

# Learning from adverse events

Adverse events reported to the  
Health Quality & Safety Commission

1 July 2015 to 30 June 2016



This report was prepared by the Health Quality & Safety Commission based on information and data provided by district health boards and other providers.

The falls pathway story on page 12 is reproduced by permission of Whanganui District Health Board.

We are grateful to everyone who has collectively contributed to this report, particularly quality and risk managers and their teams.

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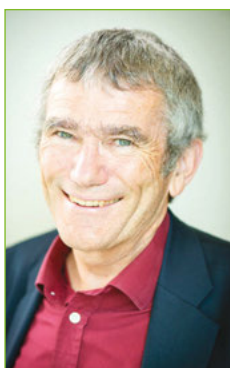
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# Foreword

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The Health Quality & Safety Commission (the Commission) was established in November 2010 to reduce deaths, harm and waste in the health and disability sector. This is achieved through promoting a culture of continuous examination and improvement.

Most consumers/patients are treated safely and successfully, but some still suffer serious harm or even die from potentially preventable adverse events.

I especially would like to acknowledge the people affected by the tragic events outlined in this report. We are looking at better ways to involve consumers/patients and their families/whānau in the process of analysing and learning from adverse events. It is important for the voice of the consumer to be heard as we grapple with the challenge of making our already excellent services safer.

In New Zealand we have reported these adverse events openly since 2006.<sup>1</sup> Every adverse event is a tragedy for the person affected and their family/whānau. Thus it is essential we respond to these tragedies by reviewing, learning, sharing and acting to decrease the risk of recurrence across the sector.

Since reporting began, the number of events reported by district health boards (DHBs) has increased from 182 to 520 in 2015-16.<sup>2</sup> This reflects a progressive increase in our culture of transparency and commitment to learning from things that go wrong in health care.

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

This year there has been a 14 percent reduction in falls resulting in serious harm reported by DHBs. Adverse event reporting is not a reliable way of demonstrating change; rather, the point of these reports is to learn from events and identify opportunities for improvement. Other methods are required to demonstrate changes over time. In this case, the decrease has also been reflected in national hospital administrative data (the National Minimum Dataset), which provides a more reliable indication that improvement really has occurred. This improvement has largely been achieved through the commitment of DHB staff working in partnership with consumers/patients and their families/whānau to assess risk and implement prevention strategies individualised to each person. We are confident the national leadership shown through the Commission's reducing harm from falls programme has had a positive impact across the sector. Our chapter on learning from falls adverse events also highlights the Commission's role in facilitating and leading work across agencies and the wider sector to integrate a whole-of-system approach to the care of falls and fractures in New Zealand.

The adverse events reported increasingly reflect the evolving maturity of organisations to include broader types of events and to recognise the systemic influences that contribute to event occurrence. In last year's report, a small number of events related to the deteriorating patient were analysed, with a focus on factors in the system amenable to improvement. This year there have been greater numbers reported of cases in which underlying factors of this type have been identified.

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1 Reports published prior to the Commission's publication in 2010 were produced by the Quality Improvement Committee.

2 The Commission published its first report on adverse events in 2010. In 2011, we decided to separate DHB mental health and addiction services adverse events from the main report. As a result, mental health and addiction figures were released in a separate report in 2012-13 (see [www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/695/](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/695/)) and were then incorporated into the Office of the Director of Mental Health's annual report for 2013 (see [www.health.govt.nz/publication/office-director-mental-health-annual-report-2013](http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2013)).



The programme's focus continues to be on learning, notably in relation to the development of effective recommendations to sharing improvement across the sector. The section on clinical management events highlights how the Commission uses information from provider organisations to generate our Open Book reports and share learnings widely.

This year, the Commission has taken the opportunity while reviewing the National Reportable Events Policy<sup>3</sup> to apply the same continuous learning approach to our own adverse events learning programme. In chapter 4, 'Patient safety reporting systems – a summary of international literature', we review international best practice and the experiences of other jurisdictions. Chapter 5, 'The National Reportable Events Policy – seeking input from stakeholders', builds on the ideas that emerged from the literature review and early stakeholder feedback, and raises some important questions for the sector to consider. The discussion document is summarised, with a link to the full version online and avenues for providing feedback. The feedback will help shape the future direction of the programme and the update of the National Reportable Events Policy. We look forward to your input to help improve our programme.

I would also like to thank the health providers that contribute to these reports. Together, we are increasingly embracing the concept of learning from adverse events. We are sharing lessons learnt from individual cases and supporting staff. We are also improving the way we work and the way we design the system within which we work. Through the openness and support of everyone involved, we can continue to reduce avoidable harm from health care.

**Professor Alan Merry ONZM FRSNZ**

Chair, Health Quality & Safety Commission

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<sup>3</sup> Health Quality & Safety Commission. 2012. *New Zealand Health and Disability Services – National Reportable Events Policy 2012*.  
URL: [www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf](http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf) (accessed 13 September 2016).

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## Executive summary

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The *Learning from adverse events* report 2015–16 focuses on how the Health Quality & Safety Commission (the Commission) uses adverse event reporting information for learning and sharing.

The adverse event reporting process is described in detail to help readers understand some of the limitations on the interpretation that can be made from the numbers in this report.

In 2015–16, 520 adverse events<sup>4</sup> were reported to the Commission by district health boards (DHBs) and 154 by other providers. This year clinical management events have overtaken falls as the most frequently reported events with 245 notifications. This large category is further broken down into sub-categories in this report. This gives us better insights into principal, underlying clinical and systems factors and how we use the case reviews we receive to share learnings.

Since 2012, the Commission has focused on falls prevention through its national reducing harm from falls programme. This year's report shows a 14 percent reduction in falls resulting in serious harm from previous years. This reduction aligns with the National Minimum Dataset (NMDS). Three DHBs have had no falls resulting in a fractured hip during this reporting year.

The adverse events learning programme is currently reviewing the National Reportable Events Policy<sup>5</sup> and the future direction of the programme. To help inform this, we have carried out a literature review of national patient safety reporting systems and undertaken initial stakeholder discussions. Summaries of this work and proposed policy changes have been included in chapters 4 and 5 of this report. We have taken this step to get wider sector engagement. Links to the full documents and avenues for feedback are included in these chapters.

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4 An adverse event is an incident affecting a health and disability consumer that has been classified as severity assessment code (SAC) 1 or 2. In general, these incidents have resulted in, or could have resulted in, serious harm or death. For further information on SAC classification of incidents, see [www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/636/](http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/636/).

5 Health Quality & Safety Commission 2012, *op.cit.*

# Chapter 1: Sharing learnings from adverse events reports

## Adverse events reporting process

Following an adverse event, organisations classify and determine the severity of the event through their own internal processes. This is based on guidance from the National Reportable Events Policy.<sup>6</sup> The Health Quality & Safety Commission (the Commission) receives notifications which meet the severity assessment code (SAC) 1 or 2 criteria.

Notifications are received in two stages. Organisations notify us of an event using the Reportable Event Brief (REB) Part A. The Part A report contains information about the organisation's initial understanding of the event. Following an event analysis, organisations provide us with a REB Part B, which contains a summary of findings and recommendations.<sup>7</sup> Some organisations send their complete, anonymised event analysis. This is encouraged and enables us to deepen our understanding of trends and learnings for sharing with the sector.

There is variation in the timeliness and numbers of completed REB Part Bs we receive. Although event analysis may have been completed by DHBs, of the 520 adverse events reported at the time adverse event data reconciliation was completed, the Commission has received 216 Part B summaries. Over the next year we will work with the sector to improve timeliness and completion of Part Bs. This will enable us to use the event analysis for the development of Open Books and other learnings. In this chapter we illustrate examples of how event analyses provided to us have generated these publications.

