and accountabilities under Te Tiriti o Waitangi and the Pae Ora (Healthy Futures) Act 2022 to address persistent inequities experienced by Māori, and to improve health outcomes for Māori.³ CCHV are committed to improving health outcomes for Māori in our district by prioritising tino rangatiratanga (self-determination); ōritetanga (equity); whakamaru (active protection); kōwhiringa (options) and pātuitanga

³ Te Whatu Ora (2023) 'Changing the system'.

(partnership).⁴ The Serious Event Review Committee (SERC) has Māori representation and, where possible, teams reviewing events involving Māori patients include a Māori staff member.

Our population

The CCHV district encompasses Hutt Valley, Kāpiti, Porirua and Wellington and includes Wellington Regional, Hutt and Kenepuru hospitals. It is a constantly evolving region diverse in cultures, ethnicities, abilities and geographic settings. Our population is expected to grow, age and become more diverse.⁵

Table 2: Population data for CCHV District from NZ Census 2023 (aggregated from territorial authority data)⁶

Ethnicity	Number	Percentage*
Māori	71,094	15%
Pacific peoples	45,531	10%
Asian	77,175	16%
Middle eastern/Latin American/African (MELAA)	11,691	2%
Other	5,169	1%
European	335,400	71%
Total	471,369	

* When using total ethnicity a person can be counted more than once if they have multiple ethnicities, therefore percentages will not add up to 100%.

A note on ethnicity data

As part of serious adverse event reporting we collect ethnicity data to better plan, tailor and deliver policies and services.⁷ However, it can be difficult to get accurate ethnicity data for our district population. This reflects the challenges in collecting ethnicity data in the wider health sector, even with the current ethnicity data protocols⁸. Since our last report, new census data has been released. This data is no longer available as prioritised

⁴ [Waitangi Tribunal. \(2023\). *Hauora report on stage one of the health services and outcomes kaupapa inquiry: WAI 2575 Waitangi tribunal report.*](#)

⁵ [Capital & Coast District Health Board \(2021\). *Capital & Coast District Health Board Annual Report.*](#)

⁶ [Statistics NZ \(2024\). *2023 Census national and subnational usually resident population counts and dwelling counts*](#)

⁷ [Ministry of Health \(2017\) *Ethnicity Data Protocols*](#)

⁸ [McLeod, M., & Harris, R. \(2023\). *Action plan for achieving high quality ethnicity data in the health and disability sector; A report for Te Aka Whai Ora: Māori Health Authority.*](#)

ethnicity therefore we have moved to reporting total ethnicity when talking about adverse events totals. We continue to use prioritised ethnicity for individual event categories.

Equity

“In Aotearoa New Zealand people have differences in health that are not only avoidable, but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes”⁹

CCHV is a pro-equity organisation committed to working with tangata whenua, people and partners across the region to achieve health equity.¹⁰ We recognise that we still have much work to do to improve inequity, particularly for Māori, Pacific peoples, LGBTQIA+ and takatāpui communities, disabled people, those with enduring mental illness and those with fewer resources. We continue to see the effects of historical institutional racism and colonialism that particularly affect Māori and Pacific peoples and we continue to see the impacts of these processes in ongoing inequitable health outcomes.

Māori continue to be proportionally over-represented in adverse events when compared with the district population. Māori make up approximately 15 percent of the total CCHV population, however 19 percent (n=20) of those affected by serious adverse events identified as Māori. Though there is limited research, this reflects a national trend in which 14 percent of Māori experienced an in-hospital adverse event compared with 11 percent of non-Māori.¹¹

Historically, our methods of identifying harm have not recognised the cultural, spiritual and psychological harm that many Māori and Pacific peoples experience when engaging with a health care system designed on European colonial principles.^{12 13} With the introduction of the new HQSC SAC guidelines we are working towards addressing this imbalance.

District and national context

The Pae Ora (Healthy Futures) Act 2022 saw the beginning of significant national health reform and the formation of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. With a change in government there have been further changes to our health system. Health NZ is now undergoing structural change which has an impact on our priorities and how we work.

