



LEARNING

FROM

ADVERSE EVENTS

Te ako i ngā pāpono kōaro

Adverse events reported to the Health Quality & Safety Commission
1 July 2017 to 30 June 2018

Ngā pāpono kōaro i pūrongorongotia ki te Kupu Taurangi Hauora o Aotearoa i te
1 o Hōngongoi 2017 ki te 30 o Pipiri 2018



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Acknowledgements | He mihi

This report was prepared by the Health Quality & Safety Commission based on information and data provided by district health boards (DHBs) and other health and disability service providers.

We acknowledge the experiences of the consumers and whānau affected by the events discussed in this report and we honour this with a commitment to learn and improve.

We are grateful to everyone who has collectively contributed to this report; particularly those who have provided expert commentary and shared their experiences and learning stories relating to adverse events reporting, review and learning.

Heather Gunter	Mother of Matt Gunter
Karyn Bousfield	West Coast DHB
Mo Neville	Waikato DHB
Paul Fake	Wellington Free Ambulance
Cheryl des Landes	St John New Zealand
Martin Carrell	Pegasus Health
Ann Rose	Te Awakairangi Health Network
Richard Whitney	New Zealand Private Surgical Hospitals Association
Acurity Health Group	
Barbara Ruby	MidCentral Health



Foreword | Kupu whakataki



Adverse events have a devastating effect on consumers and their whānau. It is vital to remember that every event described in this report has a person at its centre. Adverse events reporting makes it possible to review each event, discover the reasons behind it and put recommendations in place, with the aim of preventing anything like it from happening again. It is important that health care providers enable a just culture where staff can report patient harm, confident that the response will be to focus on learning rather than attributing blame.

This, the ninth adverse events report published by the Health Quality & Safety Commission (the Commission), summarises adverse events reported between 1 July 2017 and 30 June 2018. As in previous years, numbers have increased, reflecting the ever-increasing maturity of health providers' adverse event systems in New Zealand. It is important not to become complacent, however, as the events reported do not reflect the full amount of harm consumers have experienced.

The aim of the Commission's adverse events learning programme is to improve consumer safety by supporting organisations to report, review and learn from adverse events that occur in health and disability services. Its role is to promote a nationally consistent approach to reporting, reviewing and learning, and to share lessons learned nationally and across the health and disability sector.

This is the first time since 2013 the Commission has reported on adverse events that occurred in the mental health and addiction sector. The Commission will use this information in the mental health and addiction quality improvement programme it is running. One of the aims of the programme is to support providers to learn from and reduce serious adverse events. We will achieve this aim by providing guidelines and facilitating timely, consistent reporting and reviews. Improving consumer involvement in adverse event reviews and sharing findings are also important.

This has been the first year of reporting using the National Adverse Events Reporting Policy 2017,¹ which has a stronger focus on involving consumers and their whānau in the review process. The policy is an important evolution in adverse event management in New Zealand. Consumers can provide insights into the circumstances of an adverse event that can shed greater light on what happened and lead to a deeper analysis of underlying causes.

Adverse events reporting provides information about relatively infrequent episodes of individual harm within the health system. It is not a good way to measure the overall quality of a health system. Adverse events tend to be under-reported and providers vary in the way they classify events. Because of this, other data should be used to measure the success (or otherwise) of quality improvement initiatives. For example, quality and safety markers² are one of the measures the Commission uses to evaluate the success of quality improvement programmes and determine if practices have changed and if harm and cost have reduced. The value of adverse events reporting is that it highlights the sorts of things that are going wrong in health care and cause preventable harm. Analysing these reports can show areas in which improvements need to be made. The Commission does have to prioritise the use of its limited resources, but it has programmes or initiatives that address many of the problems identified in this report.

I would like to acknowledge all those consumers and their whānau who suffered harm from the adverse events described in this report, and the staff who reported the events, which led to the learnings set out here. Together we must continue to learn from these tragedies and work to reduce the likelihood of harm happening to others.

Professor Alan Merry ONZM FRSNZ
Chair, Health Quality & Safety Commission

¹ www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy

² www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers

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Executive summary | Whakarāpopototanga matua

This is the Health Quality & Safety Commission's (the Commission's) ninth national report on adverse events in the health sector. Each of the events discussed in this and previous reports has caused, or had the potential to cause, harm or death to a consumer or a member of their whānau. Reporting these events gives voice to those harmed and allows providers to review what happened and put in place measures to prevent consumers from suffering harm in the same way in the future.

From 1 July 2017 to 30 June 2018, health service providers reported a total of 982 adverse events to the Commission. The range of providers included district health boards (DHBs), ambulance services, private hospitals, primary care providers, aged residential care providers and the Defence Force.

The 982 reported events represent a significant increase over last year. The analysis suggests that several factors influenced this increase, including changes in reporting requirements, and the Commission's quality improvement programmes placing a spotlight on specific areas. The range of events has also expanded to include 'behavioural' adverse events reported from the mental health and addiction sector (see Chapter 3). In addition, staff have reported more events because DHBs have worked diligently to increase their ability to recognise and report adverse events. The 2017/18 year also saw the introduction of the 'always report and review' list, which has increased reporting of near misses.

Most events reported were from DHBs, in line with their positive culture of data capture, reporting and review of adverse events. The next largest group to report was members of the New Zealand Private Surgical Hospitals Association (NZPSHA) – which is similarly a reflection on their positive reporting culture, as well as indicating the large number of New Zealanders who receive health care from private surgical hospitals. As in previous years, the ambulance sector has engaged with the Commission to report events, along with other providers that reported a small number.

As noted above, this year, for the first time since 2013, we are including summarised data relating to reported mental health and addiction adverse events. This information will also be presented in the Director of Mental Health and Addiction's annual report.³ It is important to note that reporting timeframes vary between the two reports, which means that numbers of events reported will differ. Only high-level categories (suspected suicide, serious self-harm and serious adverse behaviour) are presented, and the Commission plans to work with DHBs in the upcoming year on the most effective way to present these events in the future.

Adverse events reporting 2017/18

The adverse events reported for 2017/18 are based on the National Reportable Events Policy 2012 and the National Adverse Events Reporting Policy 2017.⁴ The 2017 Policy came into effect on 1 July 2017, with providers having 2017/18 as a transition year to allow them time to update internal policies and processes to reflect the revised national policy.

³ The *Office of the Director of Mental Health and Addiction Annual Report 2017* will be published in late 2018.

⁴ www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy

Of the 982 reported adverse events:



631

were reported
by **DHBs**



232

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



91

were reported
by **members
of the
NZPSHA**



18

were reported
by **ambulance
services**



1

was reported
from the
**primary care
sector**



9

were reported
by **other
providers**

Of the 631 events reported by DHBs:



317

were **clinical
management
events**



31

were
**healthcare
associated
infections**



20

were related
to **medication
or IV fluid**



3

were due
to **medical
devices or
equipment**



5

were
**consumer
accidents**



255

were **harm
because of
falls**

Actions for improvement

To continue to improve consumer safety, and to support providers to improve their systems and processes, the Commission intends to complete the following workstreams in 2018/19.

- Release examples of severity assessment codes (SACs)⁵ specifically for maternity providers, to complement the more general examples available.
- Actively engage with the aged residential care and primary care sectors to improve reporting and management of adverse events in these areas.
- Work with the Commission's mental health and addiction quality improvement programme to learn from serious adverse events and the consumer experience.
- Conduct a survey in 2019 to establish sector capabilities and needs in adverse events and help us support the needs of health care providers.
- Begin a review to explore the impact of adverse events on whānau Māori. This information will be used to develop guidance on how to provide culturally appropriate care for Māori during and after an adverse event and during the review process.
- Review the existing adverse events training to ensure it meets sector needs.
- Deliver an adverse event master class that builds on the content of the existing two-day course.
- Develop a guide to help adverse event review teams decide which type of review methodology to use.

⁵ SACs range from 1 as the most severe to 4 as the least severe adverse event.



Introduction | Kupu arataki

In 2012 Heather Gunter lost her son Matthew as a result of complications following surgery to remove his appendix. He should not have died, and many opportunities were missed to intervene.

Karyn Bousfield is director of nursing at West Coast DHB and was part of the team that reviewed Matthew's death.

Heather and Karyn regularly present together at the Commission's adverse event review workshops, telling Matt's story. They give consumer and provider perspectives on what went wrong and what can be learned from it.

Heather Gunter: 'Matt was 15 when he developed appendicitis. I took him to the local emergency department and he had surgery that night to remove his appendix. He had complications following surgery and stopped breathing. This was managed in recovery and Matt was eventually transferred to the ward to recover, despite me raising concerns about how aggressive he was and after he coughed up pink foam. I was quite worried about him, but Matt didn't want me to stay overnight, so I went home.

'The following morning, we received a phone call to say that Matt wasn't breathing, and we rushed to be with him. Matt was being resuscitated when we arrived and after being ventilated he was transferred to Christchurch Hospital by air ambulance. They gave him a 5 percent chance of survival. After a few days Matt had an MRI, which showed his brain was not getting any oxygen. After discussion with the doctors, the heart-breaking decision was made to turn off his life support.

'I really want people to understand that adverse events aren't just about what happens there and then. Behind every event is a real person, with a real family who experience a real impact. Matt had a future, and that was taken away from him because things went wrong. I'm really clear that we can never stop harm completely - people make mistakes and systems sometimes fail - but we can reduce the risk of it happening again because, while humans make mistakes, we can definitely learn from them.'

Karyn Bousfield: 'As health care professionals, we come to work wanting to do the right thing, but no person or system is perfect all the time. What happened to Matt was a real tragedy and when something goes wrong like this, you don't hide from it - you stare it in the face. You acknowledge what's happened and do something with it. Matt's death caused us to take a step back, look at our mistakes and system errors, and learn from them.

The Commission would like to take this opportunity to formally thank Heather Gunter and Karyn Bousfield for their bravery in sharing Matthew's story and acknowledge the significant impact it is having on improving patient safety.

'It's not about blaming individuals. Everyone makes mistakes, and the ripple effect from an adverse event goes beyond family, friends and whānau - it impacts on the staff involved as well. The important thing is to learn from it. As clinicians we never stop learning and we do that by communicating with and supporting each other, and by being upfront, open and honest. We all have a responsibility to work together to improve the system.

'When Heather and I present at workshops, our hope is to support a culture where it is the norm for health professionals, those we care for, and their families and whānau to work together to prevent harm and improve health outcomes.'

David Hughes, clinical lead, adverse events learning programme: 'I showed Matthew's video at a grand round recently and a number of staff came up to me afterwards saying how deeply it had affected them. I commented that it had reminded me of times in my career where the care I had been part of providing had not gone well and that communication within teams and my ability to speak up for safety were lacking. These regrets can stay with us for years.'

Chapter 1: Learning from adverse events reported by DHBs | Wāhanga 1: Te ako i ngā pāpono kōaro kua pūrongorongotia e ngā Poari Hauora ā-Rohe

This chapter provides an overview of adverse events that DHBs have reported and describes emerging themes. It is generally based on initial notification information only, which means analysis is less detailed than it would be with information from provider reviews. Provider reviews, however, take more time to complete and share with the Commission: providers first notify us of events using the adverse event brief (AEB): part A⁶ and then provide an AEB: part B⁷ once they have completed the review of the event. The part A form contains information based on the initial understanding of the event, along with basic demographic information about the consumer involved. The part B form contains a summary of findings and recommendations, with some providers choosing to provide the full, anonymised report.

