Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Adverse Event and Incident Management

Type: Policy	**HDSS Certification Standard** 1.2.4
Issued by: Quality, Risk & Innovation	**Version:**
Applicable to: All Staff	**Document Owner:** Executive Leader Quality, Risk and Innovation – Chris Stewart

Policy Statement

At Wairarapa District Health Board (WrDHB) there is a 'just culture' and all adverse events and incidents (including near misses) are notified, reported, reviewed and managed in a professional and respectful manner that ensures lessons are learnt to improve quality and safety for patients and their family/whānau and employees. These practices will comply with:

- The New Zealand health and disability services National Adverse Events Reporting Policy 2017 and all adverse, unplanned, or untoward events will be systematically recorded and will be reported to affected consumers and where appropriate their family/whanau of choice in an open manner
- HDC Code of Rights
- The Health and Safety at Work Act 2015
- External reporting requirements outlined in the Health and Disability Services (Safety) Act 2001
- Privacy Act 1993, the Health Information Code 1994 and the DHB General Disposal Authority.

Purpose

To improve the quality, safety and experience of health and disability services through a system that:

- Provides a robust and transparent reporting, review and learning system for adverse events and incidents affecting patients their family/whānau and employees
- Demonstrates public accountability and transparency through open disclosure
- Enhances safety and is consumer and family/whānau-centered
- Empowers patients and their family/whānau and staff to report adverse events and incidents and near misses without fear of retribution
- Ensures staff are supported through any occurrence of any adverse event or incident and its subsequent review.

Scope

This policy applies to:

- All employees (permanent, temporary and casual), visiting clinicians, contractors, students and volunteers
- All healthcare adverse events and incidents (including near misses) that occur or have the potential to occur as a result of the provision of health and disability services (managed in alignment with the National Adverse Events Reporting Policy 2017)
- Occupational health and safety events affecting employees, employers, contractor or volunteers (managed in alignment with the Health and Safety at Work Act 2015).

Out of Scope

This policy does not apply to:

- Employment relationship issues and events, these are managed under the Employment Relations Act 2000 and should be referred to Human Resources; any incidents involving a criminal act, use of illicit drugs or alcohol, deliberate unsafe action or deliberate patient harm, these should be referred to Human Resources.

Roles, Responsibilities and Reporting Requirements

Role	Responsibility/accountability
All WrDHB employees	Report all adverse events/incidents through SQUARE and in patient's clinical record
Executive Leader Quality, Risk and Innovation	Develop, manage and review policy, systems and processes that support the implementation of the policy Lead and develop training for review or adverse events and incidents Support organisational learning and safety improvement from adverse events and incidents through reporting to Clinical Board and Hospital Advisory Committee
Charge Nurse Managers/Clinical Leaders/Team Leaders/Senior Medical Officers	Ensure all reporting staff are aware of their responsibilities in relation to Adverse Event and Incident Management Manage, monitor and review adverse events and incidents within areas of delegated responsibility Participate in reviews of SAC 1 & 2 and 'always report' adverse events in conjunction with Clinical Event Review Group
Medical Staff	Coroners notification, Notifiable diseases, ACC treatment injuries
Director of Area Mental Health	Reporting of patient deaths as required under section 132 of Mental Health Act (1992)
Patient Experience Coordinator	Coordination and administration of SAC 1 & 2 and 'always report' adverse events Monitoring compliance with the National Adverse Events Reporting Policy Reporting SAC 1 and 2 and 'Always Report' Events to HQSC
Quality Clinical Nurse Coordinator	Oversight of review of and trends emerging from clinical adverse events and incidents
Clinical Event Review Group	Review of clinical adverse events and incidents with the purpose of highlighting where systems, processes, policy, or procedure could be improved, emerging trends, and/or where further education/change is required Support open disclosure process
Health and Safety Manager	Oversight of review of and trends emerging from health and safety related incidents Reporting to WorkSafe where serious harm occurs
Clinical Board	Governance for implementation and compliance with this policy

Other External Reporting Requirements

Event Description	Reporting Agency
SAC 1 and 2 and 'Always Report Events'	Health Quality and Safety Commission (HQSC)
Deaths that must be reported under Section 13 (2) 2 & 3 Coroners Act 2006	Coroner
Notifiable diseases under the Health Act 1956	Medical Officer of Health , Ministry of Health
Treatment injuries	ACC
Unintended adverse reaction to medicine, psychoactive substances, recreational substance and legal high substances	Centre of Adverse Reactions Monitoring (CARM)
Events relating to quality of medicines or medical devices	Medsafe, Ministry of Health
Serious harm event involving employees or contractors Event involving explosives, electrical equipment, fuel gas	WorkSafe
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 Any investigation commenced by a member of the police into any aspects of the service Any death of a person to whom you have provided services, or occurring in any premises in which services are provided, that is required to be reported to a coroner under the Coroners Act 1988.	Director General, Ministry of Health
Events relating to misadministration of radioactive material	Office of Radiation Safety, Ministry of Health

Definitions

Adverse Event – an event with negative or unfavorable reactions or results that are unintended, unexpected or unplanned (also referred to as 'incident' or 'reportable event')

Just Culture - one in which personnel are comfortable disclosing errors, including their own, while maintaining accountability. It recognises individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients of gross misconduct

Near Miss – an event which, under different circumstances, could have caused harm to a consumer but did no, and which is undistinguished from an adverse event in all but outcome

Open Disclosure – the timely and transparent approach to communication with, engaging with and supporting patients and their family/whānau when adverse events occur

Review – a formal process that is carried out to analyse an adverse event, incident or near miss and develop recommendations based on the findings

SQUARE – Safety Quality and Reportable Events electronic reporting system (RL 6)

References

Health and Disability Commissioner - Open Disclosure
Health and disability services Standards (HDSS) 8134:2008
Health and Disability Commission 'Code of Rights'
DHB General Disposal Authority

Related Documents

Adverse Event and Incident Management Procedure
Health and Safety Policy
Open Disclosure Procedure

Legislation

National Adverse Events Reporting Policy 2017
Health and Safety at Work Act 2015
Health and Disability Services (Safety) Act 2001
Privacy Act 1993
Health Information Code 1994
Health Act 1956
HDC Code of Rights

Keywords for searching:

- Adverse event, incident, near miss

Approval Authority Signature

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