PURPOSE

The purpose of the event management system at Hawkes Bay DHB is to:

1. Identify, report and analyse all events[1] that cause harm or have to the potential to cause harm to staff, patients and anyone else affected by the HBDHB's activities.

2. Set out the system for the DHB to, review and improve the systems that assure clinical safety and personnel health and safety to reduce risk for staff, patients and others.

3. To contribute to improved quality, safety, experience and efficiency of health and disability services through:
   - early identification, reporting and review of events
   - sharing lessons learned through the review process so preventable events are not repeated
   - transparency, open communication and accountability.

4. Provide information to inform organisational improvement activities.

PRINCIPLES

The fundamental role of the event management system is to enhance consumer and staff safety by learning from events and near misses that occur in Hawke's Bay District Health Board (HBDHB). The following principles underpin this policy:

1. The National Adverse Events Reporting Policy for New Zealand Health and Disability Services (Health Quality and Safety Commission, 2017) is the foundation for this policy.

2. Open communication is essential to the event reporting and review process. Consumers, their families/whanau and staff are legally and ethically entitled to transparent, truthful and open communication at all times following an event and throughout any subsequent review.

3. Affected people are encouraged and supported to participate in the review process. Where appropriate the health consumer, families/whanau and staff involved in the adverse event will be offered the opportunity to share their story as part of the review process. Review findings and recommendations will be shared with people involved in the review.

4. Reviews of events will result in actions to improve the quality and safety of health care. Health consumers, families/whanau and staff will be assured that when events and near misses occur, action is taken. Action focuses on learning, improving safety, reliability and reducing the possibility of recurrence.

5. Analysis of trends informs continuous learning and system changes. Reporting is only of value if it is accompanied by meaningful analysis which leads to recommendations for

[1] The term event is used throughout this policy to mean a near miss/good catch or actual incident which has the potential to cause harm, or has caused harm to a patient, staff member, contractor or visitor to Hawkes Bay DHB.

system changes designed to prevent recurrence of events. Lessons learned must be disseminated.

6. Event reporting is encouraged through a no blame culture. Consumers and staff must be encouraged to report events in the interests of improvement and without fear of retribution. Events that are reported will be investigated with a focus on determining the underlying system failures and not attributing blame to individuals. Leaders must ensure a fair and just culture prevails so individuals are not held accountable or punished for system failures.

7. Event review practice will emphasise culturally safe participants. The cultural viewpoint and practices of a consumer and their whanau or staff members are considered when they are involved in the event review process.

8. Events that involve a criminal act, or substance abuse by any individual(s) employed by HBDHB, a deliberate unsafe act, or a deliberate consumer harm will be managed in a separate process and will involve the relevant regulatory authorities.

9. RADAR (electronic risk reporting system) will be readily accessible to all staff.

SCOPE

This policy applies to all HBDHB staff, including honorary or unpaid employees, temporary employees, students, volunteers, contractors and any other persons working for, or providing services to Hawkes Bay DHB.

Exclusions

This policy does not apply in the following cases:

1. Complaints; made by persons receiving care and treatment from HBDHB are covered by the Consumer Feedback Policy – HBDHB/OPM/001.

2. Employment relationship issues and events affecting any employee in health and disability service settings in New Zealand. These are managed under the Employment Relations Act 2000 (and regulations) that aim to build productive employment relationships through the promotion of good faith in all aspects of the employment environment and the employment relationship.

3. Intentional harm. In any of the following situations the event must be reported through the events system, however it will be investigated differently.

    - A criminal act
    - A deliberately unsafe act
    - Substance abuse by any individual(s) employed by HBDHB
    - Deliberate patient harm or abuse

4. *Whenever it is discovered any event has any element of intentionality it will be* reviewed *through one or a combination of the following systems:*

    - Event system = just culture i.e. focuses on systems, process issues but has zero tolerance for reckless behaviour.
    - Conflict resolution = debriefing, meetings and/or arrangements/agreements made between parties in conflict
    - Performance management
    - Disciplinary action - refer to Disciplinary Policy

EVENT REPORTING AND MANAGEMENT

HBDHB will design and review the policy and system for reporting and reviewing events to comply with guidelines set out by the New Zealand Health Quality and Safety Commission.

The procedure for reporting and reviewing events at HBDHB is set out in the accompanying Event Management Guideline – OPM123.

