



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND



Adverse Events: the “how to” guide

Sarah Upston & Iwona Stolarek
GP conference
Dunedin 2017

Overview

- Whistle stop tour of the Commission
- Adverse events learning programme team
- Updated National Adverse Events Reporting Policy (2017) and primary care



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
- Initial focus in DHBs

Building reporting culture and trust

Development of National Reportable Event Policy 2012

Updated Policy 1 July 2017

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



Open Book publications

- Share lessons learned 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.

Before...

- Be perfect and don't make mistakes
- Name, blame and shame and punish individuals closest to the bad outcome
-So don't report errors
- So.... no learning and...
- No system change or process improvement



A Just Culture

- recognises that individual practitioners should not be held accountable for system failings over which they have no control.
- recognises that many errors represent predictable interactions between human operators and the systems in which they work, and that competent professionals make mistakes.
- acknowledges that even competent professionals can develop unhealthy norms (shortcuts, routine rule violations)

Open communication

Open communication, or open disclosure, refers to the timely and transparent approach to communicating with, engaging with and supporting consumers and their whānau when adverse events occur

Health and Disability Commissioner, Guidance on Open Disclosure Policies

www.hdc.org.nz/media/18328/guidance%20on%20open%20disclosure%20policies%20dec%2009.pdf

Why review adverse events?

- To explain to the patient and/or family what happened
- To learn from the incident to try and prevent it happening again



“If we learn from our mistakes, shouldn’t I try to make as many mistakes as possible?”

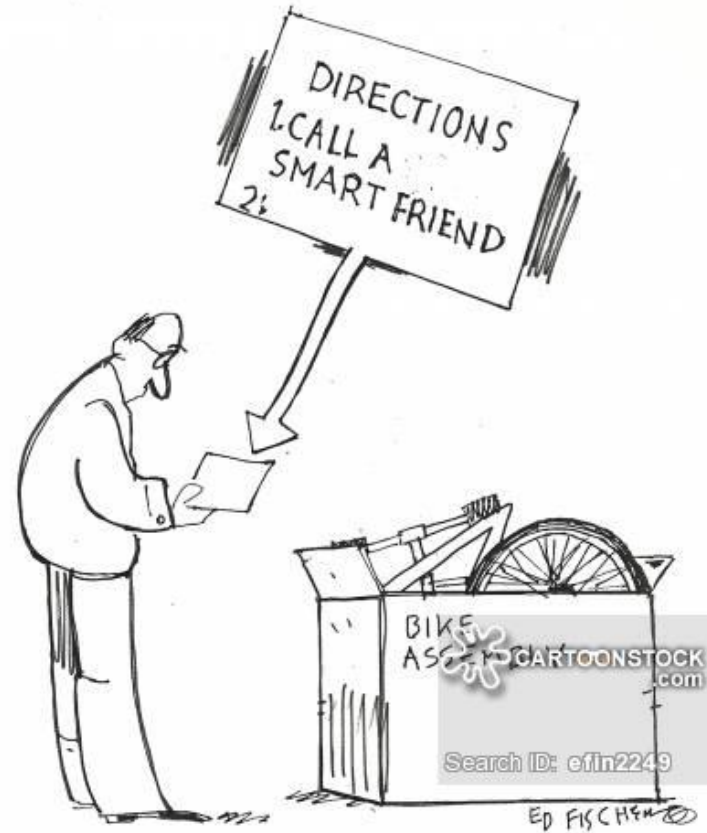
The patient's expectations

The available literature indicates patients need:

- acknowledgement, regret, empathy
- information; early, repeated and progressive
- a care plan and discussion as to extent of recovery
- preventing recurrence: what has been learned and how will that prevent similar occurrences.

Incident review – three steps

- What happened?
- Why did it happen?
- How do you prevent it happening again?



What happened?

