Review of the National Reportable Events Policy 2012

Summary of stakeholder feedback on proposed policy changes (March 2017)

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Introduction

The 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.

In New Zealand, reporting of adverse events and near misses is guided by the National Adverse Events Reporting Policy 2017, previously the National Reportable Events Policy 2012. The policy supports a nationally consistent approach to reporting, review and learning from adverse events and near misses. Under the policy, health and disability service providers with obligations under the Health and Disability Services (Safety) Act 2001, and those who voluntarily comply, are expected to (a) notify the Health Quality & Safety Commission ('the Commission') of serious adverse events and (b) provide the Commission with findings and recommendations from review of these events to enable national learning.

The National Reportable Events Policy 2012 was reviewed over 2016–17. This report provides an overview of the policy review process and a summary of stakeholder feedback on proposed policy changes.

Review approach

The policy review process included the following activities:

- online stakeholder survey seeking initial input on changes to the policy (2015)
- review of overseas literature on patient safety reporting systems (2016)
- interviews and meetings with key stakeholders on ways to improve the policy (2016)
- online and written stakeholder feedback on proposed changes to the policy (November 2016 to January 2017).

Five themes for policy change were developed by the Adverse Event Learning Programme (AELP) as a result of the initial online stakeholder survey, literature review and stakeholder meetings. These themes, which were approved and endorsed by the AELP Expert Advisory Group, were to:

1. increase the focus on people who use services (consumers/patients)
2. expand the purpose statement to clarify national and local roles and expectations
3. increase the focus on learning and action to strengthen implementation and monitoring of recommended actions
4. make it easier for organisations to report and prioritise for national reporting
5. make the policy relevant to the whole health and disability sector and move to greater coverage over time.

Proposed changes to the policy were summarised in a policy review discussion document, which included key questions for stakeholders on the five policy change themes. Stakeholders were invited to respond to these questions via an online survey or written submission. Stakeholders were also invited to provide feedback on policy terminology and reporting of mental health events.

A total of 66 people provided online feedback on the discussion document, and 24 individuals and organisations provided written feedback. Not all submitters answered every consultation question.

Stakeholder feedback is summarised below.

Terminology

There were mixed views among stakeholders on whether ‘adverse event’, ‘patient safety incident’ or ‘consumer safety incident’ should be used in the policy.

- Arguments for ‘adverse event’ included that the term is familiar, it does not imply fault and it is broad enough to accommodate non-clinical events, events that happen in an outpatient environment and events that happen to people who do not necessarily see themselves as patients (eg, a woman seeking routine maternity care or a user of mental health services). ‘Incident’ was seen by some to minimise the seriousness of the event, and could be confused with health and safety incidents.
- Arguments for ‘patient safety incident’ included that the term puts the patient and the risk to patient safety at the centre and that it better accommodates near misses because it does not imply that an adverse outcome has occurred.
- There was little support for the use of ‘consumer safety incident’.

Whichever term was selected, stakeholders were clear that it needed to be clearly defined and consistently used.

Theme 1: Increase the focus on people who use services (consumers/patients)

Enhanced consumer involvement in reporting, review and learning

The proposed expectations (outlined in the discussion document) for consumer/patient involvement in reporting and learning were supported. These were:

- practice open communication
- enable the consumer/patient and their whānau to tell their story
- enable involvement of support people (whānau, consumer representatives, mental health family advisors)
- provide opportunity for consumer/patient review of the draft report
- share the report and outcomes with the consumer/patient
- adapt the review process to include consumer/patient perspectives
- have independent consumer representation
- involve the consumer/patient in learning from adverse events
- measure consumer/patient involvement.

Stakeholders highlighted the importance of:

- actively encouraging consumers/patients to participate in the review process – this will show that an organisation truly wants the consumer/patient to be involved in the review process
- offering consumers/patients a choice regarding how much, and in what way, they want to be involved in the reporting and learning process – participation must be voluntary
- acknowledging cultural differences and using appropriate and accessible language
- ensuring expectations for consumer/patient involvement are expectations only, not requirements.

There appeared to be some confusion regarding proposed expectations for involvement of consumers/patients involved in an adverse event versus involvement of independent consumer representatives, highlighting that this aspect needed to be clearer in the revised policy and related guidance material.

