National summary of adverse events reported to the Health Quality & Safety Commission

1 July 2019 to 30 June 2020

Contents

Introduction

The impact of COVID-19 in 2020 has resulted in an extremely challenging environment for all those who work in the health and disability sector.

Despite these challenges it remains paramount that we continue to focus on the quality and safety of care we deliver to New Zealanders. At the same time, we must also support the many thousands of health and disability workers in our system who have tirelessly worked during such an extraordinary time in our history.

Overall, in the last year we have seen an increase in reporting of adverse events to the Health Quality & Safety Commission (the Commission). This demonstrates an open culture of reporting and a willingness to focus on systems learnings, to reduce preventable harm.

This past year we completed our research, *Ngā Taero a Kupe: Ngā wheako pānga kino ki ngā whānau Māori i rō hōhipera I Whānau Māori experiences of in-hospital adverse events*.[1] The research highlighted the importance of what whānau Māori consider as adverse events and the importance of culturally safe services.

Every adverse event described in this document has a consumer and their whānau at its centre. It is our duty to continually strive to improve how we manage and learn from these events, and how we communicate with and support all those who have been affected.

I would like to acknowledge all those who were harmed by the events reported here and the significant impact this has had on you and your whānau.

I would also like to thank those organisations that have reported these adverse events and their ongoing commitment to learning from events and taking measures to reduce the risk of preventable harm reoccurring.

- Dr Dale Bramley, board chair, Health Quality & Safety Commission

1 Health Quality & Safety Commisson. 2020. *Ngā Taero a Kupe: Ngā wheako pānga kino ki ngā whānau Māori i rō hōhipera I Whānau Māori experiences of in-hospital adverse events.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/4046.

National adverse events 2019/20 summary

Definition of an adverse event

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 harm or has the potential to result in harm to a consumer.

The fundamental role of an adverse events reporting system is to enhance consumer safety by learning from adverse events and near misses that occur in health and disability services.

The National Adverse Event Reporting Policy 2017 helps providers build and maintain a robust reporting, review and learning system within their organisations. Six principles underpin this policy:

- culturally appropriate review practice
- system change
- open communication
- consumer participation
- accountability
- reporting must be safe.

Note: All health and disability providers obliged to comply with the National Adverse Events Reporting Policy 2017, report SAC 1 and 2 events and Always Report and Review events to the Health Quality & Safety Commission annually.

Culturally appropriate review practice

Ngā Taero a Kupe: Ngā wheako pānga kino ki ngā whānau Māori i rō hōhipera | Whānau Māori experiences of adverse events 2019

It is commonly known that Māori, who make up 19.1 percent of the total population of Aotearoa New Zealand (source: Statistics New Zealand 2019), experience the poorest health outcomes across the population. To understand and support much-needed change to improve Māori health outcomes within the health care system, the Commission completed the *Ngā Taero a Kupē* research project, which investigated whānau Māori experiences of in-hospital adverse events. It focused mainly on whānau Māori views and how their experience was managed. The Commission believes that understanding whānau Māori experiences of adverse events will drive focused system improvements.

Five major themes and two sub-themes were identified from comments collected from a group of whānau Māori – these are illustrated below.

Culture was not included or considered at any point of their care.

a. Unconscious bias – another sub-theme that is included because whānau believed being Māori affected the care they received.

Whānau were not updated or informed about what was going on with their care.

a. Am I being heard? – a sub-theme of communication issues; whānau believed that, when voicing concerns, these were unheard.

Whānau considered the care they received was inadequate.

This is a major theme that adds value and insight into elements of change that may improve the safety and quality of care provided to whānau.

Whānau views were strong about a general lack of respect, including a real lack of empathy.

Building a more integrated picture of quality and safety within organisations

Over the past few years, we have received feedback from internal and external stakeholders that the *Learning from adverse events* annual report over-emphasises the number of adverse events and under-emphasises the lessons learnt, and improvements made, as a result of adverse event reviews.

Supported by the recent introduction of an online portal for providers to submit adverse event data, we can now move to quarterly reporting of adverse event data. This new system increases the transparency of data presented for both the Commission and providers and will lead to simpler and faster data reconciliation. Moving to quarterly reporting gives us the ability to integrate adverse event reporting with the Commission's other quality and safety reporting. This will allow for a more integrated picture of quality and safety within organisations.

Systems learning and communication

Our National Adverse Event Reporting Policy 2017 enables providers to choose a review methodology, rather than specifying one review methodology. The Commission supports the learning review methodology for the health care setting. Learning reviews uncover how the system might have contributed to errors and, more importantly, how the system can be improved to reduce the impact of those errors. The recommendations are focused on improving the whole 'system' (the way work is done in health) rather than on individuals. Learning reviews have been incorporated into the adverse event education programme.