- Read the documentation
- Speak to all involved including the patient and family
- Keep notes
- Write the story – timeline
- Think outside the boundaries
- Remove jargon – doesn't make a better report

Why did it happen

- Find your inner child – keep asking ‘Why?’
- Test your theories on someone else
- Keep asking until you understand, or if it is going nowhere

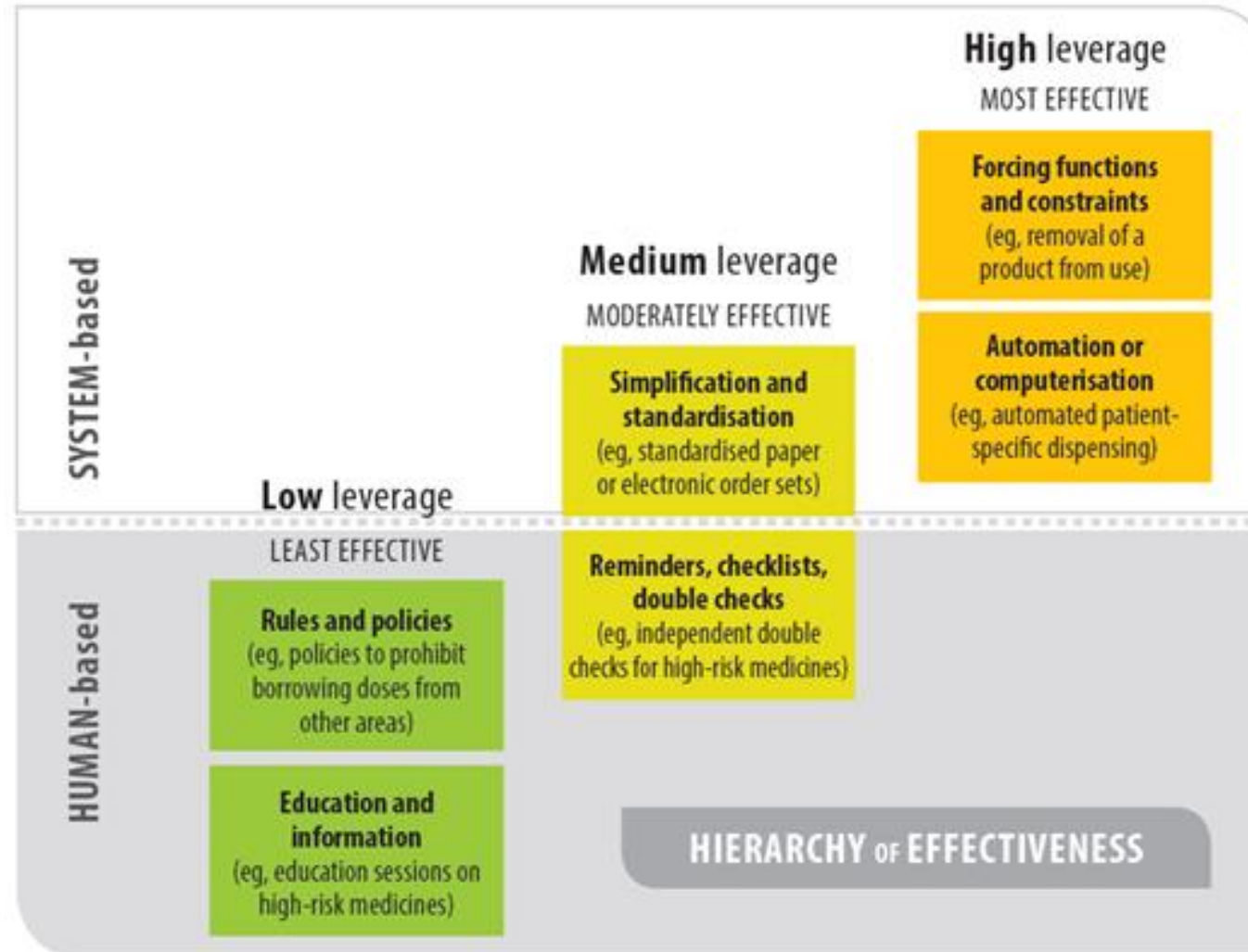


How to prevent it happening again

- Good report – which means good action plan
- Share lessons
- Have someone responsible for changes
- Check changes have worked



Recommendation effectiveness



Good report

- Tells the story clearly
- Explains the rationale
- Details all finding including incidental findings
- Has a targeted and clear action plan/recommendations
- Shared with family
- Monitored for progress

The goal for providers of care

- Identify cases that need review
- Review them properly
- Ensure recommendations address findings
- Share the lessons:
 - with the patient and family
 - with your team and governance
 - locally and with the wider sector

Increased focus in updated Policy on:

- role of patients and families
- supporting families but also staff involved
- prioritise what is reviewed in depth and reported and use of different methodologies
- human factors and systems in the context of a Just Culture
- implementing and monitoring recommendations
- increased focus on learning and sharing

... the focus of patient safety has mostly been on improving systems of care, such systems include real people, and safety events may take an emotional toll.

