Overall reporting

Total adverse events reported by district health boards (DHBs) increased from 845 in the 2019/20 financial year to 1,027 in 2020/21. This was a statistically significant increase (special cause variation) that we will monitor and evaluate in the coming year as the specific cause is not known.

Several factors contribute to variability in reported adverse events. There is considerable underreporting (Noble and Pronovost 2010); however, as the actual rate of adverse events is unknown (Shojania and Dixon-Woods 2017), so is the level of underreporting (Archer et al 2017). Although attempts have been made to estimate the true prevalence, these rely either on using methods such as global trigger tools (Health Quality & Safety Commission 2021), which review a sample of patient records looking for harm, or on using meta-analyses, which combine smaller reviews (Panagioti et al 2019) to estimate a global incidence. It is important to note that adverse event reporting alone is not an indicator of overall harm as Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) receives only reports related to severe harm (SAC1 and SAC 2).

Organisational culture also influences adverse event reporting. If staff feel safe to report adverse events without fear of retribution, and reporting is simple, then reporting rates will increase (Sim et al 2022; Szymusiak et al 2019). DHBs are constantly working to improve their safety cultures and streamline reporting processes. This work will lead to an increase in reporting; however, it is difficult to know whether this increase is due to better identification of existing harm or to new harm.

These factors make it difficult for Te Tāhū Hauora to identify increased levels of harm based on adverse event reporting alone. Supporting patient safety and delivering high-quality care is not the responsibility of any single part of the sector and relies on a complex set of interconnected roles, responsibilities and relationships between individuals and organisations.

In recognition of this, Te Tāhū Hauora and the Ministry of Health developed a dashboard of quality alerts to identify emerging quality and safety issues. The recording, analysis and reporting of adverse events is now included with other intelligence in the quality alerts to give a more comprehensive picture of harm.

A regular national quality forum is now held that provides the opportunity to talk about how the Aotearoa New Zealand health system can collectively support improved quality and safety of care, particularly when issues arise from quality alert systems. The forum is the vehicle to discuss, initiate and monitor a response to any agreed issues at the appropriate level. A response may involve a single agency or organisation or require a coordinated multiagency project to drive change and improvement.

World Health Organization (WHO) code 2 reporting

The WHO code 2 category ‘clinical process/procedure’ shows a statistically significant increase (special cause variation) in events reported in 2020/21. Within this category, ‘delayed diagnosis or treatment’ and ‘pressure injuries’ are relevant for exception reporting.

The increase in delayed diagnosis or treatment events was not statistically significant (within common cause variation), and DHB reviews of these events indicate that the impact of COVID-19 on the health and disability sector did not contribute to this increase.

The increase in pressure injuries was statistically significant (special cause variation). Pressure injury prevention is being monitored as part of the work of the newly established national quality forum, and Te Tāhū Hauora continues to work with the Accident Compensation Corporation, the Ministry of Health and other stakeholders such as the New Zealand Wound Care Society to develop resources on the prevention, assessment and treatment of pressure injuries.

When adverse events are considered by ethnicity, Māori and Pacific peoples are most represented in the following areas of harm: complications, delayed diagnosis or treatment and deterioration. To understand this better, Te Tāhū Hauora analysed these events that involved Māori and Pacific peoples using data from 1 July 2017 to 30 June 2021. This analysis can be found here: www.hqsc.govt.nz/our-work/system-safety/adverse-events/publications-tools-and-resources/thematic-analyses.

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