The principles of restorative practice have also been incorporated into the adverse event education programme. Restorative practice takes a proactive approach, focusing on relationships and people's needs, and ensuring all parties can communicate differences and concerns in a safe and respectful way when adverse events happen. In such situations, people want the harm to be acknowledged and repaired, in order to restore their personal wellbeing and their trust in health care providers. Restorative approaches are particularly well suited to Aotearoa New Zealand because they resonate with tikanga Māori approaches.

Stakeholder collaboration

We continue to collaborate with key stakeholders to continually improve our combined approach of reducing preventable harm and improving consumer experience. We have actively supported the Accident Compensation Corporation (ACC) with their district health board (DHB) workshops focused in improving the adverse event review and risk of harm process. We are also collaborating with the Diana Unwin Chair of Restorative Justice at Victoria University Wellington, Health and Disability Commissioner, Ministry of Health and WorkSafe on how best to help the health and disability sector understand restorative practice.

Adverse events reported in 2019/20, by World Health Organization (WHO) category

(See: Supplementary detail: World Health Organization (WHO) codes category definition)

627 were reported **by DHBs**

Of these:

218 were reported from the **mental health and addiction sector** (DHBs only)

113 were reported **by members of the NZPSHA**

8 were reported **by ambulance services**

3 were reported from the **primary care sector**

2 were reported from the **aged care sector**

2 were reported from a **hospice**

2 were reported **by other providers**

355 were **clinical management events**

- Pressure injuries **112**
- Delayed diagnosis or treatment **73**
- Deterioration **55**
- Complication **52**
- Adverse outcome **38**
- Wrong consumer/site/side **18**
- Treatment **3**
- Retained item **2**
- Assessment and diagnosis **1**
- Clinical process **1**

Event numbers may have changed since the annual data was finalised for publication.

231 were **harm because of falls**

20 were related to **medication or IV fluid**

13 were **healthcare associated infections**

4 were **consumer accidents**

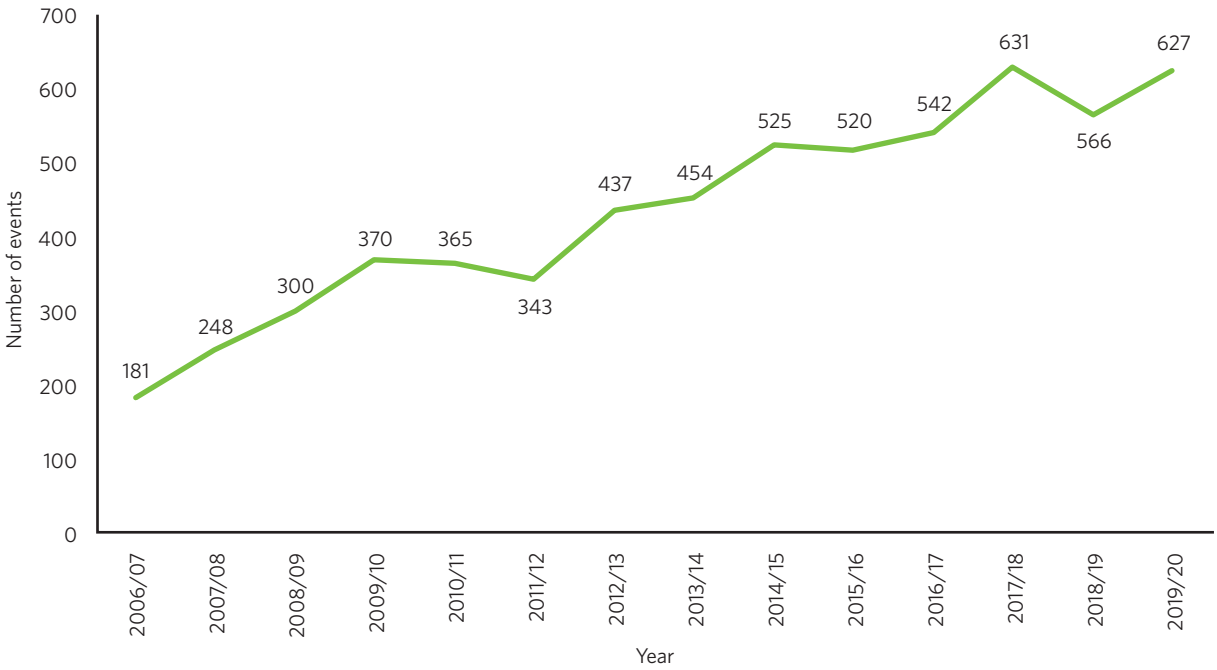
3 were related to **medical device/equipment**

1 was related to **oxygen/gas vapour**

For the purposes of this summary, DHB adverse events are hospital events.

