Hospital specialist services Always Report and Review list 2023/24

The Always Report and Review (ARR) list is a subset of events that hospital specialist services health and disability providers should report and review, irrespective of whether the consumer experienced harm.[1]

Traditionally ARR events have been considered those that could result in serious harm or death but are preventable with strong clinical and organisational systems. More recently, analysis by the Healthcare Safety Investigation Branch[2] in England and Te Tāhū Hauora Health Quality Safety Commission[3] (Te Tāhū Hauora) has highlighted that those strong clinical and organisational systems do not exist.

As part of the implementation of Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023,[4] Te Tāhū Hauora will work with hospital specialty services to identify areas of local concern where review at a regional and national level may provide insights into how fundamental system safety processes can be improved. This regional and national review will initially be supported by us in partnership with Te Whatu Ora.

We have therefore updated the current ARR list for the 2023/24 year to allow for this change period. We suggest where providers note similar ARR events they review them as a cluster and focus on systems learning opportunities.

Providers should use this list in conjunction with the national adverse events policy 2023.

Te Tāhū Hauora will review the ARR list in partnership with hospital specialist services on a yearly basis.

Wrong transfusion or transplantation
Transfusion or transplantation of ABO incompatible blood products or organs.
Wrong site
A procedure/intervention performed on the wrong site (eg, wrong knee, wrong eye, wrong level spinal surgery, wrong limb, wrong tooth or wrong organ); the event is detected at any time after the start of the procedure/intervention. • Includes interventions that are considered surgical but may be done outside a surgical environment. For example, wrong site block, biopsy, interventional radiology procedures, cardiology procedures, drain insertion. • Includes events where the wrong site surgery is due to incorrect laboratory reports/results or incorrect referral letters. • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the consumer's anatomy. This should be documented in clinical notes.

[1] See Severity Assessment Code (SAC) rating and triage tool for adverse event reporting at: www.hqsc.govt.nz/resources/resource-library/severity-assessment-code-sac-rating-and-triage-tool-for-adverse-event-reporting.
[2] See: www.hsib.org.uk/investigations-and-reports/never-events-analysis-of-hsibs-national-investigations/
[3] See: www.hqsc.govt.nz/resources/resource-library/adverse-events-exception-reporting-202021-thematic-analysis-involving-always-report-and-review-events/
[4] See: www.hqsc.govt.nz/resources/resource-library/national-adverse-event-policy-2023/

Wrong implant or prosthesis
Placement of an implant or prosthesis different than what is described in the surgical plan; the event is detected at any time after the implant/prosthesis is placed in the consumer. • Excludes where the implant/prosthesis placed in the consumer is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure. This should be documented in clinical notes. • Excludes where the implant/prosthesis placed in the consumer is intentionally planned and placed but later found to be suboptimal.
Retained foreign object post procedure
Retention of a foreign object in a consumer after a surgical/invasive procedure. • Includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment (eg, central line placement in ward areas, procedures performed in 'rooms-based' and outpatient settings). • Excludes items inserted during a procedure that are subject to the counting/checking process but are intentionally retained after completion of the procedure, with removal planned for a later time or date. This should be documented in clinical notes. If these items are not subsequently removed at the planned date, this would become an 'Always Report and Review' event. • Excludes items that are known to be missing before the completion of the procedure and may be inside the consumer (eg, screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or more damaging than retention. This should be documented in clinical notes.
Wrong consumer
Any invasive procedure/investigation performed on the wrong consumer; the event is detected at any time after the start of the procedure/investigation. • Includes radiology imaging and invasive procedures (such as biopsy, endoscopic procedures or cardiology procedures).
Unconsented treatment
• All seclusion events, regardless of the status of the consumer under the Mental Health (Compulsory Assessment and Treatment) Act 1992. • Electroconvulsive therapy (ECT) without consent and not subject to section 60 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Published in June 2023 by Te Tāhū Hauora Health Quality & Safety Commission, PO Box 25496, Wellington 6146, Aotearoa New Zealand. Available online at www.hqsc.govt.nz
For review 2024.