Making health and disability services safer

Serious adverse events 2012–13 November 2013

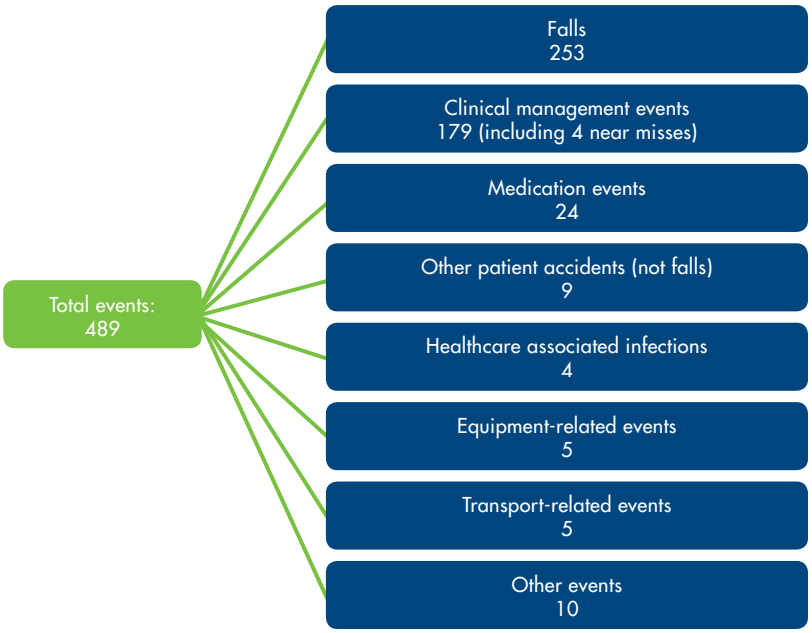
Foreword

This is a summary of the full report of the serious adverse events reported to the Health Quality & Safety Commission between 1 July 2012 and 30 June 2013. Everyone involved in caring for consumers of health and disability services is strongly encouraged to read the full report, which is on the Commission's website: www.hqsc.govt.nz

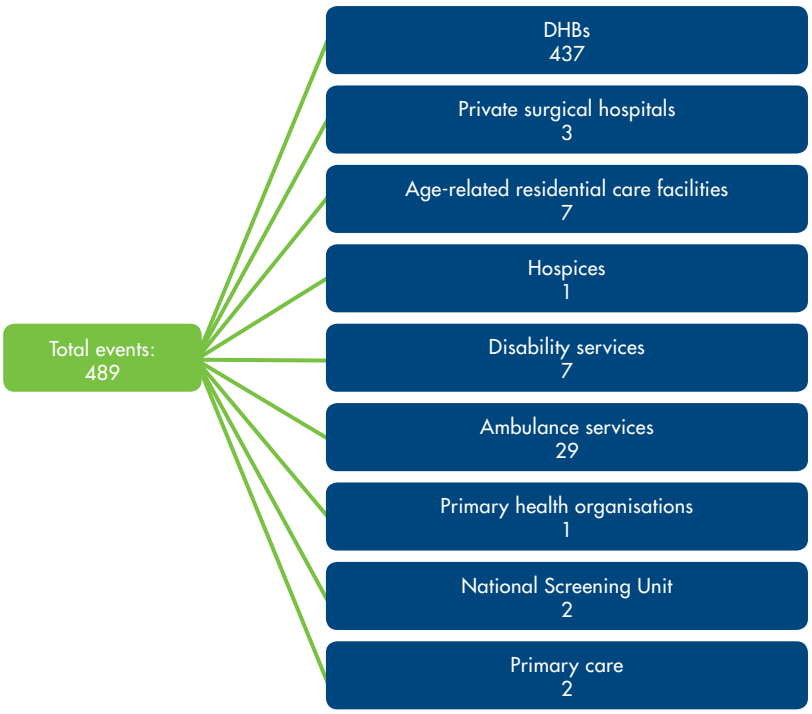
For the first time this report includes incidents that took place outside district health board (DHB) hospitals. This is an important step towards integrating the wider health and disability sector into the Commission's national programme to prevent harm from serious adverse events.

