2018/19 adverse events report released

Embargoed to 12pm, 21 November 2019

The annual *Learning from adverse events* report from the Health Quality & Safety Commission has been released.

Each year, health care adverse events are reported to the Commission by district health boards (DHBs) and other health care providers. The Commission works with these providers to encourage an open culture of reporting, to learn from what happened, and put in place systems to reduce the risk of recurrence.

Between 1 July 2018 and 30 June 2019, 916 adverse events were reported to the Commission. Clinical management events continue to make up the majority of reported adverse events.

Dr David Hughes, clinical lead for the Commission's adverse events programme, says the data in this report indicates that Māori are less likely to be reported as having had an adverse event.

'Of those events that have been reported, Māori are affected by adverse events where there is more scope for implicit bias to impact on their care, such as unrecognised deterioration.

'We are currently undertaking research into whānau Māori experiences of adverse events. We plan to use this research to develop recommendations for providers on how to better meet the needs of Māori who have experienced adverse events,' he says.

Total reported adverse events have fallen for the first time since 2011/12. Dr Hughes says in previous reports, the Commission has said that an increase in reported events does not necessarily mean an increase in harm. 'It is more likely to be as a result of better systems to identify existing harm. Equally, it would be unwise to say that a reduction in reported events is due to a reduction in harm.'

'No one should experience preventable harm when they are recieving health care.'

'The sector should work together to create a safety culture where people feel able to report harm without fear of being blamed for mistakes, and we can learn from what happened. We must do our best to prevent anyone else from being harmed.'

Key findings

Of the 916 reported adverse events:

- 566 were reported by DHBs
- 232 were reported from the mental health and addictions sector (DHBs only)
- 100 were reported by members of the NZ Private Surgical Hospitals Association
- 7 were reported by ambulance services
- 5 were reported from the primary sector
- 5 were reported by other providers
- 1 was reported from a hospice.

Of the 566 events reported by DHBs:

- 278 were clinical management events
- 255 were harm because of falls
- 18 were healthcare associated infections
- 11 were related to medication or IV fluid

- 1 was due to documentation
- 1 was related to nutrition
- 2 were consumer accidents.

ENDS

Further information attached

DHB figures

This table shows events reported annually by DHBs since 2015-2016. DHBs are steadily improving their reporting systems and more events are being reported and reviewed each year. It is not valid to compare the figures of different DHBs for a number of reasons, including widely varying population bases.

DHB adverse event numbers were correct at the time of data analysis for this report. There may be some variation in numbers included in this report compared with DHB data. This may relate to timing of reporting or reclassification following review.

DHB	2015-16	2016-17	2017-18	2018-19
Northland	17	21	19	18
Waitemata	42	45	122	62
Auckland	80	95	92	59
Counties Manukau	58	48	42	38
Waikato	41	44	49	62
Bay of Plenty	9	14	13	25
Lakes	11	13	13	6
Tairāwhiti	8	6	6	10
Taranaki	7	9	9	11
Whanganui	17	9	1	13
Hawke's Bay	13	21	24	25
MidCentral	17	21	20	35
Hutt Valley	7	6	15	13
Wairarapa	3	8	7	3
Capital & Coast	24	18	27	36
Nelson Marlborough	41	9	8	6
West Coast	8	9	8	4
Canterbury	43	73	83	77
South Canterbury	12	20	7	14
Southern	62	53	66	49