All events including near misses must be submitted into RADAR (electronic risk management system) within 24 hours of the event.

The employee who first becomes aware of the event; or the employee most involved in the event; or the employee to whom the event is reported is responsible for completing and submitting the event form

Any reported near miss or event resulting in harm to a patient must be documented in the patient's health record with a reference to the original event notification form number and any actions taken.

Any staff member involved in an event will be supported to access assistance as required through the DHB Human Resources team, Occupational Health team and/or their professional or industrial body.

If an event is regarded as "notifiable" to Worksafe NZ, the Health and Safety Advisor (or delegate) must be advised immediately. Worksafe website: https://worksafe.govt.nz/

The Directorate leadership team with overall responsibility for an event is identified by where the event occurred and can be further quantified by where the improvement work needs to occur. For example if a patient goes to radiology from a surgical ward and falls while in Radiology, the review and communication of the event is the responsibility of the Radiology Department and not Surgical Services.

The Directorate leadership team is responsible for disclosing information and communicating with consumers, their whanau and/or representative and staff.

The Directorate leadership team is responsible for finalising the review prior to CREAG and for the action of recommendations following review.

All events on the Health Quality and Safety Commission 'Always Report and Review[2]' list will be reported and reviewed.

The Severity Assessment Code (SAC) table is used to determine the severity of any event. Severity is based on ***actual*** outcome ***(see Appendix 1).***

Severity Assessment Code (SAC) 1 and 2 events (Adverse Events)
Note: see Appendix 1 for event severity definitions.

A formal review will be undertaken of all SAC1 and SAC2 adverse events (AE), including mental health events, and any events on the Always Report and Review list using a recognised event review methodology (e.g. London protocol or Root Cause analysis etc).

Recommendations or actions generated through the review of any AE are designed to eliminate, control, or accept the root causes/causal factors identified for the adverse event.

[2] HQSC Always Report and Review

Monitoring to evaluate the impact of recommended actions on care, services and outcomes will be undertaken at 6 and 12 months after the completion of the action.

SAC 1 and SAC 2 events (collectively referred to as adverse events (AE)) will be reported to the Heath Quality and Safety Commission (HQSC) within 15 working days from the date the adverse event is reported.

A summary of the findings and recommendations from any AE, using the Adverse Event Brief Part B template, is sent to the Health Quality and Safety Commission within 70 working days from the date the adverse event is reported. This summary must include an outline of the actions agreed by the Clinical Risk Event Advisory Group, the plan for implementation of the actions or the reasons for not implementing the recommendations.

The Patient Safety and Clinical Compliance Service will ensure reporting to HQSC is completed.

SAC 3 and 4 Events
Note: see Appendix 1 for event severity definitions.

The area manager or delegate is responsible for reviewing all SAC3 and 4 events and providing a robust report, including recommendations for system improvements.

When no recommendations are generated through the review, the review report must note the fact.

Reviews of SAC3 and 4 events and good catch/near misses must be undertaken and closed within 30 working days.

The area manager or their delegate is responsible for monitoring corrective actions generated through the review of SAC 3 and 4 events and maintaining an audit register.

The area manager or their delegate is responsible for analysing trends and for reporting identified system problems through organisational escalation pathways.

OPEN COMMUNICATION IN AN EVENT REVIEW

The directorate leadership team is responsible for disclosing information and communicating with consumers, their whanau and/or representative and staff in line with the Open Communication Policy OPM/111.

ACCOUNTABILITY in and EVENT INVESTIGATION - a Fair and Just Culture

HBDHB aims to maintain a fair and just organisational culture where people trust they will be treated with respect.

Maintaining and promoting a fair and just culture relies on:

- acceptance that management systems can be improved;
- recognition that people can and do make mistakes;
- understanding that people/groups at all levels may develop unhealthy /unsafe patterns of behaviour; and
- knowledge that reckless conduct will not be tolerated.

Hawke's Bay DHB supports the use of James Reason's *Decision Tree for Determining Culpability of Unsafe Acts* including the *Substitution Test* (but not limited to) to determine whether actions were reasonable and appropriate and if behaviour is risky, reckless or unintentional ***(see Appendix 2)***.

FEEDBACK IN AN EVENT REVIEW

1. Any person who submits an event form and any staff involved in an event must be given feedback by their manager (or delegate), describing investigation findings, outcomes and recommendations unless they have specified "no feedback required".