### How do we classify and report events?

All adverse events reported to the Commission are classified by the providing organisation into one of the 14 broad event categories shown in Table 1. These categories are based on the World Health Organization (WHO) International Classification for Patient Safety (ICPS)<sup>8</sup> incident type, with the adaptation of falls being added as a standalone category.

The complexity of health care means that for any adverse event there may be more than one potential underlying cause. As a result, the principal category selected can be subjective and may not reflect all contributing causes. Following event analysis, both the severity score and the event code may change. At this point, some events are withdrawn as they are re-rated as SAC 3 or 4. During the last year, 57 events reported in REB Part As as SAC 1 or 2 were withdrawn.

<sup>6</sup> Health Quality & Safety Commission 2012, *op.cit.*

<sup>7</sup> REB Part Bs are received throughout the year, as organisations finalise reviews. The Commission's adverse event database is reconciled following the closure date for reporting each year. As Part Bs may be received subsequent to reconciliation, they may not have been included in this report analysis.

<sup>8</sup> World Health Organization. 2009. *Conceptual framework for the International Classification for Patient Safety, Version 1.1.*

URL: [www.who.int/patientsafety/taxonomy/icps\\_full\\_report.pdf](http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf) (accessed 13 September 2016).



Table 1: Adverse event categories and reported DHB events per category

Adverse event category	Event code	Reported DHB serious adverse events 2015-16
Clinical administration	01	36 (7%)
Clinical process/procedure	02	183 (35%)
Documentation	03	2 (0%)
Healthcare associated infection	04	3 (1%)
Medication/IV fluids	05	21 (4%)
Blood/blood products	06	0
Nutrition	07	0
Oxygen/gas/vapour	08	0
Medical device/equipment	09	7 (1%)
Behaviour (mental health)	10	Reported in Director of Mental Health report
Consumer/patient accidents	11	5 (1%)
Falls	12	237 (46%)
Infrastructure/buildings/fittings	13	0
Resources/organisation/management	14	26 (5%)

Note: The clinical management event group consists of codes 01, 02 and 14.

This year there were no events reported under the codes 06 (blood/blood products), 07 (nutrition), 08 (oxygen/gas/vapour), or 13 (infrastructure/buildings/fittings).

Code 10 (mental health behaviour) events are reported separately through the Office of the Director of Mental Health; the next report is scheduled for publication later this year. The Commission works with the Director of Mental Health to publish adverse events affecting users of DHB mental health and addiction services. In the 2015 calendar year,<sup>9</sup> DHBs reported 185 such events.

### Total events 2015-16

The total number of adverse events reported by DHBs between 1 July 2015 and 30 June 2016 has changed little since the previous report (Figure 1).

<sup>9</sup> Mental health events are reported using the calendar year in line with the Office of the Director of Mental Health reporting structure.



Figure 1: Reported DHB adverse events (non-mental health), 2006-07 to 2015-16



Note: As mental health adverse event numbers are not included in this figure, numbers prior to 2013 will differ from those previously published in adverse events reports.

Although the total numbers of reported events remain similar to 2014-15, the major changes have been in the reduction of reported serious injury from falls and an increase in clinical management events, as shown in Figures 2 and 3.

Increased reporting has been the case for the clinical management category. This may reflect systems discussion raised in the deteriorating patient analysis in the 2014-15 report and in the Commission’s adverse event analysis workshops. Following the deteriorating patient focus, there has been an increase in clinical deterioration cases reported.

Reported serious harm from falls (fractured neck of femur, or broken hip) has decreased. This reduction has been triangulated with hospital administrative data (NMDS) and both data sets show alignment. This reflects a mature consumer/patient safety reporting system and the focused work to reduce harm from falls in the sector.

Figure 2: DHB serious adverse events by event type, 2014-15

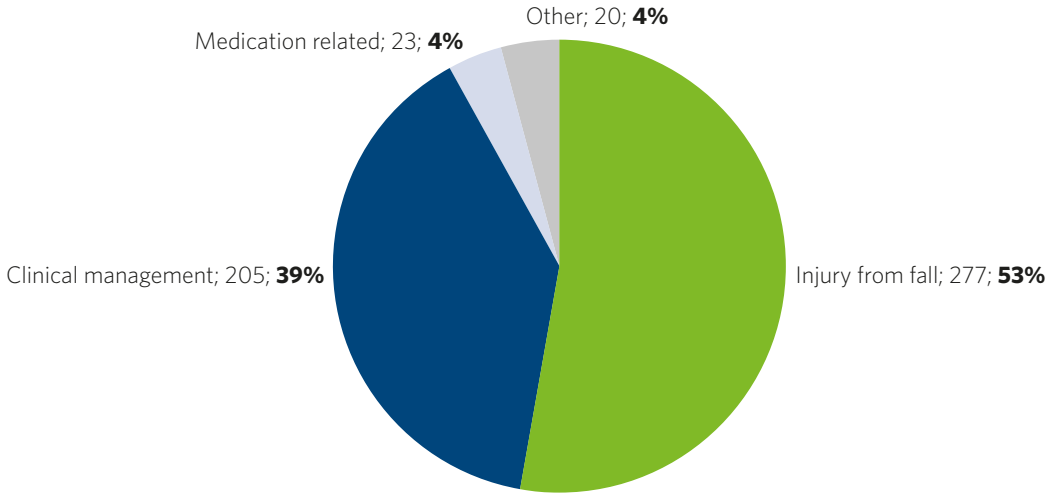
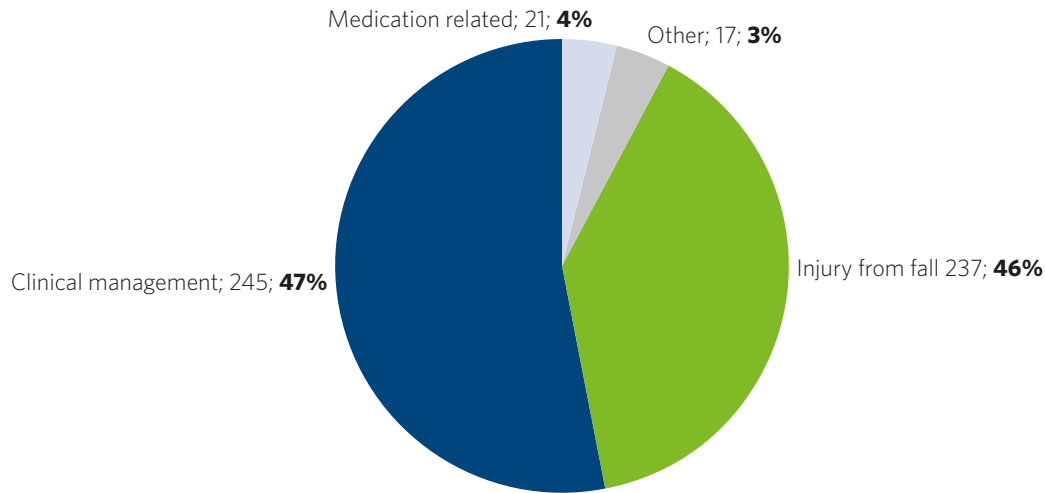




Figure 3: DHB serious adverse events by event type, 2015-16



### Learning from clinical management events

Clinical management events were the most common event type reported (245 events, 47 percent). This is an increase from last year's 205 events (39 percent). They are grouped from three individual event codes, all representing events occurring in or impacting on the clinical environment.

In previous reports, the clinical management event category only included WHO ICPS codes 01 (clinical administration) and 02 (clinical process/procedure). This year event code 14 (resources/organisation/management) has been included as these events also occur in or impact on the clinical environment. This code has not historically been well utilised, with only one event reported in 2014-15, and many of these events would have previously been included in the 'other' category or reported as a code 02. Examples of events that fall into this category could include operating theatre scheduling, availability of magnetic resonance imaging (MRI) or the management of a large influx of consumers/patients in an emergency department.

