LEARNING FROM ADVERSE EVENTS FOCUS OF REPORT

Learning from things that go wrong in health care is a focus of this year's adverse events report.

Each year, health care adverse events are reported to the Health Quality & Safety 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 went wrong and put in place systems to stop incidents recurring.

In 2014–15:

- 525 adverse events were reported (454 in 2013–14)
- serious harm from falls was the most frequently reported event, with 277 cases. Of these, 84 resulted in the patient suffering a fractured neck of femur (broken hip)
- clinical management incidents were the next most reported events, with 205 cases, including those relating to delays in treatment, assessment, diagnosis, observation and monitoring (including patient deterioration)
- incidents involving prescribing, dispensing or administration of medication were the next most frequently reported events, with 23 cases.

'Each one of these very sad incidents has affected a patient, their family and whānau, and the health professionals who care for them,' Commission Chair Professor Alan Merry says.

'While it is too late to prevent these particular events, we owe it to those affected to take a thorough look at what went wrong, so we can continue to improve systems and make care safer.'

He says the rise in the number of events reported reflects the culture change taking place in health care, with greater emphasis on learning from systems failings.

'DHBs, other health providers and the Commission are working together to help the sector better understand events leading to avoidable harm.'

Prof Merry says the 2014–15 report includes a special focus on learning from cases where there has been a delay in recognition or a lack of recognition of a patient's deteriorating condition.

'Deterioration can happen at any time in a patient's illness, but patients are especially vulnerable after surgery and when they are recovering from a very serious illness. Recognising and responding to this deterioration quickly is important to avoid cardiac arrest or admission to an intensive care unit.'

Clinical lead for the Commission's adverse events learning programme, Dr Iwona Stolarek, says the involvement of patients and families/whānau when adverse events are being reviewed is integral.

'Every affected patient engaged in a review is helping us improve our work to prevent future adverse events,' she says.

'The generosity of patients, families and whānau affected by the incidents reported is vital. I would like to thank them for the help they have provided.'

In 2015 the Commission has worked with DHBs and other health service providers to increase expertise in learning from adverse events, including providing training in the review of events.

Health professionals have also been able to share knowledge of adverse events through Open Book learning reports.

For a copy of the full report and questions and answers visit www.hqsc.govt.nz. See individual DHB websites for a breakdown of their figures.

ENDS

About adverse events

Adverse events (previously known as serious adverse events, and serious and sentinel events) are incidents which have generally resulted in harm to patients. The title has changed to signal a new direction in the programme, with a greater emphasis on learning from all events – not only the serious adverse events, but also near misses – as learning about these events can be as powerful.

A serious adverse event is one which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

DHBs are required to review these events and report them to the Commission. The national reportable events policy includes a standardised form, known as a reportable event brief, which is used as a basis for reporting events and advising the Commission of the outcome of the review.

For more information, visit the Health Quality & Safety Commission's website at www.hqsc.govt.nz or contact Communications Coordinator Dylan Moran on 021 813 591 or by email: dylan.moran@hqsc.govt.nz