WHO categories 01, 02 and 14 (page 16) are combined to make up clinical management events. Page 12, Table 2 of the 2018/19 report categorises these events in more detail. See: www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3889.

Reported DHB adverse events (non-mental health), 2006/07–2019/20



The total number of adverse events reported to the Commission in 2019/20 was 975 (916 in 2018/19). We have seen an increase in overall reporting, which demonstrates an open culture of reporting and a willingness to focus on systems learnings to reduce preventable harm. Adverse event reporting is not a reliable way of demonstrating change; rather, the point is to learn from events and identify opportunities for improvement.

It is important to note that the adverse events reported to the Commission only capture events where the consumer has suffered serious harm. We are also actively encouraging providers of health and disability services in our education programme to have good processes in place to understand near misses ('good catch'), where harm has not occurred, or mild to moderate harm, to try to prevent more serious harm.

DHB adverse events numbers are correct at the time of data analysis for each year's 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.

Key findings

Within the timeframe to complete this national summary, we have identified some key findings from some of the 627 adverse events reported by DHBs, described below. We will be able to do further analysis after this financial year (2020/21), as part of the annual in-depth thematic analyses of areas of concern and learnings.

- **Pressure injuries** – following extensive testing at four DHBs, the Commission started a robust pressure injury measurement and quality safety marker (QSM) for pressure injury prevention and management activities in July 2018. It is likely that this has increased the focus on pressure injuries and reporting of these within DHB hospital services (70 reported in 2018/19 and an increase with 112 this year). The Commission severity assessment code (SAC) examples guide includes pressure injuries (PIs) stage 3, 4 and unstageable as SAC 2 events from 2017. In addition, ACC has been working closely with DHBs as the lead in the development of guiding principles for the prevention and management of pressure injuries; it is anticipated that this increased awareness has also impacted on the increase in reporting.
- **Delayed diagnosis or treatment** – the number of reported adverse events from delayed diagnosis or treatment reduced from 79 in 2018/19 to 73 in 2019/20. We have seen a continued decrease in ophthalmology events, with five reported for 2019/20 compared with 16 in 2018/19.
- **Deterioration** – we are seeing a continued reduction in serious harm events related to clinical deterioration, from 64 events in 2018/19 to 55 in 2019/20. This demonstrates the impact of DHBs now using an early warning score. The national adult vital signs chart enables clinical deterioration to be recognised and acted upon earlier.
- **Complications** – following the introduction of the maternity Severity Assessment Code (SAC) examples in 2019, there has been an increase in reported numbers from the maternity sector (six maternity events out of a total of 29 events in 2018/19 and 27 events out of a total of 52 in 2019/20).
- **Falls** – there has been a reduction in the number of falls reported, from 255 in 2018/19 to 231 in 2019/20. These numbers relate to non-Māori who are 75 years or over. We have seen a further reduction in neck of femur or hip fracture (98 reported events in 2018/19 and 87 in 2019/20).
- **Healthcare associated infections** – the number of reported adverse events from healthcare associated infections reduced from 18 in 2018/19 to 13 in 2019/20; seven of these related to surgical procedures. Surgical site infections (SSIs) are strongly associated with increased morbidity and mortality, extended hospital stays and long-term antibiotic treatment. SSIs are also a leading reason for ACC treatment injury claims.

Where Commission work programmes are well established, such as falls or surgical site infections, we see a reduction in reports of serious harm. Where there is a recent increased focus, such as the introduction of the pressure injury measurement QSM, we see an initial increase in serious harm reporting. The scale of harm becomes clearer once these become a priority, as awareness of pressure injury management and consequences increases.

This demonstrates a culture of transparency and a willingness to focus on systems learnings to reduce preventable harm. However there is the potential that, through our current reporting focus, we see improvements only where specific efforts are targeted. We will work with the sector to

support a more proactive approach with early identification of quality and safety concerns. This is an area that we have highlighted in our Statement of Intent 2020–24 with a focus on strengthening systems for quality services.

Mental health and addiction adverse events (DHBs only)

The number of reported events from mental health and addiction services has reduced from 232 in 2018/19 to 218 in 2019/20. The reduction in the adverse event community suicides is welcome but it is too early to say whether this is a trend. We do not know enough to understand the full impact of COVID-19 on suspected suicides. It is also important to note that suicide is not influenced or caused by one factor but results from a complex interaction between multiple risk factors.