Providers vary in the timeliness and number of AEB: part Bs they provide. They reported 863 SAC 1 or 2 events to the Commission in 2017/18 (Table 1); of these, we received only 363 part Bs (42 percent) by the closing date for data reconciliation. We intend to work with providers to identify reasons contributing to this low return and support them in identifying sustainable solutions.

The numbers reported in this chapter are based on reporting requirements from the National Reportable Events Policy 2012 and National Adverse Events Reporting Policy 2017.⁸ Please note that in some categories or classifications, the numbers are small and so figures should be interpreted with caution.

Reported adverse events increased in 2017/18. DHBs reported a total of 631 SAC 1 and 2 events (excluding code 10 behaviour events), which is 16 percent more than the total number of adverse events reported in 2016/17.

The Commission believes that DHBs are improving in their ability to recognise and report adverse events. Local and international literature suggests the incidence rate for adverse events sits at approximately 10 percent.^{9,10,11} Considering that not all adverse events are SAC 1 or 2 (the threshold for reporting under the 2017 Policy), the numbers reported to the Commission in 2017/18 are well below the total that could be expected; this indicates that providers are only identifying and reporting a small percentage of adverse events that actually occur. This suggests that the increase in the number of events reported in 2017/18 is due to an increase in reporting rather than necessarily indicating more consumers are being harmed.

6 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2939

7 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2940

8 www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy

9 Davis P, Lay-Yee R, Briant R, et al. 2002. Adverse events in New Zealand public hospitals I: occurrence and impact. *New Zealand Medical Journal* 115(1167): U271.

10 Vincent C, Neale G, Woloshynowych M. 2001. Adverse events in British hospitals: preliminary retrospective record review. *British Medical Journal* 322(7285): 517-9.

11 de Vries EN, Ramrattan MA, Smorenburg SM, et al. 2008. The incidence and nature of in-hospital adverse events: a systematic review. *Quality & safety in health care* 17(3): 216-23.



Table 1: SAC 1 and 2 adverse events reported by DHBs, by World Health Organization category, 2017/18

General classification of event	Event code	DHB-reported SAC 1 and 2 adverse events 2017/18
Clinical administration	01	20
Clinical process/procedure	02	289
Documentation	03	0
Healthcare associated infection	04	31
Medication/IV fluids	05	20
Blood/blood products	06	0
Nutrition	07	0
Oxygen/gas/vapour	08	0
Medical device/equipment	09	3
Behaviour*	10	232
Consumer accidents	11	5
Falls	12	255
Infrastructure/buildings/fittings	13	0
Resources/organisation/management	14	8
Total		863

SAC = severity assessment code.

* Behavioural events are included here for completeness; for further commentary on this category of adverse events, see Chapter 3, which discusses mental health and addiction adverse events.

Health care is complex, and several underlying factors may contribute to any one adverse event. This complexity means that the principal category a provider chooses to report is subjective and may not reflect all contributing causes. For these reasons, the numbers shown in Table 1 and the commentary that follows should be considered with caution.

The adverse events in the categories with the event codes 01, 02 and 14 are combined to produce a more general category of 'clinical management events'. Clinical management events represent events that occur in, or impact on, the clinical environment.

Clinical management events were the most common event type reported, accounting for a total of 317 events. This represents 50 percent of all non-behavioural adverse events that DHBs reported to the Commission. It is only a minimal change from 2016/17, when 52 percent of all reported cases were in this category.

These events can be further classified to provide clinical context (Table 2). The more detailed classifications are dependent on the information available from providers (reported through AEB: part A and part B forms) but give a general indication of types of clinical management events that occur.

Table 2 highlights that delays (104 events), pressure injuries (84) and deterioration (50) represent the three largest sub-groups of clinical management events.

Table 2: Clinical classification of clinical management events reported by DHBs, 2017/18

Clinical management event classification	No of events	Description example (hypothetical)
Delayed diagnosis or treatment	104	Issue in referral process results in delay seeing specialist or receiving treatment
Assessment and diagnosis	2	Initial assessment did not find the key clinical issue
Resources/organisation/management	1	Insufficient clinic, equipment, staff or appointments to meet demand
Deterioration	50	Consumer deterioration not recognised or managed in expected timeframe
Complication	27	Complication of treatment or procedure (eg, stroke following surgery)
Retained item	8	Item left inside the body beyond expected time
Pressure injury	84	Pressure injury from insufficient position change/nutrition, etc
Adverse outcome	33	Unexpected, consumer death or outcome
Clinical process	0	Incomplete process during care (eg, consent, coordination of care)
Wrong consumer/site/side	7	Wrong consumer in procedure room/theatre
Monitoring	0	Inadequacy of monitoring (eg, breathing rate after morphine given)
Other	0	Security issue
Treatment	1	Allergic reaction to products used for treatment
Transfer	0	Harm related to transfer of care between services or providers
Total	317	

Only a short time was available to reconcile the data in this report with providers. As a result, much of the national learning about emerging themes is not known at the time of publication. Any learning from further analysis and discussion will be updated in later reports and through Open Book reports.¹²

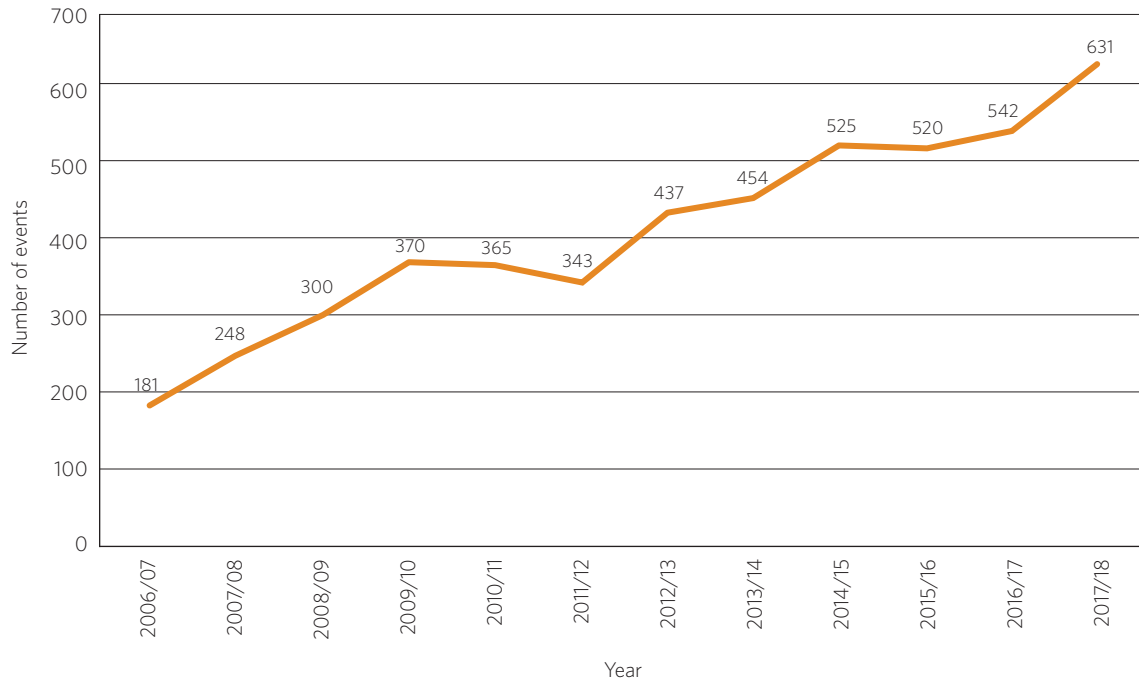
¹² www.hqsc.govt.nz/our-programmes/adverse-events/projects/open-book



Total DHB adverse events

The total number of adverse events that DHBs reported between 1 July 2017 and 30 June 2018 has increased since the previous report, consistent with the general trend since 2006/07 (Figure 1).

Figure 1: Reported DHB adverse events (excluding code 10 behaviour events), 2006/07-2017/18



Note: As this figure does not include mental health and addiction adverse event numbers, numbers before 2013 will differ from those in previous adverse events reports.

It is important to note that 83 events reported to the Commission in 2017/18 occurred in previous years. The reason for the delay was either that events did not become apparent until some time after the initial event, or that notifications from external agencies, such as the Health and Disability Commissioner, may have taken some time to reach the provider. The Commission reports events in the year they were reported to us, as a way of giving all consumers who have suffered harm a voice in this report. This number is in line with reporting from previous years and reflects the work that providers, especially DHBs, are doing to identify consumers who may have been impacted by delays in diagnosis or treatment.

Whole-of-system approach to safety

The nature of adverse events reporting is changing. This year, harm from falls is again the second-largest category of adverse events (Figure 2), with numbers at similar levels to the 2016/17 year.

However, we are seeing an increase in clinical management events, which is now our largest category of adverse event reports from the health sector.

Figure 2: DHB adverse events (non-mental health), by event type, 2017/18

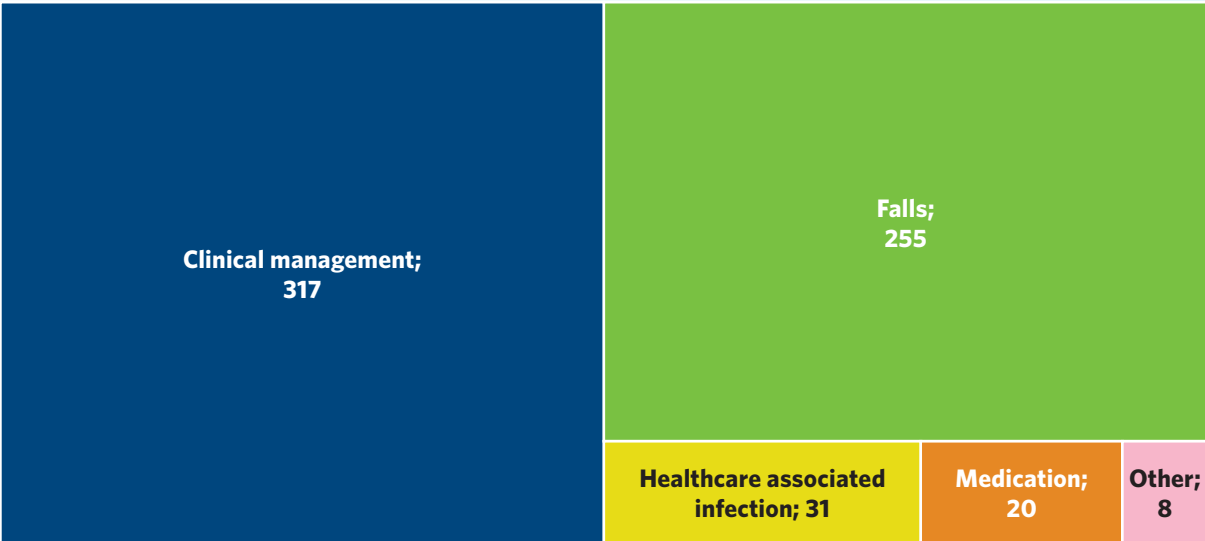


Table 2 details the range of events that fit within this broad category. Clinical management events have a combination of contributing factors. Addressing much of the harm reflected in these adverse events requires complex measures: organisations need to work across their boundaries, and national agencies need to collaborate to find system-level resolutions.

