

March 2012



HEALTH QUALITY & SAFETY  
COMMISSION NEW ZEALAND

*Kupu Taurangi Hauora o Aotearoa*

# New Zealand Health and Disability Services – National Reportable Events Policy 2012



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### 1. PURPOSE

The purpose of this policy is to:

- 1.1** contribute to improved quality, safety and experience of health and disability services through systems that are consumer-centred, provide for early identification and review of incidents and reportable events, ensure lessons are learnt so preventable adverse events are not repeated, demonstrate public accountability and transparency, and are safe;
- 1.2** provide the data and information for the Serious and Sentinel Report published regularly from the central repository.<sup>1</sup>

### 2. TREATY OF WAITANGI

Crown health and disability services are required to acknowledge the special relationship between iwi and the Crown under the Treaty of Waitangi. The principles of Partnership, Participation and Protection will continue to underpin the relationship that iwi have with Crown health and disability services in New Zealand.

### 3. BACKGROUND

The fundamental role of a reportable events system is to enhance consumer safety by learning from adverse events and near misses that occur in the health and disability services. The following principles underpin this policy.

- 3.1** Open disclosure/open communication. Consumers, their families and whanau are entitled to truthful and open communication at all times following an adverse event.
- 3.2** System changes. Reporting is only of value if it is accompanied by meaningful analysis which leads to system changes designed to prevent recurrence of events. Lessons learnt must be disseminated locally by individual health and disability providers as well as nationally by the central repository.
- 3.3** Accountability is provided by assuring the community that when adverse events and near misses occur, action is taken both at the local and national level. Action at the local level focuses on learning, improving safety and reducing the possibility of recurrence. At the national level action focuses on analysing aggregated data, reporting publicly on reportable events and sharing information about actions taken to reduce the possibility of recurrence or ensuring prevention.

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<sup>1</sup> At the time of writing this policy, the central repository is the Health Quality & Safety Commission.

- 3.4** Reporting must be safe. Consumers and staff must be empowered to report events without fear of retribution. Events that are reported must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals. Providers must ensure a just culture<sup>2</sup> prevails so individuals are not held accountable for system failures. Incidents that involve a criminal act, or substance abuse by the health practitioner, a deliberate unsafe act, or a deliberate consumer harm will be managed in a separate process and may involve the relevant regulatory authorities.

## 4. SCOPE

### In Scope

- 4.1** All New Zealand health and disability service providers who have obligations under the Health and Disability Services (Safety) Act 2001.
- 4.2** All New Zealand health and disability service providers who voluntarily comply but are not obliged to under the Health and Disability Services (Safety) Act 2001.
- 4.3** All adverse events and near misses rated 1, 2, 3, or 4 on the Severity Assessment Code (SAC) that occur, or have the potential to occur, to any person as a result of, or related to, the provision of health and disability services.

### Out of Scope

- 4.4** Occupational health and safety events affecting any employee, employer, contractor or volunteer within health and disability service settings in New Zealand. These are managed under the Health and Safety in Employment Act 1992 (and regulations) that aim to make work activities safe and healthy for everyone connected with them.
- 4.5** Employment relationship issues and events affecting any employee in health and disability service settings in New Zealand. These are managed under the Employment Relations Act 2000 (and regulations) that aim to build productive employment relationships through the promotion of good faith in all aspects of the employment environment and the employment relationship.

## 5. POLICY

This is a national policy. In the interests of national consistency and continuous improvement, all health and disability service providers obliged<sup>3</sup> to comply, and those who voluntarily agree to comply with this policy, must:

- 5.1** have a local policy and processes in place for reporting and responding to health and disability service incidents. Local policies and processes must meet the requirements of this policy and the Health and Disability Services Standards NZS8134:2008;<sup>4</sup>
- 5.2** openly disclose information and communicate with consumers, their families and whanau in line with the Health and Disability Commissioner's guidance on open disclosure;<sup>5</sup>

2 A 'Just culture' recognises that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behaviour. (Marx, D. Patient Safety and the "Just Culture": A Primer for Health Care Executives. New York, NY: Columbia University; 2001. As quoted on AHRQ Patient Safety Network: <http://www.psnnet.ahrq.gov/glossary>).

3 Obligations arise under the Health and Disability Services (Safety) Act 2001, Section 5; New Zealand Public Health and Disability Act 2000, Section 59C; 2012/13 Ministry of Health Operational Policy Framework.