More serious adverse events were reported in 2012–13 than in previous years. Much of this increase is likely to be due to improved reporting. As was the case last year, harm from falls accounted for over half of all events reported. In a parallel process, the Commission is introducing quality and safety markers and indicators to monitor progress in reducing harm in key areas.

All serious adverse events 2012–13 by event type



All serious adverse events 2012–13 by reporting provider



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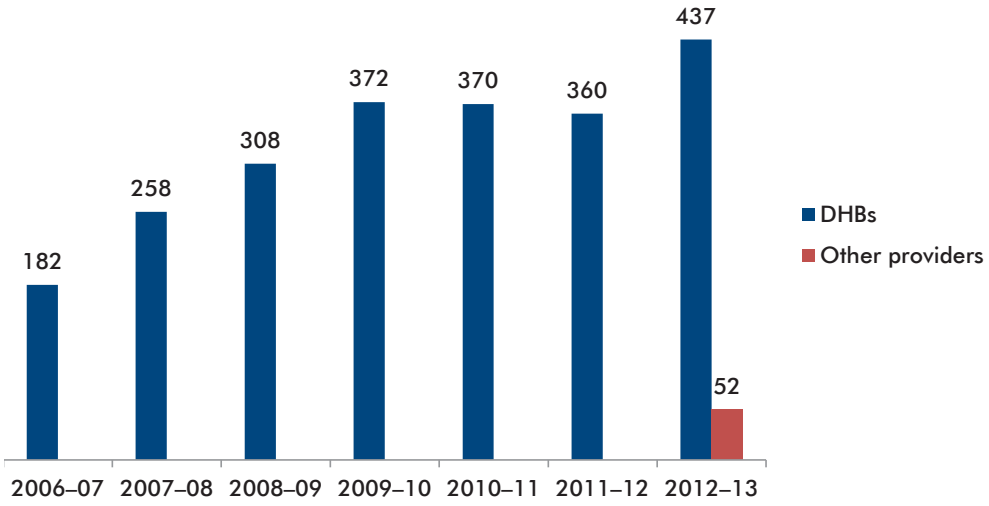
Improved reporting

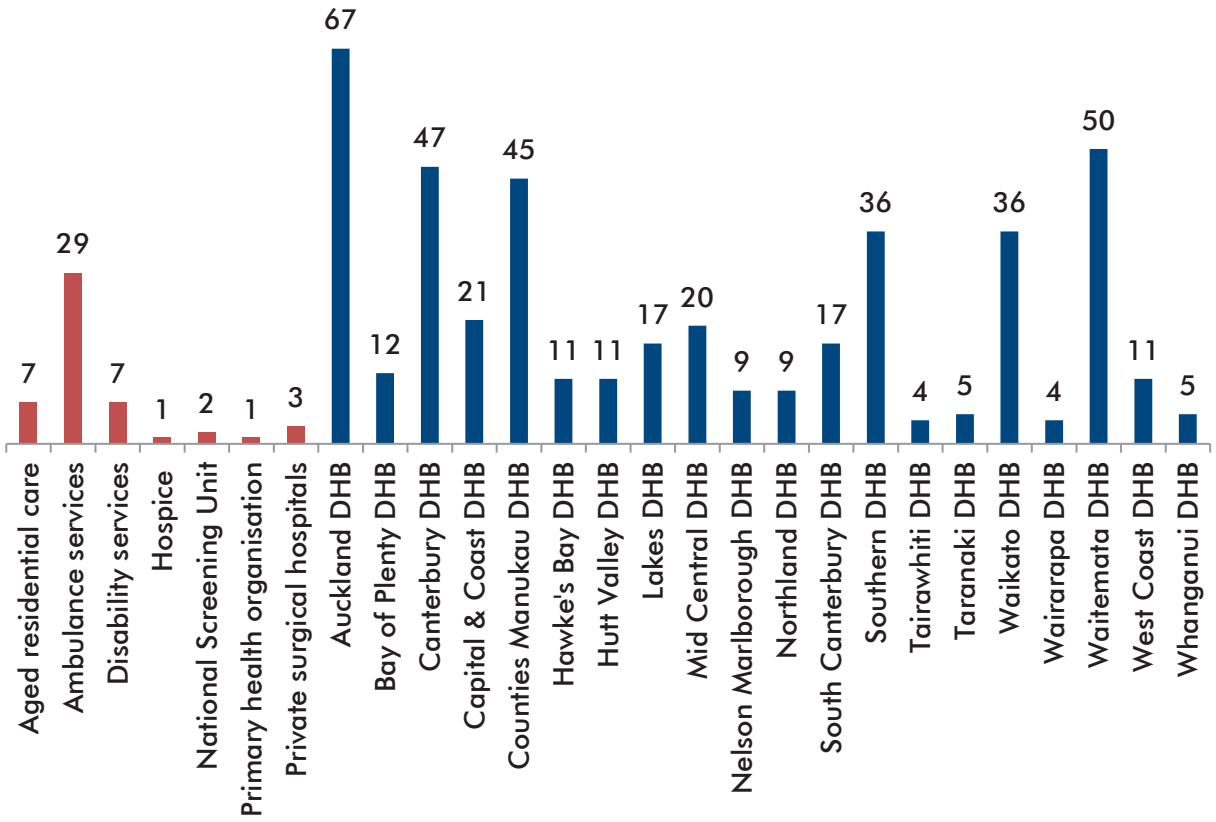
Changes made by DHBs are likely to have resulted in the increase in the number of serious adverse events reported. These changes include DHBs checking other information systems (ie, ACC claims) to ensure all serious adverse events are captured, and reporting as serious adverse events those cases with a serious outcome for the patient, but where the review showed there had been no reasonably preventable cause.