The Commission, ACC and the Ministry of Health are working together to reduce consumer harm across the health system.

Delayed diagnosis or treatment

The 2016/17 report highlighted issues with the health system related to delays in diagnosis and treatment. Following on from this, the Commission’s board requested that further work be done to better understand the extent of the problem.

The Commission facilitated a workshop, ‘Exploring the “why” of clinical delays’, in February 2018. The 50 invited participants included mortality review committee chairs; the Commission’s adverse events learning programme and other expert advisory group members; DHB leaders; consumer representatives; Ministry of Health representatives; Office of the Health and Disability Commissioner representatives; ACC representatives; and key Commission staff.

Each organisation discussed their slightly different role in the system and how this resulted in a different lens and approach to delays. Each presented their data and talked about their work. There was agreement and acknowledgment that a system-level view is required to deal with complex system problems, such as delays. Each organisation brings a part of the jigsaw puzzle, and the most useful view of the system contains all the pieces.

The Commission took up the issue of complex problems requiring system solutions in *A Window on the Quality of New Zealand’s Health Care 2018*.¹³ Published in June 2018, the Window 2018 noted:

We are now seeing issues that do not lend themselves to the sort of targeted methods and single-organisation approaches widely used in recent years. New approaches are needed, grounded in co-design with consumers, their whānau and the health workforce. (p 6)

¹³ www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3364



As well as continuing quality improvement and further strengthening a safety culture, we need to develop a whole-of-system approach to safety. That approach involves coordination of information (bringing the pieces of the puzzle together) to identify emerging and complex issues requiring a system response, and to collaborate so the response is appropriate and effective.

The Window 2018 also emphasised the collaborative nature of the response:

... no sole agency or service holds all the necessary levers to resolve an emerging issue. Regulation, performance management, quality improvement activities, leadership development or additional funding may all be appropriate responses to specific circumstances. However, each organisation has a different role in the system, and with this comes a natural tendency to see that specific role as the correct solution to any particular problem. Collaboration between agencies with different roles and perspectives makes it more likely problems will be identified early in their evolution, and effective and appropriate responses will be found in time to minimise harm to consumers. (p 50)

Learning story from Waikato DHB

'Waikato DHB has had a serious event review (SER) panel in place for a number of years, chaired by the chief medical officer with core membership made up of the chief nursing and midwifery officer and director of quality and consumer safety. During the past 12 months, we have continued to strengthen our approach to reviews within the maternity service – this has included better engagement with lead maternity carers (LMCs) and private birthing units. This has been brought about by improved working relationships and trust across the teams. The result is that we now undertake SERs with the birthing unit staff, LMCs, hospital midwives and obstetricians. Once the review is complete, the final report is presented to the DHB SER panel with LMC and birthing unit staff invited to attend and participate in the discussion and agreement of recommendations. There are a number of benefits to both staff and birthing mothers with this approach including a safer whole of system.'

Mo Neville, director of quality and patient safety, Waikato DHB

Pressure injuries

Reporting of pressure injury serious harm events has increased significantly. Ways of encouraging this reporting have included reminding staff of the harm caused by pressure injuries, providing guidance and resources on pressure injury prevention and management, and recognising and sharing the good work already happening across the sector. Another reason for the increase in reporting may have been that the Commission included pressure injuries in its guide *Severity Assessment Code (SAC) examples 2017-18*.¹⁴ This guide categorises grade 3, 4 and unstageable pressure injuries as SAC 2 events.

In 2017 the Commission developed a *Guide to preparing and implementing a pressure injury measurement programme*¹⁵ through a pilot in partnership with four DHBs. We wish to acknowledge the efforts of Waikato, Whanganui, Capital & Coast and Southern DHBs for helping to establish a robust approach to how we record in-hospital pressure injuries. Their support was invaluable. We also appreciated that DHBs shared and agreed to publishing their resources and tools.

¹⁴ www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2938

¹⁵ www.hqsc.govt.nz/our-programmes/pressure-injury-prevention/publications-and-resources/publication/3235

This work has informed the development of a suite of pressure injury quality and safety markers across the hospital sector. Data collection for these markers began on 1 July 2018.¹⁶ This process of measurement involves reviewing notes of randomly selected consumers and undertaking a skin check, with consent, to determine whether they have been assessed for the risk of developing a pressure injury, and whether a plan is in place to prevent or treat any pressure injuries found.

While all the reported events this year are from the hospital sector, the aged residential care sector has also focused strongly on pressure injury prevention and management. HealthCERT¹⁷ made this a focus topic in its 2016/17 audit programme and it continues to be a priority area in caring for this vulnerable population group.

Learning story from Waitemata DHB

In 2017 Waitemata DHB increased its focus on adverse events reporting. Because of the improvements the DHB has made, there has been an increase in the number of pressure injuries reported. This focus on reporting pressure injury adverse events shows a strong reporting culture that supports a strong learning culture – the aim being to focus on reducing preventable patient harm.

Patient deterioration

The Commission's patient deterioration programme aims to reduce harm from failures to recognise or respond to physical deterioration of adult inpatients (excluding maternity) by July 2021. The programme has three intervention workstreams that are phased over a five-year duration: recognition and response system; kōrero mai – patient, family and whānau escalation; and shared goals of care.

In 2017/18 DHBs reported 50 SAC 1 and 2 events that related to not recognising or not managing inpatient deterioration in an expected timeframe (compared with 26 in 2016/17). Because the evolution of recognition and response systems in New Zealand hospitals has occurred locally rather than nationally, there has been considerable variation in the vital sign triggers used to prompt escalation of care, models of clinical response, and organisational approaches to managing the care of deteriorating patients.

In late 2017, a Commission survey of DHB staff found that staff liked a recognition and response system because it enabled and empowered them to escalate their concerns to senior staff. The survey results indicated that being able to draw on a recognition and response system that had both a local and a national mandate helped staff address issues such as a sense of lack of support, and a fear of being blamed or reprimanded.

On a national level, during 2017/18 the patient deterioration programme supported all DHBs to prepare and implement improvements to their recognition and response systems.

Key points

The Commission has:

- published a national vital signs chart with early warning score
- supported DHBs to improve their recognition and response systems.

Sixteen DHBs have either fully or partially implemented improvements based on the Commission's improvement programme.

¹⁶ The pressure injury quality and safety markers will be first published mid-2019.

¹⁷ HealthCERT, as part of the Ministry of Health, is responsible for ensuring hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.



Staff received education and training on local escalation pathways, and a national standardised vital signs chart with early warning score was launched, along with localised clinical escalation and response processes.

By the end of June 2018, 11 DHBs had implemented these improvements across all their hospitals. An additional five had implemented the improvements at their main hospital and were preparing to implement in their other hospital(s). Four are continuing their preparations to implement improvements during the 2018/19 year.

Perinatal and maternal adverse events

The number of DHB reports of perinatal and maternal adverse events has increased to 42 events. This increase is an encouraging sign of improved reporting as, previously, reported adverse events in this area had represented only a small proportion of perinatal and maternal mortality and morbidity events reported to the Perinatal and Maternal Mortality Review Committee and the Maternal Morbidity Working Group. The Commission expects this increase in reporting to be sustained, as providers implement the maternal morbidity review toolkit.

Some current workstreams of the Maternal Morbidity Working Group are:

- developing and testing a maternal morbidity review toolkit to provide consistency in local maternal reviews
- identifying and engaging local champions who are involved in the national maternal morbidity review panels.

The adverse events learning programme will support this work by releasing examples of SACs specifically for maternal providers, to help them identify, report and review preventable harm.

Healthcare associated infections

The reporting of adverse events relating to healthcare associated infection (HCAI) has increased. The main reason for the increase is that a small number of DHBs have focused on increasing their reporting of HCAs. This same focus is not reflected across the sector, which presents the Commission with an opportunity to work with DHBs to increase reporting.

The following are current Commission programmes to reduce HCAs.

Surgical Site Infection Improvement programme

The Surgical Site Infection Improvement programme focuses on reducing surgical site infections (SSIs) following hip and knee arthroplasty and cardiac procedures through a bundle of interventions (clipping not shaving the surgical site, alcohol-based skin preparation, and administering the appropriate antibiotics in the right dose and in a timely manner). Standardised process and outcome data is recorded as quality and safety markers on all hip and knee arthroplasty and cardiac procedures funded by DHBs, which total approximately 12,500 procedures each year. The process measures focus on the correct use of surgical antimicrobial prophylaxis and use of alcohol-based skin preparation; the outcome measure is the SSI rate.

Public reporting of each DHB's performance against the quality and safety marker targets helped to align and coordinate quality improvement activities nationally. Multidisciplinary teams with strong clinical engagement from individual DHBs implemented quality improvement initiatives based on their specific opportunities and systems. The initiatives and key learnings were then shared at regional and national meetings so that Surgical Site Infection Improvement programme teams in other DHBs could also benefit. The programme has significantly improved quality and safety marker performance and most hip, knee and cardiac procedures now comply with recommended best practice.

Some DHBs have recently implemented a pre-operative bundle of interventions aimed at preventing *Staphylococcus aureus*-related SSIs. This bundle involves skin and nasal decolonisation by antimicrobial agents.

Healthcare associated-Staphylococcus aureus bacteraemia

Healthcare associated-*Staphylococcus aureus* bacteraemia (HA-SAB) data is currently the outcome marker for the Hand Hygiene New Zealand programme. In this programme, validated auditors collect and report data on hand hygiene compliance, which is one of the most important means of preventing HCAs and directly contributes to reducing consumer harm.

Peripheral intravenous catheter-related bloodstream infections

The Commission's infection prevention and control programme is starting some work on peripheral intravenous catheter-related bloodstream infections (PIVC-BSI). Although it is an informal component of the programme, many DHBs are focusing on this important topic. PIVC-BSI also overlap with HA-SAB, as some HA-SAB infections come from peripheral lines.

Preventing harm from falls

When the Commission was established in 2010, falls in hospitals accounted for the majority of reported adverse events. Due to the devastating impact of harm from falls for consumers and whānau, and the increase of reported falls events, in 2012/13 the Commission made reducing harm from in-hospital falls a high priority. This led to a national quality improvement programme in partnership with the sector to build on the good work already taking place. This programme has culminated in transitioning to falls prevention work as 'business as usual' on 30 June 2018.

The Commission will continue to provide support by reviewing the evidence and updating key resources such as the falls 10 Topics.¹⁸ It will also monitor the in-hospital quality and safety markers, update the falls Atlas of Healthcare Variation¹⁹ and support the sector to maintain a strong consumer safety focus on falls and fracture prevention in the future.

In 2017/18, 255 adverse events reported by DHBs related to harm from falls, of which 101 resulted in a neck of femur fracture (96 events) or hip fracture (5). Improved systems and processes within several providers have led to better identification and reporting, and this appears to be reflected in the number of reported falls. Although individual events have increased in 2017/18, this increase is currently within normal statistical variation. The Commission intends to monitor falls data from the adverse events system and the quality and safety markers to provide early warning if numbers increase beyond what might be expected from an improvement in reporting and systems.

Complexity and context

New Zealand has an increasingly ageing population. Many elderly people are frail and may suffer from a number of long-term medical conditions, including cognitive impairment and osteoporosis. People with osteoporosis have bones that break very easily with the impact of a fall.

