Learning from adverse events 2020
Questions and answers
Embargoed to 9am, 10 December 2020

What is an adverse event?

An adverse event is an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned. In practice, this is most often understood as an event that results in, or has the potential to result in, harm to a consumer.[1] Adverse events resulting in serious harm or death are reported by health and disability providers, guided by the Health Quality & Safety Commission's National Adverse Events Reporting Policy 2017.[2] The policy has a strong focus on involving consumers, families and whānau in the review process, and taking their cultural viewpoints and practices into account.

The purpose of adverse events reporting is to understand the experience of the affected consumers, families and whānau to improve consumer safety, encourage open communication and learn from the events. The events in the *Learning from adverse events* report reflect local interpretation and implementation of the policy guidance by individual providers.

It is important to remember that at the heart of the numbers are people, families and whānau who have been impacted by the event, as well as the health teams responsible for their care. The Commission views every adverse event in terms of that impact.

What are the key trends for this year?

- The total number of adverse events reported to the Commission in 2019/2020 was 975 (916 in 2018/2019). We have seen an increase in overall reporting of adverse events to the Commission. This demonstrates an open culture of reporting and a willingness to focus on systems learnings, to reduce preventable harm. Adverse event reporting is not a reliable way of demonstrating change; rather, the point is to learn from events and identify opportunities for improvement.
- The number of clinical deterioration[3] events continued to reduce from 64 events in 2018/2019 to 55 in 2019/2020. This demonstrates the impact of DHBs now using an early warning score. The national adult vital signs chart enables clinical deterioration to be recognised and acted upon earlier.
- Following the introduction of the maternity severity assessment code (SAC)[4] examples in 2019 there was an increase in reported numbers from the maternity sector (six maternity events out of a total of 29 events in 2018/19 and 27 events out of a total of 52 in 2019/20).

[1] For further information on SAC classification of incidents, see www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/636.
[2] www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy
[3] Acute physical deterioration can happen at any point during a consumer's admission to hospital. Many consumers show signs and symptoms of physiological instability for some time before events such as cardiac arrest or unplanned admission to an intensive care unit. This means there are opportunities to intervene and prevent these events from occurring.
[4] To assist the maternity sector with identifying reporting and learning from adverse events, the maternal morbidity working group and the adverse event learning programme collaborated to develop a maternity SAC guide. The SAC is a numerical rating which defines the severity of an adverse event and as a consequence, the required level of reporting and review to be undertaken for the event.

- Following extensive testing at four DHBs the Commission commenced a robust pressure injury (PI) measurement and quality safety marker (QSM) for pressure injury prevention and management activities in July 2018. It is likely this has increased the focus on pressure injuries and thereby reporting of PI within DHB hospital services (70 reported in 2018/2019, and 112 this year). In addition, ACC has been working closely with DHBs as the lead in the development of guiding principles for the prevention and management of PI. It is anticipated this increased awareness has also impacted on the increase in PI reporting.

- We saw a further reduction in neck of femur/hip fractures; the largest reduction in falls was in non-Māori aged 75 and over.

- The number of healthcare associated infections has reduced further, with seven events related to surgical procedures. Surgical site infections (SSIs) are strongly associated with increased morbidity and mortality, extended hospital stays and long-term antibiotic treatment. SSIs are also a leading reason for ACC treatment injury claims.

What was the most common adverse event in 2019/20?

Falls is the most common type of adverse event at 231. However, clinical management events are the most common group of adverse events in this reporting period based on data collected, with a total of 355. This includes pressure injuries, delayed diagnosis or treatment, deterioration, and complications.

How many people died from an adverse event over this period?

Two hundred and eighty deaths were reported to the Commission, including one hundred and eighty deaths from suspected suicide. The one hundred deaths in a non-mental health setting were not necessarily directly related to the adverse event.