The increase in reporting of code 14 this year reflects the greater systems and organisational factors focus by providers in recognising the wider influences contributing to adverse events. This does not necessarily indicate a change in organisational management or resources, as many similar events may previously have been captured in the other codes.

The clinical management events can be further classified to provide clinical context (Table 2). Determining these classifications is dependent on the information available from providers (REB Part A and Part B), but gives some general indication of the types of clinical events. The event analyses received in these areas are used by the adverse events team to generate the Commission's Open Book reports. These were started in November 2014.<sup>10</sup>

An issue that has emerged from information reported in 2015-16 relates to systems for consumer/patient appointments. This issue accounts for events reported from a variety of settings. Included in these events were a large number from ophthalmology services (most of which were follow-up appointments); these contributed 18 percent of the total clinical management events reported. The organisations who reported these cases contacted the Commission to alert it and discuss the issues. The providers have initiated reviews to understand underlying factors and are undertaking work to address findings. If there are national learnings and recommendations once all Part Bs are available, these will be shared with the sector.

<sup>10</sup> See [www.hqsc.govt.nz/our-programmes/adverse-events/projects/open-book](http://www.hqsc.govt.nz/our-programmes/adverse-events/projects/open-book).

Table 2: Clinical classification of clinical management events, 2015–16

Clinical management event	Events per sub-group	Example (hypothetical rather than actual)
Delayed diagnosis or treatment	56	Issue in referral process resulting in delay seeing specialist
Assessment and diagnosis	32	Initial assessment did not find the key clinical issue
Resources/organisation/management	26	Insufficient clinic/equipment/staff/appointments to meet demand
Deterioration	25	Consumer/patient deterioration not addressed in accepted timeframe
Complication	22	Complication of treatment/procedure (eg, stroke following surgery)
Retained item	19	Wound dressing left inside wound beyond expected time
Pressure injury	14	Pressure injury from insufficient position change/nutrition etc
Adverse outcome	12	Unexpected consumer/patient death/outcome
Clinical process	9	Incomplete process during care (eg, consent, coordination of care)
Wrong consumer/patient/site/side	9	Wrong consumer/patient in procedure room/theatre
Monitoring	7	Inadequacy of monitoring (eg, breathing rate following morphine)
Other	6	Security issue
Treatment	5	Allergic reaction to products used to treat consumer/patient
Transfer	3	Issues related to transferring a consumer/patient to another facility
<b>Total</b>	<b>245</b>	

## Open Book reports

Open Book reports alert providers to the main findings of adverse event reviews. The reports are short and emphasise changes implemented by a provider to prevent a similar event happening again. The accessibility of the Open Book format, directing information to particular services or health professionals, allows the learning to be shared quickly between organisations. We recommend providers consider Open Book reports, and whether the changes made are relevant to their own local systems.

As of June 2016, 20 Open Book reports have been published. Many are based on clinical management events, as shown below.

### Delayed diagnosis or treatment:

- *Delay due to the use of an unfamiliar acronym*
- *Ensuring referrals happen*

### Assessment and diagnosis:

- *Red reflex assessment in newborns*



**Complication:**

- *Central venous catheter (CVC) removal*
- *Reviewing trigger tool notes to uncover harm*

**Retained item:**

- *Retained vaginal swabs following childbirth*

**Adverse outcome:**

- *Incorrect assembly of surgical equipment*

**Clinical process:**

- *Safe discharge processes – norovirus*
- *Surgery abandoned due to unavailable instruments*

**Examples of Open Book reports related to other event codes include:**

- *Bloodstream infection related to peripheral intravenous cannula*
- *Transmission of ‘super-bug’ in hospital*
- *Epidural medicines through intravenous lines*

We would like to thank the various organisations involved for their commitment to learning from adverse events, and for sharing these cases with the wider sector. We continue to encourage organisations to share their learnings from event analyses with us to help develop more of these Open Book reports.

# Chapter 2: Learning from falls adverse events and the reducing harm from falls programme

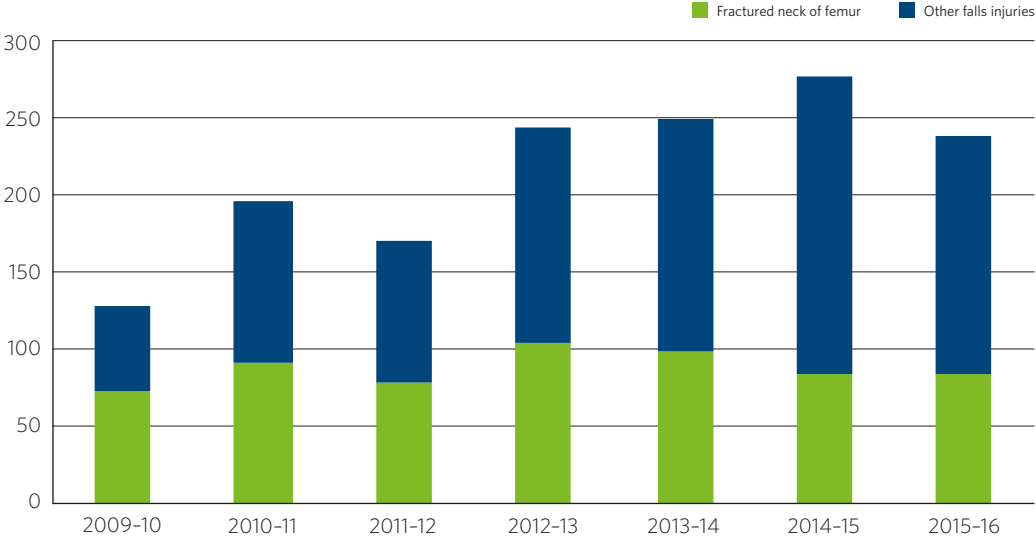
At the time of the Commission’s inception in 2010, falls in public hospitals accounted for a substantial percentage of reported adverse events. Reports of harm from falls were increasing in number. Reducing harm from falls in hospitals is a high priority for the Commission because of the often devastating resulting impact on consumers/patients and their families/whānau, and the costs involved.

In 2015-16, there were 237 falls, making up 46 percent of total events reported. Of these falls, 84 (35 percent) resulted in a fractured neck of femur (Figure 4).

The 14 percent reduction from 2014-15 in the number of falls resulting in serious harm reported is reflected in the NMDS. The reduction in consumer/patient harm has occurred because of two factors: the support provided by the Commission’s reducing harm from falls programme team; and the efforts across the sector to reduce the risk of falling and the risk of sustaining serious harm from a fall. Most importantly, the improved results have been achieved through the commitment of clinical staff working in partnership with and their families/whānau to assess the risk of falling and implement individualised prevention strategies and care plans.

The continued commitment to reporting all falls with serious harm is demonstrated by some DHBs reporting not only in-hospital falls but several outpatient and visitor falls as well. These types of falls events are not included in NMDS data.

Figure 4: Reported falls adverse events, 2009-10 to 2015-16





## Making a difference in Whanganui

The Commission is pleased to report that in the 2015–16 year, three DHBs had no falls that resulted in a fractured hip. One of these is Whanganui DHB. The story below highlights the success of Whanganui's integrated approach to falls and fracture prevention. It includes the development of a falls and osteoporosis pathway involving significant cross-sector engagement. While the natural tendency has been to focus on the in-hospital setting, Whanganui has expanded beyond the hospital to keep older people safe and well in the community.

The reducing harm from falls programme has promoted a series of interactive evidence-based resources in the falls '10 Topics',<sup>11</sup> with the final topic 10 focusing on 'integration'. It has provided advice and guidance that has been reflected in the Whanganui approach and we see this same approach now being applied across the sector.

