HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Setting the Scene

The springboard from Safety I to Safety II

"When Heather and I present at workshops, our hope is to support a culture where it is the norm for health professionals, those we care for, and their families and whānau to work together to prevent harm and improve health outcomes."

Karyn Bousfield – Director of Nursing West Coast DHB

2017/18 Adverse Event Report

Health Quality & Safety Commission New Zealand

Of the 982 reported adverse events:

631 were reported **by DHBs**

232 were reported from the **mental health and addiction sector** (DHBs only)

91 were reported **by members of the NZPSHA**

18 were reported **by ambulance services**

1 was reported from the **primary care sector**

9 were reported **by other providers**

Of the 631 events reported by DHBs:

317 were **clinical management events**

31 were **healthcare associated infections**

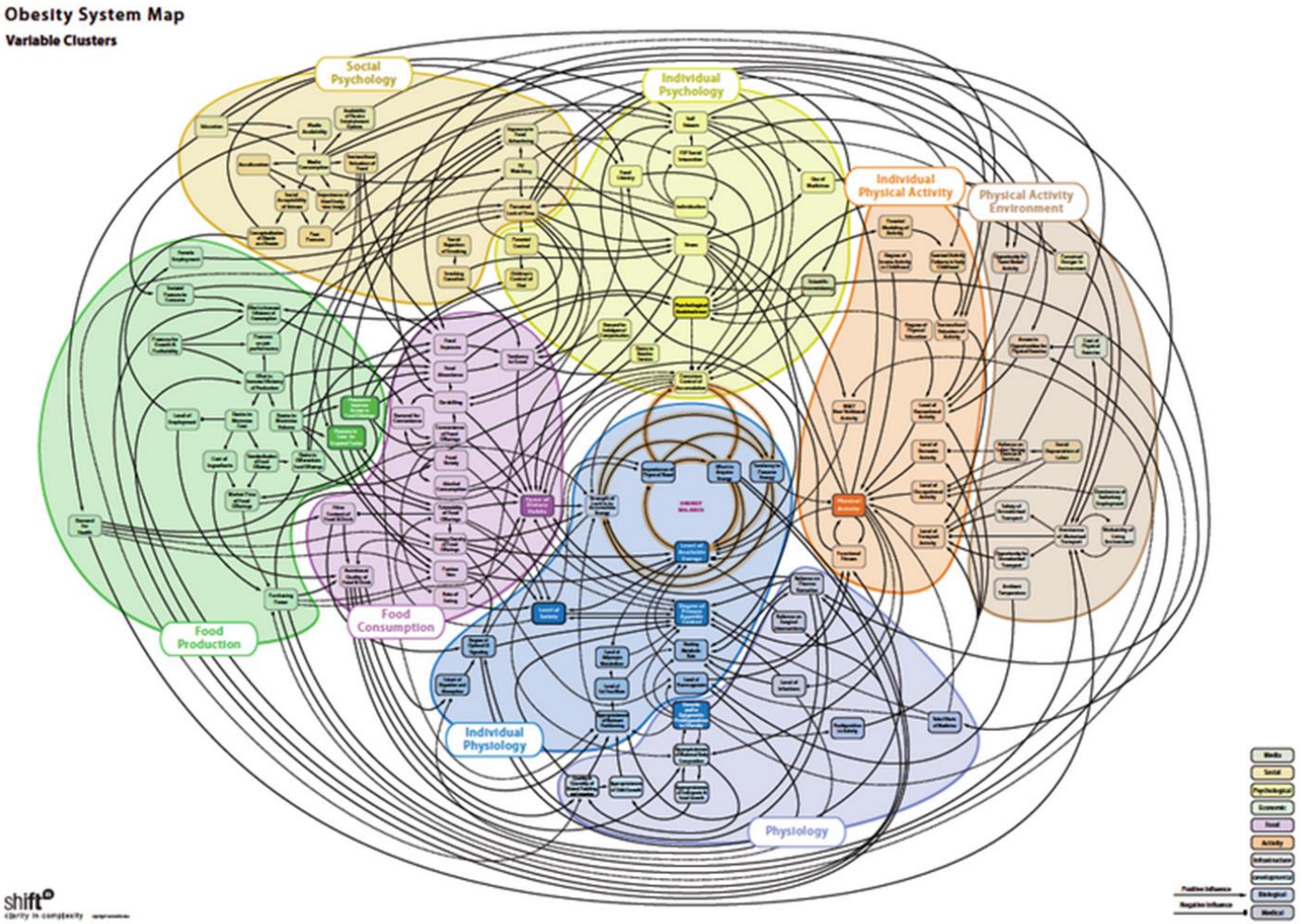
20 were related to **medication or IV fluid**