4 Copies of this standard can be purchased from: <http://www.standards.co.nz/services/publications/8134+2008+Information+page.htm>

5 <http://www.hdc.org.nz/media/18328/guidance%20on%20open%20disclosure%20policies%20dec%2009.pdf>

- 5.3** determine the severity of every reported incident using the Severity Assessment Code (SAC);
- 5.4** report all SAC 1 and SAC 2 events to the central repository **within 15 working days** from the date the adverse event is reported to the provider;<sup>6</sup>
- 5.5** undertake formal review of all SAC 1 and SAC 2 events using a Root Cause Analysis (RCA) methodology, or a serious incident review for serious and sentinel mental health events;<sup>7</sup>
- 5.6** develop recommendations to eliminate, control, or accept the root causes or causal factors identified for the adverse event;
- 5.7** send a summary of the findings and recommendations of all SAC 1 and SAC 2 event reviews to the central repository **within 70 working days** from the date that the adverse event is reported to the provider.<sup>8</sup> This summary must include an outline of the actions agreed by the Chief Executive Officer, Chief Medical Officer or Chief Nursing Officer (or other equivalent senior personnel), or the reasons for not implementing the recommendations of the RCA or serious incident review.
- 5.8** have a system in place for managing, reporting, learning about and staying up-to-date with local incident management and national reporting requirements.

In the interests of national consistency and continuous improvement, all health and disability service providers are encouraged to consider:

- 5.9** notifying the central repository of near-miss incidents with a high potential SAC rating, or those adverse events rated as SAC 3 or SAC 4, where national learning can occur.

## **6. REVIEW OF THIS POLICY, OPERATIONAL GUIDANCE AND FORMS**

This policy, supporting operational guidance and forms will be reviewed at least every three years.

## **7. DEFINITIONS**

### **Adverse event**

An adverse event is an incident which results in harm to a consumer (see incident; near miss; reportable event).

### **Alert**

An alert is the mechanism used to transmit urgent information to the central repository.

### **Blood component**

For the purposes of Section 3 of the Severity Assessment Code (SAC), this relates to consumer specific allocation of a blood component that is incorrectly prescribed and/or administered.

### **Central repository**

As at January 2012, this means the Health Quality & Safety Commission which is the central point for collecting, analysing and disseminating learnings from reportable events.

<sup>6</sup> Complete Part A of the Health Quality & Safety Commission Reportable Events Brief.

<sup>7</sup> See definitions.

<sup>8</sup> Complete Part B of the Health Quality & Safety Commission Reportable Events Brief.

## Consumer

For the purposes of this policy a consumer can also be a client, patient or resident. It is the person who receives health and disability services.

## Incident

An incident is any event that could have or did cause harm to a consumer (see adverse event, near miss, reportable event).

## Misadministration of radioactive materials

This refers to an incident resulting from the use of therapeutic ionising radiation.

## Near miss incident

This is an incident which under different circumstances could have caused harm to a consumer but did not, and which is indistinguishable from an adverse event in all but outcome.

## Open disclosure

Open disclosure, or open communication, refers to the timely and transparent approach to communicating with, engaging with and supporting consumers, their families and whanau when things go wrong.<sup>9</sup>

## Reportable event

Any adverse event classified as a SAC 1 or SAC 2 rating.

## Reportable event brief (REB)

This is the form used to transmit information about reportable events and alerts to the central repository. Health and disability service providers may also use the REB at their discretion to notify the central repository about near misses and SAC 3 and SAC 4 adverse events if they consider there are lessons to be learnt nationally.

**Part A** of the REB is used to communicate the nature of the event and allocate a provisional SAC rating. Part A must be sent to the central repository within **15 working days** of notification of the adverse event to the provider.

**Part B** of the REB is used to confirm the SAC rating, describe consumer age and gender and provide a summary of the findings and recommendations related to the reportable event. Reasons must be included for not implementing any of the recommendations. Part B must be sent to the central repository within **70 working days** of notification of the adverse event to the provider.

## Retained item

A procedural item (for example instruments, swabs, needles, packs, etc.) unintentionally left in the body following a procedure. Identification of the item can be:

- *Delayed*  
Any retained item that is not identified until after the transfer of the consumer from the location of the procedure; or
- *Immediate*  
Any retained item that is identified prior to the transfer of the consumer from the location of the procedure.

## Review

A review is another name for an investigation that is carried out by the health care or disability service. (See root cause analysis).