### We developed a falls pathway focused on helping people to help themselves

Catherina admits she doesn't know a lot about Whanganui's falls prevention and osteoporosis pathway but she does know that falls nurse Viv Labone (pictured below on left) has been doing all she can to help her over the past year following two falls.

On both occasions, Catherina fell at home in the bathroom, and both times her doctor arranged for her to have an x-ray. The first fall was found to have caused a cracked kneecap. The second fall resulted in three cracked bones in her foot.

Viv says she referred Catherina to the falls team physiotherapist who gave her strength and balance exercises. 'And I picked up a number things that needed Catherina's attention including not walking backwards with her walking frame; planning her trips to the washing line and back; and making sure she leaves the back door open so she has no obstacles to negotiate on her way back into the house,' Viv says. 'I didn't want her having to step backwards to open the fly-screen door, for example.'

'I also suggested Catherina ask a family member to highlight cracks in her concrete drive by having them painted white and to cut back the plants that were spreading onto the pathway.'

Aware of the devastating harm that falls can cause people like Catherina, a group of like-minded Whanganui organisations have pulled together this year to create the district's first ever 'falls pathway'.

Launched in April, the falls pathway represents, in the truest sense of the word, the combined efforts of the Whanganui Regional Health Network (WRHN), Whanganui DHB (WDHB), the Accident Compensation Corporation (ACC), St John, Whanganui district general practitioners (GPs), non-government organisations (NGOs) and, most importantly, consumers.

'You could say that the pathway has glued us all together,' says collaborative clinical pathways joint lead Julie Nitschke.

'Given WDHB director of nursing Sandy Blake's role as national clinical lead for the Health Quality & Safety Commission's falls programme, it seems very fitting that we should work as one team to help people in our community prevent themselves from falling.'



<sup>11</sup> See [www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-topics/](http://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-topics/)

'Besides the devastating physical harm that falls can cause, we are mindful of the millions that is spent each year treating and rehabilitating people who have fallen and the impact that a fall can have on a person's family or those who care for them.'

Julie says the hugely popular Steady As You Go fitness programme run by Age Concern is an essential component of the falls pathway.

Another success is the falls team was established to include a fracture liaison nurse, an occupational therapist, a physiotherapist and a falls prevention nurse.

'Encouraging people to purchase equipment that can help them avoid falls is a key part of the project,' Julie says.

'It's all about providing practical support such as where to purchase equipment like bathroom handrails, where to apply for funding and how to check your home for obstacles that can cause falls.'

In developing a connected approach, the following organisations, services and information have been linked:

- **St John**, which frequently receives 111 calls to attend to a person who has fallen or who falls often.
- **Community exercise programmes** run in the community through Age Concern.
- **The ACC-funded physiotherapy and occupational therapy programme.**
- **A home environmental assessment** that uses the national Health Quality & Safety Commission form. Information is given to patients presenting to GPs and through the falls prevention nurse who, having identified hazards in homes, encourages individuals to take self-responsibility.
- **Equipment providers.** While there are a number of equipment providers in the community, information on how to access equipment and the associated costs was limited. This has now been streamlined and made available. The falls pathway also includes information on how to access funding through Work and Income for those that are eligible.
- **Information** linking best practice information on Health Quality & Safety Commission online resources for the workforce and for the community.
- **The falls prevention team.** Having identified the need for a well-resourced falls prevention team, a nurse was appointed for one year to work in people's home to assess their risk and appropriate management. This role also provides education to GP teams and aged care providers and is supported by an occupational therapist, physiotherapist and physiotherapy assistant.

Focused on preventing secondary fractures (making sure the patient receives the right treatment with the aim of preventing another fracture occurring), fracture liaison nurse Kerry Watson works with people aged 50 plus who have fallen and presented with a fracture. She implements strategies to prevent further falls as outlined in the osteoporosis pathway. She makes sure people are screened for the risk of osteoporosis and that they receive the right treatments.

Julie says collaborative pathways are all about developing a consistent approach to care through use of best practice but the most significant gains have been in the development of relationships across the sector. By reducing barriers we are coming up with, and celebrating, some very innovative solutions.

'Taking a whole-of-systems approach through placing the patient and their family/whānau at the centre of the work we are doing is really working for all concerned,' Julie says.



### Learning from falls adverse event analysis: a personal reflection from clinical lead for the reducing harm from falls programme Sandy Blake

*'I am always very interested in what we can learn from the review and analysis of reported falls incidents, and the development of recommendations that will help prevent similar events occurring in the future. I offer the following composite consumer/patient story developed from several REB Part Bs to provide some questions for reflection and action.'*

A 71-year-old woman was admitted to hospital with confusion and fluid overload. She was on multiple medicines, including antipsychotics. She was considered to be at risk of falling. A sensor mat was placed at the door of her room to warn staff if she wandered out. She got up in the night. The room was dark, and a distance from the nursing station. When she reached the door of the room she tried to avoid the sensor mat and fell, resulting in a fractured hip.<sup>12</sup>

This composite case raises a number of questions:

1. Where and when should sensor mats be used?
2. How has the impact of multiple medicines for this older person been addressed?
3. To what extent has the confusion/cognitive impairment been addressed?
4. While the sensor mat has been placed at the door, why has it not been placed at the bedside, having recognised the falls risk and potential for serious harm?

Other factors to consider are lighting, the position of the patient within the ward and the importance of close observation for those suffering from any form of cognitive impairment.

### Linking adverse events to quality improvement



Within the Commission we strive to ensure our internal programmes are linked to help the sector learn from adverse events, the capability and leadership for quality improvement and patient safety team and the reducing harm from falls team worked collaboratively to develop the *Quality improvement toolkit. For use in age related residential care*.<sup>13</sup> This helps guide those working in the age related residential care sector to look at events such as falls and start to undertake quality improvement. It aims to provide a foundation-level introductory guide to key aspects of improvement science.<sup>14</sup> The toolkit uses the common language of quality improvement and shares some of the techniques underpinning the improvement work of the Commission. It

helps teams working on quality improvement activities in age related residential care understand if the changes they are making have resulted in the desired improvement. The idea is to move from a culture of thinking in 'projects' to one of continuously striving for improvement.

<sup>12</sup> This is a composite story, made from a number of event analyses received by the Commission. It reflects typical events and underlying complex issues potentially contributing to falls.

<sup>13</sup> See [www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/publications-and-resources/publication/2483/](http://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/publications-and-resources/publication/2483/).

<sup>14</sup> 'Improvement science' is the use of evidence-based and practical learning strategies to make a timely difference to outcomes. Marshall M, Pronovost P, Dixon-Woods M. 2013. Promotion of improvement as a science. *The Lancet* 381(9864): 419-21.



## An integrated systems approach to reducing harm from falls

Safer and better-quality care occurs when consumers/patients, health care workers, non-clinical staff, and those in governance and management work together with a common purpose. The common purpose is expressed through the New Zealand Triple Aim.<sup>15</sup> This can only occur in a system where consumer/patient safety and experience of care are top priorities.

Figure 5 illustrates how the reducing harm from falls programme works to integrate a systems approach with other agencies and the wider sector to achieve the New Zealand Triple Aim and reduce harm from falls.

<sup>15</sup> See [www.hqsc.govt.nz/news-and-events/news/126/](http://www.hqsc.govt.nz/news-and-events/news/126/).



Figure 5: Alignment of the reducing harm from falls programme with the New Zealand Triple Aim<sup>16</sup>



16 The resources produced have been aligned with a specific focus of the New Zealand Triple Aim, accepting there is overlap with all initiatives, in promoting an integrated approach to falls and fracture management in New Zealand.