⁹ Te Whatu Ora (2023) *Achieving equity*

¹⁰ Te Whatu Ora Capital Coast & Hutt Valley (2023) *Pro-equity*

¹¹ HQSC. (2019). *Ngā Taeoro a Kupe: Whānau experiences of in-hospital adverse events.*

¹² Ryan D., Grey C., Mischewski B. (2019). *Tofa Saili: A review of evidence about health equity for Pacific Peoples in New Zealand.* Wellington: Pacific Perspectives Ltd. ISBN 978-0-473-48927-4

¹³ Graham, R. & Masters-Awatere, B. (2020) Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research, *Australian and New Zealand Journal of Public health* 44(3) p193-200

CCHV, like other districts, has continued to see increased demand for services and high occupancy. This causes flow-on effects for those waiting to be seen in our hospitals. We have an ageing population who require longer hospital stays and have more complex needs. This, combined with limited capacity in the aged residential care sector means there can be delays to discharge for the older adult population. A primary health care sector under considerable pressure, with long waits for seeing General Practitioners has further exacerbated the pressure, particularly on emergency departments (ED).

Workforce resourcing continues to be a challenge when combined with increasing demand. There are increased presentations and longer wait times in emergency departments. We are also starting to see increased waits for some surgeries and procedures beyond the recommended timeframes as well as delays in treatment or transfer. There has been an increase in resource related SAC 1 or 2 events (n=5) for CCHV, where previously there had been none.

Reviewing and improving how we work

CCHV is always working to review and improve the care and services we provide. A number of improvement projects and initiatives have occurred, or are underway, as a result of recommendations from reviews into the events in this report. Some reviews are not yet completed so recommendations are not finalised.

In some circumstances, changes are not able to be made locally as they require major changes to infrastructure or services that need endorsement or funding from national teams. Where this is the case CCHV makes sure to raise concerns and risks with both regional and national teams.

The work below describes the range of improvements that have occurred over the past year as a result of reviews into adverse events and other improvement work. These have been grouped to relate back to the event themes.

Summaries of SAC events

The events described below have been grouped into themes and anonymised to protect the privacy of patients and whānau.

We have used the following ethnicity groupings consistent with the most recent ethnicity data protocols from Manatū Hauora Ministry of Health: Māori, Pacific Peoples, Asian, Middle Eastern/Latin American/African (MELAA), Other and European.¹⁴ Where a patient identifies with multiple ethnicity groups, we have used prioritised output reporting.

Clinical administration events

There were two events due to clinical administration errors.

Patient ethnicity: Māori (n=1), European (n=1)

Table 3: Clinical administration events 1 July 2023 to 30 June 2024

Number	Event summaries
1	One person had a delay in their First Specialist Appointment due to outpatient appointment processes
1	One person experienced a delay in treatment due to an issue with the referral process

What we are doing to improve our clinical administrative processes:

- We continue to advocate for information and communication technology (ICT), and national improvements, escalating through national Health NZ governance structures as needed
- Over the past 12 months we have rolled out Single Clinical Portal (SCP), this allows better access to clinical information from all sites within the CCHV district and Wairarapa
- The Patient Administrative Service team and service specific administrators are working to streamline and digitise referral and booking processes

¹⁴ [Ministry of Health \(2017\) Ethnicity Data Protocols](#)

Clinical process/procedure events

There were 58 adverse events related to clinical process or procedures. These events have been themed into five categories:

- Delay in recognition of patient deterioration
- Pressure injury
- Delay in treatment
- Complication during or following a procedure
- Process of care

1. Delay in recognition of patient deterioration

Thirteen events occurred due to a delay in recognition of patient deterioration across a range of healthcare settings. Six of these were SAC 1 events.

Patient ethnicity: Māori (n=2), Pacific peoples (n=2), Asian (n=2), European (n=7)

Table 4: Delay in recognition of patient deterioration events 1 July 2023 to 30 June 2024

Number	Event summaries
3	Three events related to delay in recognition of abnormal traces or changes for patients on continuous monitoring
5	Five events related to a delay in recognising changes in a patient's neurological condition or level of consciousness
2	Two events involved delayed recognition of a complication from a procedure
3	There were three events where a patient's deteriorating vital signs were not escalated appropriately

What we are doing to improve recognition of patient deterioration:

- A survey of clinical staff was completed around understanding of early recognition and escalation to identify areas for targeted education
- An increase in resource for the Patient at Risk (PAR) service has enabled the PAR team to provide more education and new resources on patient deterioration
- The PAR teams across the district are now working more closely to share knowledge and improve processes
- The PAR service is now included on SmartPage, improving access to the service across the district.

