Making Our Hospitals Safer

Serious and Sentinel Events 2010/11

Factsheet 3, February 2012

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

This is the third in a serious of regular factsheets from the Health Quality & Safety Commission.

It summarises a full report about the serious and sentinel events that occurred in New Zealand hospitals in the 2010/11 year. Every health professional is strongly encouraged to read the full report, and the breakdown of events for each district health board (DHB), which can be found at www.hqsc.govt.nz.

A **serious adverse event** is one that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function. A **sentinel adverse event** is life threatening or has led to an unexpected death or major loss of function.

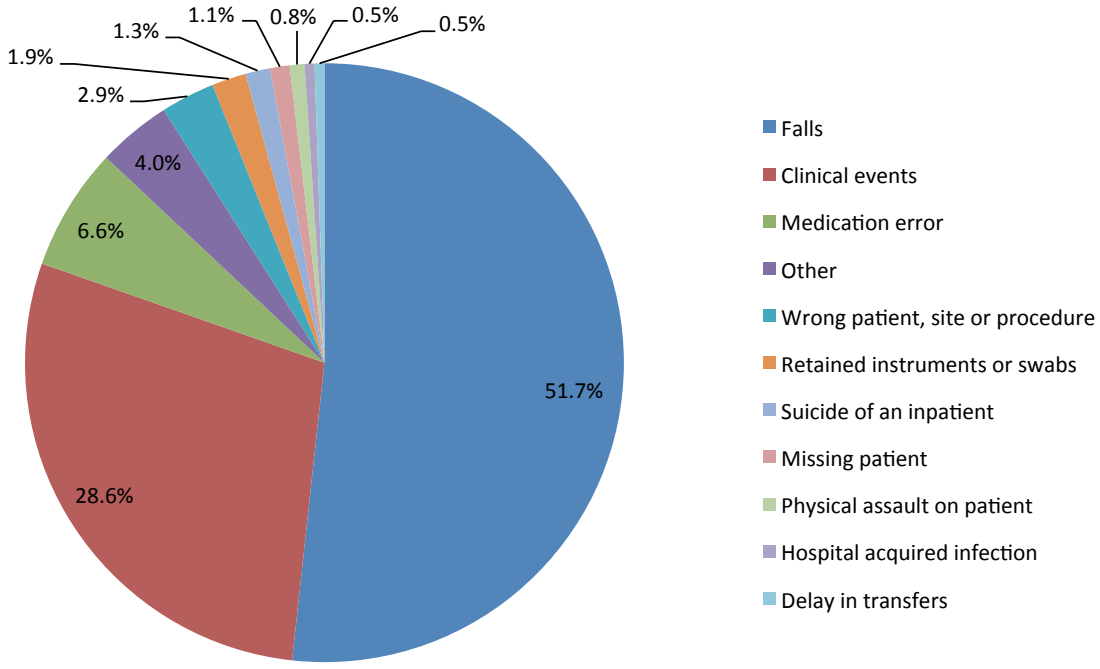
Serious and sentinel events 2010/11

In the 2010/11 year, 377 serious and sentinel events took place in our public hospitals. Of this total, 86 people died during admission or shortly afterwards, though not necessarily as a result of the event.

For the fourth successive year, the number of serious and sentinel events reported by DHBs has increased. This is mainly due to the greater number of falls being reported.

Each year, over 2.7 million people are treated in our public hospitals[1] and, as a proportion, few suffer serious harm. However, that does not change the fact that 377 serious or sentinel events occurred – a rate of more than one for every day of the year. As a consequence of these incidents, some people died and many suffered serious injury or disability.

Figure 1: Serious and sentinel events 2010/11



1 Workload in public hospitals during 2010/11: day patients: 407,000; inpatients: 634,000; outpatients: 1,744,000 (Source, Ministry of Health).

They were let down by the system that exists to protect them. We should view these incidents through the eyes of our patients and their families: many of them should never have happened.

