Learning from Adverse Events
Adverse Events Reported to the Health Quality & Safety Commission
1 July 2015 to 30 June 2016

Embargoed to 12 noon, Thursday 10 November 2016

What is an adverse event?

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

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 a serious adverse event.

The Commission views every adverse event as a tragedy. It is important to remember at the heart of these numbers is a real person, with a family/whānau which has been impacted by the event, as well as their friends, colleagues and the health team responsible for their care.

How many adverse events were there?

In 2015–16:

- 520 adverse events were reported to the Commission by DHBs (525 in 2014–15) and 154 by other providers
- clinical management events were the most frequently reported, with 245 incidents (47 percent), including those relating to delays in treatment, assessment, diagnosis, observation and monitoring (including patient deterioration). Ophthalmology events fall into this category.
- serious harm from falls events were the next most reported, with 237 incidents (46 percent). Of these, 86 resulted in the patient suffering a broken hip
- medication-related events were the third most reported, with 21 incidents (4 percent).

Other providers (excluding private surgical hospitals and ambulance services) reported 5 serious adverse events to the Commission in 2015/16:

- Aged residential care: two reports relating to serious harm from falls.
- Primary health organisations: two events, relating to medication.
- Hospice: One event relating to serious harm from a fall.

From 1 July 2015 to 30 March 2016, ambulance services reported 101 serious adverse events. For more information, see the Ministry of Health website. Private surgical hospitals reported 48 adverse events.

[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/.

Is this year's decrease in adverse events related to reporting or is it an 'actual' decrease?

The decrease appears to be related to the decrease in reported falls resulting in serious injury. Falls adverse events data has been compared with the National Minimum Data Set (NMDS) and the decrease aligns. There has been an increase in reporting clinical management adverse events, which shows there is still commitment to reporting. The adverse events reported increasingly reflect the evolving maturity of organisations to include broader types of events and to recognise the systemic influences contributing to their occurrence.

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 2015 -2016 report explains the process for adverse event reporting to provide clarity and context to the numbers reported. The Commission believes in some categories the number of reported adverse events is an increasingly accurate picture of the actual number of adverse events that occur. 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 NMDS, 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 2015/16 as a direct result of an adverse event?

Of the 520 adverse events reported by DHBs, 72 people died (13.8 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 2014/15. The Association's 26

members are responsible for 39 hospitals and treat about 164,000 patients each year, carrying out around 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. In 2015 – 2016 there were just over a million in-patient episodes in New Zealand public hospitals and most people were 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 reduce the risk of the same thing happening to someone else.

Which DHBs have the longest waiting lists?

The Commission's Adverse Event Learning Programme guides the local implementation of the National Reportable Events Policy in District Health Boards (DHBs) and other voluntarily participating non-DHB providers.

The Commission receives notifications of serious adverse events from providers based on their implementation of the policy and also receives the outcome of reviews of these events.

As such, the Commission can only comment on adverse event notifications we receive, and do not have information regarding waiting list numbers.

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.

Adverse events are rarely the result of incompetence or malice.

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, improve recommendations 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.

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

The Adverse Events Learning Programme is currently reviewing the National Reportable Event Policy and the future direction of the programme. Proposed policy changes and associated documents are linked within the report for sector feedback. We will continue to share the lessons learned from AE reviews with the health and disability sector.

What are the 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	2015-16
Northland	6	5	7	4	4	10	9	15	18	17
Waitemata	22	11	20	17	29	29	50	51	53	42
Auckland	26	30	31	32	54	62	67	82	96	80
Counties Manukau	7	23	29	38	35	24	45	47	69	58
Waikato	24	36	60	52	51	26	36	39	52	41
Bay of Plenty	1	5	5	13	14	10	12	9	13	9
Lakes	1	6	3	7	4	7	17	9	9	11
Tairawhiti	1	3	7	3	5	5	4	2	2	8
Taranaki	5	7	2	7	3	18	5	6	18	7
Whanganui	3	4	7	9	9	4	5	12	9	17
Hawke’s Bay	12	7	5	9	7	11	11	10	11	13

MidCentral	4	2	8	18	22	15	20	19	20	17
Hutt Valley	2	7	10	10	4	10	11	8	7	7
Wairarapa	1	2	2	4	2	4	4	7	9	3
Capital & Coast	14	16	22	18	16	19	21	22	27	24
Nelson Marlborough	7	5	6	1	8	6	9	8	11	41
West Coast	5	11	2	4	4	4	11	13	5	8
Canterbury	22	41	44	69	49	49	47	55	59	43
South Canterbury	3	12	7	9	10	17	17	6	5	12
Otago	3	7	20	39						
Southland	13	18	11	9						
Southern					40	30	36	34	32	62