Serious adverse event reporting 2006–07 to 2012–13



Serious adverse events 2012–13

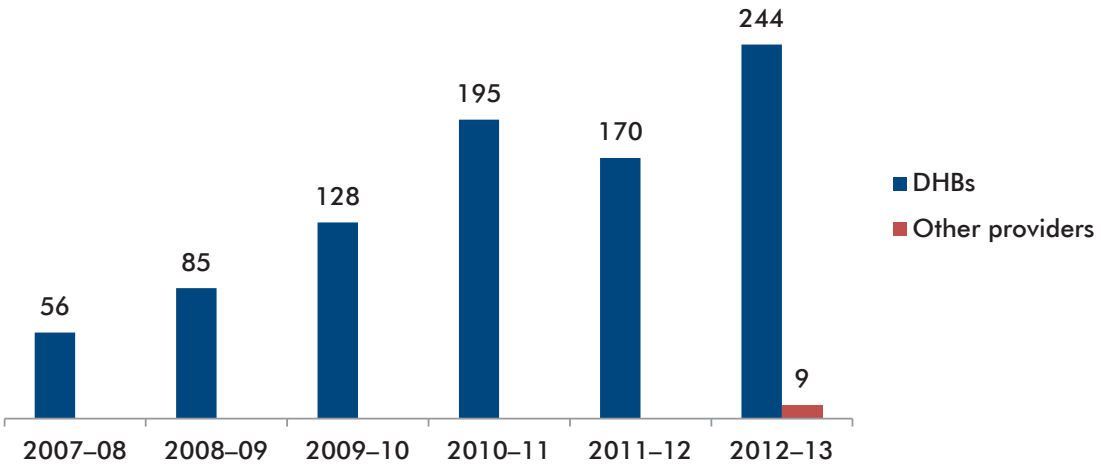
Serious adverse event reporting 2012–13



Falls

Incidents resulting in serious harm from falls are the most frequently reported serious adverse events. The number of falls reported has increased from previous years to 253 (244 DHB, 9 other providers) but this is probably due to factors affecting reporting, rather than an increase in events.