Some stakeholders noted concerns about increased consumer/patient involvement in the reporting and learning process, including:

- the extra time and resource that might be required – it was suggested that consumer/patient involvement could be limited to certain stages of the review process or certain types of events
- the need to ensure staff are adequately supported and the process is adequately facilitated to avoid a situation of blame and risk of harm to staff involved
- the need to ensure health professionals have the knowledge, confidence and skills to manage consumer involvement effectively
- the need to avoid duplication of consumer feedback mechanisms
- the risks of involving untrained consumers in the review process.

Consumer-initiated reporting

There was mixed support among stakeholders for consumer-initiated reporting. The most significant reservation related to the risk of confusion with, and duplication of, existing consumer complaints systems. Stakeholders suggested that the design and development of any consumer-initiated reporting system would need to consider the following:

- accessibility – easy to use, multiple engagement options, use of plain English
- real-time reporting – periodic surveys can be inaccurate
- some sort of 'triage' system to manage expected volume of consumer reports
- consumer involvement in system design
- resources to support the system
- support for consumers to use the system
- promotional approaches to ensure consumer awareness and understanding of the system
- clear distinction between complaints and adverse events, and where and how they should be reported
- reports would need to be identifiable if a review is going to take place.

Culturally appropriate review practice

Stakeholders had a range of suggestions for how the policy could best support culturally appropriate review practice at a local level. These included:

- engage local Māori, Pacific and Asian groups in development of local review processes
- include Māori and Pacific consumer representatives on review teams when the affected consumer/patient is Māori or Pacific (ideally this principle would apply to consumers/patients of all ethnicities)
- ensure availability of cultural advisors who can contribute to reviews where appropriate (these could be from district health board (DHB) Māori and Pacific health services).
- provide culturally appropriate support for consumers/patients and whānau
- ensure accessibility of processes – multiple engagement options, culturally tailored communications and information, use of translators
- appreciate cultural influences on family/whānau willingness to report and what they want from the review process
- improve collection of information on the ethnicity of consumers/patients involved in adverse events
- set out expectations in the policy for culturally appropriate review practice at a local level
- provide education, training and guidance on culturally appropriate review practice and accessing cultural support for the review team and the consumer/patient/whānau.

Theme 2: Expand the purpose statement to clarify national and local roles and expectations

Most stakeholders were supportive of the suggested, expanded purpose statement for the policy. The most common suggestions were to refine the wording to better demonstrate relevance to non-DHB parts of the health and disability sector, reduce use of jargon and ensure use of consistent terminology and plain English.

Stakeholders were also supportive of the proposed roles and expectations at local and national levels, highlighting the importance of shared learning across national and local levels. With regard to local roles, a key suggestion was to strengthen expectations of the role of governance bodies in reporting, review and learning. Feedback on the Commission's role included emphasis on its role in promoting a national approach to reporting, review and learning and providing training, tools and timelines to support effective reporting, review and learning.

Theme 3: Increase the focus on learning and action to strengthen implementation and monitoring of recommended actions

Enhanced support to improve quality of reviews and recommended actions

There was strong support for measures proposed in the discussion document to help organisations carry out high-quality reviews and make effective recommendations:

- *Guidance*: Stakeholders suggested that guidance needs to be clear, simple, support consistency in review structure and outcomes, and include exemplars and templates.
- *Expansion of the Commission's training programme to offer advanced training and training for primary care and disability support providers*: Stakeholders emphasised the need for more education and training opportunities, nationally provided education and training to encourage standardisation and consistency in local practice, and Train the Trainer approaches to enable quality teams to lead education within their own organisations. Suggestions for training topics included consumer involvement in reporting, review and learning, different review methodologies, report-writing and just culture.
- *Feedback to local organisations on the content of their reviews and recommendations*. Stakeholders identified exemplars as a useful learning approach.

Enhanced expectation that organisations act upon reporting and monitor resulting actions

Many stakeholders supported the idea of the Commission reporting numbers of completed reviews on the basis that this would support transparency and accountability and demonstrate that the process is working. However, some had significant concerns about this approach, arguing that:

- numbers of completed reviews do not tell us anything meaningful (an organisation might have high numbers of completed reports because it has high numbers of adverse events or because it's good at completing review processes – which is more important?)
- it's not about numbers, it's about quality and outcomes of the review process
- reporting numbers of completed reviews might encourage people to rush the review process
- numbers of completed reviews may be treated by the public as a measure of DHB performance
- the time it takes to complete a review is often outside the control of organisations.