# Chapter 3: Adverse events reported by other providers 2015-16

A total of 154 adverse events were reported to the Commission by providers other than DHBs.

## Private surgical hospitals

The New Zealand Private Surgical Hospitals Association (NZPSHA) represents the interests of private surgical hospitals. Twenty-six organisations are members, responsible for 39 hospitals. NZPSHA members provide procedures for approximately 164,000 consumers/patients every year, representing around 50 percent of all elective surgery performed in New Zealand.

A requirement of NZPSHA membership is involvement in the reporting of clinical indicators (including adverse events). The Injury Prevention Research Unit of the University of Otago analyses this data and reports back to member organisations without identifying individual providers, other than providers' own figures. The clinical indicator information is used internally at members' hospitals and the NZPSHA shares the aggregated data exclusively with the Commission annually. Member organisations are able to utilise the data for benchmarking and driving internal quality improvement initiatives.



*'The NZPSHA supports increased transparency and working collaboratively with the Commission and all providers of elective surgery to drive quality improvement and reduce patient harm.'*



**Dr Ian England**  
President, NZPSHA

Between 1 July 2015 and 30 June 2016, the NZPSHA reported 48 aggregated SAC 1 or 2 incidents from 163,992 admissions. The rates are reported per 1000 admissions for all participating NZPSHA member hospitals. This figure cannot be compared directly with DHB-reported events because the reporting criteria differ. Private surgical hospitals have a broader range of cases classified as a SAC 1 than DHBs. The Commission aims to improve clarity to improve consistency as part of the National Reportable Events Policy update.

## Ambulance services

There were over 480,000 '111' calls for ambulance services in 2015-16, which is a 6 percent increase in calls from 2014-15.

A broader approach to quality improvement and a push to identify and learn from adverse events has resulted in a significant increase in reporting. This is expected to continue.

In 2015-16 there were 101 adverse events reported, an increase from nine adverse events reported over nine months in 2014-15. This increase reflects an ambulance sector that has significantly improved and deepened its culture and systems to confidently identify and report adverse events. It is critical for ambulance services to learn from and reduce these risks.

The ambulance sector is applying lessons learned from the aviation sector, which has for years worked on the principle of comprehensive reporting of near misses and incidents - investigating them and improving systems as a way of reducing future incidents.



Since our last report there has been a shift in how ambulance services manage adverse events, which the National Ambulance Sector Office believes accounts for the increase (as opposed to more adverse events occurring) and is therefore viewed as a positive step. For example, previously only events related to direct consumer/patient care were managed as adverse events, whereas today adverse events can be actual harm or near misses, and are reported within all parts of the system (including call-taking, dispatch and clinical telephone advice systems).

In the last year, the ambulance sector has established an adverse event review group. The group has representation from ambulance services, the National Ambulance Sector Office and the Commission. Its purpose is to improve and align how adverse events are managed, and to share what others have learnt from their investigations. The group adds considerable strength to the service's management of adverse events.

### All other reporting

The National Reportable Events Policy was designed for DHBs. However, the consumer/patient safety and quality improvement systems supported by the policy are increasingly relevant to other organisations. The review of the policy in 2016 will consider how reporting can meet the needs of both DHBs and other organisations. We encourage and welcome reporting from the wider sector.

Other providers reported five adverse events to the Commission in 2015-16:

- aged residential care: two events relating to serious harm from falls
- primary health organisations: two events relating to medication
- hospice: one event relating to serious harm from a fall.

# Chapter 4: Patient safety reporting systems – a summary of international literature

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## Introduction

This chapter summarises key findings from the Commission's recent review of the literature on patient safety reporting systems. The full report is available here: [www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2679](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2679).

The Commission carried out the literature review to increase understanding of the latest developments in the evolving field of consumer/patient safety, and to inform the National Reportable Events Policy update.

The literature review aimed to describe best and emerging practices for patient safety reporting systems, and to summarise overseas approaches. It was a scan of the most recent publications rather than a comprehensive review.

## Context

Patient safety reporting systems are one of the most widespread improvement strategies in the health and disability sector.

In essence, frontline workers submit reports about situations in which a consumer/patient or service user has been harmed or had the potential to be harmed. Reported incidents are investigated and, importantly, key issues for resolution and improvement are identified and acted on.

Patient safety reporting systems were originally adapted from aviation and other safety-critical industries. Landmark reports in the USA and UK recommended the creation of national systems for reporting and analysing adverse health care events.

In New Zealand, only serious adverse events are reported nationally to the Commission. In other countries (or jurisdictions) all patient safety incidents are reported nationally.

## *Challenges facing patient safety reporting systems*

Despite their rapid and widespread uptake, patient safety reporting systems around the world face many challenges.

Challenges include:

- insufficient action from reporting (ie, 'We collect too much and do too little')
- pressure to provide both a learning platform and a reporting and surveillance system
- limited evidence that reporting leads to improvements in consumer/patient safety
- barriers to incident reporting by frontline staff (eg, time and resource constraints, uncertainty or apathy about reporting and its value, and fear of consequences)
- limited engagement from doctors, in particular
- failure to capture evolving health information technology developments
- inadequate funding and institutional support.



## Emerging approaches to meet new demands

Complexity and challenges in the delivery and management of health and disability support services are rapidly increasing. To meet the changing demands facing the health and disability sector, we need to consider new models and approaches.

Current thinking is drawing on the principles of resilience engineering, and this is reflected in the latest safety definitions and processes.<sup>17</sup>

**Resilient care is defined as the ability of the care system to 'adjust its functioning prior to, during or following changes and disturbances, so that it can sustain required performance under both expected and unexpected conditions'.<sup>18</sup>**

In other words, health and disability services need to do more than simply recover from threats and stresses. Instead, they must perform as needed under a variety of conditions – and to respond appropriately to both disturbances and opportunities.

Emerging thinking suggests that, while we must continue to learn from adverse events, we should increasingly emphasise more proactive and positive approaches to safety.

This includes broadening the focus beyond past harm to a wider systems approach to build reliability and resilience, in order to develop a more comprehensive and responsive safety management system.

It is also important to recognise that 'one size doesn't fit all' – multiple safety strategies are needed to suit diverse health and disability contexts.

## Improving the effectiveness of patient safety reporting systems

A large body of literature provides guidance and expert consensus on potential ways to address the challenges with current reporting systems, and to improve the effectiveness of patient safety reporting and learning.

### Recommendations from the literature for improving effectiveness

#### What should be reported?

##### Never events

Never events are serious, largely preventable adverse events. They are of concern to both the public and care providers for public accountability. Some countries, such as England and the USA, have specified a set of events to be reported nationally – irrespective of harm. These types of events can also be referred to as 'always report and review'. This is the Commission's preferred terminology, as is discussed in chapter 5.

International expert opinion supports mandatory reporting of never events at both local and national levels.<sup>19</sup>

<sup>17</sup> Hollnagel E, Wears RL, Braithwaite J. 2015. *From Safety-I to Safety-II: A white paper*. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

<sup>18</sup> Hollnagel E, Braithwaite J, Wears RL. 2013. *Resilient health care*. Farnham, England: Ashgate.

<sup>19</sup> Howell AM, Burns E, Hull L, et al. 2016. International recommendations for national patient safety incident reporting systems: an expert Delphi consensus-building process. *BMJ Quality & Safety*. DOI: 10.1136/bmjqs-2015-004456.

## Near misses

A near-miss incident is one that could have – but did not – result in harm to a consumer/patient. Experts strongly agree that near misses should be reported locally,<sup>20</sup> but are less united on whether (or which) near misses should be reported at a national level. One recommendation is to nationally report higher-risk near misses, which could have resulted in death or disability.<sup>21</sup>

### Prioritise events to be reported nationally

There is consensus that, at the national level, priorities should be set to determine which incidents are reported to the national programme from local reporting systems. Events can be prioritised by focusing on a finite set of events likely to be of greatest benefit to learning and systems improvement. The event may be based on level of harm, frequency, preventability or regional/national priority.

