



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND



What's new?

Adverse Events and Primary Care

Sarah Upston & Iwona Stolarek
RNZCGP conference
Dunedin 2017

Overview

- Whistle stop tour of the Commission
- Adverse events learning programme
- Primary care consultation and feedback with Policy review
- Updated National adverse events reporting policy key messages



Commission Work Programmes

Pressure
Injuries

Medication
Safety

Infection
Prevention
and Control

Adverse
Events

Mental
Health

Primary Care

Recognising
and
Responding
to
Deterioration

Aged
Residential
Care

Safe Surgery
NZ

Falls

Consumer engagement, evaluation, capability building



Adverse Events Learning Programme

- Public reporting of DHB adverse events began 2006/7
- Foundation programme of the Commission
- Initial focus in DHBs

Building reporting culture and trust

Development of national 2012 Reportable Event Policy

- Collect notifications and reviews of AEs
- Publish learning reports “Open Book”
- Publish annual report



Open Book publications

- Share lessons learnt from reviews
- Illustrate simple steps that can be taken
- Focus on changes, not incident
- Supply in simple format
- Make it 'safe' to report

Open Book

Learning from close calls and adverse events

Ensuring referrals happen

This report alerts providers to key findings from three similar recent incident reviews at different hospitals. Each incident involved failures in referral and follow up processes. We advise providers to consider this report, and whether the changes being made are relevant to their own systems.

This report is relevant to:

- managers responsible for medical records and patient booking and scheduling
- all clinicians sending and receiving referrals.

Incident 1

A patient had delayed care because a biopsy result was not responded to appropriately.

Chronology

- A patient who was admitted with pregnancy complications complained of a neck lump. The admitting service referred her for biopsy.
- A biopsy of the lump was performed and reported as 'inadequate for diagnosis', but no further action was taken.
- The patient presented five years later with a neck lump at the same site as before. The result of the previous biopsy was noted, a further biopsy taken and treatment started for a malignant diagnosis.

Review

The incident review found:

- there was no consistent process for communicating non-obstetric issues to other specialties
- the biopsy results were not communicated to the patient's lead maternity carer (LMC)
- the lab report involved was one of a large number of unacknowledged reports reviewed in a short space of time. The significance of 'inadequate for diagnosis' was not recognised

- pathology did not follow up the result at the time of the biopsy, for reasons unknown.

Actions subsequently taken

- After the incident, the hospital introduced an electronic clinical record system. The record works in conjunction with inpatient notes and provides a summary plan for discharge documentation.
- If a patient receives maternity care, information is now sent to the relevant LMC and general practitioner.

Incident 2

A patient referral to another service failed, with cause unknown.

Chronology

- An internal referral was made from general surgery to oncology, but the referral was never received so further care was not provided.
- Nine months later, following a query from the patient, it was realised that the referral had not occurred. An additional referral was made, resulting in the treatment being provided.

What have we done so far?