- Kōrero Mai is an initiative to ensure patients and whānau are able to voice their concerns if worried about their or their loved ones care or condition. This was already in place at Wellington Hospital but has now been launched at Kenepuru and Hutt Hospitals. A co-design approach was used with consumers and staff to ensure resources and information met the needs of different populations
- A pilot audit of patient early warning score (EWS) modifications has been carried out. Data from this will be used to improve our processes and training relating to appropriate and safe EWS modification
- A new multi-system tracer audit has been released to all inpatient areas. Tracer audits encompass all aspects of the patient stay, following a patient's journey from admission to discharge, and capture a snapshot that helps to identify gaps. This assesses compliance with local policies on vital signs measurement and recording to help highlight areas for improvement and education in each ward/unit
- We continue to advocate for information and communication technology (ICT) local and national improvements, such as the implementation of electronic systems for recording, scoring and escalating patient vital signs, escalating through national Health NZ governance structures as needed.
- EWS education, including scenarios, are part of the resuscitation education sessions for all new staff, and revisited in refresher education sessions. This also includes a process to escalate concerns (graded assertiveness tool)
- We continue to deliver the Acute and Life Threatening Events (ALERT) course to staff working in acute areas. This is a multidisciplinary course focusing on the recognition and management of the acutely unwell or deteriorating patient

2. Pressure injury

There was a decrease in pressure injury related events, from 25 last year. Eighteen patients sustained a pressure injury graded as either three, four, deep tissue or unstageable*. There was one SAC 1 event related to a pressure injury. The heel and sacrum are vulnerable areas for developing pressure injuries as well as under casts or devices. This is reflected in the events.

Patient ethnicity: Māori (n=1), Pacific peoples (n=1), European (n=15), Not stated (n=1)

Table 5: Pressure injury events 1 July 2023 to 30 June 2024

Number	Event summaries
14	Fourteen patients developed pressure injuries to their heels, sacrum or elbow while in hospital
4	Four patients developed pressure injuries under a cast, bandage, or medical device

**Pressure Injury Classification:*

Deep tissue: There is no open wound but the tissue beneath the skin’s surface has been damaged.

Stage 3: Subcutaneous fat may be visible, no exposed bone tendon/muscle.

Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle.

Unstageable: Depth unknown. Full thickness tissue loss and base of the pressure injury covered by slough and/or eschar.

What we are doing to reduce patient harm from pressure injuries:

- A district wide policy of pressure injury prevention and management is complete
- A new multi-systems tracer audit which provides up to date feedback on nursing cares and assessment has been introduced. Tracer audits encompass all aspects of the patient stay, following a patient’s journey from admission to discharge, and capture a snapshot that helps to identify gaps
- The nursing leadership team are undertaking a review of all nursing assessments and care planning documents, including those relating to pressure injuries
- A district wide pressure injury champion study day has been introduced, and more education days on pressure injury prevention and management are being held. This has helped areas learn from each other and collaborate on pressure injury prevention strategies
- November was Pressure Injury Prevention month, there were education sessions for clinical staff, new training resources and a pressure injury prevention awareness campaign was run across the district

- The Moving and Handling education team are working with services to embed the use of appropriate equipment to increase the ease of repositioning patients easily and safely

3. Delay in treatment

Twelve events occurred due to delays in treatment. Three of these were SAC 1 events.

Patient ethnicity: Māori (n=2), Pacific peoples (n=1) and European (n=9)

Table 6: Delay in treatment events 1 July 2023 to 30 June 2024

Number	Event summaries
3	Three patients experienced a delay in assessment while in the emergency department which resulted in delayed treatment
4	Four patients experienced delays in having a procedure or surgery
3	Three patients experienced delays in having a scan
2	Two patients had a delay in receiving medication

What we are doing to reduce delays in treatment:

- A new process is in place to ensure all operating theatres are utilised across the district to address delays for patients having elective surgery. This includes patients having regular reviews by their specialist while on a waitlist, and outsourcing when available
- The Patient Flow Council has been established and leads several key pieces of work in alignment with the National Acute Flow Standards. Priority projects are reducing waiting times to be seen in ED and shorter stays in ED
- The server software suite which is used to process radiology scans has been replaced and upgraded
- There has been targeted education for different clinical staff on the treatment of pulmonary embolism

4. Complication during or following a procedure

There were six events related to complications that occurred during or following a procedure. One of these was a SAC 1 event.

Healthcare is complex and all procedures carry a risk of complication. Some of the complications experienced by patients in these events were known complications of their procedures. While steps can be taken to reduce the risk of adverse effects from interventions, we acknowledge that not all complications are avoidable.

Patient ethnicity: Māori (n=3) and European (n=3)

Table 7: Complication during or following a procedure events 1 July 2023 to 30 June 2024

Number	Event summaries
3	Three patients experienced complications related to a line or catheter
3	Three patients experienced complications related to their surgery

What we are doing to reduce complications during or following procedures:

- A district wide procedural sedation and analgesia policy has been developed to standardise how we use procedural sedation
- Specialist support for the paediatric surgery team has been provided to help build paediatric surgical expertise within the district
- The policy that provides guidance on how to document items used in surgery is currently being updated

5. Process of care

Process of care refers to actions or interventions performed during the delivery of patient care in accordance with evidence based best practice. There were nine process of care events, one of which was a historical event. Three of these were SAC 1 events.

