|  |  |
| --- | --- |
| **Purpose** | name of service applies a systematic approach to adverse, unplanned and untoward events to ensure that such situations are managed in a transparent manner. The analysis of the events will be used to continuously improve the services provided.  |
| **Scope** | This document applies to all name of service * service users
* their family/whānau
* personnel (personnel includes employed and contracted people)
 |
| Related image | This document is about adverse events that relate to service delivery.For example: medication errors, infections, crisis requiring interventions, complaints by service users or their families, abuse, neglect etc.Health and safety at work accidents/incidents need to be managed in line with Health and Safety at Work legislation as per Health and Safety at Work Policy and Procedures.It is suggested that organisations set up their adverse event system to match the reportable event codes in the [National Reportable Event Policy](http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf). |
| **References** |
| **Type** | **Title** |
| **Related internal** **policies/****procedures** | Infection Prevention and Control Manual Complaints Management Medication ManagementQuality FrameworkDeath of a Service User |
| **Legislation** | * [Coroners Act 2006](http://www.legislation.govt.nz/act/public/2006/0038/latest/whole.html)
* [Health Act 1956](http://www.legislation.govt.nz/act/public/1956/0065/latest/DLM305840.html)
* [Health and Disability Services (Safety) Act 2001](http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html)
* [Health Practitioners Competence Assurance Act 2003](http://www.moh.govt.nz/hpca)
* [Mental Health (Compulsory Assessment and Treatment) Act](http://www.legislation.govt.nz/act/public/1992/0046/latest/whole.html)
* [Section 31 Reporting](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31)
 |
| **Documents/****Guidelines** | * [Guidance to open disclosure policies](http://www.hdc.org.nz/decisions--case-notes/open-disclosure)
* [Open disclosure e-learning](http://learnonline.health.nz/)
* [Guide to adverse medication response reporting](http://www.medsafe.govt.nz/profs/PUarticles/ADRreport.htm)
* [New Zealand Health and Disability National Reportable Events Policy](https://www.hqsc.govt.nz/our-programmes/reportable-events/national-reportable-events-policy/)
* [Reporting and reviewing adverse events involving users of mental health services](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf)
* [WHO: Conceptual Framework for the International Classification for Patient Safety](http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf)
 |
| **Standards** | * [NZS 8134:2008, Health and Disability Services Standards](https://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf)
 |
| **Definitions ( NZ Health Quality and Safety Commission)** |
| **Adverse Event** | An adverse event is an incident which results in harm to a service user.  |
| **Incident**  | An incident is any event that could have or did cause harm to a service user.  |
| **Near miss incident** | An incident which under different circumstances could have caused harm to a service user but did not, and which is indistinguishable from an adverse event in all but outcome. |
| **Open Disclosure** | [Open disclosure](http://www.hdc.org.nz/decisions--case-notes/open-disclosure), or open communication, refers to the timely and transparent approach to communicating with, engaging with and supporting service users, their families and whānau when things go wrong. |
| **RCA** | [Root cause analysis](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf): a formal process of investigation designed to identify the root causes of adverse events. |
| **Reportable event** | Any adverse event classified as a SAC 1 or SAC 2. Refer to the [Severity assessment code](https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/636/). Services that require HealthCert certification will also need to report events under [Section 31 Reporting](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31) |
| **SAC** | [Severity assessment code](https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/636/). This is a risk matrix.  |
| **Serious incident review** | This term refers to the type of [review](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf) conducted for serious and sentinel mental health events.[The London Protocol](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/528/) is also recommended to use in analysing serious incidents.  |
| **Abbreviations** |
| **AEICR** | Adverse Events Incident Complaint Record: This is a template used to record all adverse events and health and safety related accidents and incidents. |
| **AL** | Adverse events log. This is the system services use to log all adverse events and accidents. |
| **SIR** | Service Improvement Request: This is a term used instead of corrective action. |

**Managing a near miss incident**

**Same day**

**Personnel involved**

* Completes the adverse event/incident/complaint report (AEICR).
* Inform the ……….