### How can reporting be more meaningful?

**Make reporting easier** with simple systems that can be used with minimal or no training.

**Make reporting meaningful** with timely feedback to the person who reports an event, institutional resourcing of review/analysis of events, sharing of reports and outcomes with staff, and sharing lessons at local, regional, national and international levels.

**Improve engagement with doctors** by supporting doctors and all clinical staff to feel truly safe when reporting; establishing strong medical leadership of reporting systems; and showing that reporting has led to tangible action.

### How can consumers/patients and families/whānau contribute to reporting?

The literature broadly supports the enabling of consumers/patients and family/whānau members to report adverse events – and many overseas countries have systems for consumer/patient reporting.

Consumers/patients and their families/whānau are seen as a rich resource for learning and safety improvement, by providing timely, important and complementary information about the safety of care.

Consumer/patient reporting of incidents is under-researched, with a need for development and evaluation of interventions to encourage and enable consumer/patient involvement. Studies indicate that barriers restrict consumers'/patients' use of existing incident reporting systems.

Consumer/patient-initiated and administered surveys may offer one solution to the problem of poor uptake, where consumers/patients and their families/whānau can report incidents using a tool they have designed themselves.

### How can reporting be encouraged across all care settings?

There is strong agreement in the literature that patient safety reporting systems should cover all care settings and enable reporting by public and private organisations.

Many reporting systems are set up for acute care provided by multiple persons. It can be difficult to apply this system to other care settings, such as primary care or disability support services.

One recommendation in the literature is to develop generic patient safety reporting systems initially, and then adapt to the specifics of care settings in later phases of development.<sup>22</sup> The UK, for example, is focusing on how to enhance and support reporting from non-acute care settings, particularly primary care. There is some evidence that the majority of reports to generic systems come from nursing staff and quality managers. Some clinical specialty groups such as general practice and anaesthesia have developed specialty-specific

<sup>20</sup> *Ibid.*

European Commission Patient Safety and Quality of Care Working Group. 2014. *Key findings and recommendations on reporting and learning systems for patient safety incidents across Europe. Report of the reporting and learning subgroup of the European Commission PSQCWG.* URL: [http://ec.europa.eu/health/patient\\_safety/docs/guidelines\\_psqcwg\\_reporting\\_learning\\_systems\\_en.pdf](http://ec.europa.eu/health/patient_safety/docs/guidelines_psqcwg_reporting_learning_systems_en.pdf) (accessed 17 June 2016).

<sup>21</sup> Van Spall H, Kassam A, Tollefson T. 2015. Near-misses are an opportunity to improve patient safety: adapting strategies of high reliability organizations to healthcare. *Current Opinion in Otolaryngology & Head and Neck Surgery* 23: 292-6.

<sup>22</sup> European Commission Patient Safety and Quality of Care Working Group 2014, *op. cit.*



'craft-based' reporting systems, and these seem to have buy-in from the relevant medical staff. There is an opportunity to integrate key learnings from these systems into the Commission's work, for wider dissemination.<sup>23</sup>

Some experts believe there may be a need for a sector-specific reporting system for primary care because of its complexity and distinction from secondary care, such as differences in organisational culture, incident types and staffing composition.

***How can we ensure that reporting translates into action and shared learning?***

'Closing the feedback loop' means that the learning from adverse event reviews is acted upon and the resulting actions are monitored and shared. Recommended actions need to be tracked to ensure the intended changes to systems and practice are both implemented and effective.

International experts emphasise that to 'close the feedback loop' for consumer/patient safety, the original reporter should be updated about the outcomes of the reporting and/or review. Other relevant providers should be alerted about any potential specific improvements in safety.

It is clear that effective consumer/patient safety feedback involves timely, visible and repeatable corrective action and quality improvement processes – not just the publication of incident rates.

A lack of feedback to those who report – both frontline staff and consumers/patients and families/whānau – has been identified as a major barrier to incident reporting in international literature.

The review highlighted these key messages for translating reporting information:

- Feedback on the review's outcomes and recommended actions needs to be built into the regular reporting of safety issues at all levels. Reports are crucial to consumers/patients and/or families/whānau, and to the governing board of the provider organisation. The recommended actions need to be carried out and monitored. Feedback should also be evaluated.
- Multiple means of feeding back actions and consumer/patient safety information are needed to promote safety awareness, improve clinical processes and maintain reporting.
- A comprehensive framework that incorporates multiple modes may be useful for health and disability organisations.<sup>24</sup>

## **Overseas approaches to patient safety reporting – three examples**

The literature review identified the key features of national reporting systems in five countries (or jurisdictions). Table 3 presents three examples: England and Wales, Scotland and Denmark.

<sup>23</sup> Chair, Health Quality & Safety Commission. 2016. Personal communication.

<sup>24</sup> For example, the Safety Action and Information Feedback from Incident Reporting (SAIFIR) model sets out requirements for the feedback elements of an incident reporting and learning system. Benn J, Koutantji M, Wallace L, et al. 2009. Feedback from incident reporting: information and action to improve patient safety. *Quality & Safety in Health Care* 18: 11-21.



Table 3: Key features of the national patient safety reporting systems in England and Wales, Scotland and Denmark

	England and Wales	Scotland	Denmark
How are reportable incidents defined?	Common broad definition, includes never events.	No common definitions currently. National reporting includes near misses and non-clinical events.	Specified adverse events, includes near misses.
Can consumers/patients report?	Yes	No	Yes
How are incidents analysed?	All serious incidents are investigated through the patient safety domain, as well as those that offer potential for national learning or represent new or emerging risks.	<ul style="list-style-type: none"> <li>All adverse events are subject to review.</li> <li>Guidance is provided on the review process.</li> <li>A human factors approach is emphasised.</li> </ul>	A national agency analyses serious incidents and conducts specific analyses based on alerts and special focus areas.
Is reporting for all care settings?	Available to National Health Service-funded organisations, including primary care and pharmacies.	Not yet – initial focus has been on acute care, but they intend to expand to all.	Yes
How is reporting used for learning?	Safety alerts, organisational-level incident reports, national reporting and learning system data are published online.	Safety alerts, no national reporting, community of practice to share tools and learnings.	Safety alerts, various information-sharing channels, national agency required to share learnings.

## Emerging thinking on patient safety reporting systems

New approaches and ideas on the future of patient safety reporting are emerging, which can inform policy and practice in New Zealand. Several key ideas are summarised below.

### *Proactive management of risk and opportunities*

Some authors have proposed expanding incident reporting models with strategies to manage risk and potential opportunities in a more proactive way. They suggest moving beyond a focus on single incidents.

As well as examining specific adverse events, where things have gone wrong, it's important to examine and learn from successes, where things have gone as planned, or when potential errors have been detected and corrected.

Vincent and Amalberti have expanded the London Protocol to consider a longer timeframe for analysis, and to include analysis and reflection on success, detection and recovery.<sup>25</sup> Known as ALARME, this new approach considers both benefit and harm along the whole consumer/patient journey.

<sup>25</sup> Vincent C, Amalberti R. 2016. *Safer healthcare: Strategies for the real world*. New York: Springer.



The ALARME approach requires looking at episodes of care rather than a particular incident. Analysis would start from a person's admission to hospital and extend the analysis until rehabilitation at home.

Hollnagel and colleagues advocate a shift in perspective from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'.<sup>26</sup> They believe that while many adverse events may continue to be addressed using a traditional approach, this won't work for a growing number of cases. The traditional approach misses the opportunity for important learning about how safety is achieved in everyday practice.