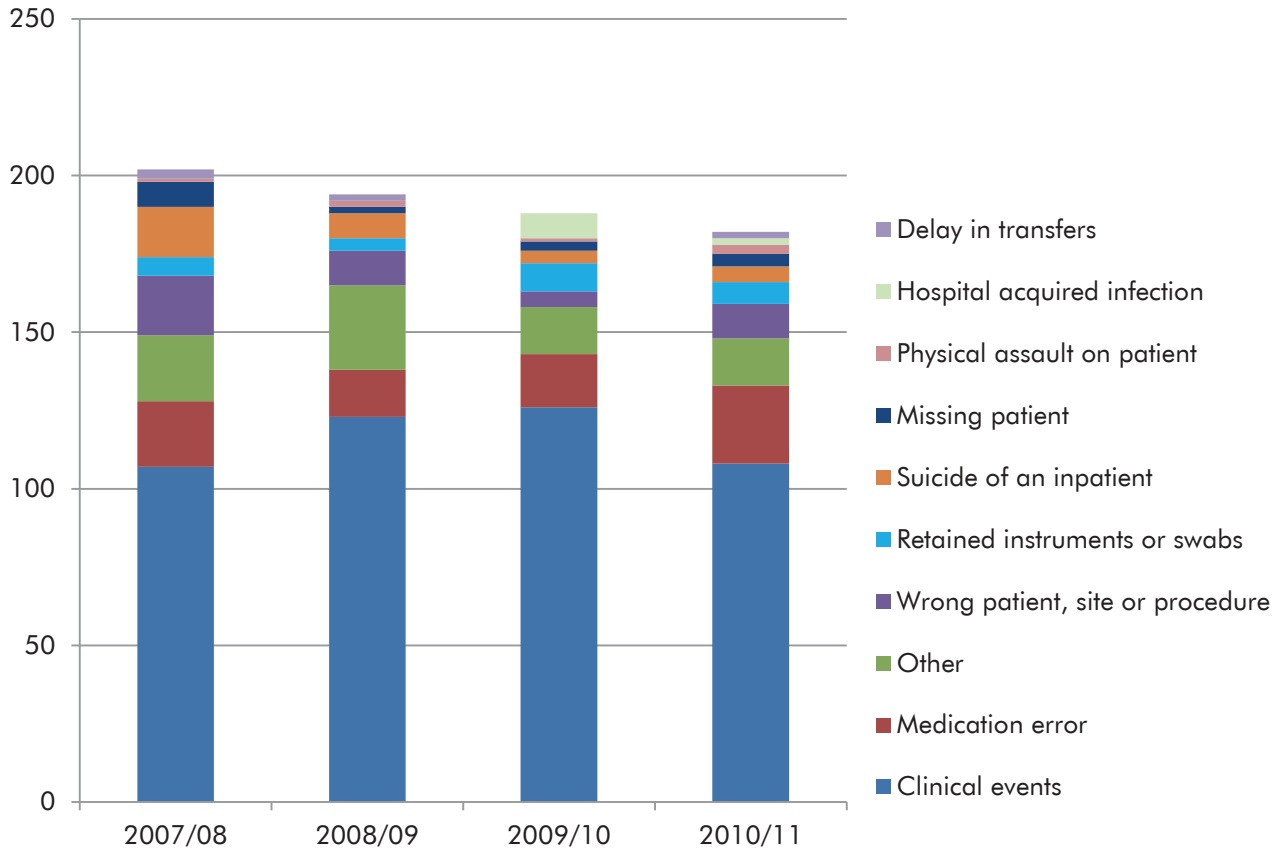
Summary of events

- For the 2010/11 fiscal year, DHBs reported that 377 people treated in their hospitals were involved in a serious or sentinel event that was actually or potentially preventable. This compares with 318[2] people in the 2009/10 year.
- Falls accounted for 52 percent of all serious and sentinel events reported in 2010/11 (195 incidents), a figure that has steadily increased each year from 2007/08. This increase in reporting of falls has driven the overall increase in serious and sentinel events reported, with no other category of event showing a similar increase. The Commission is working with the sector to reduce harm from falls.
- Clinical management events (eg, errors of diagnosis and treatment) accounted for 29 percent (108 incidents).
- Medication events (eg, giving a patient the wrong medicine, or an incorrect dosage) is the third largest category at 7 percent (25 incidents). Addressing these is a priority for the Commission. Fifteen DHBs have begun implementation of the national medication chart for adult inpatients (a paediatric chart is being developed), and 19 have implemented medicines reconciliation. Proposals have been sought for design, consultation and piloting of a national medication chart for the aged care sector. Agreement has been reached between the National Health Board, National Health IT Board and the Commission to a clinically-led national programme to implement patient-centred electronic medicines management in all public hospitals by 2014.