¹⁸ www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-topics

¹⁹ www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/falls



Every person harmed is a loved one who has their life changed forever, dies too soon or is admitted to aged residential care earlier than expected. Maintaining a focus on falls prevention should be everyone's business and is a long-term commitment for all health care providers.

In New Zealand, we have embarked on a national approach to improve falls and fracture prevention, and rehabilitation outcomes for older people as part of the Healthy Ageing Strategy.²⁰

In the future, we would expect to see a positive impact from interventions now being promoted in the community, with their focus on improving bone health and supporting improved physical strength and balance through in-home and community-based exercise programmes.

Supporting a whole-of-system approach through the 'Live stronger for longer' movement

While the Commission's initial focus on reducing harm from falls was on consumers in the hospital setting, this has broadened to a community and whole-of-system approach, given most falls and serious harm from falls occur in the community. To meet the need in this setting, we have partnered with other central agencies including ACC, the Ministry of Health and key stakeholders.

This approach responds to the challenges of an ageing population, which includes a need to understand and identify frailty. It puts efforts into interventions where the evidence remains the strongest. It also keeps us all working across the system to keep our older population living independently and safely in their place of choice.

ACC has accelerated this effort through a significant investment in and the development of a national movement, 'Live stronger for longer'.²¹ This brings together older people, health and community providers and central funding agencies to promote the positive aspects of ageing and the value we place on older people by supporting them to live independently and well at home, free from falls and fragility fractures.



20 www.health.govt.nz/publication/healthy-ageing-strategy

21 www.livestronger.org.nz

The Commission has also worked with partners to develop a falls and fractures outcomes framework and dashboard,²² which identify five outcome domains:

1. fewer fall injuries
2. fewer serious harm falls
3. improved recovery (hospital)
4. improved recovery (home)
5. integrated care.

These domains have been selected based on research that indicates benefits for a specific at-risk population across the entire health system from primary care through secondary care and returning home again.

The framework helps to align data to key system-level measures and allows reporting back to the sector in a timely manner. The model is used to reflect an individual's experience of care that is delivered in a collaborative and coordinated way throughout their health journey.

Alliance partnerships at all levels

The Commission continues to partner with ACC, the Ministry of Health and key stakeholders in supporting the sector to work through local health system alliances, which will be vital in sustaining this whole-of-system approach to falls and fracture prevention and management. Falls and fracture prevention is indeed everyone's business.

While we acknowledge the great work happening across the sector, we encourage you all to maintain the momentum and prioritise this work both in the hospital setting and through your local alliances. This is essential to help every older individual receive the seamless care they deserve and experience improved health outcomes.

Key points

The Commission has:

- worked with partners to develop a falls and fractures outcomes framework and dashboard
- partnered with ACC, the Ministry of Health and other key stakeholders to expand the work on reducing harm from falls to a community and whole-of-system approach.

Always report and review events

Following consultation with the sector, the 2017 Policy introduced always report and review events.²³ These are a subset of adverse events that should be reported and reviewed, no matter whether they led to harm to the consumer or not. The Commission updates the always report and review list regularly in consultation with the sector. As this is the first year DHBs have reported on these events, it is difficult to identify trends, so the data is presented here with minimal commentary.

Of the 84 always report and review events reported, 36 caused minimal harm or no harm²⁴ or were near misses.²⁵ This reporting is important as being able to identify, review and learn from events where little to no harm occurred offers the opportunity to fix system errors that may cause serious harm.

²² www.livestronger.org.nz/home/resources/resources#ResourceSection-13

²³ Always report and review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems.

²⁴ A no-harm event is one where an adverse event occurs, but the consumer does not suffer any harm because of it. For example, a consumer receives a larger dose of a drug than intended but does not suffer any harm because of it.

²⁵ A near miss is an event that has potential for harm, but the event is managed before harm can occur. For example, the wrong consumer is taken for an X-ray but the error is noticed before the procedure begins so that patient is not X-rayed.



Forty-four percent of the reported events for wrong site, wrong implant/prosthesis, wrong consumer/procedure involved radiology services. This should prompt providers to consider ways to translate evidence-based processes and improve teamwork and communication to areas outside of operating theatres.

The Commission has published an Open Book on this topic: *Under the radar: Interventions or procedures performed outside operating theatre settings – wrong procedure/wrong site/wrong person.*²⁶

Retained item and wrong consumer/site/side/treatment/procedure events are part of the new always report and review list in the 2017 Policy.

Table 3 shows the always report and review events reported, broken down by the degree of harm they caused to the consumer.

Table 3: Always report and review events DHBs reported, by the degree of harm caused to the consumer, 2017/18

Always report and review event	Total	SAC 2	SAC 3	SAC 4/ near miss
Wrong blood component	3	0	1	2
Retained foreign object post-procedure	27	9	7	11
Wrong site, wrong implant/prosthesis, wrong consumer/procedure	54	10	21	23
Total	84	19	29	36

SAC = severity assessment code; 1 = most severe, 4 = least severe adverse event.

Demographic information

Demographic information provides a snapshot across a range of individuals where information has been collected about them at a particular point in time. This is the first year that the Commission has collected and reported on demographic data, and we plan to review this data further over the coming year. Of the 631 individuals for whom DHBs have recorded an adverse event in 2017/18, only one individual's age was not recorded.

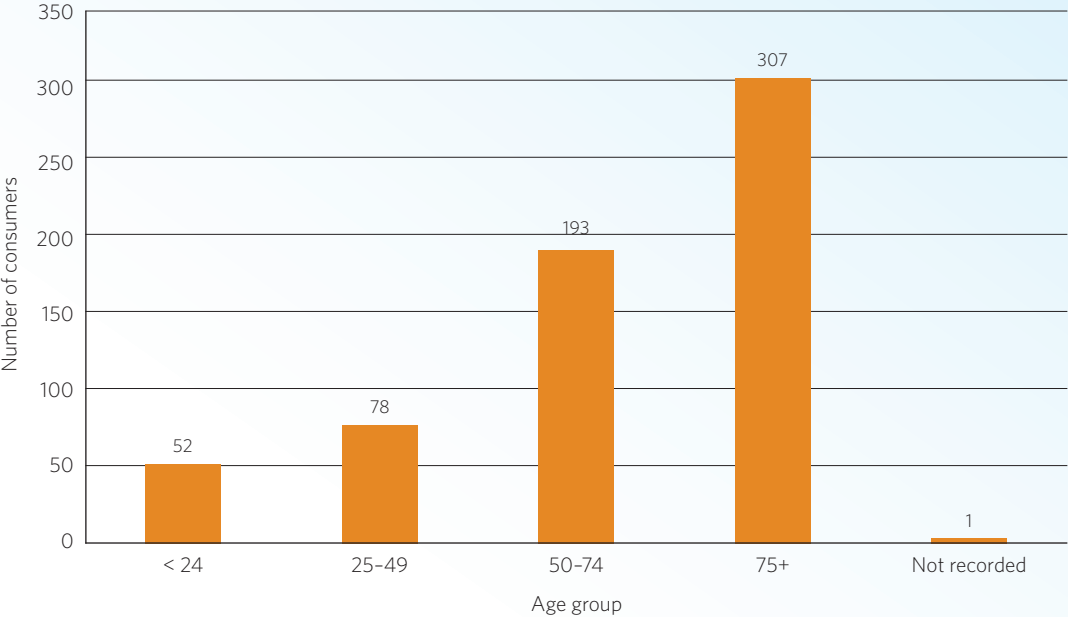
Key points

Many always report and review events involved radiology services. Providers need to have robust systems for ensuring right site, right implant/prosthesis (where applicable) and right consumer/procedure.

Most consumers who suffered adverse events in this reporting period were aged 50 years or over (a total of 500 individuals), which is approximately 79 percent of the total number of reported events (Figure 3). This age group may be reflected in the high number of events reported for falls causing serious harm.

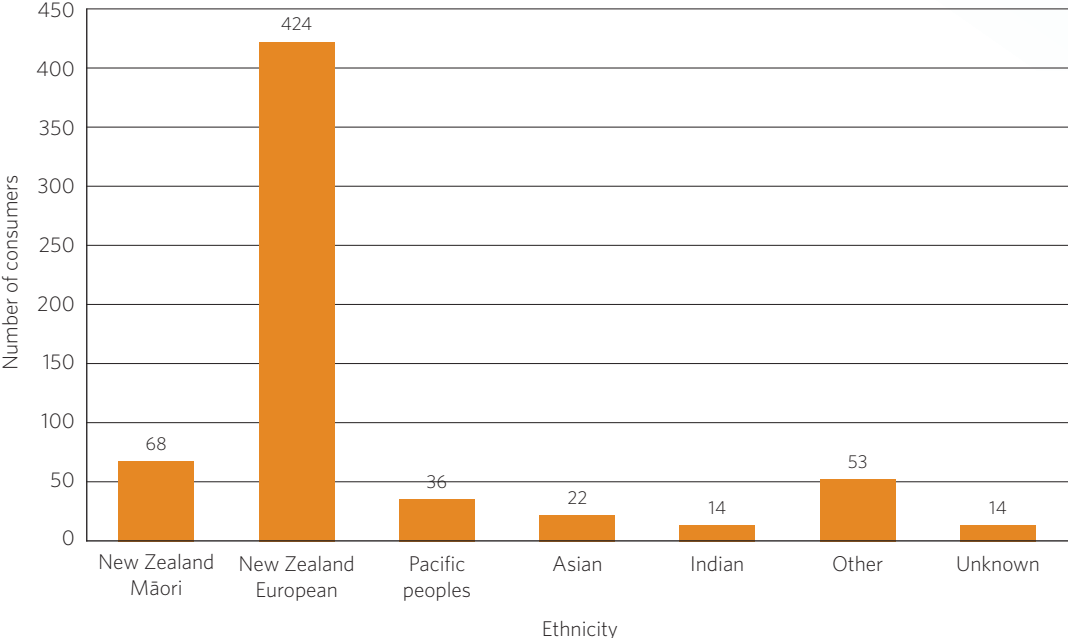
²⁶ www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3091

Figure 3: Age range of consumers suffering SAC 1 and 2 adverse events reported by DHBs, 2017/18



Most individuals were of New Zealand European ethnicity (Figure 4). The second-highest ethnicity was Māori (11 percent), with 'other'²⁷ the third-highest category. We will be working to understand this data in 2018/19 (see Chapter 4 for details on this work).

Figure 4: Ethnicity of consumers suffering SAC 1 and 2 adverse events reported by DHBs, 2017/18



27 Ethnicities are grouped as 'other' if there were two or fewer consumers reported for an ethnicity.



Chapter 2: Learning from adverse events reported by other health and disability providers | Wāhanga 2: Te ako i ngā pāpono kōaro kua pūrongorongotia e ērā atu kaiwhakarato hauora, hauā hoki

This chapter details reports received from the national ambulance sector, aged residential care, primary care and private surgical hospitals. It includes learning stories from several organisations about the work they are doing to improve adverse event management within different sectors of the health system.

The 2017 Policy is intended to be relevant to all health and disability services that use it to support consumer safety and quality improvement systems and processes. We encourage and welcome reporting from across the sector and have received reports of a total of 119 adverse events in 2017/18 from health and disability providers other than DHBs. We continue to work with ACC, the ambulance sector and members of the New Zealand Private Surgical Hospitals Association (NZPSHA) on reporting adverse events, with a common purpose of improving consumer safety.

