What’s new?
Adverse Events and Primary Care

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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
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?