3 were due to **medical devices or equipment**

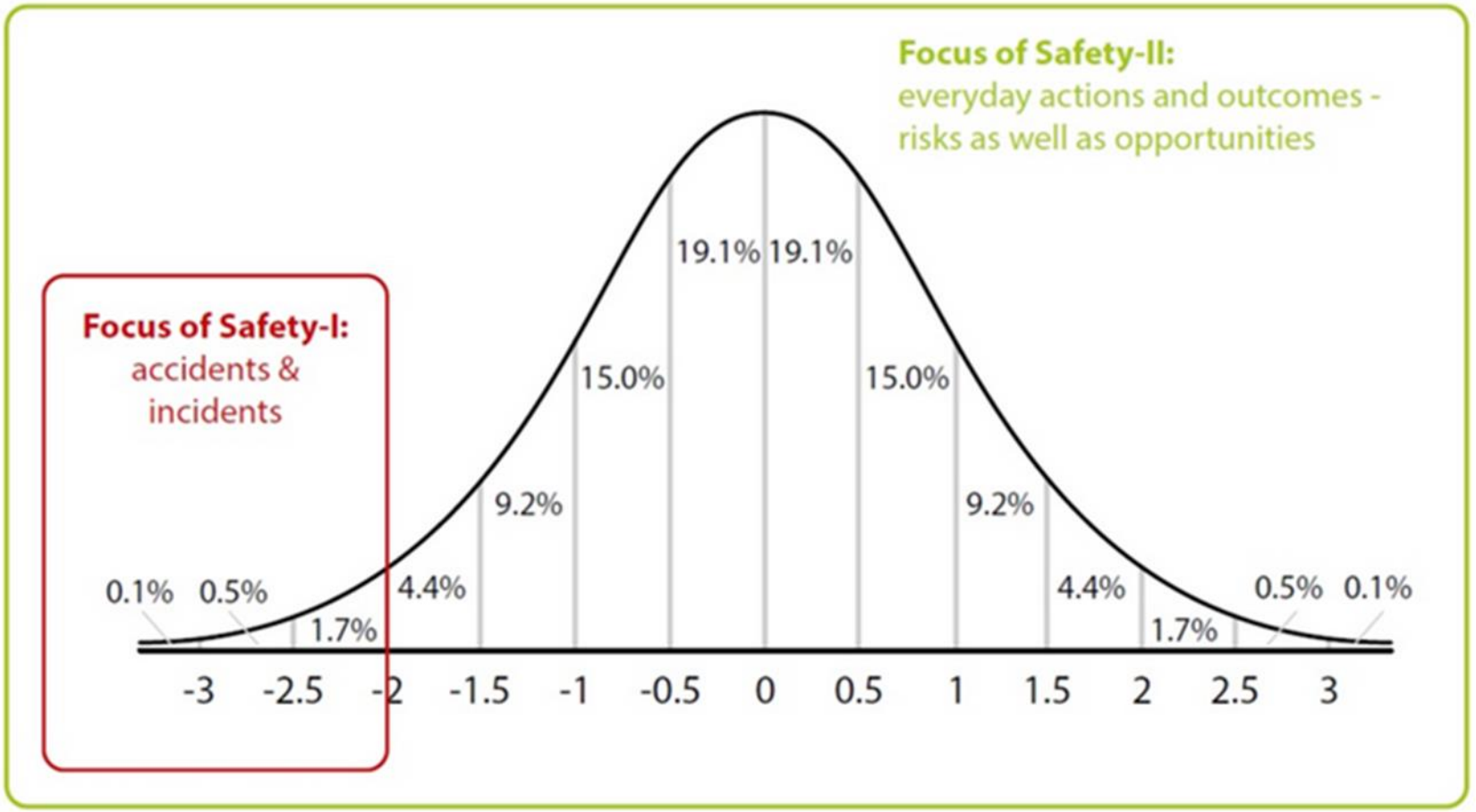
5 were **consumer accidents**

255 were **harm because of falls**

Healthcare is a complex adaptive system



Safety I	Safety II
The work environment can be specified, and is predictable and controllable. Safety is a static, linear phenomenon which can be produced by mechanistic changes in policy and procedure. Safety = reduced number of adverse events Therefore: Focus on what goes wrong	Safety is co-created by workers who are adapting daily to a work environment that is complex, non-linear, and unpredictable. (Hollnagel, Dekker, Cook, etc.) Safety= ability to succeed under varying conditions Therefore: Focus on what goes right and normal performance success


Focus of Safety-II:
everyday actions and outcomes - risks as well as opportunities
Focus of Safety-I:
accidents & incidents
19.1%
19.1%
15.0%
15.0%
9.2%
9.2%
4.4%
4.4%
1.7%
1.7%
0.1%
0.5%
0.5%
0.1%
-3
-2.5
-2
-1.5
-1
-0.5
0
0.5
1
1.5
2
2.5
3


work as done
work as imagined