

## **Rapid Notification of Serious Adverse Clinical Event.**

Rapid notification of all serious adverse clinical events is essential to enable the SCA to identify:

- Potential litigation
- Quality improvement opportunities at enterprise level

A verbal or email notification should be made to the relevant CIS Clinical Risk Adviser within 48 hours of occurrence of such an event. The adverse event should of course also be notified routinely via STARSWeb. A list of adverse clinical events requiring this action is listed below for the guidance of all enterprises. On receipt of these notifications, the CIS Clinical Risk Adviser will generally request more detailed information from the reporting enterprise. This information will include, but is not limited to, the outcome of any relevant diagnostics that establish the level of harm, further treatment delivered, date of Coroner's Inquest etc.

### **List of Serious Adverse Clinical Events for Rapid Notification to the CIS**

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure, including retained vaginal swabs and tampons.
- Unexpected Intra-operative or immediately postoperative death.
- Unplanned return to operating suite.

### **Product or Device Events**

- Patient death or serious adverse outcome associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
- Patient death or serious adverse outcome associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious adverse outcome associated with intravascular air embolism that occurs while being cared for in a health care facility

### **Patient Protection Events**

- Patient suicide, or attempted suicide, resulting in serious adverse outcome while being cared for in a health care facility
- Patient death or serious adverse outcome associated with patient absconding.

- Infant discharged to the wrong person

### **Care Management Events**

- Patient death or serious adverse outcome associated with high alert drugs as determined by Drugs & Therapeutic Committees, pharmacy etc.
- Patient death or serious adverse outcome associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious adverse outcome associated with a haemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Maternal death.
- Serious adverse outcome associated with labour or delivery.
- Death or serious adverse outcome associated with delayed diagnosis.
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinaemia in neonates
- Hospital Related death reportable to the Coroner
- Patient death or serious adverse outcome due to spinal manipulative therapy

### **Environmental Events**

- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious adverse outcome associated with a burn incurred from any source while being cared for in a health care facility
- Patient death or serious adverse outcome associated with a fall while being cared for in a health care facility
- Patient death or serious adverse outcome associated with the use of restraints or bedrails while being cared for in a health care facility

(Adapted from The National Quality Forum's List of the 28 "Never Events")