Such events occasionally result in an intense period of professional and personal anguish, even among the 'strongest' caregivers...

Staff support

- The importance of this should not be underestimated
- Being available for staff is crucial
- Staff need a safe and confidential space to discuss the event
- ASSIST ME model (from Ireland which has been adapted from the ASSIST model of communication from MPS)

Messages to the sector

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



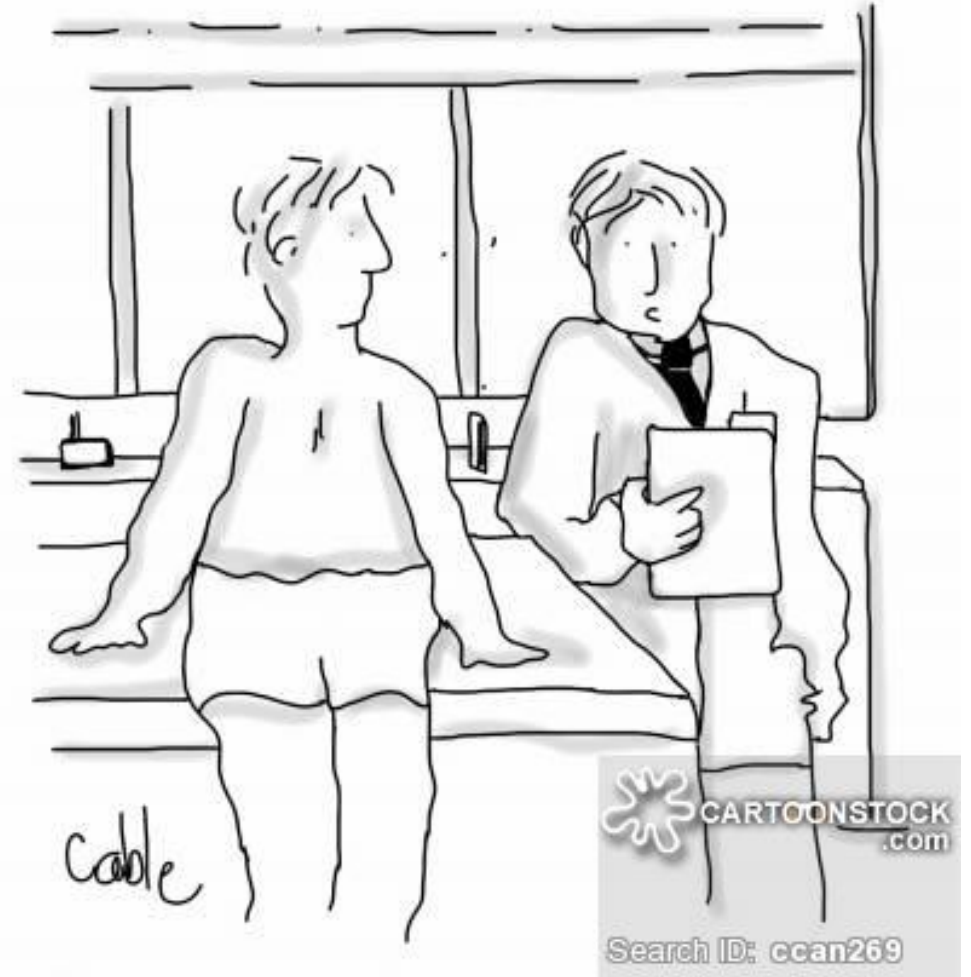
"Now WHY would you want to do something like that?"