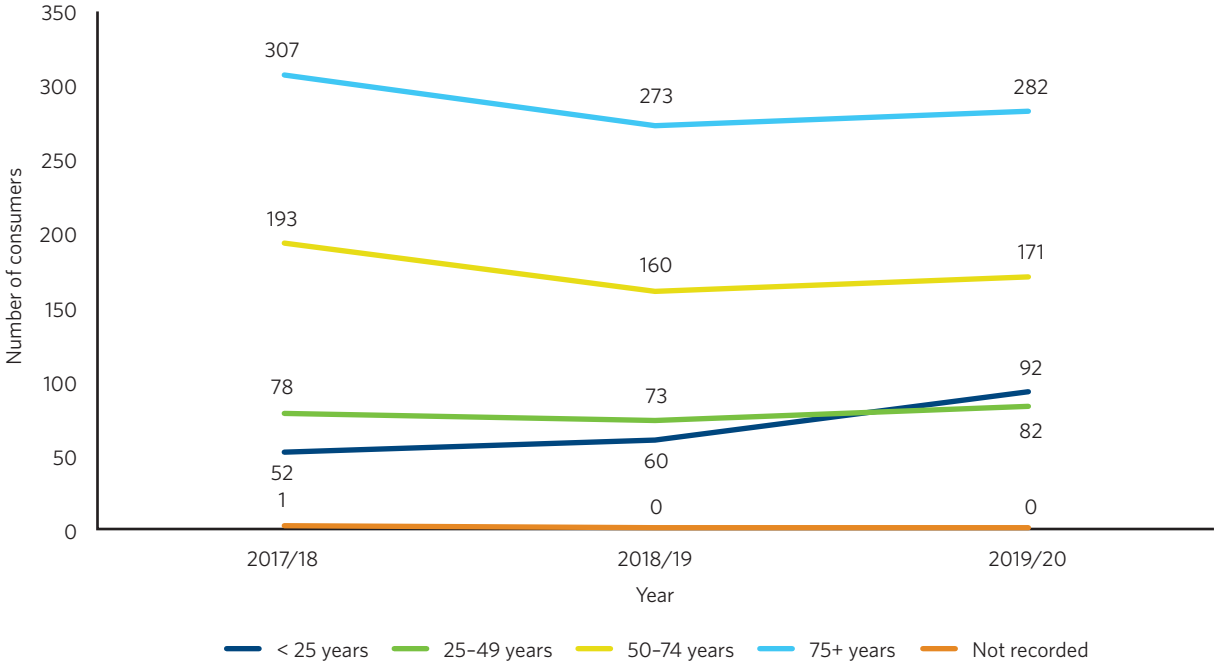
Mental health and addiction adverse events, 2011/12–2019/20

Type of mental health and addiction adverse event	Community	Inpatient unit	Total
Suspected suicide events	169	11	180
Serious self-harm	14	12	26
Serious adverse behaviour	7	5	12
Total	**190**	**28**	**218**

Age range of consumers experiencing SAC 1 and 2 adverse events (DHBs only)

There has been an increase in the number of events experienced by the under-25 age group. The gender of those who suffered harm is split evenly: female 54 percent, male 46 percent.

Age range of consumers experiencing SAC 1 and 2 adverse events reported by DHBs, 2017/18–2019/20



Ethnicity of consumers experiencing SAC 1 and 2 adverse events (DHBs only)

From the 2017/18 financial year we started collecting ethnicity data on the adverse event brief Part A form. We have seen a gradual increase in reporting of serious harm events in the European category over the last three years, and in the last year an increase for Māori and Pacific peoples from 2018/19. We want to influence and inform the use of ethnicity data to better understand impacts for different populations.

DHB clinical management events from 2018/19–2019/20 shows that there has been a sharp increase in the reporting of WHO Code 01 and 02 adverse events involving Māori consumers. In the breakdown of these clinical management events, the category of complications has shown the majority to be maternity-related events. This may reflect the overall increased reporting of maternity events following the introduction of the maternity SAC examples guide.

The planned thematic analysis of Māori experiences in 2021 will help us understand the reasons for this increase.

Several of the Commission's programmes have a particular focus on improved consumer-clinician communications and shared decision-making. These programmes help build the confidence of consumers and whānau to engage with the health system and raise concerns when they arise; potentially improving safety and reducing avoidable harm.