<sup>9</sup> <http://www.hdc.org.nz/media/18328/guidance%20on%20open%20disclosure%20policies%20dec%2009.pdf>

### **Root Cause Analysis (RCA)**

A root cause analysis (RCA) is a formal process of investigation designed to identify the root causes of adverse events.

### **Serious incident review**

This term refers to the type of review conducted for serious and sentinel mental health events. The Commission has worked with the mental health sector to develop a process that reflects the principles of this policy but applies a more appropriate set of operational guidance for these types of investigations.

For process see:

<http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf>.

### **Severity Assessment Code (SAC)**

The SAC is a numerical rating which defines the severity of an adverse event and as a consequence the required level of reporting and investigation to be undertaken for the event.

## APPENDIX A – Form

### Part A: Reportable Event Brief

**(To be sent to Central Repository (HQSC) within 15 working days of notification of the event to the provider organisation)**

Organisation: \_\_\_\_\_

Organisation event reference: \_\_\_\_\_

Name of person to contact with any queries: \_\_\_\_\_

Contact Details: Tel: \_\_\_\_\_

E-mail: \_\_\_\_\_

Type of provider: (tick all that apply)

DHB	<input type="checkbox"/>	Private Medical / Surgical	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	Pacific Health Provider	<input type="checkbox"/>
Aged Care	<input type="checkbox"/>	Maori Health Provider	<input type="checkbox"/>
Community Trust	<input type="checkbox"/>	NGO	<input type="checkbox"/>
PHO	<input type="checkbox"/>	Disability Services Provider	<input type="checkbox"/>
Other:			

Provisional SAC:

SAC 1	<input type="checkbox"/>	SAC 2	<input type="checkbox"/>	Alert (Y/N)*	<input type="checkbox"/>
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Provisional Event Code:

Date of event: \_\_\_\_\_

Date of internal notification/report: \_\_\_\_\_

Description of event:

This Reportable Event Brief (Part A) has been approved for transmission to the Central Repository (HQSC) by the organisation's CEO (or delegated manager) who endorses the accuracy and content of the document:

Name: \_\_\_\_\_

Position: \_\_\_\_\_ Date sent: \_\_\_\_\_

**Please send completed forms and any queries to: [reportable.events@hqsc.govt.nz](mailto:reportable.events@hqsc.govt.nz)**

\* Alert Y/N: State "Y" if the reporting provider wishes to raise an alert, which will result in the Central Repository (HQSC) contacting the provider for further details.

# Part B: Reportable Event Brief

**(To be sent to the Central Repository (HQSC) within 70 working days from the date the event is notified to the provider)**

Name of person to contact with any queries: \_\_\_\_\_

Contact Details: Tel: \_\_\_\_\_

Email: \_\_\_\_\_

Organisation event reference: \_\_\_\_\_

Date review completed: \_\_\_\_\_

Confirm SAC:

SAC 1		SAC 2		Other	
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Event Code:

Consumer details:

Age:	Gender:
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Summary of findings:

Key recommendations, including changes to systems and processes:

Other comments (including reasons for not implementing any of the recommendations):

This Reportable Event Brief (Part B) has been approved for transmission to the Central Repository (HQSC) by the organisation's CEO (or delegated manager) who endorses the accuracy and content of the document:

Name: \_\_\_\_\_

Position: \_\_\_\_\_ Date sent: \_\_\_\_\_

**Please send completed forms and any queries to: [reportable.events@hqsc.govt.nz](mailto:reportable.events@hqsc.govt.nz)**

## Reportable Event Codes

The reportable event codes below are derived from the World Health Organization classifications for patient safety.<sup>10</sup>

Following receipt of the final report, the Central Repository (HQSC) will classify the event in more detail.

If there are any queries about what classification to apply to the event being reported, please contact [reportable.events@hqsc.govt.nz](mailto:reportable.events@hqsc.govt.nz) for advice.

General classification of event	Event code
Clinical administration (eg handover, referral, discharge)	01
Clinical process (eg assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (eg wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (eg intended self-harm, aggression, assault, dangerous behavior)	10
Patient accidents (not falls) (eg burns, wounds not caused by falls)	11
Patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14

<sup>10</sup> Conceptual Framework for the International Classification for Patient Safety, Version 1.1; Final Technical Report, January 2009.  
[http://www.who.int/patientsafety/taxonomy/icps\\_full\\_report.pdf](http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf)



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