Learning from adverse events 2019
Questions and answers
Embargo – 12pm, 21 November 2019

What is an adverse event?

An adverse event is an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned. In practice, this is most often understood as an event that results in, or has the potential to result in, harm to a consumer.[1] Adverse events resulting in serious harm or death are reported by health and disability providers, guided by the Health Quality & Safety Commission's National Adverse Events Reporting Policy 2017.[2] The policy has a strong focus on involving consumers, families and whānau in the review process, and taking the cultural viewpoint and practices of consumers and whānau into account during the review process.

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

It is important to remember that at the heart of the numbers are people, families and whānau who have been impacted by the event, as well as the health teams responsible for their care. The Commission views every adverse event in terms of that impact.

How do providers notify the Commission about adverse events?

The Commission is notified in two stages: firstly, through a form that contains information setting out an initial understanding of the event,[3] then through a second form at a later date, which contains a summary of review findings and recommendations.[4] Some providers also submit anonymised copies of the full report. This allows the Commission to provide feedback on the quality of the review and gain more understanding of the event.

Are providers required to report?

DHBs are required to report adverse events to the Commission in accordance with the policy guidance. Some 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 Commission believes providers are continually improving their ability to recognise and report adverse events. In some categories, such as falls, we use reporting from other sources to give an indication of the number of adverse events we might expect to be reported. For example, although the reporting criteria are slightly different, we use data from the NMDS (National Minimum Dataset), to show the number of broken hips that occur in hospital.

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[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
[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

Reporting in other areas is also improving, which reflects the quality improvement programmes being carried out by providers and the Commission.

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

How many people died in 2018/19 as a direct result of an adverse event?

A total of 312 deaths were reported to the Commission in 2018/19. Of these deaths, 209 were suspected suicides reported from the MHA sector, and 103 were from across the rest of the health sector. However, these deaths were not necessarily directly related to the adverse event.

How does New Zealand's adverse events rate compare with those in other countries?

It is difficult to gather accurate and comparable statistics on each country's rate of adverse events, as different jurisdictions have different reporting criteria. The Commission believes that, based on local and international literature, the incidence of adverse events in New Zealand is comparable to other jurisdictions.

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 more than one million inpatient hospitalisations 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. People harmed by health care and their families and whānau 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 data from the Commission's improvement programmes[5], and 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, as well as direct reporting from the Ministry of Health.

The Commission publishes an annual window on quality that reports on the quality and safety of the health and disability system.[6]

[5] https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/

[6] www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3364/

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

A safety culture places the goal of zero preventable harm to consumers, whānau and staff at the centre of the organisation. A safety culture is one where there is accountability, but not blame for mistakes, and harm is reviewed and learnt from, in order to improve systems and processes.

Adverse event reviews seek to understand what happened, why it happened and what needs to be done to make the system safer. Reporting adverse events is about learning, in order to make care safer by identifying system issues rather than finding an individual to blame.

There are separate processes to hold health professionals accountable for the quality of their work and for maintaining professional standards throughout their careers.

Is training in reviewing adverse events being offered?

The Commission offers adverse event 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 event reviews.

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

Much of the information received by the Commission is based on initial notification information only, which limits the ability to offer detailed analysis because reviews take time to be completed and notified to the Commission. If too few reviews have been received by the Commission for events to be analysed in-depth, we continue to monitor the category and share relevant learnings. Those learnings then help prioritise improvement programmes.

Emerging themes are used to inform quality improvement programmes within the Commission or passed on to the relevant bodies.

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 deteriorating patients.

What action is being taken to prevent adverse events?

The Commission has a very strong focus on preventing adverse events and works closely with 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, consumer engagement, mental health and addiction, and health measurement and evaluation.

The Commission publishes Open Books,[7] which help organisations learn from adverse events.

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

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