Learning from Adverse Events
Adverse Events Reported to the Health Quality & Safety Commission
1 July 2014 to 30 June 2015

What is an adverse event?

An adverse event is an incident that results in harm to people using health and disability services. Adverse events[1] are reported by health and disability providers guided by the Commission's national reportable events policy, and in general are those incidents that have resulted in a patient dying or suffering serious harm.

The learning from adverse events report published by the Health Quality & Safety Commission does not record all adverse events in public hospitals and other health care settings. It records only those considered by district health boards (DHBs) and other reporting organisations to meet the criteria to be considered an adverse event.

How many adverse events were there?

In 2014/15, DHBs reported a total of 525 adverse events. Non-DHB providers (such as private surgical hospitals, aged care homes, disability services and hospices) voluntary reported an additional 67 events.

The number of DHB-reported events rose by 16 percent from 2013/14.

As in every year since the Commission began reporting adverse events, serious harm from falls were the most frequently reported events. In 2014/15, there were 277 cases, making up 53 percent of total events reported. Clinical management events were the next most common (205 events, 39 percent) and medication incidents the third (23 events, 4 percent).

In general, the number of adverse events occurring in each DHB is proportionate to the population each DHB serves.

The 67 adverse events reported by non-DHB providers for 2013/14 include:

- From 1 July 2014 to 30 June 2015, the New Zealand Private Surgical Hospitals Association reported 43 incidents from 163,311 admissions. This figure cannot be directly compared with DHB reported events because the reporting criteria differ. Private surgical hospitals have a broader range of cases that are classified as a SAC 1 than DHBs. The Commission will seek to address this variation as part of the National Reportable Events Policy review in 2016.

Other providers (excluding private surgical hospitals and ambulance services) reported 15 serious adverse events to the Commission in 2014/15.

- Aged residential care: Five reports relating to serious harm from falls.
- Primary health organisations: Four events, including two relating to clinical administration, one to a fall and one relating to medication.

[1] An adverse event is an incident affecting a health and disability consumer that has been classified as severity assessment criteria (SAC) 1 or 2. In general, these incidents have resulted in, or could have resulted in, serious harm or death. For further information on SAC classification of incidents, see www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/636/.

- Other private providers: Two providers each reported an event relating to clinical management.
- Hospice: One event relating to serious harm from a fall.
- Disability services provider: One event relating to clinical management.
- New Zealand Defence Force: One event relating to clinical management.
- Breast Screening Unit: One event relating to documentation.

From 1 July 2014 to 30 March 2015, ambulance services reported nine serious adverse events. Two were clinical management events, one was a transport-related event, three were equipment related and three were other types of events. For more information, see the Ministry of Health website.

Why is the number of adverse events increasing?

The number of adverse events has increased from 181 in 2006/07 to 525 in 2014/15. The latest figure is a 16 percent annual increase in SAEs, up from 454 in 2013/14.

The increase most likely is a result of the health sector's commitment to reporting, and the improved systems they have developed. The falls analysis and comparison with the National Minimum Data Set shows all falls resulting in a fracture are now being reported, and in addition other falls with injuries are now being captured. This shows a greater transparency and commitment to reporting events.

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

No. In 2012/13, the Commission released a separate report on serious incidents affecting people who used mental health and addiction services. Most of these were cases of suspected suicide.

The Commission collaborates with the Director of Mental Health to publish adverse events involving people using DHB mental health and addiction services. These events will be included in the Director of Mental Health's annual report rather than in a separate report by the Commission.

How accurate is the adverse events data?

The Commission believes the number of reported adverse events is an increasingly accurate picture of the actual number of adverse events that take place. For example, the number of broken hips in hospital reported by DHBs in this report is almost identical to the number of broken hips reported in the National Minimum Data Set, which records information produced by public hospitals when a patient is discharged.

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

It is difficult to gather accurate 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.

Is it possible to say exactly how many people died in 2014/15 as a direct result of an adverse event?

Of the 525 adverse events reported, 73 people died (13 percent). However, these deaths were not necessarily a result of the adverse event.

Is adverse events reporting voluntary?

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

Members of the New Zealand Private Surgical Hospitals Association began routinely reporting data on adverse events to the Commission in 2013/14. The Association's 25 members are responsible for 35 hospitals and treat about 163,311 patients each year, carrying out half of all elective surgery in New Zealand.

How safe is our health care system?

The standard of health care in New Zealand is generally high, 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 life-changing harm or has died in the care of the health system. Patients harmed by health care can expect their case to be reviewed to find out what happened and what can be done to prevent the same thing from happening to someone else.

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

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

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

They are. 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 incidents 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?

When patients are injured by the health and disability system, patients and their families want to know what happened, how it happened, and how it can be prevented from happening again.

Reportable adverse events are uncommon, and while clinical units may have experience in investigating, some newer staff may not have ready access to experts who can help or have experience in these investigations.

To address this issue, the Commission offers adverse event review training to clinicians and quality managers in DHBs and other health organisations. This training is expected to improve the quality of reviews and increase the pool of expert staff available.

What action 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 now produces regular Open Books, which help organisations learn from adverse events. The Open Books are easy to share, read and implement if the provider feels the strategy will work for them.

In addition, the Commission is leading a national patient safety campaign, *Open for better care*, which was launched in May 2013 and is being implemented by DHBs and private health care providers around New Zealand. The campaign focuses on reducing harm from falls, infections, surgery and medication and on clinical leadership for health, quality and safety.

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

In the coming year, the Commission will place greater emphasis on responding to reports of serious adverse events and looking at changes which can prevent them from happening again. We will continue to share the lessons learned from SAE reviews with the health and disability sector.

What are individual DHB figures?

This table shows events reported annually by DHBs since 2006-07. 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	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014-15
Northland	6	5	7	4	4	10	9	15	18
Waitemata	22	11	20	17	29	29	50	51	53
Auckland	26	30	31	32	54	62	67	82	96
Counties Manukau	7	23	29	38	35	24	45	47	69
Waikato	24	36	60	52	51	26	36	39	52
Bay of Plenty	1	5	5	13	14	10	12	9	13
Lakes	1	6	3	7	4	7	17	9	9
Tairawhiti	1	3	7	3	5	5	4	2	2
Taranaki	5	7	2	7	3	18	5	6	18
Whanganui	3	4	7	9	9	4	5	12	9
Hawke’s Bay	12	7	5	9	7	11	11	10	11
MidCentral	4	2	8	18	22	15	20	19	20
Hutt Valley	2	7	10	10	4	10	11	8	7
Wairarapa	1	2	2	4	2	4	4	7	9
Capital & Coast	14	16	22	18	16	19	21	22	27
Nelson Marlborough	7	5	6	1	8	6	9	8	11
West Coast	5	11	2	4	4	4	11	13	5
Canterbury	22	41	44	69	49	49	47	55	59
South Canterbury	3	12	7	9	10	17	17	6	5
Otago	3	7	20	39					
Southland	13	18	11	9					
Southern					40	30	36	34	32