2. RADAR allows the submitter of an event to log into that event and check the progress via the File Submission Tracker page.

3. Lessons learned from event review will be shared with staff through quality reports, department meetings, internal committees and staff newsletters etc.

DOCUMENTATION IN AN EVENT REVIEW

Storage and retention of information related to events

The original event form, all related documentation and correspondence must be filed securely in the event management system and associated systems for a minimum of 15 years.

Copies of event forms involving employees will be kept **indefinitel**y by the OH&S Team for ACC purposes and in compliance with the Health and Safety at Work Act 2015.

Each event notification form will be sequentially numbered to enable easy access, tracking and identification.

System Assurance

Documentation of any event review may be audited.

Periodic audits by the system administrators will evaluate compliance with event management policies and procedures. The event management contingency plan will be activated in the event of failure of the event management system.

All documentation, including the event form, investigation, identified causal / contributing factors, recommendations, action plans and evaluation of implemented changes must be saved in a way that enables ready access for audit.

Protection of Information

Where a patient or external agency requests information related to an event, the request must be forwarded to the HBDHB Privacy Officer/s who will determine the appropriate person or department to respond to the request.

Information gained from the event notification is confidential to HBDHB except where disclosure is required by law, e.g. notification of accidents to WorkSafe New Zealand, NZ Police, HBDHB's risk insurer or under the Privacy Act 1993, Health Information Privacy Code 1994 or Official Information Act 1992 (subject to withholding grounds).

MEASUREMENT CRITERIA

Directorate Leadership Teams are responsible for monitoring ***all*** event recommendations, actions, trends, evaluating changes and disseminating lessons learned to staff.

All adverse events, recommendations and trends are monitored and analysed by HBDHB Clinical Governance Committees. The Clinical Governance Committees include but are not limited to Clinical Risk & Event Advisory Group, Pharmacy and Therapeutic Advisory Group, Patient Safety and Risk Management Committee.

ASSOCIATED DOCUMENTS

- Clinical Risk and Event Advisory Group Terms of Reference
- Critical Incident Stress Management Defusing Debriefing Policy - EPM/031
- Consumer Feedback Policy – OPM/001
- Disciplinary Policy - PPM/012
- Event Management Guideline – OPM/123
- Event Management Process Flowchart (Appendix 1) – OPM123
- Event Reporting and Consumer Feedback Training Guides
- Open Communication Policy – OPM/111
- Health and Disability Code of Rights
- Health and Safety Policy – OPM/019
- Health and Safety at Work Act 2015 and associated regulations
- Health & Safety Standard 4801
- ISO 31000
- National Adverse Events Reporting Policy (2017) and associated documents https://www.hqsc.govt.nz/our-programmes/adverse-events/
- New Zealand Standard 8134:2008 Health and Disability Services (General) Standard
- Retention Schedule - General Disposal Authority for District Health Boards

REFERENCES

Health Quality and Safety Commission (HQSC). *Health and Disability Services' National Reportable Events Policy*. Wellington; 2017

Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A framework for Safe, Reliable, and Effective Care.* White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.

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Vincent C, Patient Safety. Second Edition. Wiley-Blackwell. BMJIBooks. 2010

DEFINITIONS

Adverse Event
An event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned13 (also referred to as 'incident' or 'reportable event'). In practice this is most often understood as an event which results in harm or has the potential to result in harm to a consumer.

Consumer
For the purposes of this Policy a consumer can also be a client, patient or resident. It is the person who uses/receives health and disability services, or their representative.

Near Miss
This is an event which, under different circumstances, could have caused harm to a consumer but did not, and which is indistinguishable from an adverse event in all but outcome.

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.

RADAR (Report, Analyse, Determine, Act, Resolve)
The electronic risk management system where events, complaints, complements and organisational risk is reported, managed and monitored.

Review
A review is another name for a formal process that is carried out by the health or disability service provider to analyse an adverse event or near miss and develop recommendations based on the findings. There are a variety of review methodologies.17 Reviews can be undertaken at different levels, depending on the adverse event (e.g. comprehensive, concise, desk-review or single aggregated review of similar events).

Severity Assessment Code (SAC)
The SAC is a numerical rating which defines the severity of an adverse event and as a consequence the required level of reporting and review to be undertaken for the event.18

Whānau
The family or extended family/group of people who are important to the consumer.