The Commission also continues to engage with other providers, especially the primary care and aged residential care sectors, to help them to implement the 2017 Policy.

Table 4 sets out the SAC 1 and 2 adverse events reported by other health and disability providers, broken down by type of event. Table 5 focuses on clinical management events with details of the clinical classifications of events within this category.

Table 4: SAC 1 and 2 adverse events reported by other health and disability providers (excluding events from NZPSHA members),²⁸ by World Health Organization category, 2017/18

Adverse event category	Event code	Reported non-DHB SAC 1 and 2 adverse events 2017/18
Clinical administration	01	11
Clinical process/procedure	02	12
Documentation	03	0
Healthcare associated infection	04	0
Medication/IV fluids	05	1
Blood/blood products	06	0
Nutrition	07	0
Oxygen/gas/vapour	08	0
Medical device/equipment	09	0
Behaviour	10	2
Consumer accidents	11	0
Falls	12	2
Infrastructure/buildings/fittings	13	0
Resources/organisation/management	14	0
Total		28

SAC = severity assessment code.

²⁸ The NZPSHA provides a single aggregated number of events, rather than reporting individual events by category. This means they cannot be included in any analysis.

Table 5: Clinical classification of clinical management events reported by other health and disability providers, 2017/18

Clinical management event classification	No of events	Description example (hypothetical)
Delayed diagnosis or treatment	16	Issue in referral process results in delay seeing specialist
Assessment and diagnosis	1	Initial assessment did not find the key clinical issue
Resources/organisation/management	0	Insufficient clinic, equipment, staff or appointments to meet demand
Deterioration	3	Consumer deterioration not recognised or managed in expected timeframe
Complication	2	Complication of treatment or procedure (eg, stroke following surgery)
Retained item	0	Item left inside wound beyond expected time
Pressure injury	1	Pressure injury from insufficient position change or nutrition, etc
Adverse outcome	0	Unexpected consumer death or outcome
Clinical process	0	Incomplete process during care (eg, consent, coordination of care)
Wrong consumer/site/side	0	Wrong consumer in procedure room/theatre
Monitoring	0	Inadequacy of monitoring (eg, breathing rate after morphine given)
Other	0	Security issue
Treatment	0	Allergic reaction to products used for treatment
Transfer	0	Harm related to transfer of care between services or providers
Total	23	

National ambulance sector

There were 533,669 '111' calls for ambulance services in 2017/18, which is a 5.4 percent increase in calls from 2016/17. The two emergency ambulance providers reported 18 adverse events in 2017/18 – delay in treatment (14); missed diagnosis (1); deterioration (1); complication (1); and failure to monitor (1).

The sector adverse events review group has continued to bring sector representatives, the National Ambulance Sector Office and the Commission together, and now includes representatives from several of the air ambulance providers nationally. This cooperation between the adverse events review group and the Commission is invaluable in assisting the sector to achieve consistency with the wider health sector. Areas the sector has focused on are embedding the national policy, improving systems and processes, and aligning reporting.

The ambulance sector has continued to build ties with the wider health sector around adverse events. Staff from DHBs and ambulance providers collaborate on reviews of adverse events that involve an overlap between organisations.



At the beginning of 2018, the two providers, Wellington Free Ambulance and St John New Zealand, began publicly reporting SAC 1 and 2 events on their websites. Previously these events were reported on the National Ambulance Sector Office's website. The move to 'owning' the reporting is an important step in the evolution of adverse event management within the ambulance sector and shows the increasing maturity of the adverse event programmes in both providers.

Open disclosure has been an increasing focus for the sector, and the two providers are working towards embedding it fully into their processes.

Learning story from Wellington Free Ambulance

'Wellington Free Ambulance (WFA) has practised open communication since 2015; however, the 2017 Policy provided a great road map on how it could be done better. Since the policy was released, WFA has focused on involving the patient and/or their whānau in the review process for all SAC 1 and 2 events. Open communication is now an explicit part of our policy, and senior managers are assigned to be the liaison for the patient and their whānau during the review process. Ultimately, we will have consumers involved in our review process. We offer the opportunity to meet early in the process, so patients and whānau can ask questions and let us know if they have any questions they would like answers to. We have found that the questions patients and their whānau have are not always the ones that we have - answering their questions invariably strengthens the review and makes it more meaningful for them. Once the draft report is finished, we send it to the consumer or their whānau for comment and once the final report is signed off, we meet with them to go over the report and apologise in person if necessary. It helps us keep the patient at the centre of what we do, and not lose sight of the fact that every adverse event involves a person who has suffered in some way.'

Paul Fake, executive director – quality improvement and innovation, Wellington Free Ambulance

Learning story from St John New Zealand

'St John has a process of open disclosure for all SAC 1 and 2 consumer safety incidents. If we feel we have contributed to the death of a consumer involved in a consumer safety incident, we notify the coroner. A St John operations manager will initiate contact with the family of the consumer 4–6 weeks after the death of the consumer to arrange a meeting; this will involve a St John medical director either attending in person or on a video/phone conference. That operations manager will continue to engage with the family and provide the family with our findings of the consumer safety incident investigation. St John will also consider openly disclosing on a case-by-case basis with the consumer or family if we feel we have contributed to causing further harm to the consumer. It is important to St John, as a large organisation involved in health care, that we can assist consumers and/or families in times of grieving and/or stress (both emotional and physical) by being open, honest, transparent and engaging with them during their time of need.'

Cheryl des Landes MStJ, head of patient safety and quality, St John New Zealand Hato Hone Aotearoa

Aged residential care

During 2017/18 the Commission began to engage with the aged residential care sector to plan and develop a quality improvement programme focused on improving the experience of care for residents.

We conducted a scoping exercise to identify what areas aged residential care service providers, consumers and whānau considered important priority areas and where we would add the most value to the sector. From that exercise, six major themes were identified: leadership; using existing data to measure improvement; strengthening the voice of consumers and their whānau; promoting a culture of shared learning; building capability for quality improvement; and improving the culture of safety and quality.

When adverse events occur, it is always devastating for aged residential care consumers and their whānau. It is also upsetting for staff, who often feel they have let the consumer and their whānau down.

We know that the process of reporting these events, thoroughly reviewing them to understand what happened and developing recommendations to help prevent similar adverse events from happening again both respects the consumer and provides an opportunity for learning. Continually strengthening a culture of safety and quality will influence and improve morale, as well as confidence and knowledge about what to do when things do not go as expected, with the goal of reducing consumer harm and improving their experience of care.

The Commission will be working with the aged residential care sector across a number of priority areas the sector has identified. In addressing opportunities for shared learning through the reporting, analysis and learning from adverse events, we will work closely with HealthCERT so that quality assurance processes complement the Commission's quality improvement work rather than requiring providers to duplicate their reporting activities. We will partner with the sector and key stakeholders to identify how training and education can be delivered for staff to improve their skills and understanding in quality improvement and resident safety processes and systems.

Primary care

Quality standards such as the Royal New Zealand College of General Practitioners' Foundation Standard and Cornerstone® apply to general practice. These standards require all practices to have active incident management processes (including for adverse events) in place.

In 2017/18, the Commission received a report of one adverse event from a primary health organisation (PHO) and no reports of events directly from general practices. We would like to increase the reporting from primary care and will continue working with providers to achieve this and to help providers build capability to manage adverse events.

Martin Carrell, quality programme manager at Pegasus Health and chair of the PHO Quality Improvement Network, recognises the potential for work in this area:

'Lower levels of reporting can be improved with more effective pathways linking general practices, PHOs and the Health Quality & Safety Commission... There is an opportunity to engage with PHOs and primary care providers to enhance processes that support increased reporting of adverse events.'

He also acknowledges both the challenges and rewards of adverse events reporting:

'The commitment to using previous adverse events as opportunities for learning and quality improvement can vary across the primary care sector. Reporting, review and learning from adverse events helps improve consumer safety. Learning from these adverse events would help reduce harm to consumers and staff.'



Learning story from Te Awakairangi

'All Te Awakairangi Health Network (TeAHN) practices are accredited with either the Royal New Zealand College of General Practitioners' *Aiming for Excellence* Cornerstone® quality improvement programme or Foundation Standard quality assurance programme as of June 2016. As part of this process, practices have had to meet the required standard of Indicator 28: "There is an effective incident management system". This requires **all practices** to have an incident management policy and register to record incidents and near misses. Also required is ensuring that all adverse reactions to medicines and immunisations are recorded in the practice management system and reported to the Centre for Adverse Reactions Monitoring. Cornerstone further requires that there is evidence of incidents and their review being used for learning and quality improvement.

'In January 2017, the clinical quality manager presented a paper to the TeAHN Clinical Governance Committee to provide an update on the national developments of reporting significant events and to discuss proposed suggestions for future development in this area for TeAHN practices. This followed an early paper in June 2016, where the National Reportable Events Policy was presented.

'Over the last year the clinical quality manager has been working with some practices to introduce a reportable events system, whereby events that are SAC 1 and 2, and "near misses" are reported to TeAHN and, if required, to the Health Quality & Safety Commission. The reporting of events that have gone well is also encouraged, including analysis of this, so that the process may be able to be replicated in the future. This system also aids practices to meet the new aspirational level of Cornerstone, which requires the practice to provide evidence of how a practice team works with its PHO/network to share learnings from the review of incidents. It was agreed that the process of recruiting practices to this programme should be taken slowly given the workload of practices with new programmes being implemented. To date, three practices have agreed to reporting events while others are considering this at present.

'The systems in place and being developed across the network are similar to those we are aware of in other PHOs across New Zealand. To assist with this process, the Commission has presented two sessions to TeAHN practices. These sessions explained the Commission's role and **how non-identified incidents** are reported to it and used for learning locally and nationally. This included looking at examples of the Commission's Open Book (sharing of events) and the newly developed 2017 Policy.

'Later in 2018, TeAHN will be holding an incident management workshop supported by the Commission, to further enhance incident reporting within the practice arena and further identify what would be considered as a reportable event.'

Ann Rose, clinical quality manager, Te Awakairangi Health Network

Private surgical hospitals

The NZPSHA represents the interests of 27 organisations, which are responsible for 39 private surgical hospitals in total. In the year ending 30 June 2018, NZPSHA members discharged approximately 179,000 elective surgical consumers. This represents a significant proportion of all elective surgery performed in New Zealand.

The NZPSHA has a suite of clinical indicators that members are required to report on (including adverse events). The Injury Prevention Research Unit of the University of Otago analyses this data and reports back to member organisations without identifying individual providers, other than providers' own figures. The clinical indicator information is used internally at members' hospitals and the NZPSHA shares the aggregated data

each year with the Commission. Member organisations can use the data for benchmarking and driving internal quality improvement initiatives.

Over the last year the NZPSHA has been working to align its reporting criteria with those of the Commission. With this work completed, the NZPSHA-affiliated hospitals are now using the Commission's SAC rating tool and the same patient denominator.

Between 1 July 2017 and 30 June 2018, the NZPSHA reported 91 aggregated SAC 1 or 2 incidents. Between 1 July 2017 and 31 December 2017, incident rates were reported per 1,000 admissions for all participating NZPSHA member hospitals. Then on 1 January 2018, the denominator changed to discharges. This variation in definitions has resulted in a slight variation between the NZPSHA discharge figure and admission rate for the same period. The figures cannot be compared directly with DHB-reported events because the reporting criteria differ. In addition to reporting to the NZPSHA, some private surgical providers report directly to the Commission.