Patient ethnicity: Māori (n=2), MELAA (n=1), European (n=6)

Table 8: Process of care events 1 July 2023 to 30 June 2024

Number	Event summaries
2	Two events related to processes for ordering and reporting laboratory results
2	Two events involved management of food and fluid intake
2	Two events related to communication issues with external providers
1	One event related to support available for a patient
1	One event related to processes around assessment and discharge
1	One event related to non-medication-based pain relief

What we are doing to reduce patient harm due to process of care events:

- There have been improvements made to the reporting of urgent CT scans at Hutt Hospital. This includes overnight reporting cover from an external provider with access to an on-call radiologist
- Investigation of options for safe provision of heat therapy for pain relief is underway
- We continue to advocate for information and communication technology (ICT) local and national improvements, escalating through HNZ | Te Whatu Ora governance structures as needed
- A project is underway to review and redesign patient care plans and assessments
- There has been targeted education for clinical staff on caring for patients with swallowing concerns

Documentation

There were two SAC 2 events related to documentation.

Patient ethnicity: Māori (n=1) Pacific peoples (n=1)

Table 9: Documentation events 1 July 2023 to 30 June 2024

Number	Event summaries
2	Two events involved gaps in documentation related to a procedure resulting in emotional harm

What we have done to improve the quality of our documentation:

- A pre-procedure checklist has been reviewed and revised to give more clarity around conversations and documentation requirements before a procedure
- The district wide Medical Records (electronic and hard copy) Content and Documentation Policy is currently under review. This will clarify the organisations obligations and encourage robust documentation

Healthcare associated infection (HAI)

There was one SAC 2 healthcare associated infection event.

Patient ethnicity: European (n=1)

Table 10: HAI events 1 July 2023 to 30 June 2024

Number	Event summaries
1	One patient developed an infection from an inserted line

What we have done to reduce patient harm from HAI:

- New guidelines for the length of time an IV line can remain in place have been implemented
- A new paediatric sepsis pathway is being used in both emergency departments (EDs) and an adult pathway will be trialled in the surgical assessment and planning unit (SAPU), Medical Assessment and Planning Unit (MAPU) and both EDs

Medication/Intravenous (IV) Fluids

There were seven medication or IV Fluid events, one of these was a SAC 1 event. There were six events related to medication and one event related to intravenous fluid administration.

Patient ethnicity: Māori (n=3), European (n=4)

Table 11: Medication and IV fluid events 1 July 2023 to 30 June 2024

Number	Event summaries
2	Two people received an incorrect dose of medication
2	Two people received the incorrect medication
1	One person received a medication to which they had a known allergy
1	One person did not have their medication restarted
1	One person received an inadvertent bolus of intravenous fluid

What we are doing to reduce medication and IV fluid related events:

- We have contributed to the development of a national anti-coagulation stewardship programme in collaboration with Te Tāhū Hauora HQSC
- A dedicated smart pump pharmacist continues to build and improve the drug library on the IV pumps used to deliver IV medication and fluids. This supports safe administration of IV medications and fluids and reduces the potential for error
- A neurosurgical venous thromboembolism (VTE) guideline was developed at CCHV with national collaboration. The guideline has now been adopted by neurosurgical units nationwide
- We continue to advocate for the implementation of an electronic medication management system for the prescribing and administration of inpatient medications

Nutrition

There were three nutrition related events. All were SAC 2 events.

Patient ethnicity: European (n=3)

Table 12: Nutrition events 1 July 2023 to 30 June 2024

Number	Event summaries
3	Three patients received food to which they had a known allergy

What we are doing to reduce nutrition and hydration related adverse events:

- A district wide Kai Committee has been established to review multiple aspects of food provision. The committee includes clinical, management and food services staff
- Work has begun on a project to improve food allergy documentation and management
- Peanuts have been removed from patient menu items prepared on site at all our hospitals

Medical device/equipment

There was one SAC 2 event related to a medical device or equipment.

Patient ethnicity: Asian (n=1)

Table 13: Medical device/equipment events 1 July 2023 to 30 June 2024

Number	Event summaries
1	One event involved failure of equipment used to deliver oxygen

What we are doing to reduce medical device related events:

- The district wide airway committee has reviewed the equipment used to deliver oxygen to patients in an emergency
- The patient safety team work with procurement to review any product shortages or issues, assess patient risk and communicate information to relevant clinical teams

Behaviour

There was one behaviour related event. This was a SAC 2 event.

