HQSC Summary of adverse events for 2019/2020
Wairarapa District Health Board

An adverse event is an event with results that are unintended, unexpected or unplanned. In practice, this is most often understood as an event that results in, or has the potential to result in, harm to a consumer.

Reporting adverse events is one part of a broader safety framework within New Zealand to make health care as safe as possible.

Every adverse event represents someone who has suffered harm or has died in the care of the health system. People harmed by health care and their families and whānau can expect their case to be reviewed to understand what happened and what can be done to reduce the risk of the same thing happening again.

The purpose of adverse events reporting is to understand the experience of the affected consumers, families and whānau to improve consumer safety, encourage open communication and learn from the events. Adverse event reviews seek to understand what happened, why it happened and what needs to be done to make the system safer. Reporting adverse events is about learning, in order to make care safer by identifying system issues rather than finding an individual to blame.

DHBs are steadily improving reporting systems and more events are being reported and reviewed each year. There has been an increase in overall reporting of adverse events to the Commission. This demonstrates an open culture of reporting and a willingness to focus on systems learnings, to reduce preventable harm.

In New Zealand, between 1 July 2019 and 30 June 2020, a total of 975 (916 in 2018/19) serious adverse events were reported to the Commission. Of those, 627 were reported by District Health Boards.

Falls is the most common type of adverse event, with 231 reported across the 20 DHBs. The most common 'group' of adverse events is clinical management, which includes pressure injuries, delayed diagnosis or treatment, deterioration, and complications. There were 355 clinical management events reported across all 20 DHBs.

Six adverse events were reported this year by Wairarapa DHB.

This is consistent with the average number of reported events over the previous five years.

Events reported annually	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Wairarapa DHB	3	8	7	3	6

Of those six events reported this year, three related to falls resulting in fractures, and the other three related to clinical management events (eg, assessment, diagnosis, treatment, general care).*

Chief Executive, Dale Oliff apologises to the patients affected.

“On behalf of Wairarapa DHB, I offer our sincere apologies to the patients and their whānau impacted by these adverse events,” she said.

“We are extremely grateful for the opportunity in front of us to now improve our care from their experience.”

“We have thoroughly reviewed each event, identified contributing factors and learnings, and we are committed to implementing the recommendations that have been made. We readily share the learnings with our staff and teams to ensure we continue to always improve, and provide the best patient care we can deliver for all of our patients at all times.”

**Given the small number of events and the small size of the DHB, no further detail will be provided in the interests of protecting the identity of the patients and whānau involved.*

ENDS

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