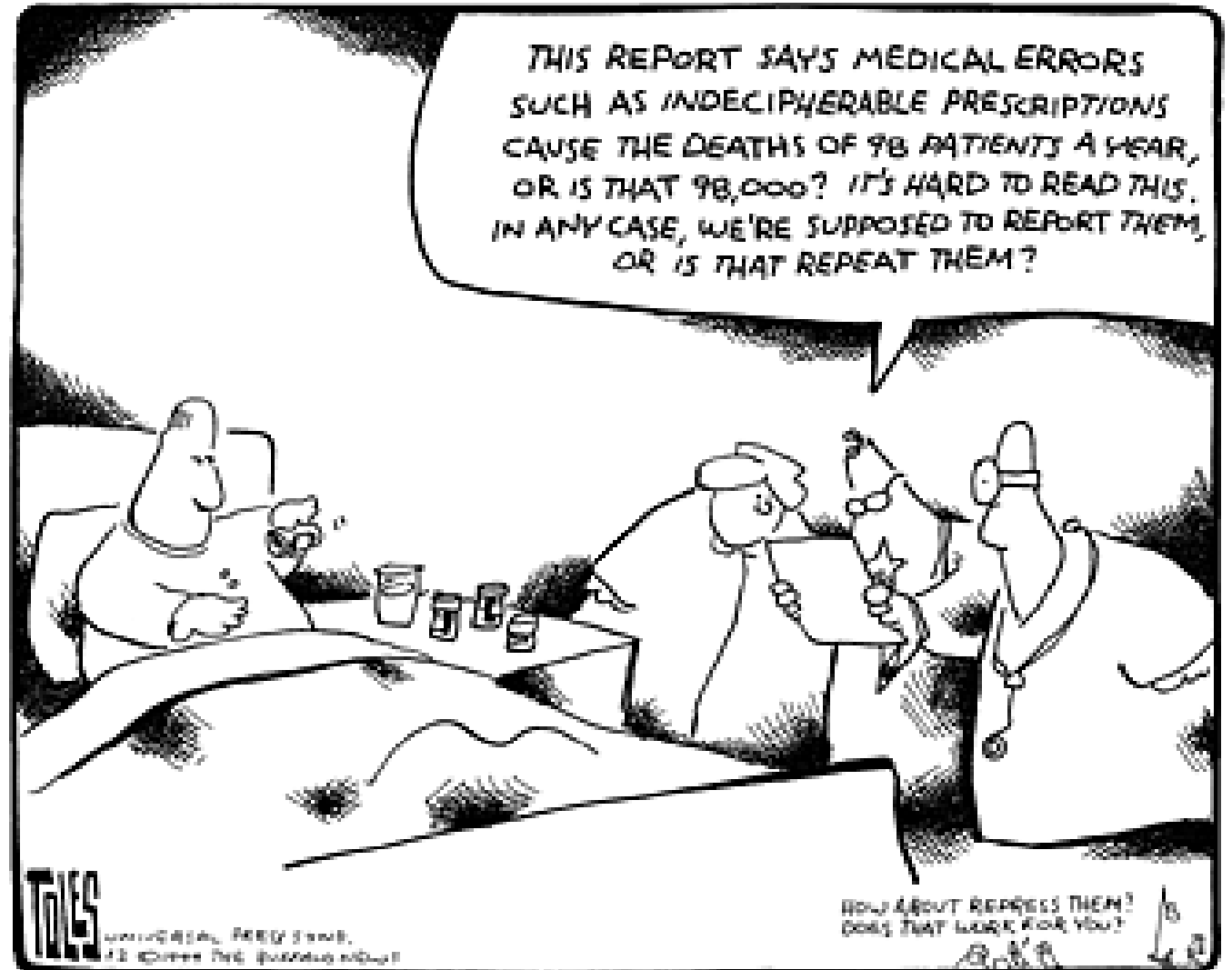
- Increased reporting by DHBs
- Increased range of events reported
- Improved learning focus
- Adverse Event policy updated July 2017
 - For the wider health and disability sector
- AE training with focus on improving the quality of reviews and recommendations



"Give it to me straight, Doc. How long do I have to ignore your advice?"

What do we know about AEs in Primary Care?

- ACC claims data for Treatment Injury
- Adverse events reported to HQSC
 - 1 in 2016-17
 - 2 in 2015-16
 - 4 in 2014-15
- Literature
- Safety in Practice Northern Region Collaborative



Policy review: Feedback from primary care

Feedback: Consumer involvement

- Important that consumers are listened to and the seriousness of any event is acknowledged
- Preferred term “consumer safety incident”
- Strong support for consumer representatives when a review is done
- Risk of confusing consumer initiated reporting with complaints and the Health and Disability Commission role



“ The sales team did all they could, so I’d have to say the blame for that must fall on the consumer.”

Feedback: Staff implications

- Education and training is needed in doing reviews
- Greater awareness of the AE policy is needed
- Need support for staff involved in adverse events – PHOs may not have support mechanisms such as the employee assistance programs in DHBs



Feedback: Concerns

- The policy has implications for general practice and PHOs
- Aspects should be piloted so implementation issues are thought through
- Key element is education as most don't know this policy
- There is a responsibility for 'governance' to ensure policies are in place
- What is the key purpose that we want to achieve through reporting?
- Will district health boards in the future mandate this in contracts?
- Is this another compliance program with no extra funding training or resources?
- How will the commission encourage all organisations to participate?