Proposed new practices include looking specifically for what frequently goes right (to learn from successes). It is important to learn from more commonplace events because small improvements to everyday performance may have more impact than a large improvement in one rare circumstance.<sup>27</sup>

### **Consumer/patient involvement in reporting**

Some experts call for consumer/patient identification of adverse events. Studies show that consumers/patients can reliably report adverse events and provide new information to supplement practitioner information.

Vincent and Amalberti recommend that events considered for analysis should be selected from the consumer's point of view as well as by professionals.<sup>28</sup> Viewing safety from a consumer/patient perspective will require a focus on overall coordination of care rather than isolated incidents. It will also mean increasing the role and involvement of consumers/patients and families/whānau in monitoring and maintaining safety.

### **A sector-wide systems approach**

The World Innovation Summit for Health Patient Safety Forum 2015 sets out the case for a systems approach to consumer/patient safety. Key features include:

- organisational leadership must influence consumer/patient safety at all levels
- transparency and open communication are professional expectations.

Also, the forum argues for addressing system-level gaps, including the need for a sector-wide approach and a more integrated system of safety and risk assessment.

The health and disability sector is diverse. Reporting and managing incidents – and safety more broadly – will require different approaches in different settings.

### **Adverse events are one component of improving safety**

Finally, rather than standing alone, patient safety incident reporting should be an integrated part of quality and safety improvement initiatives.<sup>29</sup> We need to see patient safety reporting in the context of a wider consumer/patient safety management system.

<sup>26</sup> Hollnagel et al 2015, *op. cit.*

<sup>27</sup> *Ibid.*

<sup>28</sup> Vincent and Amalberti 2016, *op. cit.*

<sup>29</sup> Rabol LI, Gaardboe O, Hellebek A. 2016. Incident reporting must result in local action. *BMJ Quality & Safety*. DOI: 10.1136/bmjqs-2016-005971.

## Key messages from the literature review

Patient safety reporting systems should:

- re-orient patient safety reporting systems to put consumers/patients and their experience of health and the health care system at the centre
- expand the focus, over time, from learning from past harm and single incidents to learning from what goes well, and managing risk as part of a wider systems approach to consumer/patient safety management
- focus on enhancing consumer/patient safety feedback – this is a critical dimension of a learning system and essential for motivating reporting
- be clear about the role of a patient safety reporting system and in particular whether its primary focus is on learning or reporting and accountability
- be clear about the distinct yet complementary roles of national versus local patient safety reporting systems, and design systems accordingly
- prioritise reports submitted at a national level and, at both national and local levels, prioritise reports investigated
- maximise the opportunities provided by new digital technologies, electronic health records and behavioural insights to make reporting easier and more engaging, and to enhance the quality and effectiveness of data transfer and information sharing.

**'A safer care system is conceived from the perspective of the patient, following his or her journey through different care settings, irrespective of organisational boundaries. It is networked, so that successes and failures identified in one part of the system can be readily accessed, understood and built on in another. And it is judged not by the prevalence of adverse events, but by the ability to proactively identify hazards and risks before they harm patients.'**<sup>30</sup>

<sup>30</sup> The Health Foundation. 2015. *Continuous improvement for patient safety: the case for change in the NHS*. London: The Health Foundation.



## Chapter 5: The National Reportable Events Policy – seeking input from stakeholders

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### Introduction

The Commission has produced a discussion document to seek views on potential changes to the National Reportable Events Policy 2012 (the policy). This chapter summarises the discussion document and how you can contribute.

We are in the process of updating the policy. After stakeholder engagement on the discussion document, we plan to release a new policy in early 2017.

The policy is intended to guide organisations in developing their own policies on reporting, reviewing and learning from adverse events. It also sets out the guidance and process for reporting a subset of adverse events to the Commission.

### How to have your say

We invite you to contribute to the policy revision by reading and responding to our full discussion document, which is available at [www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2681](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2681).

More detailed background papers on our literature review and initial meetings with stakeholders will be available during the discussion period on the Commission's website at [www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/adverse-events-report-2015-16](http://www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/adverse-events-report-2015-16).

The timeframe for having your say runs from 10 November 2016 to 1 February 2017.

### Seeking feedback from across the sector

The discussion document is aimed at all health and disability organisations – including those in primary health care, aged residential care, disability support services and secondary care. We also invite consumer representatives to take part.

### Background

To inform the policy revision, we have completed:

1. an electronic survey of stakeholders
2. a literature review
3. initial meetings with stakeholders and people using services.

Our initial work suggests a need for the policy to focus more on facilitating learning from adverse events, so that changes can be made to improve the safety and experience of care for consumers/patients. We found widespread support for policy changes to lift the quality of review (and recommended actions), and to make reporting easier.

We have identified the following five themes, or directions, for potential policy change. These are summarised below.

## Directions for policy change

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 policy changes

The main proposed changes to the policy are summarised below.

### *Increase the focus on consumers/patients*

A new section on consumers/patients will be added to the policy. The section will encourage organisations to consider adverse events in the context of the broader care experience and to engage with consumers/patients and their families/whānau. We plan to introduce a set of expectations for involving consumers/patients and their families/whānau in reporting and learning from adverse events.

Examples of the proposed expectations include open communication, starting with the consumer's account of what happened, and sharing the report and outcomes with the consumer/patient and/or family/whānau. These expectations will be encouraged – not mandatory – to recognise organisational diversity and flexibility.

### *Increase the focus on learning and action*

#### ***Additional support to improve the quality of reviews and recommended actions***

New guidance will accompany the policy to help organisations carry out high-quality reviews and make recommended actions for effective change. The guidance will include the elements needed for a good review, a human factors template with system-level prompts, and a 'hierarchy of effectiveness' tool to assist with developing strong recommendations.

#### ***Renew and strengthen expectations to ensure that reporting is acted upon***

We expect each organisation has a follow-up process in place to ensure recommendations are completed and the impacts of resulting changes are tracked. A proposed new expectation is that the organisation has a process for regularly updating the board or governance body.

#### ***Continue to report the number of reviews submitted (Part B) in the Commission's report***

Previously, our annual *Learning from adverse events* publication reported the number of adverse events received (Part A of the REB). In 2015-16 we have reported the number of completed reviews (Part B) received to shift the focus to reviewing and learning rather than simply reporting.

#### ***Encourage more learning from lower-level events and near misses***

If your organisation is willing to share selected SAC 3 and 4 adverse events and near misses for national learning in an Open Book report, please report them to us. We can provide guidance to help you report these events and share learnings with others.

#### ***Mechanisms to support staff***

An expectation will be added to the policy that organisations have a formal process in place to support practitioners (and other staff) directly involved in adverse events.



## *Make it easier for organisations to report and prioritise*

### *Introduce a list of 'always report and review' events*

An 'always report and review' list is a subset of highly preventable events that should always be reported and reviewed as a serious adverse event, regardless of whether harm has occurred.

The Commission will introduce an initial list at the national level. In addition, we invite provider organisations to create their own list of events, to complement the national list. These events could reflect particular settings, such as primary care, aged residential care or disability support services.

### *Triage all serious adverse events to determine the best review process*

Some common events may not always require a comprehensive review and can produce learning in other ways. For example, through a desktop review or reviewing a cluster of common events within one review. Common events could be falls, hospital-acquired infections or suicides that occur in the community.

We will change the policy to encourage organisations to triage adverse events to decide whether a comprehensive review or concise review is required.

### *Enable a wider range of review methodologies*

It is important that the review follows a methodology that is most appropriate to the setting of the event. Many health settings are complex and require methodologies that reflect that complexity and include multiple agencies. The revised policy will enable more flexibility to use various review methodologies, not only root cause analysis. Alternative methodologies are now in use, such as the London Protocol, because a root cause analysis may not suit all situations.