Mentimeter

www.menti.com

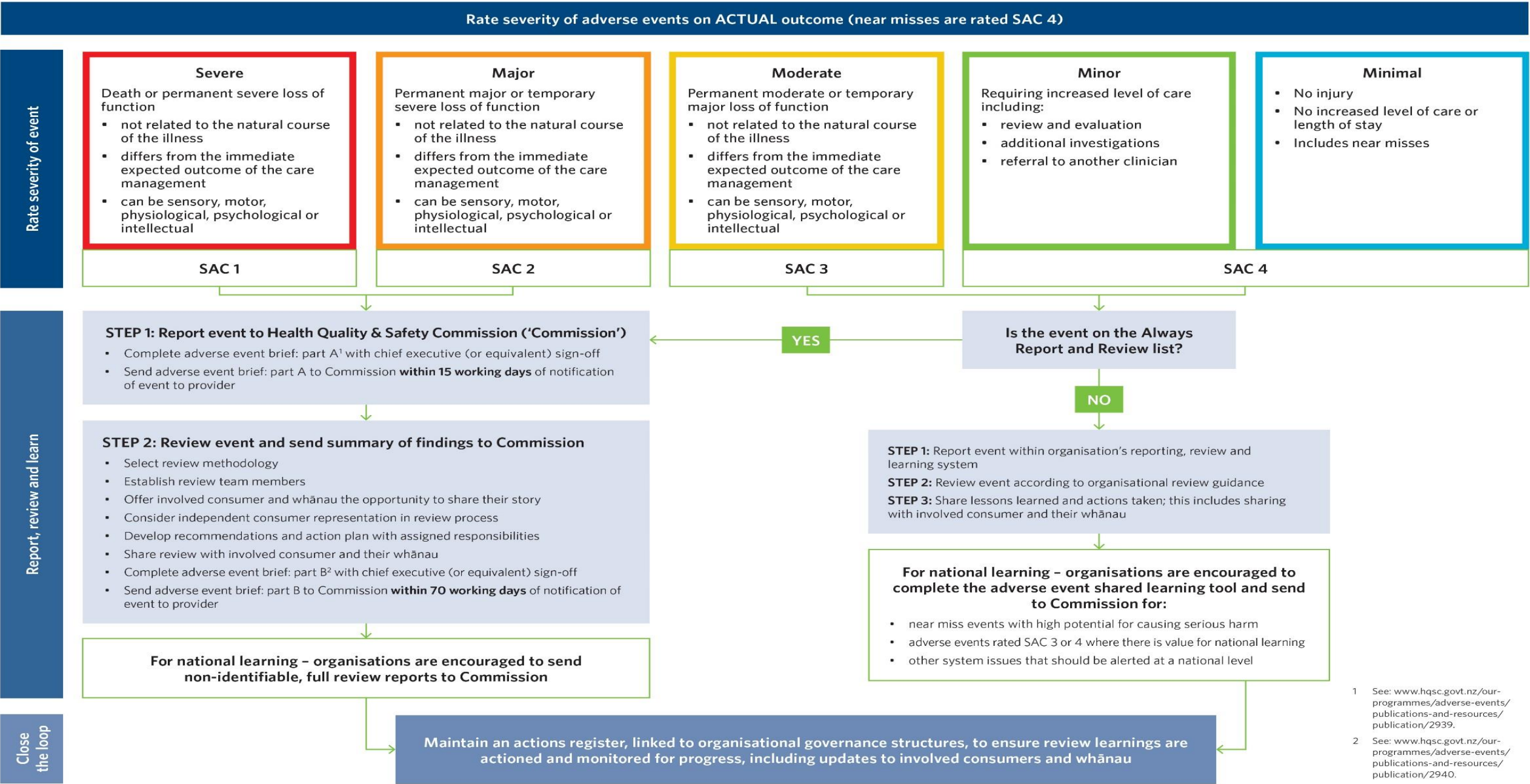
A screenshot of the Mentimeter mobile app interface. It shows a text input field with the code "15 29 07" entered. Below the field is a teal "Submit" button. Underneath the button, it says "The code is found on the screen in front of you". At the bottom, there is a link that says "Find nearby presentations".

Code: 15 29 07



*"Great news. There's a new, highly effective app
for what you've got."*

Severity Assessment Code (SAC) rating and triage tool for adverse event reporting



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

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

Always Report and Review List

Should be reported irrespective of harm

- Wrong blood product
- Wrong site
- Wrong implant/prosthesis
- Retained foreign object
- Wrong consumer/patient
- Child/infant abduction or discharge to wrong family

Mentimeter

www.menti.com

A screenshot of the Mentimeter mobile app interface. It shows a text input field with the code "15 29 07" entered. Below the field is a teal "Submit" button. Underneath the button, it says "The code is found on the screen in front of you". At the bottom, there is a link that says "Find nearby presentations".