Feedback: Advantages and opportunities

- Opportunity to develop cross-sector reviews instead of service silos to look at safety issues along a patient journey
- Opportunity in joint reviews to learn from district health board teams
- Fosters openness and transparency
- Much to gain by sharing learnings

Always report and review list

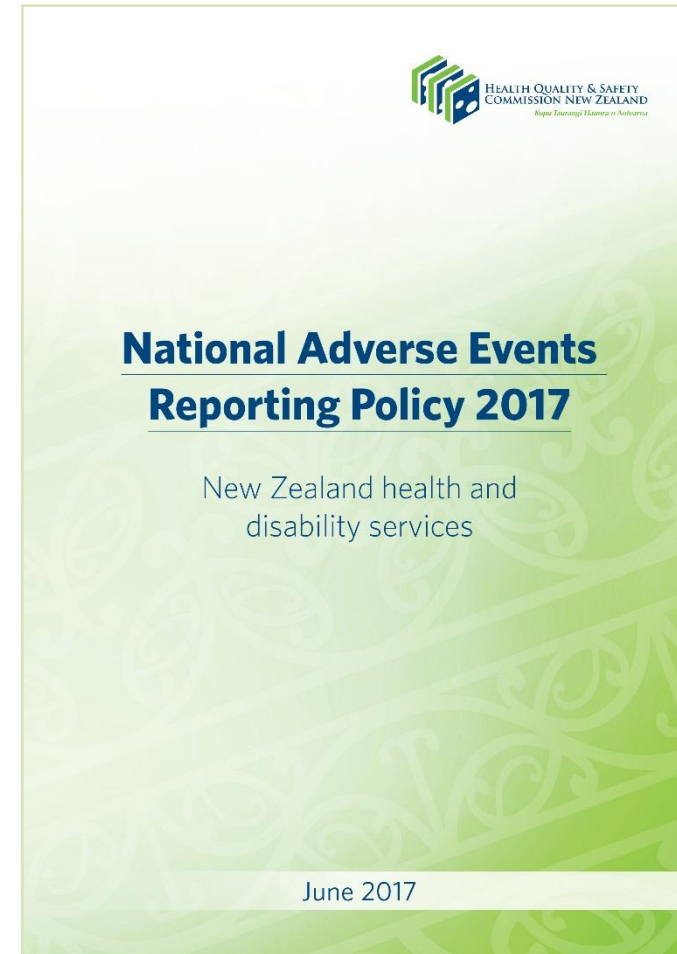
- Support and develop this with specialist colleges for some areas

Feedback: Prerequisites

- A governance or board person should be trained in safety incident reviews
- Keep it simple with clear guidance so that a review could be led by any champion who is trained and supported
- Videos, tools and other resources please
- Needs greater socialisation of safety culture and safety frameworks
- Guidance as to triage and types of methodologies to use
- Make it the easy thing to do
- Work with the College and Cornerstone and Foundation standards
- Consistency of language with other documents