### *Reduce duplication through a single adverse event review being used for various purposes*

By increasing the quality and consistency of event analysis and strengthening recommendations, the Commission would like to see a provider's adverse event analysis used for various purposes. A high-quality, consistent case analysis could be used by other work programmes in the Commission (eg, Maternal Morbidity Working Group) and by other agencies (eg, Health and Disability Commissioner, Coronial Services, ACC) to inform their investigations and reduce duplication.

## *Make the policy more relevant to the whole sector*

### *Work towards whole-sector involvement*

The Commission wants to work towards a 'whole-sector' approach, over time and in close collaboration with sector groups, including primary care, disability support services and aged residential care. We propose having further discussions with representatives from these providers to talk about potential involvement and next steps. The development and adaptation of reporting systems will need to take into account the diversity of these systems.

## **Conclusion**

This chapter provides a snapshot of the potential policy changes under consideration. The full discussion document gives more detail and other suggestions for change.

Please respond to the full document, available at [www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2681](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2681). In the document, we ask a range of questions to seek your input and views.

The engagement with stakeholders from 10 November 2016 to 1 February 2017 aims to seek your advice on the best ways to facilitate better learning and action through the National Reportable Events Policy. Insights from key people with an interest in incident reporting – both providers and consumers – will be vital to shape the revised policy.

## Chapter 6: Adverse events learning programme 2015–16

The Commission remains committed to supporting the sector in improving consumer/patient safety. Our intention is to provide opportunities to share information from all sources across the sector and stimulate discussion on safety in health care.

The goal of the adverse events learning programme is for the sector to learn and improve from adverse events, and to reduce the risk of events happening again in the future. The adverse event learning team works collaboratively across the Commission and other agencies to support and inform a focus on consumer/patient safety. Examples of this collaborative work are described below. The programme aims to:

- develop capability to improve the review and reporting of adverse events
- improve reporting to support quality improvement activities
- collate and report adverse events from all health and disability providers
- collaborate with other agencies with a responsibility for safety and quality of health and disability support services.

### Highlights of the 2015–16 year

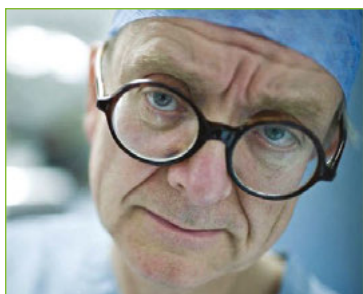
#### *Adverse event analysis workshops*

Improving the quality of adverse event analysis is a priority. The Commission laid the foundation for ongoing adverse event analysis training by holding two workshops in 2015 and a further four workshops regionally in 2016.

We have trained over 140 staff, clinicians and administrators across the country and across the health sector. The courses were designed to help clinicians improve the quality of their own event analysis processes, and are tailored to meet the needs of local providers. The training is not restricted to DHBs – attendance has included staff from private surgical facilities, non-DHB mental health organisations, hospice, aged residential care, disability support and the ambulance sector.

We would like to acknowledge the individuals and organisations who contribute their time to support our workshops. This significant contribution and commitment enables our success.

The workshops have recently been evaluated, and this will inform the future direction of this work.



#### *Open Forum: Dr Henry Marsh (CBE, FRCS), neurosurgeon and author of Do No Harm*

Dr Marsh was the keynote speaker for our forum on clinical leadership in quality and safety, part of the Commission's Open Forum: International Speaker Series. Dr Marsh discussed what he had learned about clinical leadership for quality improvement over his career. He used his morning briefings with all surgeons, both senior and junior, as an example of how teamwork, communication and sharing experiences are vital to safe care.



### ***Associate Professor Jeanne Huddleston workshop: Improving reliability of systems to detect and rescue deteriorating patients***

The Commission supported the Health Roundtable's workshop focused on systems factors influencing detection and escalation of care for the deteriorating patient. This workshop featured keynote speaker Associate Professor Jeanne Huddleston from the Mayo Clinic. The clinical lead for our deteriorating patient improvement programme, Dr Alex Psirides, also contributed to the programme.

### ***Patient Safety Week***

In 2014, the Commission coordinated New Zealand's first Patient Safety Week. This is now an annual event representing a commitment to consumers and patients that New Zealand's health services strive to provide the best and safest care possible.

As part of Patient Safety Week activities in 2015, the Commission focused on information for consumers/patients for keeping safe while in hospital, and for discharge planning. A number of resources and a video were developed and distributed widely to hospitals.

The resources for 2015 and links are all available on the *Open for better care* website: [www.open.hqsc.govt.nz/patient-safety-week/publications-and-resources/publication/2333/](http://www.open.hqsc.govt.nz/patient-safety-week/publications-and-resources/publication/2333/).

These resources help consumers to be actively engaged in understanding the potential risks in hospital, and how they can work with health care teams to minimise these risks.

### ***Information Sharing Forum***

The Commission continues to work in partnership with other agencies to support the Information Sharing Forum. This includes representatives from the ACC, the Ministry of Health and the Health and Disability Commissioner. The forum meets quarterly under a memorandum of understanding signed in May 2014 to cooperate on issues relating to adverse event information collection, review and sharing.

## **Learning from trigger tools**

Since 2012, the Commission has supported a work programme to encourage the use of trigger tools in New Zealand.

Trigger tools can be used in both secondary and primary care settings. They provide a methodology for identifying, documenting and learning from consumer/patient harm. They use a systematic record review process on a randomly selected set of medical records using triggers as flags for consumer/patient harm. The purpose is not only to count harms, but more importantly, to identify themes so steps can be taken to reduce the risk of harm and improve the experience of care.

In 2015-16 two regional workshops focused on ways of analysing trigger tool data and how we can use this information for learning and improvement. These were well attended, and it is evident there is now considerable expertise in the sector around the trigger tool methodology.

For the first time, an Open Book report based on trigger tool data was published, demonstrating the value of the tool in providing learning opportunities both locally and nationally. Sharing cases in this way engages clinicians to prompt questions about care processes and encourage conversations to find solutions.

As one of several approaches to measuring consumer/patient harm in health care, the trigger tool programme has been re-positioned to sit within the adverse events learning programme. This reflects our understanding that there is no single robust methodology for measuring harm in health care and we need to understand harm from multiple perspectives, including those of consumers/patients.



## Adverse events learning programme expert advisory group

The adverse events learning programme is supported by an expert advisory group whose membership is listed in Appendix A.

The programme would like to acknowledge the contribution made by Associate Professor Samuel G Charlton and the human factors expertise he provided the programme as a member of the expert advisory group over a number of years. Professor Charlton has now stepped down from the group.

We welcome Brionny Hooper as our new human factors expert on the expert advisory group. Brionny has worked in specialist operational and consultant human factors roles in numerous complex, high-risk, mission-critical industries.



## Appendix A: Adverse events learning programme expert advisory group 2015-16

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Jane Bawden (LLB/LLM Hons)	<i>Consumer representative</i>
Dr Denys Court	<i>Auckland DHB</i>
Diana Gunn	<i>Canterbury DHB</i>
Brionny Hooper	<i>Human factors expert</i>
Dr Colin McArthur	<i>Auckland DHB</i>
Julie Patterson (Chair)	<i>Whanganui DHB CEO</i>
Gillian Robb	<i>Health Quality &amp; Safety Commission</i>
Cristina Ross	<i>Northland DHB</i>
Dr David Sage	<i>Consultant</i>
Dr Iwona Stolarek	<i>Health Quality &amp; Safety Commission (programme clinical lead since 2015)</i>
Richard Whitney	<i>CEO Mercy Hospital Dunedin for NZPSHA</i>