There was good support for publishing anonymised, summary versions of serious adverse event reviews (Part B summaries) on the Commission's website to support shared learnings, as long as consumer/patient consent is given. There were some concerns regarding publication of these reports on local organisations' websites, reflecting the difficulties of ensuring anonymity (particularly in smaller communities). Some stakeholders commented that New Zealand is not ready for this step and we need to get the reporting, review and learning culture and quality of reviews right first.

Encourage reporting of lower-level events and near misses for national learning

Most stakeholders supported more reporting of lower-level events (SAC 3 and 4) and near misses at a national level where there is potential for national learning. The biggest concerns regarding this approach related to the potential for increased work, the risk of slowing down the review process and the risk that national and local reporting systems may not be equipped to accommodate increased reporting. One stakeholder made the following comment:

> [We] need to ensure adverse event reporting process doesn't become so large that the health and disability sector is unable to resource it and our systems don't support it.

To encourage more learning from lower-level events and near misses, stakeholders suggested the Commission do the following:

- Facilitate education and information sharing.
  - Promote the importance of learning from lower-level and near miss events.
  - Encourage and support DHBs to routinely discuss and review lower-level and near miss events.
  - Consolidate learning points from lower-level and near miss events, then assist DHBs to target specific issues.
  - Build on DHB-analyses of lower-level and near miss events for national learning.
  - Share learnings.
- Support capacity and capability building in local organisations to report and review lower-level and near miss events.
- Provide guidance on standardised reporting and review methods for lower-level and near miss events.
- Consider different (simple) reporting pathways for lower-level and near miss events.
- Use findings from trend/cluster analysis of lower-level and near miss events to:
  - trigger organisational-level reviews of events with similar antecedents
  - trigger a request that all DHBs report specific events
  - workshop trends with DHB quality managers to inform development of quality improvement initiatives.
- Request reporting of particular types of events for set time periods (targeted, time-limited reporting of specific incidents).

Some stakeholders did not like the term 'lower-level events', believing that it diminished the significance of the event for the consumer/patient involved and suggesting that 'SAC 3 and 4' should be used instead.

Increase the focus on supporting staff

Stakeholders were very supportive of the need to ensure staff involved in an adverse event and its review are supported by their organisation. Several commented on the importance of promoting and establishing an organisational just culture, to avoid blame and encourage learning and improvement. One stakeholder commented that:

> Staff are the second victim – [we] need to do more to support them and encourage organisations to have processes in place for both clinical and non-clinical staff. Greater support encourages greater reporting.

Suggested support tools and services included:

- providing education, training and resources, for staff and management, on supporting staff through an adverse event review process – this should be aligned with Health and Disability Commissioner (HDC) expectations for employers and employees (eg, timely communications, documentation, feedback, right to review information)
- ensuring adverse events, review processes and the concept of just culture are included in staff induction and undergraduate training programmes
- advising staff to seek support from professional bodies, indemnity insurers and organisational support systems, prior to taking part in an investigative process
- offering de-brief sessions, counselling, clinical supervision/mentoring and peer support.

Theme 4: Make it easier for organisations to report and prioritise for national reporting

'Always report and review' list

There was good support for having a national list of 'always report and review' events. Supporters believed that having an 'always report and review' list would provide increased certainty regarding what to report, it would help organisations focus on highly preventable events, and having a list would be consistent with international practice. Any list would need to be regularly reviewed and have the flexibility to change.

Stakeholders' key concern about having an 'always report and review' list was that people might stop identifying and reporting other adverse events.

Key feedback from stakeholders on the Commission's proposed 'always report and review' list was that it is very focused on secondary care – it needs revision to reflect other parts of the sector. It was also suggested that the list should have more of a focus on adverse events that feature strongly in national programmes of work (eg, falls, suicides). However, this feedback may reflect confusion regarding the purpose of an 'always report and review' list (ie, 'always report and review' events are a sub-set of events that can be prevented outright through strong clinical and organisational systems, rather than common or nationally important events).

Stakeholders provided detailed feedback on what should be added to the Commission's proposed list and suggested changes to terminology (not reported here).

Local triage of serious adverse events to determine level of review required

There were mixed views among stakeholders on whether organisations should be encouraged to have their own triage process to decide the level of review required for SAC 1 and 2 events. Those who supported this approach argued that it would allow organisations

to prioritise resources where most needed and it would enhance learning as the events being reviewed would reflect organisational priorities.