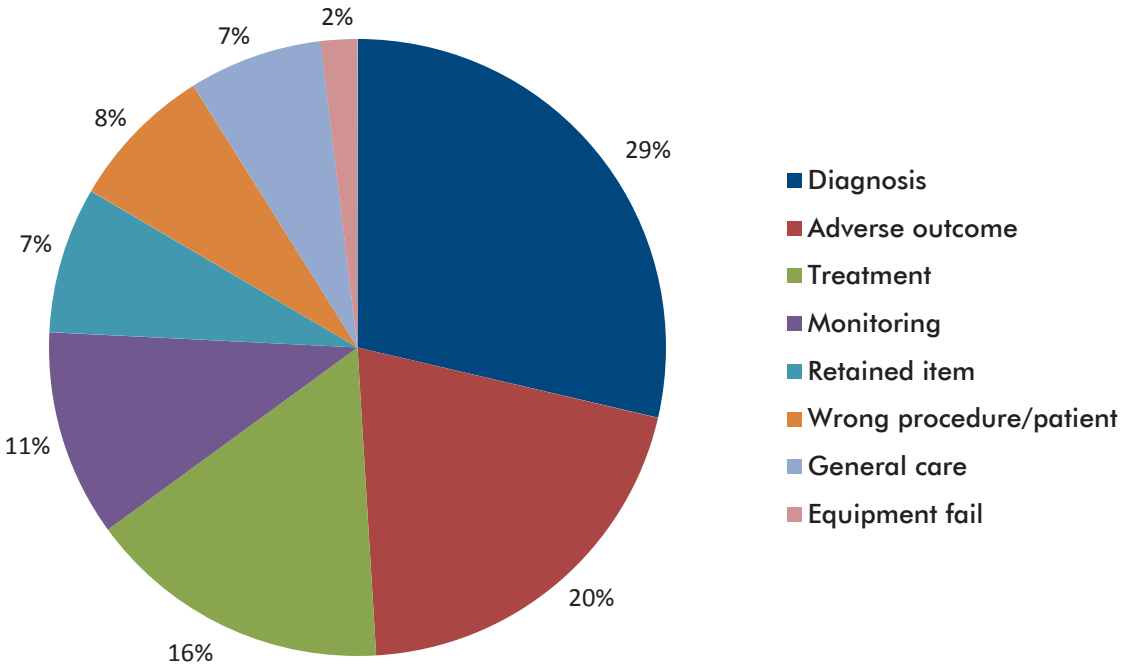
Falls serious adverse events 2007–08 to 2012–13



DHB clinical management events

Clinical management incidents are the second most frequently reported events, with 179. The increased reporting of pressure injuries is captured within this category, and the cross-checking of internal information systems with ACC claims is also likely to have increased reporting.

Clinical management serious adverse events 2012–13



Commission programmes to reduce harm

The Commission runs a number of harm-prevention programmes, which are part of its *Open for better care* national patient safety campaign.

Reducing harm from falls

Falls prevention is everyone's business and 'reducing harm from falls' was the first topic of the Commission's *Open for better care* campaign. Falls prevention is challenging for all health care professionals and providers, especially as our population ages. The Commission is focused on supporting health professionals to put in place the best evidence-based strategies to help keep patients safe while receiving health care. Our first priority has been the hospital environment, and the focus is extending to the age-related residential care sector and community settings.

Sandy Blake
Clinical Lead, Falls

Reducing harm from medication errors

We all have a responsibility to learn from reported events and work to identify how we can reduce patient harm. A key driver for the Commission's Medication Safety Programme is to continually identify quality improvement initiatives to ensure the safe and quality use of medicines. The programme has multiple workstreams with the following core objectives:

- reducing harm from high-risk medicines
- improving prescribing and administration of medicines
- improving the transfer of medicine information at transition points of care
- providing expert advice and strategic thinking on medication safety.

Dr Mary Seddon
Clinical Lead, Medication Safety

Reducing perioperative harm

The Commission has a work programme to reduce unintended harm to patients during the perioperative stages of their care. This covers the planning of a procedure, the procedure itself and the time immediately afterwards. The Commission has been encouraging hospitals to use a key process – the World Health Organization's Surgical Safety Checklist. It covers a set of crucial safety checks and helps improve teamwork and communication between members of the operating team, who may not have worked together before.

Ian Civil
Clinical Lead, Reducing Perioperative Harm

Miranda Pope
Nursing Clinical Lead, Reducing Perioperative Harm

Infection prevention and control (Reducing surgical site infections)

Reducing surgical site infections (SSIs) is one component of the Commission's Infection Prevention and Control Programme. The Surgical Site Infection Improvement Programme was established to standardise the collection and reporting of SSIs and to encourage practice improvements and culture change among health care workers that will help prevent SSIs. Several evidence-based interventions designed to prevent SSIs have been identified and will be implemented in stages by DHBs over the next year.

Dr Sally Roberts
Clinical Lead, Infection Prevention and Control

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