**Reporting under section 31 Health and Disability Services Act 2001 to HealthCert:**

Examples:

Service user has left facility without staff knowledge where cognitive impairment/medical condition causes a safety risk to the resident.

A police investigation has started because late night revellers causing noise/damage or there has been an abusive visitor.

**Within 24 hours**

**Manager or designated staff member**

* Follows open disclosure.
* Puts measures in place to prevent recurrence of the near miss incident.
* Enters the near miss incident into the adverse event log.

If relevant include:

* other service providers (DHB, GP),
* cultural advisors,
* family/whānau.

**Within 1 week**

**Manager or designated staff member**

* Analyze cause of the near miss incident.
* Develop service improvement measure (SIR)

Consider applying the [Severity assessment code](https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/636/).

**Within 8 weeks**

**Quality Committee**

* Monitor implementation of service improvement measures.
* Update the adverse event log.

**Managing an adverse event**

**Immediately**

Examples:

* Apply first aid.
* Do CPR.
* Call the ambulance.
* Call the fire service.
* Call Mental Health crisis service.
* Ensure the service user receives appropriate treatment/intervention.

**One person to take charge of the situation**

Phones manager or on call staff.

Takes measures to ensure safety of the service user and persons present.

**As soon as safety has been established**

Follows the notification requirements [section 31](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31) of the Health and Disability Services Act 2001.

**Person in charge**

Puts measures in place to mitigate**,** contain and manage the cause and/or effect of the adverse event.

**Within the same day**

For [SAC 1 and SAC 2](http://www.hqsc.govt.nz/assets/Reportable-Events/Resources/severity-assessment-code-poster-v1-1.pdf) incidents consider implementing the [Health Quality and Safety Commissions processes](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf).

**Person in charge**

* Completes the adverse event report

If relevant include:

* other service providers (DHB, GP),
* cultural advisors,
* family/whānau.

**Within 24 hours**

**Manager or designated staff member**

 or

* Plan and/or apply open disclosure.
* Notify/communicate (refer to last page)
* Respond to the adverse event and follow through with documentation on the adverse event report
* Ensure [de-brief](http://www.psqh.com/novemberdecember-2008/91-november-december-2008/278-debriefing-for-patient-safety.html) occurs – for service users and staff occurs.

Initiates a Root Cause

Analysis.

Templates and processes are available in the [national reportable events policy](http://www.hqsc.govt.nz/our-programmes/reportable-events/national-reportable-events-policy/)



**Do not manage a serious incident on your own – call for assistance!**

Refer to the Notification/Communication Flowchart!

**Managing a serious harm event/sentinel event- Additional to the adverse event process**

* Reviews all documentation.
* Determines the severity of the incident [(SAC)](http://www.hqsc.govt.nz/assets/Reportable-Events/Resources/guide-to-using-sac-2008.pdf)
* Signs off the completed Adverse Event Report.
* Ensures action to prevent recurrence is taken.
* Ensures service improvement measures are formulated.

**Within 2 working days of the event**

**Manager/delegate**

Arranges ‘Serious Harm Review’ panel who will conduct a ‘Root Cause Analysis’,[The London Protocol](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/528/) or [Review](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf) of the event.

**Within 15 working days (SAC 1 and SAC 2)**

**Within 10 working days of the event**

**Serious harm review panel**

**Manager/delegate**

* Clarify the facts surrounding the event.
* Identify causative factors.
* Root cause analysis, [The London Protocol](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/528/) or [Review](https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reporting-reviewing-adverse-events-MH-Dec-2012.pdf) is completed.
* Complete the Serious Incident Report (or use the [national template)](http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf).
* Provide the report to identified individuals/ services.
* Ensure [open disclosure](http://www.hdc.org.nz/decisions--case-notes/open-disclosure) is implemented.
* Ensure service improvement measures are formulated.
* Inform staff involved of the outcome of the review.
* Consider reporting to the [central repository](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/306/).

of the outcome of the investigation

**Follow-up processes**

**Manager or delegate**

**6 monthly or yearly (depending on the frequency of adverse events)**

**1 Month after the completion of the report**

1. Assesses adverse event documentation and interventions.
2. Makes necessary changes.
3. Monitors effectiveness of service improvement measures.
4. Evaluates trends.
5. Monitors continuous improvement strategies.
6. Initiates reporting to the required authorities occurs (refer also to the list on the next page.