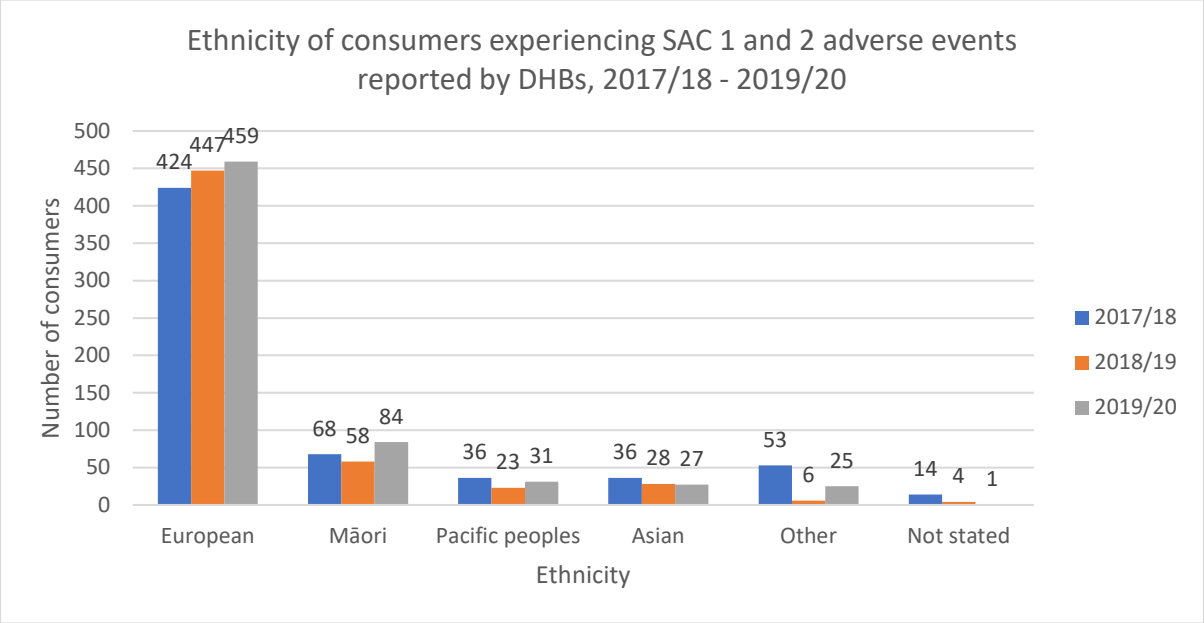
How do I find out more information about specific events?

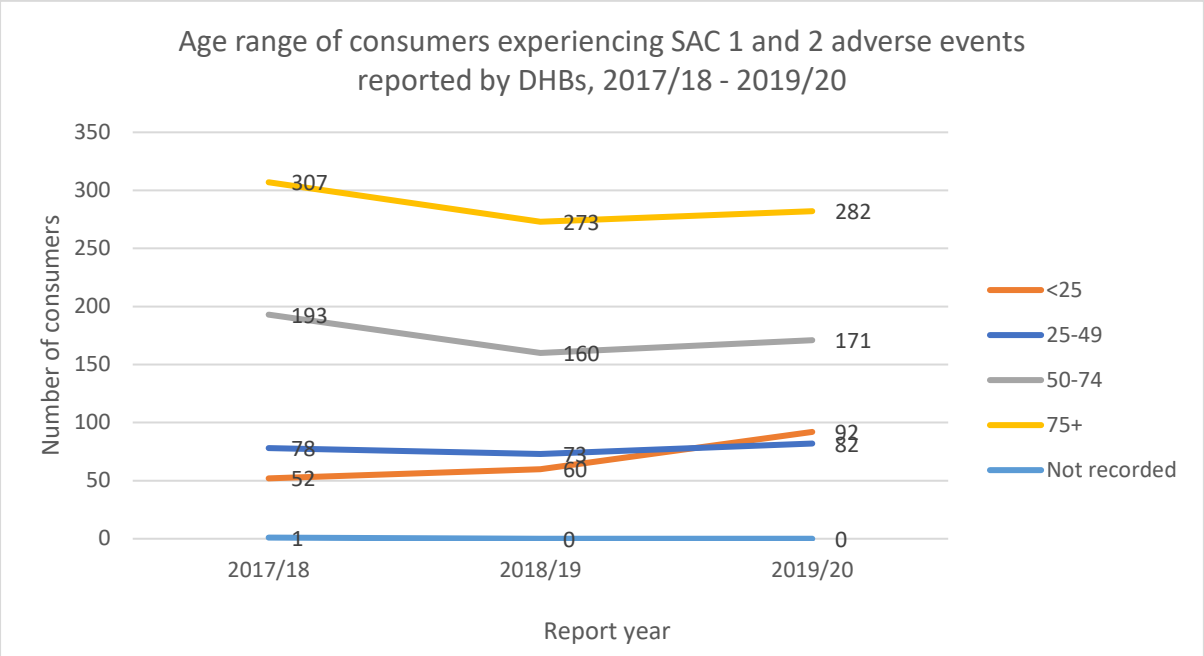
The Commission does not provide information about specific events. Please refer to the relevant district health board or provider.