'The NZPSHA supports private surgical sector transparency and working collaboratively with the Commission and all providers of elective surgery to drive quality improvement and reduce patient harm.'

Richard Whitney, president, NZPSHA

Learning story from Acurity Health Group

In July 2015, private surgical hospitals that are part of the Acurity Health Group replaced their paper-based reporting process with an electronic reporting platform to support incident and complaint management across the hospitals. Staff complete an electronic form, which is then sent to their direct line manager for review and follow-up.

This system provides an efficient mechanism that has reduced the time needed for data entry collating information, and has made it possible to trend, analyse and report data at hospital and group levels. Accountability can be assigned to corrective actions, with all follow-up requirements recorded and tracked to complete the quality loop within designated timeframes.

Acurity has used the Commission's work and resources for adverse event management. For example, senior staff have attended training workshops, and Acurity has aligned the incident management policy to the national policy and participated in the serious events reporting programme.

Acurity uses this system within a culture of open communication and full transparency of the process and outcomes for all incidents and for all staff. Data is shared with clinical benchmarking programmes, including internal benchmarking across the group, and lessons learned are shared.



Chapter 3: Mental health and addiction | Wāhanga 3: Hauora ā-hinengaro me te waranga

This chapter gives an overview of the mental health and addiction (MHA) adverse events reports and considers what we can learn from the patterns they show. It discusses the Commission's MHA quality improvement programme, including its specific focus on supporting the sector in its reporting and review processes. The final section considers the work of the Suicide Mortality Review Committee (SuMRC), which also contributes to the MHA sector (as well as to the health sector more broadly), and the processes it is establishing for reviewing suicides and developing suicide prevention advice.

In February 2018, the Mental Health Commissioner reported that as many as one in five New Zealanders live with mental illness and/or addiction each year. Between 50 percent and 80 percent will live with a mental illness and/or addiction at some stage during their lifetime.²⁹

Service providers work hard to give New Zealanders the best possible MHA services. However, there are opportunities to improve the quality of those services by engaging with consumers, learning from adverse events and reducing variation through using quality improvement methods. Internationally, quality improvement methods have been successful, resulting in fewer people harmed, more lives saved and more effective use of health care funding.³⁰

In July 2016, senior leaders from the MHA sector identified the need for a quality improvement programme for MHA services and requested support for it. As a result, in July 2017 the Commission's MHA quality improvement programme began. The programme aims to improve the quality and safety of MHA services and the experience of care for consumers. This programme includes a strong focus on learning from serious adverse events.

In the past, the Commission supported the Office of the Director of Mental Health to publicly report adverse events from the MHA sector in its annual report. The Director's annual report was useful in providing a broader mental health context for understanding MHA adverse events, which the Commission's reporting did not provide. However, with the Commission working ever more actively with the MHA sector, we can now usefully report MHA adverse events in an improvement framework that will complement the broader view of the Director of Mental Health.

- While the Director's annual report will report incidents from January to December (the calendar year), the Commission will report incidents from July to June (the financial year), to fit with the requirements of the 2017 Policy.
- Data will be different across the two reports, due to different timeframes.
- Both reports will usefully highlight MHA reported events, as well as encouraging awareness of and learning from them. We see this 'double focus' as beneficial to the sector.

²⁹ Health and Disability Commissioner. 2018. *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner*. Auckland: Health and Disability Commissioner. URL: www.hdc.org.nz/resources-publications/search-resources/mental-health/mental-health-commissioner-monitoring-and-advocacy-report-2018 (accessed 26 April 2018).

³⁰ Healthcare Improvement Scotland. 2018. *Scottish Patient Safety Programme*. URL: <https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-mental-health> (accessed 26 April 2018).

Why adverse events reporting is important in mental health

The role of an adverse events reporting, review and learning system is to enhance consumer safety by learning from adverse events and near misses occurring in health care and disability support services, including mental health services. Partnering with consumers, their families and whānau in the review and learning process is pivotal to improving safety and quality in mental health services.

The 2017 Policy sets a useful foundation for adverse events reporting to facilitate:

- open communication
- consumer participation
- culturally appropriate review practice
- meaningful analysis and system change
- accountability at local and national levels
- a focus on the system and improvement. (pp 3-4)

A range of guidance in applying the policy is available, which can also help mental health services to facilitate culturally appropriate local review processes that engage whānau in identifying and solving problems. In fact, a chapter in the 2016/17 *Learning from adverse events* report focuses specifically on how services should engage with consumers following an adverse event and sets out an eight-step guide to partnering with whānau following an adverse event.³¹ The foundation, goals and processes set within the Commission's policy and guidance are just as important and relevant to the mental health sector as they are to other areas of the health system.

Adverse events reporting is designed as a process that:

- enhances local learning and system improvement
- facilitates national learning (through national annual reports such as this) and improvement (by informing work such as the MHA quality improvement programme and the SuMRC).

How adverse event reviews differ from suicide mortality reviews

The aim of adverse event review and reporting is to improve the quality, safety and experience of health and disability services through developing systems that:

- are safe
- are consumer- and whānau-centred
- provide for early identification and review of adverse events
- ensure lessons are learned to minimise the risk of repeating preventable adverse events
- demonstrate public accountability and transparency.

Suicide mortality reviews try to consider all the factors that contribute to a suicide, going well beyond focusing only on health and disability services. They take a 'whole-of-life' focus to better understand causal and contributing factors, and potential prevention opportunities. The SuMRC uses information and data from a wide range of sources, including retrospective DHB and national serious adverse event data, to review suicide deaths and advise on how to reduce the number of them in New Zealand.

31 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3111



What we can learn from MHA adverse events reporting

To understand and use the information about reported events from the MHA sector, we need to understand where it has come from and how it is collected. We need to understand the 2017 Policy and how it is applied within MHA services.

While there are limitations to the data that we have and how it can be used, we can still consider what we can learn from it. This can also help us focus on how we can best work with the MHA sector to improve it.

What the 2017 Policy means for MHA services and their adverse events data

- In the MHA sector, MHA health services identify and report adverse events.
- Serious adverse events in MHA services often relate to serious self-harm, suicide or harm to others.
- As for all other DHB services, MHA services are required under the 2017 Policy to review all MHA adverse events and report all SAC 1 and 2 events to the Commission, with the aim of learning from them and identifying opportunities to prevent similar events in the future.
- Adverse events are classified using the SAC rating tool³² and event codes.³³
- This chapter reports only on events coded as 10 'behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)'.³³
- It is important to note that the ability to compare reports from year to year is limited as the parameters around consumer contact with services before MHA adverse events have changed.
- Providers report demographic information when they first notify the Commission of an adverse event. The age, gender and ethnicity data collected is discussed in this chapter.

This is the first year since 2013 that the Commission has reported on mental health events. Because of this gap in reporting, the events reported here are presented as high-level categories only. The Commission will work with providers over the coming year to agree on how best to present these events in the future. Previous data we collected (but did not report) has highlighted the need for more work to be done in this area, which led to a feasibility study into, and establishment of, the SuMRC. The data reported here will be fed back to the SuMRC to help its work. The events reported here are those that were classified as 'behaviour (eg, intended self-harm, aggression, assault, dangerous behaviour)' and given the event code of 10. These events do not include the small number of adverse events in MHA services coded as other than 10, which have been included in the general reporting categories. The low level of reported events from within the MHA sector that related to other health needs is of concern and will be addressed as part of the MHA quality improvement programme, which is discussed in detail later in this chapter.

In total, DHBs reported 232 mental health adverse events to the Commission in 2017/18. Table 6 provides a breakdown of this total by type of event during the year. Most suspected suicides took place in a community setting.

³² www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2937

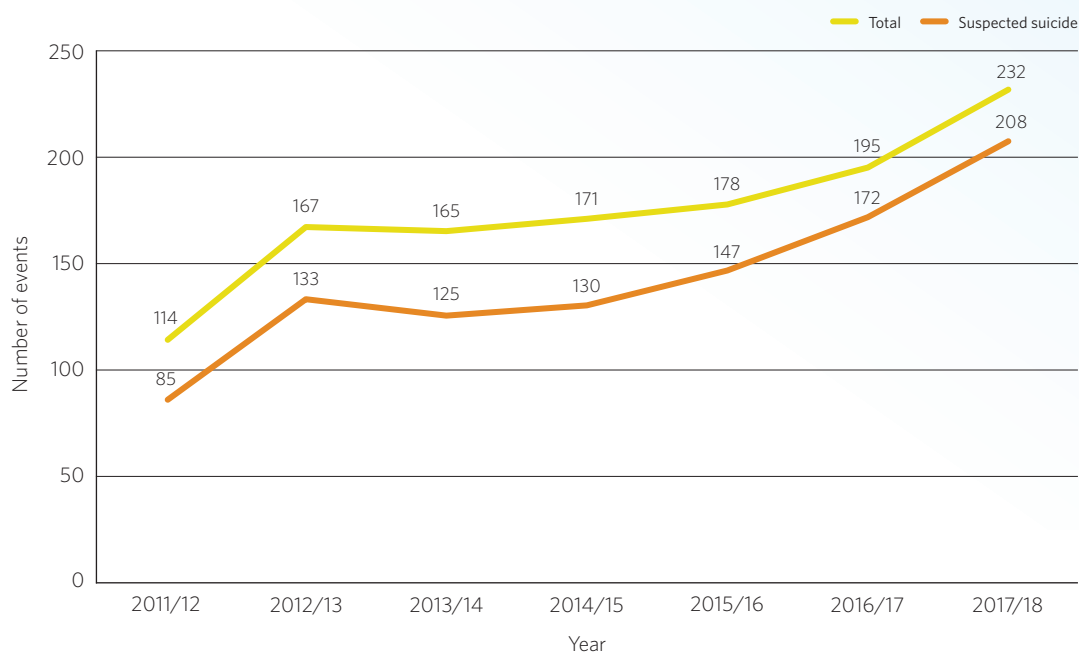
³³ Event codes are based on the World Health Organization classifications for patient safety. The 2017 Policy lists 14 codes (see Appendix B for details).

Table 6: Adverse events (code 10 behaviour) reported by DHBs, 2017/18

Type of event	Community	Inpatient unit	Total
Suspected suicide	196	12	208
Serious self-harm	6	6	12
Serious adverse behaviour	6	6	12
Total	208	24	232

Figure 5 shows the number of mental health adverse events DHBs reported each year from 2011/12 to 2017/18.

Figure 5: Mental health adverse events, 2011/12-2017/18



Although each adverse event reported here represents harm to a consumer and their whānau, an increase in reported adverse events does not necessarily indicate an increase in actual events. As discussed in Chapter 1, it is most likely that this increase represents an improvement in the ability of providers to recognise and report events. In particular, it suggests a just culture is developing that supports reporting by both clinicians and whānau.