Patient ethnicity: European (n=1)

Table 14: Behaviour events 1 July 2023 to 30 June 2024

Number	Event summaries
1	One patient experienced psychological harm as a result of inpatient care

What we are doing to reduce behaviour related events:

- The feasibility of developing an AI teaching and feedback tool for clinicians to improve person and whānau-centred care and communication is currently under investigation
- Te Mauri o Rongo (The New Zealand Health Charter) sets out expectations for staff, management, and organisational behaviour. Training on putting Te Mauri o Rongo into practice is available for all staff
- Findings from the HNZ Pulse survey, a tool for measuring staff wellbeing, have been disseminated to managers. The findings will be used to guide organisational development activities to improve wellbeing within teams
- HNZ has released a new training series for all frontline clinical staff that focuses on de-escalation techniques and communication with patients and whānau. This has been advertised and we have encouraged our staff to complete the training

Falls

There were 24 falls causing serious harm in this reporting period. A fall with serious harm is considered to be one in which a patient experiences a head injury or significant fracture as a result of a fall. One of the fall events was a SAC 1.

These fall events primarily occurred amongst the older adult population across different hospital locations. A range of environmental, assessment, care planning, and process factors were found to have contributed to these events. Unfortunately, sometimes falls do occur despite safety huddles and appropriate falls assessment and management.

Patient ethnicity: Māori (n=3), Asian (n=2) and European (n=19)

Table 15: Falls 1 July 2023 to 30 June 2024

Number	Event summaries
4	Four patients had a fall while supervised resulting in fracture or head injury
10	Ten patients had an unwitnessed fall while mobilising resulting in a fracture
7	Seven patients had an unwitnessed fall from a bed chair or the toilet resulting in a fracture
3	Three patients had an unwitnessed fall resulting in a head injury or non-bony injury

What we are doing to reduce patient harm from falls:

- We have re-established the Falls Committee as the district wide Falls Prevention Committee with representation from a range of professional groups. The Committee is working on aligning policies and procedures related to falls prevention, education and management, and falls risk assessments. The Committee works closely with nursing and allied health profession leaders and the group has set “decreasing patients falls” as a key focus for 2025
- A new multi-systems tracer audit which provides up to date feedback on nursing cares and assessment has been created. Tracer audits encompass all aspects of the patient stay, following a patient’s journey from admission to discharge, and capture a snapshot that helps to identify gaps in care processes
- Access to equipment to minimise risk of falls, and to assist patients following a fall, has been improved across CCHV
- Moving and Handling education includes assessing mobility needs and safe ways of supporting patients to mobilise

Resource/organisational management

There were five events related to organisational resources, three of these were SAC 1 events.

Patient ethnicity: Māori (n=2), European (n=3)

Table 16: Resource/organisational management events 1 July 2023 to 30 June 2024

Number	Event summaries
4	Four patients had prolonged wait times for a surgery or procedure due to resourcing. Sadly, three of these people died before receiving their surgery or procedure
1	One patient had a prolonged ED wait time

What we are doing to improve our resourcing:

- There has been an increase to the number of nurses and senior medical officers in Te Pae Tiaki | Emergency Department (Wellington)
- The creation of a hybrid theatre suite at Wellington Regional Hospital has been approved by HNZ and work will commence in 2025
- A Patient Flow Council has been established and is leading several key pieces of work in alignment with the National Acute Flow Standards. Two priorities are reducing ED waiting times to be seen and reducing total ED length of stay
- A high dependency unit (HDU) is due to open at Wellington Regional Hospital in 2025. This will create an additional 12 critical care beds
- A business case for the angiography suite upgrade has been approved with completion of a new angiography suite scheduled for 2025. There are further improvements scheduled as staged upgrades over 2025 – 2027, which will improve capacity for interventional procedures across multiple specialties

Final comment

The staff at Health New Zealand | Te Whatu Ora Capital Coast and Hutt Valley work every day to improve the care provided for people in our district, but there is always more that can be done to ensure the care we deliver is safer, more effective and more equitable for everyone in our community.

Most people who come to us for care and treatment do so without preventable harm occurring to them. However, those patients who were affected by the adverse events in this report have either experienced serious harm or in some cases, have died. We acknowledge that each event described in this report represents an individual who is loved by their whānau and wider community, and we sincerely apologise to all who have been affected.