Stakeholders who did not support this approach felt that there needs to be a nationally agreed, consistent triage process for serious adverse events to support standardised reporting, or at least national guidelines regarding what a local triage process should contain. There was some concern that a local triage process would allow organisations to not review some serious adverse events at all – in fact, the approach is suggesting that organisations decide which serious adverse events require a comprehensive review and which are appropriate for a concise review.

Single local review

Stakeholders suggested that the Commission work with other agencies (HDC, Coronial Services, Accident Compensation Corporation and Ministry of Health) to progress use of a single local review and develop national guidance and templates to support this approach.

Some stakeholders were concerned that a single local review would not be able to satisfy the information needs of all agencies and that trying to meet all information needs could lead to a reduction in review quality.

Changes to the SAC classification system

There were mixed views among stakeholders on whether the SAC classification system needed to be changed, and if so, how. Feedback from those who supported a change included that the classification system needed to:

- be more relevant for primary care
- include non-clinical and systems issues
- be simpler/clearer
- accommodate potential harm as well as actual harm
- differentiate between adverse events and known complications
- have a separate category for death as a result of an adverse event
- have a clearer definition of ‘severe’, ‘major’, ‘moderate’ and ‘temporary’ loss of function.

Stakeholders who did not support changes to the SAC classification system argued that the current system is familiar, changes will cause confusion, and adopting two or three categories (as used in Scotland) would be too generalised and unlikely to capture the level of detail required.

Changes to the likelihood table

There were also mixed views among stakeholders on whether the likelihood table should be removed. Those who supported its removal argued that it is confusing, subjective and leads to inconsistency. Those who did not support its removal suggested that it provides a useful focus on degree of risk to consumer/patient/organisation and is a useful tool for determining risk.

Theme 5: Make the policy relevant to the whole health and disability sector and move to greater coverage over time

Stakeholders had a variety of suggestions on how the Commission could work with different parts of the sector to enable reporting to the Commission. These included:

- Introduce cross-sector reporting in a collaborative, consultative way (cross-sector forums, steering groups, working groups).
- Involve consumers, sector-led organisations (eg, primary health organisations), professional bodies, private institutions.
- View cross-sector system from patient journey perspective rather than service delivery model perspective.
- Identify champions in specific fields.
- Establish standardised reporting with initial variation in reporting requirements for different parts of the sector, as needed.
- Establish an agreed taxonomy, perhaps with sub-categories for different parts of the sector.
- Provide guidance and templates.
- Ensure reporting system and supporting resources are easily accessible.
- Incorporate requirement to report in provider contracts.

There was good support for all SAC 1 and 2 events from the entire health and disability sector being reported to the Commission. Cross-sector reporting was seen to:

- provide a complete picture of adverse events across the continuum of care
- reduce the likelihood of adverse events being missed
- provide a record of each service's involvement in an adverse event
- enable learning from other parts of the sector.

Concerns about extending reporting to the whole sector related to adequacy of systems and resources to support a cross-sector reporting system, duplication of processes and lack of mandate to require private institutions to report.

Mental health events

Inclusion of mental health events in the updated policy

There was strong agreement among stakeholders that the revised policy should cover all events, including mental health events. Comments included that:

- mental health consumers engage with all parts of the health and disability sector, not just mental health services
- not including mental health consumers in the national reporting system is a form of discrimination
- separation of reporting may contribute to compartmentalisation of care, whereas integrated reporting may highlight system issues
- integrated reporting may promote wider awareness of mental health issues in the general health environment and support shared learnings across the sector
- integrated reporting may help put numbers of mental health adverse events into perspective for the wider health sector and contribute to de-stigmatisation around mental health.

One stakeholder commented:

> Mental health services should be subject to the same scrutiny of reporting, with possible variation to process to account for complexity and nature of patient issues. Separate processes only continue stigmatisation of mental health consumers.

The main concern about including mental health events in national adverse event reporting related to suicides occurring in the community. Several stakeholders argued that community suicides, which are categorised as SAC 2, are not comparable with other SAC 2 events. It was also suggested that, if mental health events are to be included in the national reporting system, there needs to be variation in reporting processes to account for the complexity and unique aspects of mental health service delivery.

Sharing of learnings from mental health event reviews

There was strong agreement that learnings from reviews of mental health events should be widely shared across the health and disability sector (provided that the anonymity of individuals and organisations is protected and consumers/patients consent to their story being shared).