Figure 6: Age range of consumers suffering mental health SAC 1 and 2 adverse events, 2017/18

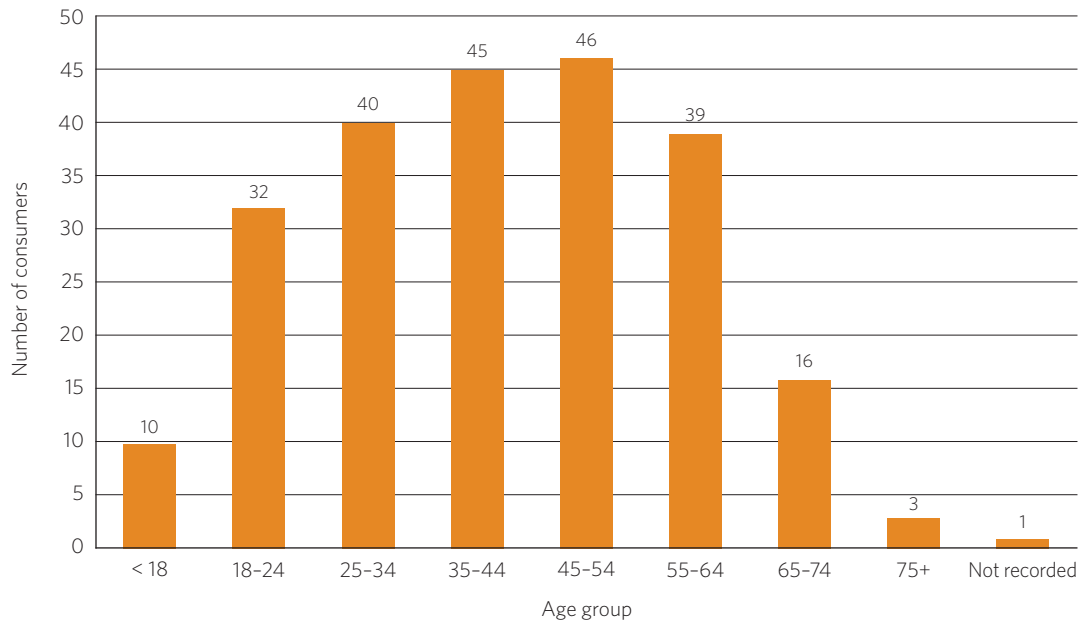
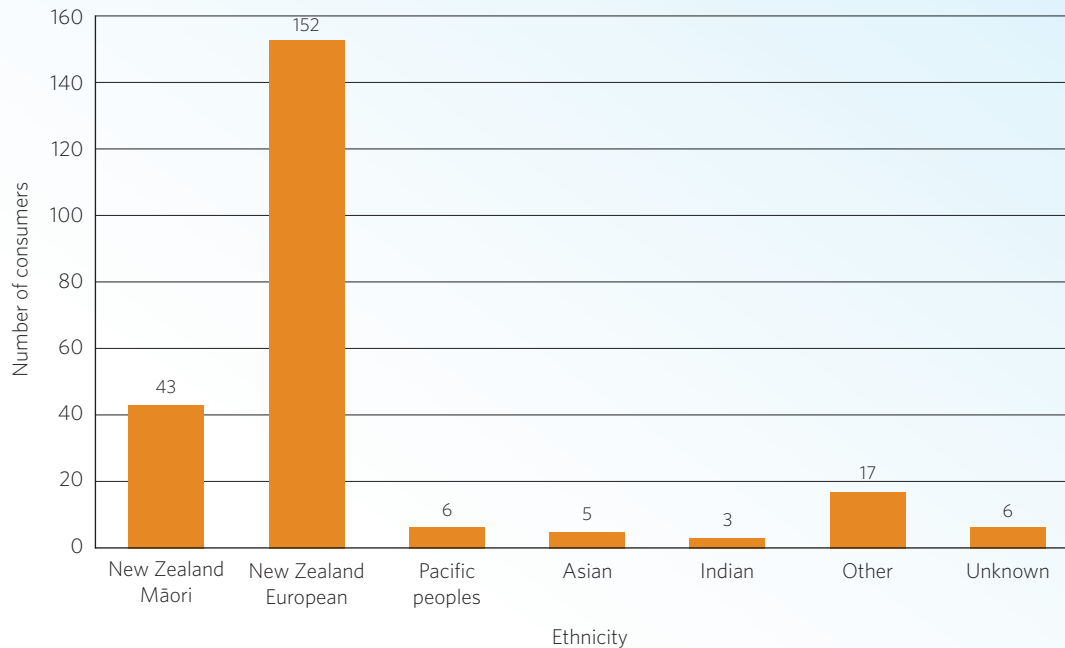


Figure 6 shows that reported adverse events involve a wide range of age groups. The pattern suggests more people between 25–64 years are involved in mental health adverse events than young people and those aged 65 years and over. People from within three age groups (25–34, 35–44 and 45–54 years) were involved in 40 or more events, with those aged 45–54 years experiencing the most events (46).

The most common ethnicity reported for consumers involved in a mental health adverse event was New Zealand European (65 percent). The second-largest group was Māori (19 percent). A further 24 consumers were noted as 'other', which included seven different ethnicities. Of the 232 mental health adverse events reported, six involved consumers who had no recorded ethnicity.

The Commission plans to review this data further over the coming year and to provide more detail in the 2018/19 report.

Figure 7: Ethnicity of consumers suffering mental health SAC 1 and 2 adverse events, 2017/18



Key points

- Most suspected suicides took place in a community setting.
- The number of reported mental health adverse events has increased each year since 2013/14 (noting that reporting criteria changed in the same period).
- Māori were slightly over-represented in mental health adverse events (based on Census 2013 data).

MHA quality improvement programme

The Commission is leading the MHA quality improvement programme in partnership with health service providers, consumers and their families and whānau. The five-year programme will identify, select and implement quality improvement initiatives and build quality improvement capability in the MHA sector, drawing on evidence-based approaches used internationally.

The planning and development of the MHA quality improvement programme involved significant consultation with the MHA sector and consumers. Engagement has identified the following five priority quality improvement initiatives to build quality improvement capability and reduce the incidence of adverse events in the MHA sector:

- zero seclusion: towards eliminating seclusion by 2020 (minimising restrictive care)
- connecting care: improving service transitions
- learning from serious adverse events and consumer experience
- maximising physical health for people with MHA issues
- improving medication management and prescribing.



The first two MHA quality improvement initiatives, zero seclusion and connecting care, started in 2018. The next section gives an overview of work planned for the third initiative: learning from serious adverse events and consumer experience.

Learning from MHA serious adverse events and consumer experience

Serious adverse events in MHA services often relate to serious self-harm, suicide or harm to others. As for all other DHB services, mental health services are required under the 2017 Policy to review and report on all serious MHA adverse events, with the aim of learning from them and identifying opportunities to prevent similar events in the future.

However, feedback from MHA sector leaders identified that reviews are currently too slow and providers vary significantly in the way they conduct their reviews. Leaders identified a clear opportunity for the MHA quality improvement programme to support providers in their efforts to learn from and reduce serious adverse events, by providing guidelines and facilitating timely, consistent reporting and review. Improving consumer involvement in adverse events review and sharing findings are also seen as important.

In addition to learning from review of serious adverse events, feedback identified that a well-executed review process can minimise harm to the consumer, their family and whānau, and staff members involved in the event.

The Commission is conducting an evidence review (to be published in 2018/19) to inform the adverse events initiative in MHA services. This draws on the earlier review that informed the 2017 Policy, as well as evidence relating specifically to MHA services. The learning from serious adverse events and consumer experience workstream will start in March/April 2019. With the 2017 Policy as its framework, the initiative will aim to:

- improve learning from serious adverse events and consumer experience in MHA services
- minimise harm and maximise benefit from the review process for the consumer, their family and whānau, and staff members involved in the event
- promote a just culture in an organisation that encourages reporting of errors and sees such reporting as a positive action
- improve public confidence in MHA services
- develop standardised, simplified processes and protocols for investigating, reporting, learning from and following up adverse events in MHA services (within the framework of the 2017 Policy).

Timeline and steps planned for the learning from adverse events and consumer experience workstream

- Engage with internal stakeholders in planning stages, including the Commission's adverse events learning programme team and SuMRC (see below).
- Conduct workshops, with an emphasis on a just learning culture and safety, for MHA quality managers and their teams in Auckland, Wellington and Christchurch (March–April 2019).
- Quality managers establish teams to understand current processes and identify opportunities to reduce variation (teams to include consumers and their families and whānau) (September 2019).
- Co-design processes that will include workshops, followed by online sessions and coaching (September 2019).
- Develop the change ideas from the co-design processes and the literature (September 2019–February 2020).
- Develop a suite of key outcome, balancing and process measures (by November 2019).
- Develop a series of quality improvement learning sets (February–July 2020) to support the testing and implementation of change ideas and evidence-based interventions.
- Produce standardised, simplified process and protocols for investigating, reporting, learning from and following up adverse events in MHA services (consistent with the 2017 Policy) (by July 2020).

The Suicide Mortality Review Committee

The other Commission work programme that is central to, although more broadly focused than, MHA, is the SuMRC. The SuMRC is an independent, statutory mortality review committee that reviews the lives and deaths of those who die by suicide, to learn and share information about suicide prevention. The SuMRC uses retrospective DHB and national serious adverse events data (along with other data) for review and to develop prevention advice. It also works with the other mortality review committees: the Family Violence Death Review Committee, the Perinatal and Maternal Mortality Review Committee and the Child and Youth Mortality Review Committee.

The SuMRC was established with funding from the Ministry of Health in direct response to one of the key recommendations of *Ngā Rāhui Hau Kura: SuMRC Feasibility Study 2014–15*.³⁴

Ngā Rāhui Hau Kura: SuMRC Feasibility Study 2014–15

Ngā Rāhui Hau Kura was undertaken to assess the cost and benefits of suicide mortality review as a tool for learning about and preventing suicide in New Zealand. Based on the epidemiology of suicide in New Zealand, the following three population groups with especially high rates of suicide were identified as the cohorts to consider in the feasibility study:

- rangatahi Māori, aged 15–24 years at the time of death (194 people)
- users of specialist mental health services, defined as those who had had face-to-face contact with specialist MHA services in the year before their death (829 people)³⁵
- men of working age, aged 25–64 years at the time of their death (1,272 people).

³⁴ www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/2471

³⁵ This group was selected, in part, due to the large number of deaths by suicide reported through the adverse events reporting process.



The study included deaths between 1 January 2007 and 31 December 2011 that a coroner confirmed as suicide. These suicides accounted for 71 percent of all suicides in the five-year period.

The objectives guiding the study were to:

- improve knowledge of factors that contribute to suicide
- understand patterns of suicidal behaviour
- identify key intervention points for suicide prevention
- gather information to inform suicide mortality reviews.

The study collected data from a wide range of agency data sets and statutory administrative databases. A tiered approach was used to explore a variety of quantitative and qualitative research methods and analyses for the three sub-groups. These included demographic overviews of the lives of those who died by suicide; a paper-based system review for the mental health service users; and qualitative story-based inquiries for the rangatahi Māori sub-group.

Selected findings from *Ngā Rāhui Hau Kura, the SuMRC Feasibility Study 2014-15*

- Māori were over-represented among those who died by suicide.
- For all three sub-groups, evidence of engagement with service providers before and at the time of death suggested potential opportunities for suicide prevention existed.
- Almost one-third of the men of working age were unemployed at the time of suicide. Men in the 'construction and trade' and the 'farm and forestry' industries had especially high rates of unemployment. This information points to targeted suicide prevention initiatives that may be effective.
- Mental health consumers face complex issues, but their patterns of use suggest some of them are using services more, with limited effect on outcomes.
- Some mental health consumers showed a pattern of increased service use and activity in the period leading up to suicide.
- Those with complex needs were often offered more service contacts in response but this did little to address their changing needs.
- Frequent consumers of mental health services and those with complex mental health issues had numerous risk assessments during their care. These assessments were often ad hoc or short term in nature rather than being part of a long-term care plan.
- Consumers, their families and whānau, and other support networks were seldom involved in the planning of their care.

