**Learning from adverse events**
**Adverse events reported to the Health Quality & Safety Commission**
**1 July 2016 to 30 June 2017**

**Questions and answers**

## What is an adverse event?

An adverse event is an incident that results in harm to people using health and disability services.[1] Adverse events resulting in serious harm or death are reported by health and disability providers, guided by the Commission's National Reportable Events Policy.[2] The policy was updated on 1 July 2017, but adverse events discussed in this year's report are based on the 2012 policy.

The purpose of adverse events reporting is to understand the experience of the affected consumers, families and whānau to improve consumer safety, open communication and learning from these events. The events in the *Learning from adverse events* report reflects local interpretation and implementation of the policy guidance by individual providers.

It is important to remember that at the heart of the numbers is a person, with a family or whānau who has been impacted by the event, as well as the health team responsible for their care. The Commission views every adverse event in terms of that impact.

## How many adverse events were there?

A total of 542 adverse events were reported by DHBs in 2016–17 (520 in 2015–16):

- 282 clinical management events
- 210 falls resulting in serious harm, including 77 where the patient broke their hip
- 19 medication-related events
- 16 healthcare associated infections
- 15 other events (such as dietary management and documentation).

Other providers reported 86 adverse events in 2016–17:

- New Zealand Private Surgical Hospitals Association: 52
- ambulance services: 28
- aged residential care: one report relating to pressure injury
- primary health organisations: one event, relating to serious harm from a fall
- hospice: two events; one pressure injury and one serious harm from a fall
- community service: two events.

[1] For further information on SAC classification of incidents, see www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/636/.
[2] www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy

**How do providers notify the Commission about adverse events?**

The Commission is notified in two stages: firstly, through a report that contains information setting out an initial understanding of the event,[3] then through a second report at a later date that contains a summary of review findings and recommendations.[4]

**Does the report include incidents affecting people using mental health and addiction services?**

No. The Commission collaborates with the Director of Mental Health to publish adverse events involving people using DHB mental health and addiction services. These events are reported to the Commission, but published in the Office of the Director of Mental Health's annual report.

**Are providers required to report?**

DHBs are required to report adverse events to the Commission in accordance with the policy guidance. Many non-DHB health providers – such as private surgical hospitals, aged residential care facilities, disability services and hospices – voluntarily provide information.

**How accurate is the adverse events data?**

The 2016–17 report explains the process for adverse events reporting to provide clarity and context to the numbers reported. The Commission believes that in some categories the number of reported adverse events is an increasingly accurate picture of the actual number of adverse events that occur. The number of broken hips in hospital reported by DHBs in this report, for instance, closely aligns with numbers included in the NMDS (National Minimum Dataset), which records information produced by public hospitals when a patient is discharged.

The adverse events reported increasingly reflect the evolving maturity of organisations to include broader types of events and to recognise the systemic influences contributing to their occurrence.

**Is it possible to say exactly how many people died in 2016–17 as a direct result of an adverse event?**

Of the 542 adverse events reported by DHBs, 79 people died. However, these deaths were not necessarily directly related to the adverse event.

**How do New Zealand's levels of adverse events compare with levels in other countries?**

It is difficult to gather accurate and comparable statistics on each country's level of adverse events, but the increasing amount of adverse events data will provide a better idea of performance over time. At present, we believe New Zealand's adverse event levels are broadly comparable to Australia and the United Kingdom.

[3] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2939
[4] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2940

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

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

**How safe is our health care system?**

The standard of health care in New Zealand is generally high. In a typical year there are approximately a million in-patient episodes in New Zealand public hospitals, and most people are treated safely and without incident. However, a small number of people are harmed while they receive care.

Every adverse event represents someone who has suffered harm or has died in the care of the health system. Patients harmed by health care can expect their case to be reviewed to understand what happened and what can be done to reduce the risk of the same thing happening again.

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

Other measures and methods are required to demonstrate changes over time. These include reports and recommendations developed by the Commission's mortality review committees, the Health and Disability Commissioner's reports, Accident Compensation Corporation treatment injury reports, coronial findings and reports, and direct reporting from the Ministry of Health.

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

Adverse events are rarely the result of incompetence or malice. There are separate processes to hold clinical professionals accountable for the quality of their work and for maintaining professional standards throughout their careers.

The reporting and review of adverse events aims to examine ways to improve health care systems by asking what happened, why it happened and what are the underlying causes. Reporting adverse events is about learning to make care safer by identifying system issues rather than finding an individual to blame.

**Is training in reviewing adverse events being offered?**

The Commission offers adverse events review training to all health and disability sector staff. The training is expected to improve capability in quality of reviews and development of effective recommendations. and increase the pool of staff able to support adverse events review.

**How does the Commission respond to emerging themes and issues from reporting?**

Chapter 4 of this year's report provides information on adverse events with some further breakdown of emerging themes from reporting.

Much of the information is based on initial notification information only, which limits the ability to offer detailed analysis as reviews take time to be completed and notified to the

Commission. If not enough reviews have been received by the Commission for these events to be analysed in-depth, we continue to monitor the category and share relevant learnings. Those learnings then help prioritise improvement programmes.

It should be noted that work undertaken by the Commission and other agencies on focused programmes, training and current issues can drive reporting practice, for example, increased reporting of pressure injuries.

**What action is being taken to prevent adverse events?**

The Commission has a very strong focus on preventing adverse events and works closely with DHBs and other health and disability service providers to improve patient safety. This happens across a range of areas, including infection prevention and control, medication safety, surgery, falls, mortality review, consumer engagement, and health measurement and evaluation.

The Commission publishes Open Books,[5] which help organisations learn from adverse events. Since these reports were first developed by the Commission in 2014, a total of 22 have been published.

The Commission is also responsible for statutory mortality review committees, which have a significant role to play in preventing harm.

In 2017 the adverse events learning programme updated the National Reportable Event Policy, now called the National Adverse Events Reporting Policy 2017,[6] and the future direction of the programme. Policy changes, implications and supporting resources and documents are discussed and linked within the report.

The policy places a major emphasis on partnering with consumers and their families and whānau in adverse events review and learning as a pivotal contribution to improving safety and quality.

Some of the policy changes now being introduced will take time to embed, and 2017–18 will therefore be a transitional year with regard to reporting, review and learning practice. The changes may also impact on the number of and types of adverse events reported to the Commission in future years.

[5] www.hqsc.govt.nz/our-programmes/adverse-events/projects/open-book

[6] www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933