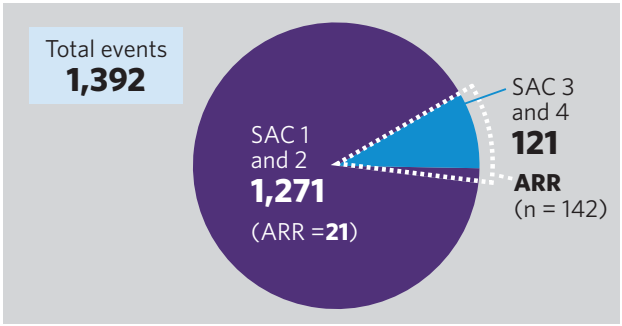
# 2023/24 Health and Disability Sector Harm (Adverse) Events

Te Tāhū Hauora Health Quality & Safety Commission

**Harm during the provision of health care has wide-ranging negative impacts on human wellbeing and relationships, for consumers, whānau, health workers and communities.**

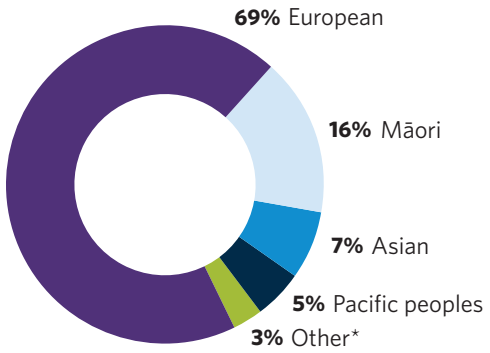
This infographic shows major events for consumers involving death or severe loss of function (SAC 1) or major loss of function (SAC 2) reported to Te Tāhū Hauora Health Quality & Safety Commission between 1 July 2023 and 30 June 2024. For context: 12% of patients experience harm across different medical care settings.* More information: hqsc.govt.nz/AdverseEvents

*World Health Organization. 2024. Global patient safety report 2024. Geneva: World Health Organization.




## By prioritised ethnicity

SAC 1 and 2 harm (adverse) events reported by Health New Zealand | Te Whatu Ora (Health New Zealand)




* Other = other ethnicity + MELAA + residual categories

## SAC 1 and 2 harm (adverse) events were reported by:

- **1,051** Health New Zealand
- **81** New Zealand Private Surgical Hospital Association
- **45** Aged Residential Care
- **59** Other groups
- **25** Ambulance Service
- **10** Hospice

## Health New Zealand harm (adverse) events

493 SAC 1 and 2 harm (adverse) events (excluding clinical management).

**493** Total

- **246** Behaviour (inpatient 34, community 212)
- **195** Falls
- **22** Healthcare associated infection
- **20** Medication/ IV fluids
- **10** Other (≤5 per category)

## Clinical management sub-classification harm (adverse) events

There has been a sustained reduction in reported harm events for delayed recognition of patient deterioration resulting in death, cardiopulmonary resuscitation, or severe loss of function. There has been a sustained increase in reported harm events for hospital acquired Stage 3, 4 or unstageable pressure injuries.

**558** Total

- **197** Pressure injury
- **126** Adverse outcome
- **106** Delayed diagnosis or treatment
- **55** Complication
- **28** Deterioration
- **20** Wrong consumer/ site/side
- **17** Clinical process
- **9** Other (≤5 per category)

## Always Report and Review (ARR)

The ARR list is a subset of events that hospital specialist services report and review, irrespective of whether harm happened.

**142** Total

- **60** Wrong site
- **56** Wrong consumer
- **18** Retained item
- **8** Other (≤5 per category)

Te Kāwanatanga o Aotearoa
New Zealand Government