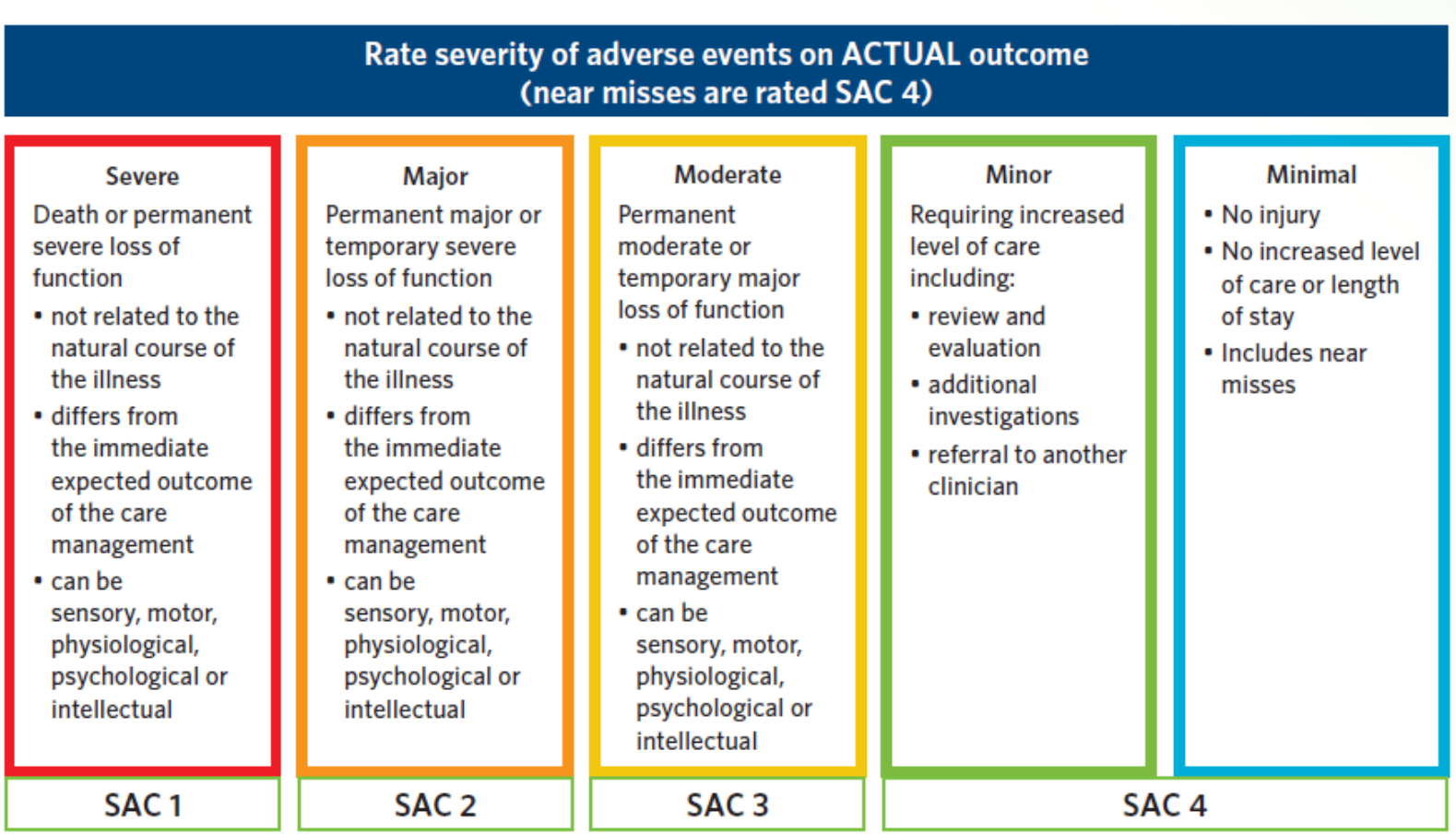
KEY WORDS

Adverse
Event
Incident
SAC
Notifiable
RADAR

For further information please contact the Patient Safety Advisor.

Appendix 1

Severity Assessment Code (SAC) Rating Tool*



**Extract from National Adverse Events Reporting Policy (2017).*

Appendix 2

James Reason's Decision Tree for determining culpability of unsafe acts including the Substitution Test