In consultation with senior mental health professionals and consumer representatives, we have concluded that the outpatient suicides reported in previous years are different in nature from, for example, a wrong-sided operation or harm to a patient from a fall.

In order to develop a more effective approach to addressing these very distressing events, the Commission has taken them out of the general reporting process and is working with experts from the mental health sector to develop a separate report that will consider them in the wider context of suicide.

Figure 2: Main event categories (minus falls) 2007/08 to 2010/11



2 Does not include cases of outpatient suicide.

Contributing factors to events

There are several recurring themes in the findings of events reported by DHBs:

- delays in responding to a patient's changing or deteriorating condition
- poor communication between health professionals resulting in harm to a patient
- delayed diagnoses due to failings in referral processes and the reporting of investigation results
- procedures that were wrong, or were performed on the wrong patient or site (11 in the 2010/11 year).

Events by DHB

The reporting of these events by DHBs is voluntarily, however the Commission expects DHBs will engage in this important process, particularly in analysing the root causes of these events and developing effective local responses to reduce them in the future. The Commission can then promote these nationally.

We recognise that DHBs reporting the most events in the greatest detail may have better local systems for reporting and investigating events, and perhaps a superior safety culture. A low rate of events reported by a DHB may indicate under-reporting and under-investigation of matters that go wrong; conversely, it may reflect the outcome of a very successful risk management programme – or a combination of both.

A new national reportable events policy has been introduced to make our expectations explicit. Among other things, this requires the chief executive (or equivalent) of every organisation to sign off on the recommendations of the reviews that have been carried out, therefore committing management at the highest level to this process.

Learning from events

This process is about ensuring these events become less frequent. Until now, we have mostly worked with DHBs, but all providers need to deliver services that are, first and foremost, safe. Our focus will be expanded to include other parts of the sector, including providers of disability services and community services, private providers, and aged care residential services.

It can be challenging to invest in safety. There are always competing demands on limited resources, and these resources vary – some DHBs are a tenth the size of others and many private providers smaller again. One way of addressing this is by working collaboratively, and we encourage DHBs to develop and enhance regional networks focused on quality and safety.

Reliable data are key to developing and monitoring strategies to improve the safety of patients in our hospitals. Accordingly, we are working with providers to improve