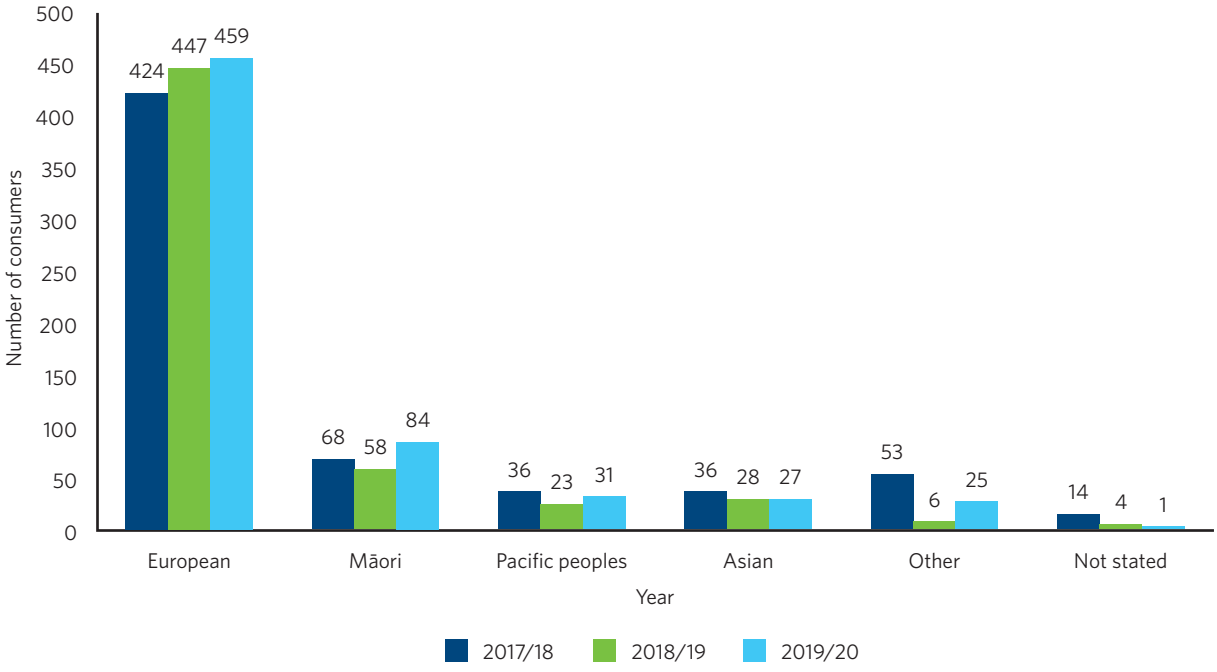
For example: Kōrero mai encourages patients, families and whānau to speak up if they recognise subtle signs of patient deterioration, even when vital signs are normal. The aim is to identify and address patient deterioration earlier.

The process of advance care planning encourages consumers to have a voice and direct their care. It supports them to capture what matters most to them (goals, values, concerns and care preferences) so they can direct the care and treatment that is offered now and in the future. For example, the Serious Illness Conversation Guide is a tool that supports clinicians to have conversations with seriously ill people and their whānau about what is most important to them if time were limited and/or their functional abilities were to change. The advance care plan and the shared goals of care form also help capture what matters most to people, and their future treatment choices.

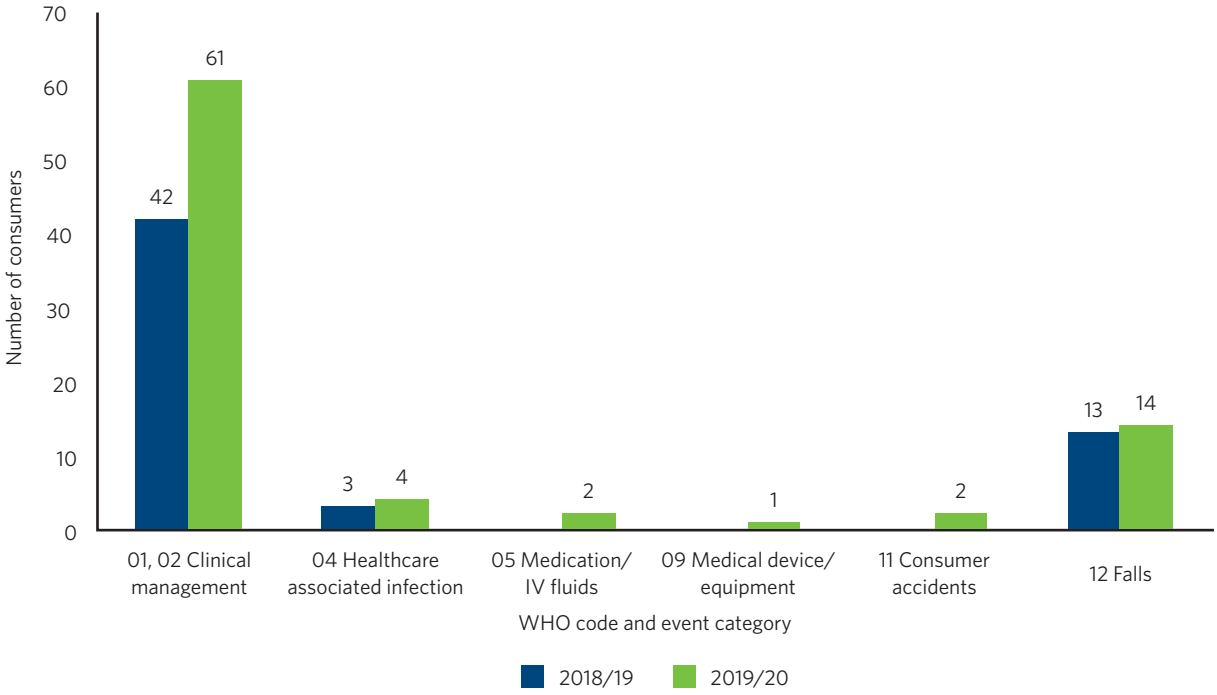
Choosing Wisely encourages consumers and clinicians to have well-informed conversations around their treatment options, leading to better decisions and outcomes. This includes which tests, treatments and procedures are really necessary, and which may add little value.