What impact has COVID had on the number and type of adverse events?

During the initial lockdown period starting in late March, there was a significant change in the pattern of hospital admissions. There were fewer motor vehicle crashes, non-urgent elective operations were postponed, and childhood respiratory illnesses reduced. However, acute adult medical and surgical admissions continued. It is within this group that many of the events reported to the Commission occur, reflecting the age, frailty and complexity of the patients cared for in our hospitals.

Breakdown of adverse events by age and ethnicity





How do providers notify the Commission about adverse events?

The Commission is notified in two stages: firstly, through a form that contains information setting out an initial understanding of the event,[5] then through a second form at a later date, which contains a summary of review findings and recommendations.[6] Some providers also submit anonymised copies of the full report. This allows the Commission to provide feedback on the quality of the review and gain more understanding of the event.

[5] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2939
[6] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2940

Are providers required to report?

DHBs are required to report adverse events to the Commission in accordance with the policy guidance. Some non-DHB health providers – such as private surgical hospitals, ambulance services, aged residential care facilities, disability services and hospices – voluntarily provide information.

How accurate is the adverse events data?

In some categories, such as falls, we use reporting from other sources to give an indication of the number of adverse events we might expect to be reported. For example, although the reporting criteria are slightly different, we use data from the NMDS (National Minimum Dataset), to show the number of broken hips that occur in hospital.

The adverse events reported reflect the evolving maturity of organisations to include broader types of events and to recognise the systemic influences contributing to their occurrence.

How does New Zealand's adverse events rate compare with those in other countries?

It is difficult to gather accurate and comparable statistics on each country's rate of adverse events, as different jurisdictions have different reporting criteria. The Commission believes that, based on local and international literature, the incidence of adverse events in New Zealand is comparable to other jurisdictions.

Is there an acceptable, or expected, number of adverse events?

International studies show 10–15 percent of hospital admissions can be associated with an adverse event, although about half of the events occurred before admission to hospital, in other health settings. In addition, some adverse events are known complications of treatment and are not preventable.

How safe is our health care system?

The standard of health care in New Zealand is generally high. In a typical year there are more than one million inpatient hospitalisations in New Zealand public hospitals, and most people are treated safely and without incident. However, a small number of people are harmed while they receive care.

Every adverse event represents someone who has suffered harm or has died in the care of the health system. People harmed by health care and their families and whānau can expect their case to be reviewed to understand what happened and what can be done to reduce the risk of the same thing happening again.

Reporting adverse events is one part of a broader safety framework within New Zealand to make health care as safe as possible.

Other measures and methods are required to demonstrate changes over time. These include data from the Commission's improvement programmes[7], and reports and recommendations developed by the Commission's mortality review committees, the Health and Disability Commissioner's reports, Accident Compensation Corporation treatment injury reports, coronial findings and reports, as well as direct reporting from the Ministry of Health.

[7] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/

The Commission publishes an annual window on quality that reports on the quality and safety of the health and disability system.[8]

Shouldn't health professionals be held accountable when things go wrong?

A safety culture places the goal of zero preventable harm to consumers, whānau and staff at the centre of the organisation. A safety culture is one where there is accountability, but not blame for mistakes, and harm is reviewed and learnt from, in order to improve systems and processes.

Adverse event reviews seek to understand what happened, why it happened and what needs to be done to make the system safer. Reporting adverse events is about learning, in order to make care safer by identifying system issues rather than finding an individual to blame.

There are separate processes to hold health professionals accountable for the quality of their work and for maintaining professional standards throughout their careers.

What action is being taken by the Commission to prevent adverse events?

The Commission has a very strong focus on preventing adverse events and works closely with health and disability service providers to improve patient safety. This happens across a range of areas, including infection prevention and control, medication safety, surgery, falls, consumer engagement, mental health and addiction, and health measurement and evaluation.

The Commission is also responsible for statutory mortality review committees, which have a significant role to play in preventing harm.

[8] www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3364/