Figure 3: Sentinel or Serious Events, by DHB, 2006/07 to 2010/11

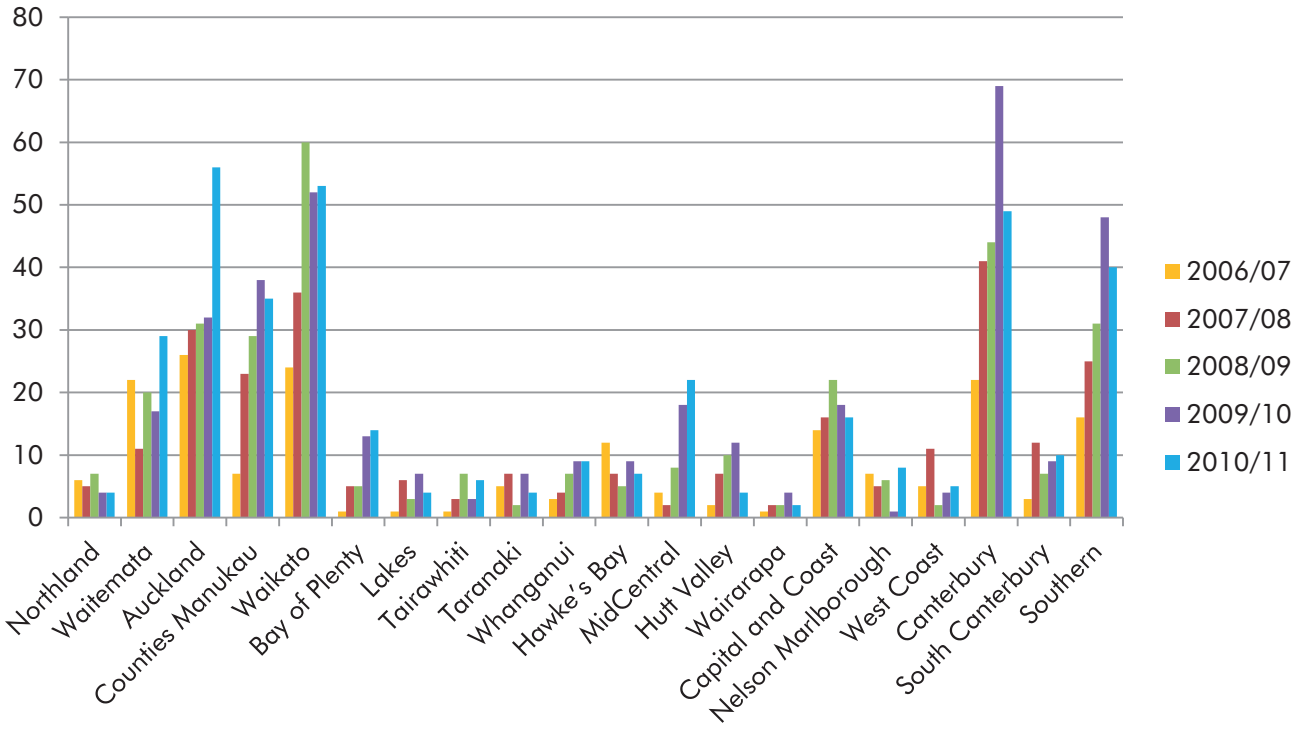
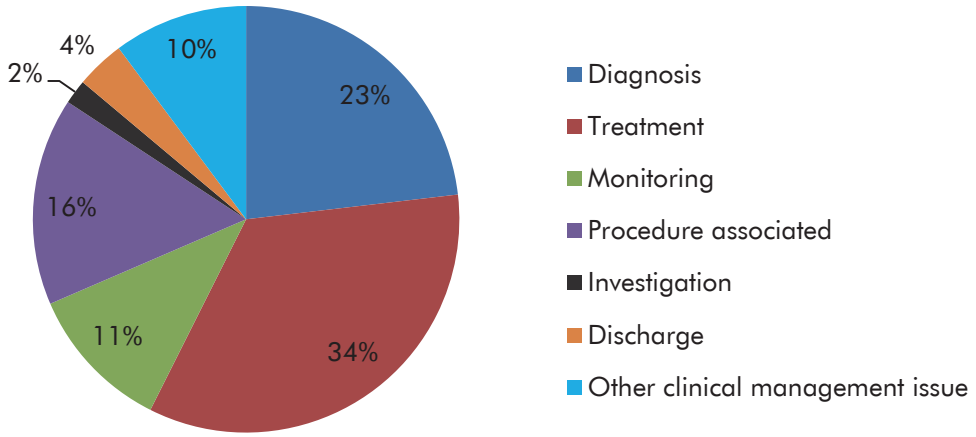


Figure 4: Clinical management events 2010/11



consistency in the reporting of these events. More work is needed to ensure every serious and sentinel event is locally analysed, the lessons learned implemented, and the key information sent to the Commission for collation at a national level.

The Commission is concentrating on a number of specific work programmes to support the health and disability sector to reduce the incidence of harm from preventable incidents.

These include:

- education and training, in particular web-based training packages
- publishing of detailed case studies
- development of a central repository for serious and sentinel events
- development of strategies to reduce harm from falls
- enhancing the engaged use of the World Health Organization's Safe Surgery Checklist
- national reportable events policy
- national medication chart, medicine reconciliation, and electronic medicines management
- infection prevention and control.

I have every confidence in the New Zealand health and disability sector's ability to rise to the challenge of reducing harm to patients. The point of reporting on these events is to learn from them, and to take actions that will make our health services progressively safer.

I consider that every health professional within our hospitals has a responsibility to read the full report, and particularly the details about how real people have been injured by our health care services during 2010/11. These reports are compelling and provide powerful motivation to continue this important effort to achieve the highest possible levels of safety within our health system and community services providers, and aged care residential services.

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Published in February 2012 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146.
ISBN 978-0-478-38518-2 (print)
ISBN 978-0-478-38519-9 (online)
This document is available on the Health Quality & Safety Commission website at: ***www.hqsc.govt.nz.***

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