We recognise more work needs to be done to raise awareness of consumers to enable them to engage safely with the health system.

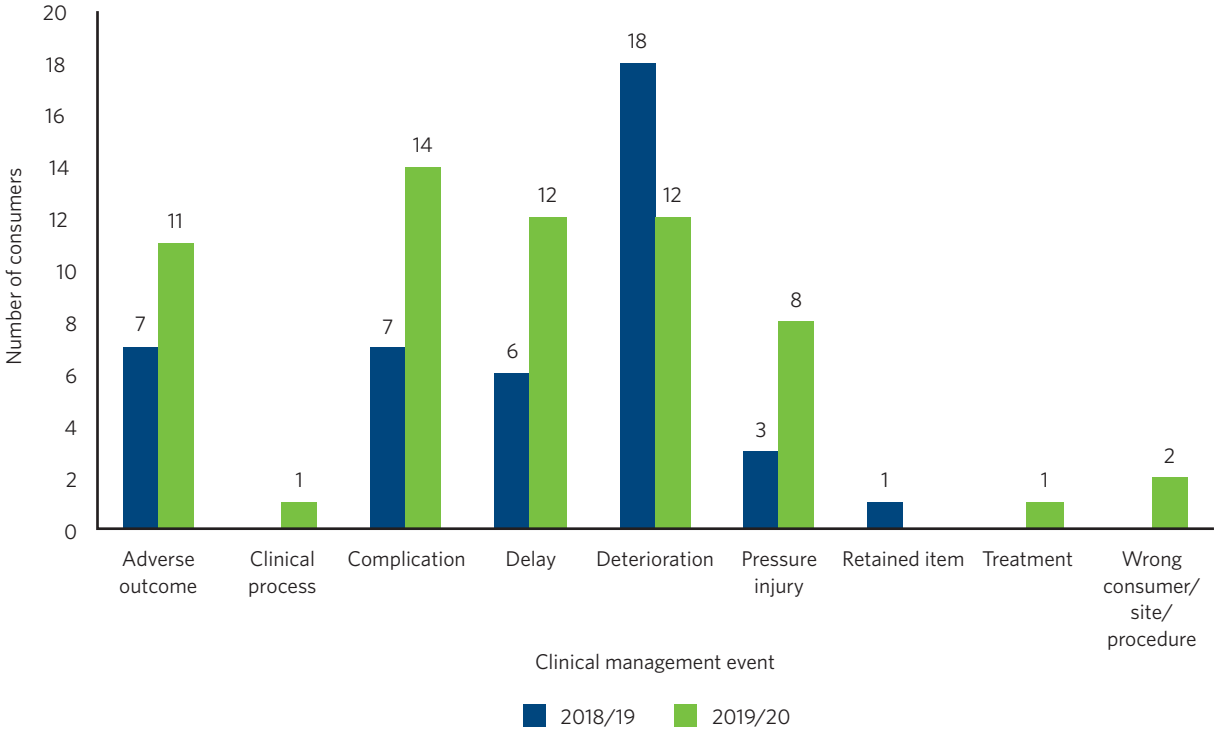
Ethnicity of consumers experiencing SAC 1 and 2 adverse events reported by DHBs, 2017/18–2019/20



