Serious Adverse Events 2012–13
Questions & Answers

What are serious adverse events (SAEs)?

An adverse event is an incident which results in harm to people using health and disability services. Serious adverse events are reported by health and disability providers in accordance with the Commission's national reportable events policy, and in general are those incidents where serious harm to a consumer or death has resulted.

Also reported by DHBs during 2012–13 were four 'near-miss' events, where there was no harm but the incident itself was considered serious enough to warrant review, as it had the potential to result in harm.

The SAE report published by the Health Quality & Safety Commission does not record all adverse events that occurred in public hospitals and other health care settings, only those considered by district health boards (DHBs) and other reporting organisations as meeting the criteria to be considered a serious adverse event.

How many cases of SAEs have occurred?

A total of 489 SAEs were reported in 2012–13 by DHBs (437 events) and other health providers (52 events). This compares with the 360 events reported in 2011–12 by DHBs, and represents a 21 percent increase in the number of events reported by DHBs.

Of the 489 events reported, 82 patients died, although not necessarily as a result of the adverse event. In the 2011/12 year, 91 patients died, although again this was not necessarily the result of an adverse event.

Adverse events reported for 2012–13 include:

- 253 instances of serious harm from falls, comprising 52 percent of all SAEs. Of these, 106 patients suffered a broken hip
- 179 clinical management events, including delays in treatment, concerns about the accuracy of diagnoses, patient monitoring in hospital, and near misses
- 24 medication events, with 11 of these related to administration of an incorrectly prescribed drug or drug dose
- 9 other patient accidents (not falls)
- 4 healthcare associated infections
- 5 transport-related events
- 5 equipment-related events
- 10 other events.

These break down further, as follows:

DHBs (437 events):

- 244 falls
- 159 clinical management events, including four near misses
- 18 medication incidents
- 6 other patient accidents (not falls)
- 4 healthcare associated infections
- 6 other events.

Other providers (52 events):

- 9 falls
- 20 clinical management events
- 6 medication incidents
- 3 other patient accidents (not falls)
- 5 transport-related events
- 5 equipment-related events
- 4 other events.

Adverse events involving people using DHB mental health and addiction services were reported separately by the Health Quality & Safety Commission in September 2013, and are not included in this report (click here for more information).

Why has the number of SAEs involving falls increased?

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: 170 falls were reported by DHBs in 2011–12 and 244 by DHBs in 2012–13 (with another 9 falls reported by non-DHB providers).

This increase in falls is probably due to improved reporting, rather than simply being an increase in the number of falls occurring.

For example, DHBs are increasingly cross-referencing other forms of data with their reportable event systems. These include ACC claims and information from the National Minimum Dataset, the national collection of public and private hospital discharge information. This cross-referencing may have identified SAEs that would otherwise not been recorded or reviewed. Some DHBs are also lowering the threshold for reporting serious falls.

The falls reported as SAEs in 2012–13 involved the following injuries:

- 106 fractured hips
- 24 serious head injuries
- 21 broken arms
- 21 broken pelvises
- 14 broken femurs
- 67 other injuries.

What type of incidents are termed clinical management events?

Clinical management events are the second most frequently reported SAE, with 179 reported in 2012–13. This figure includes delays in treatment, concerns about the accuracy of diagnoses, patient monitoring in hospital, pressure injuries, and near misses.

Examples of clinical management events include:

- delays in diagnosis of a fractured femur, an ectopic pregnancy being missed, and an abnormality on an X-ray being missed
- concerns about treatment or an injury which occurred during treatment; for example, a patient becoming blind as a result of inadequate postoperative care
- concerns about the standard of monitoring of patients in hospital; for example, cases where patients' conditions worsened but alarms were not raised with the right staff

- items left inside patients following a surgical procedure; for example, swabs, portions of drains, and needles
- delays in receiving treatment; for example, a delay in diagnosing a patient's breast cancer.

Do you know how many people died in 2012–13 as a direct result of an SAE?

No. We know that of the 489 SAEs reported, 82 patients died, but this was not necessarily as a result of the adverse event which occurred.

What do these SAE figures say about the safety of New Zealand's health care system?

People are treated in New Zealand's public hospitals nearly three million times each year, and many more people are seen in community and other health care settings, or receive care at home. The overwhelming majority of people are treated safely and without incident, but a small number are harmed in the course of receiving care.

Any harm that occurs to any patient, for whatever reason, needs to be reviewed to find out why it happened and if a recurrence can be prevented.

New Zealand is well served by a skilled, motivated workforce of health professionals, who are committed to delivering the best care possible for patients and to learning from adverse events when these occur.

It should be noted that international literature does not support using the number or rate of reported events as a way of judging a hospital's safety, as there is considerable variation in the rates of reporting, not just in the rate of events. For example, DHBs reporting the most adverse events may have better systems in place for reporting and investigating events, and perhaps a greater focus on safety within the DHB. Large DHBs are likely to report more events than smaller DHBs, which may reflect the size of the populations they serve as well as the particular mix of health services they provide.

The Commission is focused on obtaining good quality, consistent data which can contribute to an overall picture of how well the health and disability sector is performing, and provide useful information to pinpoint areas for improvement.

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

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

However, many events are preventable. The Commission is paying particular attention to reducing both the number of adverse events which occur and the harm to patients from these events. This includes harm from healthcare associated infections, surgery, medication, and falls.

DHBs and other health providers have sophisticated systems in place for checking and reviewing safety. However, there is always room for improvement as modern health care becomes more complex and the risk of human error increases. Given the large number of patients treated in New Zealand health settings each year, it is still rare in this country to experience a serious adverse event.

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

They are. There are separate processes that hold clinical professionals accountable for the quality of their work and maintaining professional standards. The reporting of incidents is about continually looking at our systems and the ways we can improve them to minimise the risk to patients in the future. Reporting of serious adverse events is about learning from mistakes, rather than apportioning blame.

Who reports serious adverse events?

This is the Commission's fourth report on serious adverse events, and the seventh since all national reporting on these events began. To date, only DHBs have reported adverse events occurring in public hospitals but this year – for the first time – a number of non-DHB providers have also reported their adverse events.

Non-DHB providers in this report include private surgical hospitals, rest-homes, hospices, disability services, ambulance services, primary health organisations, the national screening unit, and primary care providers.

Reporting is voluntary but strongly encouraged by the Health Quality & Safety Commission as part of steps to integrate the wider health and disability sector in to the Commission's national programme to prevent harm. A national reportable events policy provides guidance to health organisations.

What is the Commission doing to prevent adverse events from occurring?

The Commission is working closely with DHBs and other health and disability service providers to improve patient safety across a range of areas, including infection prevention and control, medication safety, falls, mortality review, consumer engagement, and health measurement and evaluation.

In addition, the Commission launched a national patient safety campaign, *Open for better care*, in May this year. The campaign is being implemented by DHBs around New Zealand, and focuses on four priority areas: falls, healthcare associated infections, perioperative care, and medication.

Further information about the Commission's programme areas is available on our website.

Each DHB has released a brief description of each of the serious adverse events it has reported. The Commission website has a link to the DHB websites. A summary document giving details of these descriptions of serious adverse events is available at http://www.hqsc.govt.nz/our-programmes/reportable-events/serious-and-sentinel-event-reports/serious-adverse-events-report-2012-13/.