Code: 15 29 07



*"Great news. There's a new, highly effective app
for what you've got."*

SAC rating

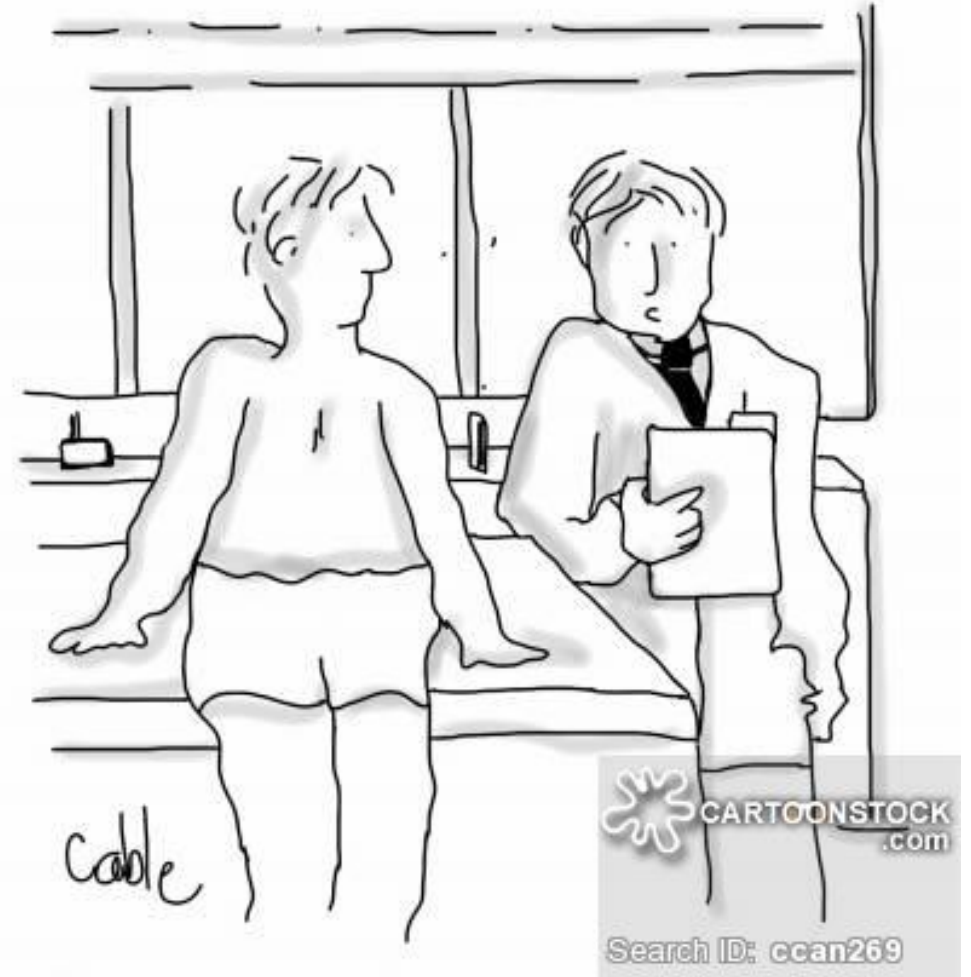
| Severe | Major | Moderate | Minor | Minimal |
|---|---|---|--|---|
| <p><u>Death</u> or <u>permanent severe</u> loss of function</p> <ul style="list-style-type: none"> • not related to the natural course of the illness • differs from the immediate expected outcome of the care management • can be sensory, motor, physiological, psychological or intellectual | <p><u>Permanent major</u> or <u>temporary severe</u> loss of function</p> <ul style="list-style-type: none"> • not related to the natural course of the illness • differs from the immediate expected outcome of the care management • can be sensory, motor, physiological, psychological or intellectual | <p><u>Permanent moderate</u> or <u>temporary major</u> loss of function</p> <ul style="list-style-type: none"> • not related to the natural course of the illness • differs from the immediate expected outcome of the care management • can be sensory, motor, physiological, psychological or intellectual | <p>Requiring <u>increased level of care</u> including:</p> <ul style="list-style-type: none"> • review and evaluation • additional investigations • referral to another clinician | <ul style="list-style-type: none"> • No injury • No increased level of care or length of stay • Includes near misses |

Mentimeter

www.menti.com

A screenshot of the Mentimeter mobile app interface. It shows a text input field with the code "15 29 07" entered. Below the field is a teal "Submit" button. Underneath the button, it says "The code is found on the screen in front of you". At the bottom, there is a link that says "Find nearby presentations".

Code: 15 29 07



*"Great news. There's a new, highly effective app
for what you've got."*

Thank you for listening

- Questions?...

Contact us

adverse.events@hqsc.govt.nz



"There are no stupid questions, so let's also agree there are no stupid answers."