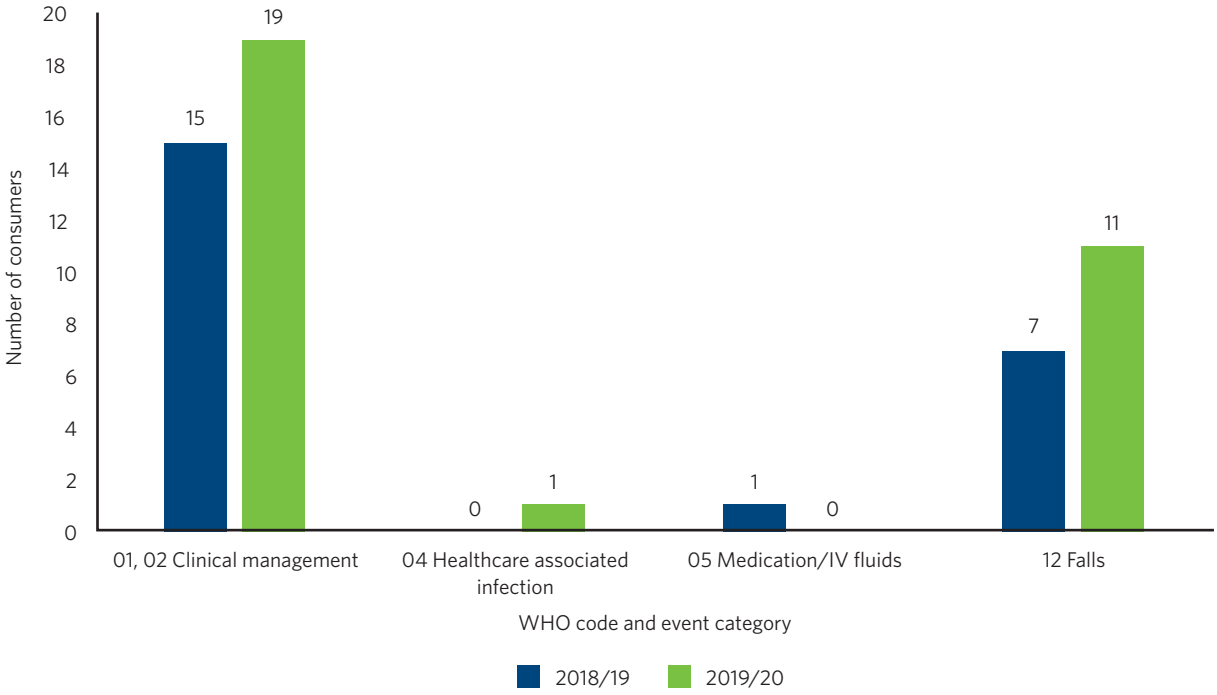
Reported DHB adverse events involving Māori consumers, 2018/19–2019/20



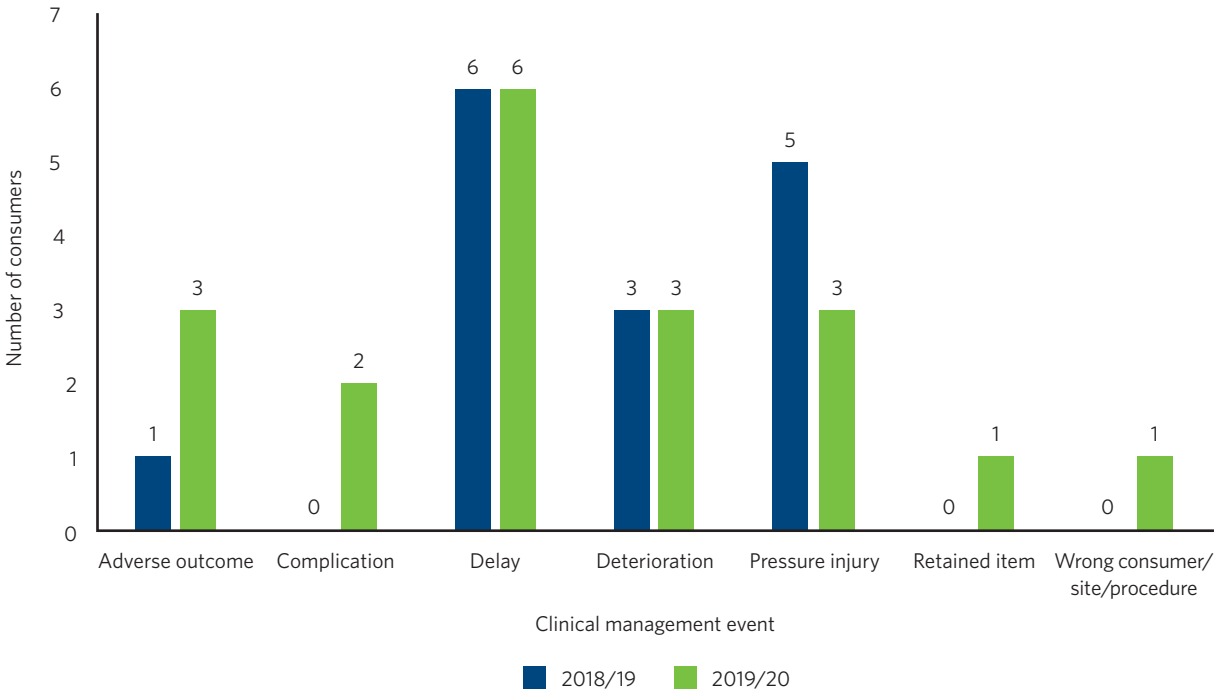
Reported DHB clinical management events involving Māori consumers, 2018/19–2019/20



