Always Report and Review list 2018–19

The Always Report and Review list is a subset of adverse events that should be reported and reviewed in the same way as SAC 1 and 2 rated events, irrespective of whether or not there was harm to the consumer/patient.[1] Always Report and Review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. Reporting Always Report and Review events can highlight weaknesses in how an organisation manages fundamental safety processes.

This is the 2018–19 Always Report and Review list. It applies to all events that occur on or after 1 July 2017. Health and disability service providers should use this list in conjunction with the National Adverse Events Reporting Policy 2017.[2]

The Always Report and Review list will be updated regularly by the Health Quality & Safety Commission in consultation with the sector. To provide feedback on the list or suggest changes, contact adverse.events@hqsc.govt.nz.

Wrong blood component
Actual or near-miss transfusion of ABO incompatible red cells.
Wrong site
A procedure/intervention performed on the wrong site (eg, wrong knee, wrong eye, wrong level spinal surgery, wrong limb, wrong tooth or wrong organ); the event is detected at any time after the start of the procedure/intervention. • Includes interventions that are considered surgical but may be done outside of a surgical environment. For example, wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion (eg, peripherally inserted central catheter (PICC)/Hickman lines). • Includes events where the wrong site surgery is due to incorrect laboratory reports/results or incorrect referral letters. • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in clinical notes.
Wrong implant/prosthesis
Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the consumer/patient is other than that specified in the surgical plan; the event is detected at any time after the implant/prosthesis is placed in the consumer/patient. • Excludes where the implant/prosthesis placed in the consumer/patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure. This should be documented in clinical notes. • Excludes where the implant/prosthesis placed in the consumer/patient is intentionally planned and placed but later found to be suboptimal.
Retained foreign object post-procedure
Retention of a foreign object in a consumer/patient after a surgical/invasive procedure.

[1] See the Severity Assessment Code (SAC) rating and triage tool for adverse event reporting (www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2937).

[2] The National Adverse Events Reporting Policy 2017 is available at: www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933.

- Includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment (eg, central line placement in ward areas, procedures performed in 'rooms-based' and outpatient settings).
- Excludes items inserted during a procedure that are subject to the counting/checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date. This should be documented in clinical notes. If these items are not subsequently removed at the planned date, this would become an Always Report and Review event.
- Excludes items that are known to be missing prior to the completion of the procedure and may be within the consumer/patient (eg, screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention. This should be documented in clinical notes.

Wrong consumer/patient

Any invasive procedure/investigation performed on the wrong consumer/patient; the event is detected at any time after the start of the procedure/investigation.

- Includes radiology imaging and invasive procedures (such as biopsy, endoscopic procedures, cardiology procedures).

Child/infant abduction or discharge to wrong family/whānau

Includes all events regardless of time absent from area or successful return.