The study had several limitations, including a tight timeframe, lack of data from some key agencies and variable quality of data. However, the report concluded that the work had been successful in meeting its objectives and recommended establishing an ongoing SuMRC.

The current work programme of the SuMRC

The SuMRC was re-established in 2018. It has now developed and initiated a programme of stakeholder engagement that will provide a foundation for implementing the SuMRC death review methodology in the future.

Ongoing stakeholder engagement is crucial to making change. To date, the SuMRC has engaged with New Zealand Police, coroners, Ministry of Education, ACC, Health Promotion Agency, Ministry of Health, Oranga Tamariki and a range of community-based initiatives such as Lifeline, InsideOUT and Women's Refuge.

A core function of the SuMRC is to establish a database that collects information related to suicide.

The SuMRC will create safe, reliable processes for transferring data from agencies. It will include agency and Ministry minimum data sets, as well as qualitative narratives from agency written reports.

The SuMRC has started to develop a robust, sensitive, suicide mortality review process. This will use a kaupapa Māori approach to qualitative research that involves those who knew the deceased, in addition to service providers.

Rangatahi suicide report

As part of its work programme, the SuMRC is working closely with the Child and Youth Mortality Review Committee to create a report on suicide inequity and its impact on Māori youth.

The report will inform Government and its agencies, rangatahi, families, whānau and the public on the extent, nature and scope of the differences in the suicide rates between rangatahi and other young people.

The report will include both a quantitative and qualitative analysis of data contained in the Child and Youth Mortality Review Committee database. It will aim to identify the factors and patterns of relationships that underpin rangatahi suicide from 2002 to 2016.

The report will be published in June 2019 and will draw on evidence to help identify potential system improvements to reduce rangatahi suicide rates.



Chapter 4: Adverse events learning programme | Wāhanga 4: Hōtaka ako pāpono kōaro

This chapter summarises the activities of the Commission's adverse events learning programme. It discusses the implementation of the 2017 Policy, reviews improvement opportunities for the programme and gives feedback on the uptake of quality reviews for providers. A highlight of the chapter is the planned work to investigate how whānau Māori experience adverse events. This work will lead to the development of guidance on how to provide culturally appropriate care for Māori during and after an adverse event.

National Adverse Events Reporting Policy

The Commission first developed the National Reportable Events Policy in 2012. Its aim was to promote a consistent approach and to enable public accountability and transparency of adverse events and near misses in New Zealand.

The revised National Adverse Events Reporting Policy 2017 was released after consultation with key stakeholders in DHBs and the wider health and disability sector and came into effect on 1 July 2017. Under the 2017 Policy, all health and disability service providers with obligations under the Health and Disability Services (Safety) Act 2001, and those who voluntarily comply, are expected to notify the Commission of serious adverse events and provide findings and recommendations from their reviews of these events.

The 2017 Policy strongly emphasises consumer and whānau engagement, particularly in involving consumers as partners who participate in the review process. This focus encourages providers to apply a consumer- and whānau-centred approach along with systems and processes that support reducing harm. This year the Commission developed the 'Consumers as partners in learning from adverse events' chapter from the 2016/17 annual report as a published resource guide³⁶ to support providers in partnering with consumers.

A strengthened expectation in the 2017 Policy is that, from 2018/19, providers will report ethnicity and other demographic data in the initial adverse event notifications. With this change, the Commission can consider equity in analysing future adverse events reports and identify trends to inform its work programmes.

The 2017/18 year was a transitional year as providers updated their internal policies and systems to match the 2017 Policy.

Opportunities for improvement for the adverse events learning programme

From 2018/19 the Commission will be taking a systems-level view of the opportunities to improve consumer safety and the sharing of lessons learned across New Zealand, working more closely with providers across the whole health sector. We recognise that, while health care providers vary in their approach to adverse event management, it is important that all providers are enabled to support an open culture of adverse events reporting. To meet the needs of health care providers, we will be running a survey in early 2019 to identify sector capabilities and requirements in this area.

³⁶ www.hqsc.govt.nz/our-programmes/adverse-events/projects/engaging-with-consumers

Whānau Māori experience of adverse events

Literature that examines the whānau Māori experience of adverse events is scarce. The research that is available suggests Māori experience more adverse events than non-Māori, non-Pacific consumers. Davis et al showed that after age standardisation, 14 percent of admissions for Māori were associated with an adverse event compared with 11 percent for non-Māori, non-Pacific consumers. After age, socioeconomic factors and case mix were controlled for, this disparity was significantly higher for in-hospital adverse events.³⁷

Davis et al recommended further research to identify the factors involved in adverse events for Māori and to broaden the scope to research issues of policy, health system organisation, enhanced participation for Māori and cross-cultural competence.

In 2018/19 the Commission will begin a review to explore the impact of adverse events on whānau Māori. This information will be used to develop guidance on how to provide culturally appropriate care for Māori during and after an adverse event.

The review will use a kaupapa Māori methodology. Tikanga, kawa, manaakitanga and whakawhanaungatanga will also be key protocols used in developing, delivering and writing the review.

The review will involve:

- interviewing Māori consumers and whānau about their experience of adverse events pathways, including their reflections on pre-event, event and post-event review and communication processes
- testing the themes identified from the analysis of the consumer and whānau interviews at selected community hui
- interviewing clinicians and review team participants (if relevant) to follow up on issues and identify what barriers may exist for quality engagement and review processes with whānau
- using the review findings to make recommendations on how providers can improve their engagement with whānau Māori who have experienced an adverse event. These recommendations will be used to develop a resource for health care providers.

The overall findings and recommendations of the review will be published in the 2018/19 *Learning from adverse events* annual report.

Adverse event review training

To encourage an open culture of adverse events reporting, the Commission delivered four 'learning from adverse events' training workshops, attended by 177 health professionals, to improve the quality of reviews and engagement with consumers. Feedback from the two-day workshop has identified that health care providers find this training does meet the learning objective of enabling them to understand and master the essential components of a high-quality adverse event review. From 2018 we will be considering how best to respond to sector requests for detailed discussion of other types of review, as well as discussion of practical experiences of a complex health environment and diverse communities, and how the processes are managed with multiple constraints.

In 2019 the Commission will be running an adverse event master class. The master class will build on the learning from the current two-day workshop and enable participants to strengthen and build best practice in local consumer safety processes and prepare or train people to lead and run local adverse event reviews. We expect this to lead to a regional network of consumer safety champions who can provide expertise and training on adverse event review and potentially contribute to our programmes and teaching at a national level.

³⁷ Davis P, Lay-Yee R, Dyall L, et al. 2006. Quality of hospital care for Māori consumers in New Zealand: retrospective cross-sectional assessment. *Lancet* 367(9526): 1920-5.



Types of adverse event reviews

Several methods can be used to review different types of adverse events. The 2017 Policy allows health and disability providers to choose the adverse event review method that is most appropriate to their circumstances. With this change in mind, the Commission is developing a guide to help adverse events teams decide which type of review methodology to use.

National sharing of lessons learned

The Commission strongly encourages providers to also share events that were managed before harm occurred (near misses) and SAC 3 and 4 events because these events still had high potential for causing serious harm. We will use these reports to monitor trends that may affect many providers and to make lessons learned at a local level available to all providers if necessary.

In 2017/18 the Commission presented three Open Book reports. These covered: interventions or procedures performed outside operating theatre settings – wrong procedure/wrong site/wrong person;³⁸ alert for prescribing error – dabigatran and enoxaparin;³⁹ and lessons learned from reviewing consumer falls.⁴⁰

Quality of reviews

This year providers were offered the opportunity to request feedback from the Commission on the quality of their adverse event reviews. We received a total of 71 requests for feedback for 2017/18. The main feedback we gave was to:

- ensure consumer representation on review teams
- ensure the consumer or their whānau had the opportunity to tell their story
- write clear, measurable recommendations.

The feedback is based on the quality check template we developed for adverse event review report analysis. This template is available on our website⁴¹ and providers can use it to also guide their own review processes.

‘We were excited to take the Commission up on its offer to provide feedback on our adverse events reporting. The feedback we received was positive and supportive, and we are working on updating our templates to align with the feedback received from the [Commission] on process. Additionally, we have created a one-page checklist from the [Commission’s] framework which I believe will be of benefit to MidCentral DHB for preparing future reviews.’

Barbara Ruby, acting manager, quality and clinical risk, MidCentral DHB

38 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3091

39 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2992

40 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2858

41 www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3318

Appendix A: Adverse events learning programme expert advisory group 2017/18 | Āpitihanga A: Rōpū mātanga tohutohu mō te hōtaka pāpono kōaro 2017/18

The purpose of the adverse events learning programme expert advisory group is to provide advice to the Commission to support the achievement of the adverse events learning programme's outcomes and objectives. This advice will contribute to achieving the Commission's vision that:

New Zealand will have a sustainable, world-class, consumer-centred health care and disability support system, which will attract and retain its workforce through its commitment to continually improve health quality and deliver equitable and sustainable care.

The aims of the expert advisory group are to:

1. proactively support effective relationships between the health and disability sector and the Commission
2. provide advice and make recommendations to the Commission on strategies to improve the quality and safety of health and disability services – with a focus on learning from adverse events – that are informed by evidence and international, national and local knowledge
3. share information that supports a national approach to quality and safety improvements and learning from adverse events
4. foster an integrated approach to improving the quality and safety of health and disability services and learning from adverse events, including integration at national and local levels and integration with other Commission programmes and committees.

The expert advisory group's specific priorities are to:

- support health and disability sector engagement with the adverse events learning programme
- support and facilitate collaboration and coordination between the entities represented in the expert advisory group
- provide advice on the adverse events learning programme's strategic direction, work programme and activities
- provide advice on high-level information on adverse events reported to the Commission
- provide advice and leadership that supports best-practice national and local reporting, review and learning from adverse events and near misses
- provide advice on updates of the 2017 Policy to ensure it remains fit for purpose.

The following are the members of the expert advisory group.

Jane Bawden	Consumer representative
Taima Campbell	Clinical services manager, Hauraki Health
Dr Denys Court	Obstetrician and gynaecologist, Auckland DHB
Ros Gellatly	General practitioner, Nelson Marlborough DHB
Diana Gunn	Director of nursing, Canterbury DHB
Brionny Hooper	Human factors scientist, Scion
Dr David Hughes	Deputy chief medical officer, Counties Manukau DHB
Amber O'Callaghan	General manager quality, service improvement and innovation, Hutt Valley DHB
Julie Patterson	Interim chief executive, Capital & Coast DHB
Richard Whitney	Chief executive officer, Mercy Hospital, Dunedin



Appendix B: Event codes | Āpiti hanga B: UHINGARO PĀPONO

General classification of event	Event code
Clinical administration (eg, handover, referral, discharge)	01
Clinical process (eg, assessment, diagnosis, treatment, general care)	02
Documentation	03
Healthcare associated/acquired 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/patient accidents (not falls) (eg, burns, wounds not caused by falls)	11
Consumer/patient falls	12
Infrastructure/buildings/fittings	13
Resources/organisation/management	14

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