Reported DHB adverse events involving Pacific consumers, 2018/19–2019/20



Reported DHB clinical management events involving Pacific consumers, 2018/19–2019/20



Always Report and Review (ARR) events

Following consultation with stakeholders the 2017 national reportable events policy (the policy) introduced ARR events. These are a subset of adverse events that should be reported and reviewed no matter whether they led to harm for the consumer or not. These events can result in serious harm or death but are preventable with strong clinical and organisational systems in place.

ARRs were first reported in the 2017/18 year as the sector transitioned to the new policy with 84 events submitted. When the policy came into full effect we saw an increase in ARR events reported with a total of 114 events reported in 2018/19; the largest category being wrong site/wrong consumer. This year we have received 115 ARRs. As with other AE reports the notifications are received in two stages. Organisations notify the Commission of an event using the Adverse Event Brief Part A. The Part A contains information regarding the organisation's initial understanding of the event with a provisional initial SAC rating. Following an event analysis, organisations provide the Commission with a Part B, which contains a review of the event findings and recommendations and a final severity rating.

Due to late reconciliation because of impact of COVID-19, 8 part Bs for the 20 SAC 2 ARR events have been received to date. Initial review of these events show they have occurred in inpatient and outpatient settings.

Six of these events were reported by surgical specialties with nine from radiology settings. The Commission will complete a thematic analysis on these events.

Always Report and Review adverse events	SAC 1		SAC 2		SAC 3		SAC 4		Total	
	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19
Retained item	0	0	2	9	4	10	5	12	11	31
Wrong blood component	0	0	1	0	0	0	2	1	3	1
Wrong consumer	0	0	4	1	4	5	36	34	44	40
Wrong procedure	0	0	0	0	0	1	0	2	0	3
Wrong implant/ device	0	0	0	1	0	1	1	0	1	2
Wrong site	0	0	13	2	9	6	34	29	56	37
Total	**0**	**0**	**20**	**13**	**17**	**23**	**78**	**78**	**115**	**114**

Ongoing quality improvement actions 2020/21

Improving cultural safety

Over the 2020/21 year, the Commission aims to improve the transparency of preventable harm for Māori. We will work in partnership with Māori to develop guidance for the health and disability sector on managing adverse events in culturally appropriate ways and embed the articles of Te Tiriti o Waitangi in the National Adverse Events Reporting Policy 2017.

Education and training for providers across the health and disability sector

We want to continue our work in supporting the wider health and disability sector (aged residential care, primary care and intellectual disability) on applying the National Adverse Events Reporting Policy 2017. Through the development of a virtual adverse events education programme, we will aim to improve access for all health and disability providers across the sector.

Resilient health care

Resilient health care represents a move towards thinking about our health care provision as a complex, adaptive system based on relationships. This means it has more in common with a te ao Māori worldview. We will work in partnership with Māori to define what this means for future systems thinking with the health and disability sector.

Restorative practice

The Diana Unwin Chair in Restorative Justice, in partnership with the Commission and ACC, will help to 'socialise' the concept of restorative practice by creating socialisation of a restorative practice video. This video will support the health and disability sector in understanding what is meant by restorative practice both generally and in the context of mental health.

Please note: Due to COVID-19 pressures on the health and disability sector, the Commission delayed reconciliation of 2019/20 adverse events data. As a result, we were unable to include an annual summary of aggregated adverse event data at a national level for 2019/20 in the Commission's annual report. To meet our reporting obligations, this summary is being published on our website on 10 December 2020.

The Commission's 2020/21 annual report will have a national summary, with the addition of two annual in-depth thematic analyses of areas of concern and learnings from that financial year; one will be focused on Māori experiences and one on the general population; focused on ARR events.

Supplementary detail: World Health Organization (WHO) codes category definitions

WHO codes category definitions – general classification of event	Event code
Clinical administration (eg, handover, referral, discharge)	01
Clinical process/procedure (eg, assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour (eg, wrong gas, wrong concentration, failure to administer)	08
Medical device/equipment	09
Behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)	10
Consumer accidents (eg, burns, wounds not caused by falls)	11
Falls	12
Infrastructure/building/fittings	13
Resources/organisation/management	14

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