**Trend analysis (examples)**:

* volume
* date/time patterns
* location
* nature of the event
* repetitive patterns
* interrelationships with other events
* effectiveness of service improvement measures
* risk rating.

**Adverse Events Notification/Communication**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reported to** | **Type of adverse event** | **Examples** | **Reported by** | **Time frame** |
| Funding and planning agency(for example: DHB, MSD)and name of service Board/Director | **Near miss incident**Any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided. | Media have knowledge of the near miss incident | CEO/Manager/Director | Within 48 hours or next working day.Quarterly reports. |
| Cause of the near miss incident was misconduct or neglect of any service provider involved in service users’ service delivery. |
| [HealthCert](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31) (only services that include accommodation). | Service user has left facility without staff knowledge where cognitive impairment/medical condition causes a safety risk to the resident.  |
| A police investigation has started because late night revellers causing noise/damage or there has been an abusive visitor. |
| **Health Quality and Safety Commission -** [central repository](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/306/)**.** | The near-miss incident is of national interest in terms of learning.SAC 4 | Within 70 days of the incident.  |

**Adverse Events Notification/Communication**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reported to** | **Type of adverse event** | **Examples** | **Reported by** | **Time frame** |
| Funding and planning agency(for example: DHB, MSD)and name of service Board/Director | **Adverse event**Any investigation commenced by a member of the police into any aspects of the service. | Infectious disease outbreaks.Adverse event requiring transfer to higher level of care, including hospitalization.All the situations that are reported to HealthCert and the Health Quality and Safety Commission. | CEO/Manager/DirectorThe service users’ general practitioner.CEO/Manager/Director | Within 48 hours or next working day.Quarterly reports. |
| Public Health | [Notifiable diseases](http://www.health.govt.nz/our-work/diseases-and-conditions/notifiable-diseases)  | When condition is identified. |
| [HealthCert](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31) (only services that include accommodation). | Physical assault by staff of service user or service user assaulting a service user or a member of the public. Financial abuse by staff of service user or service user financial abuse of another service user. When police investigation started as a missing service user not found. Service user on leave and not returned by family. | Within 48 hours or next working day. |
| Health Quality and Safety Commission **-** [central repository](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/306/) | Permanent or temporary loss of function that is related to the process of health care and differs from the expected outcome of that care. | Administering medication the service user is allergic to.SAC 1,2,3 | Within 70 days of the adverse event. |

**Adverse Events Notification/Communication**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reported to** | **Type of adverse event** | **Examples** | **Reported by** | **Time frame** |
| Funding and planning agency(for example: DHB, MSD)and name of service Board/Director | **Serious harm event and sentinel event.**Sudden deaths.Death or permanent severe loss of function that is related to the process of health care and differs from the expected outcome of that care. | All situations that are reported to HealthCert and the Health Quality and Safety Commission. | CEO/Manager/Director | Within 24 hours |
| [HealthCert](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31) (only services that include accommodation). | Unexpected death in otherwise stable resident.Suicide.Unsigned death certificate because locum GP unwilling to sign.Death of a service user who is under a Compulsory Treatment Order (Mental Health). |
| Health Quality and Safety Commission **-** [central repository](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/306/) | Wrong consumer or wrong procedure that caused severe harm. | SAC 1 and SAC 2: Within 15 days of the adverse event. |

# Consultation

|  |  |
| --- | --- |
| Group/Role | Date |
|  |  |
|  |  |
|  |  |
|  |  |