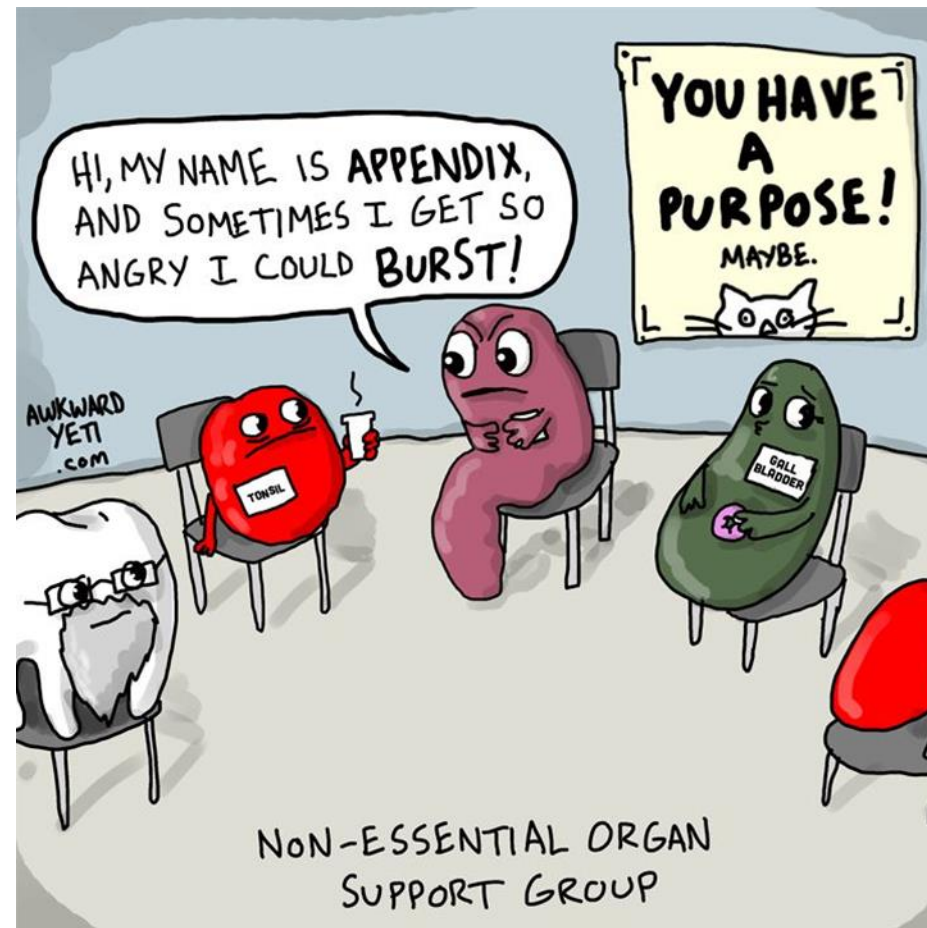
New Policy: Increased focus on

- Role of patients and families
- Supporting families and also staff
- Prioritise events for in depth review
- Use of different review methodologies
- Human factors and systems focus in the context of a 'Just Culture'
- Focus on implementing and monitoring effective recommendations
- Increased focus on learning and sharing



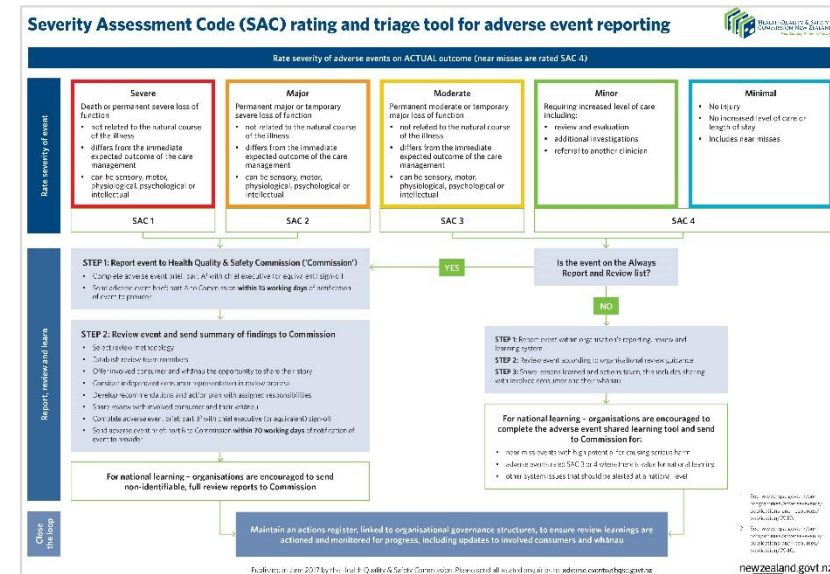
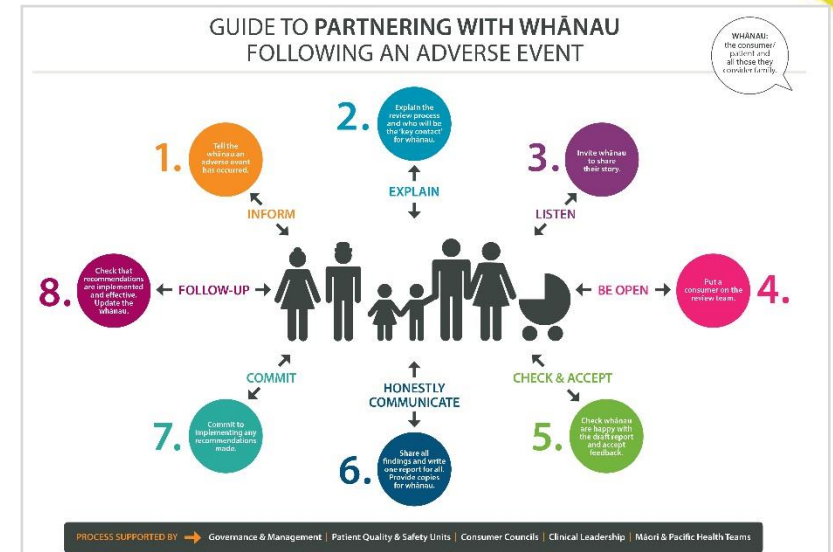
Take home messages to the sector

- Safety culture and framework
- Open communication
- Make reporting easy
- Triage and use a methodology for reviews
- Feedback the outcome of the review to families and staff
- Support for both families and staff
- Share learnings



We're here all week!

- Come visit the Commission booth
- Come to our longer session on Saturday
 - Principles for adverse event review
 - Rationale
- Tools/resources



Any questions?