The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Outdated guidance – do not use

13.3 Adverse event reporting

The National Adverse Events Reporting Policy 2023 came into effect on 1st July 2023. The Health Quality & Safety Commission's new Healing, learning and improving from harm policy adopts a relational approach to health care, focused on meeting the needs of the people within the system.

It is recommended that practices remain on the 2017 Adverse Events Policy until the College signals a new date to transition from the 2017 to the 2023 Adverse Events Reporting Policy. The College continues to work with HQSC on applying this policy to general practice.

The Commission will provide workshops and supportive resources from March 2023 . More information on learning from adverse events, tools and resources is available on the Commission's website

To assist you with implementation of the new policy, the **Healing, learning and improving from harm policy hub** is now live at http://hqsc.govt.nz/harmpolicy. On the hub you will find a user guide and a suite of templates and resources to support you, organised under the eight principles of the policy.

If you have any queries about the 2023 policy, please email adverse.events@hqsc.govt.nz

Standard - what we'll be assessing on	**Evidence to provide for assessment**
The practice complies with the National Adverse Events Reporting Policy by recording, reviewing, analysing and mitigating all adverse events, incidents and near misses.	• Incident/adverse event risk management policy and processes. • Maintain an up-to-date register of adverse events and near misses.

The National Adverse Events Reporting Policy

An adverse event is described as 'an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned. 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.

Other incidents occur in general practice, such as team member accidents and injuries, fire or other damage to the facilities, loss or disruption to service delivery; however, these need to be managed using a different process to adverse events, as there are different applicable standards and requirements for managing non-adverse events.

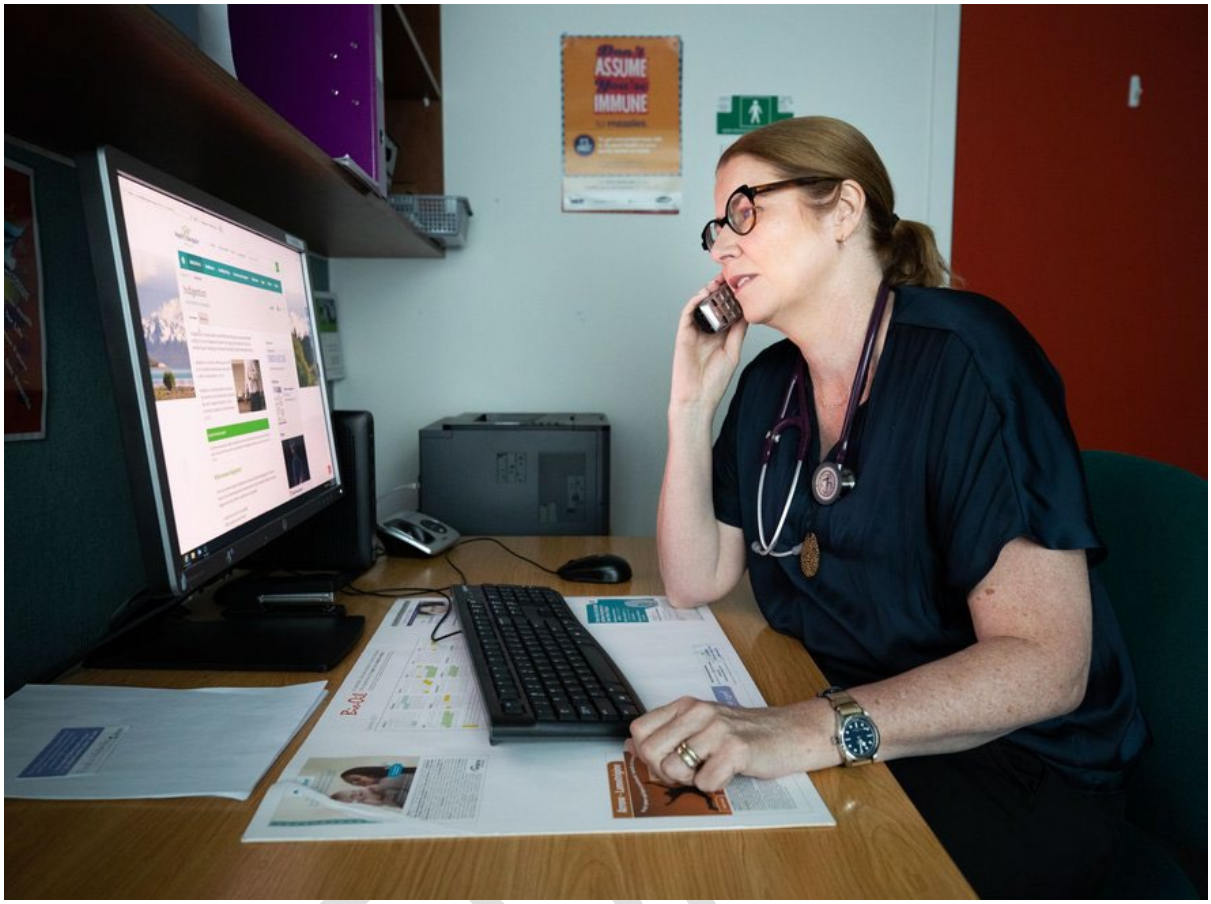
Near-miss events are often an early warning system that help identify potential gaps in systems and processes before an incident occurs. Some major health and safety incidents and accidents will require the practice to notify WorkSafe NZ.

Incident/adverse event risk management policy and processes

The policy and process must include:

- roles and responsibilities for practice team members
- categorising of events
- measuring risk levels
- register or logging process
- reporting adverse drug reactions
- reporting and follow up within set timeframes
- how feedback occurs
- quality improvement activities.

Yours practice's policies/procedures need to follow the College's recommended structure



Dr Ros Wall reports an adverse event

Adverse event management

The purpose of adverse event reporting and management is to identify, analyse and correct or minimize the risk relating to patient harm, including near misses, to reduce the likelihood of recurrence and to improve patient safety.

A clearly defined system for reporting and managing all levels of adverse events is important.

The system for managing adverse events needs to include CQI mechanisms to ensure:

- all reports are acted upon appropriately and within set timeframes
- feedback to affected team members and patients occurs
- the appropriate levels within the practice/organisation/sector are involved to support quality and safety of service provision

There are several components that help support and guide the process:

- using a system to categorise events enables the team members to identify trends and patterns that supports CQI activities for system and process improvement
- Using a risk level measurement (also referred to as the severity assessment code [SAC] will assist the practice in determining the level of harm caused by an incident and to assist in determining the level of investigation required HQSC Severity Assessment Code tables
- Using a register or log (preferably electronic) enables the team members to monitor trends and processes in the practice that may need adjustment or change to reduce potential risk.

Benefits of a good system include:

- greater support for individual practices or business units to meet legislative, industry or best practice requirements for recording, investigating and reporting adverse events as necessary
- increased levels of understanding about key areas of risk that can be addressed to minimise harm/loss
- shared lessons leading to greater patient safety (and team members' safety)
- enhanced reputation and transparency of CQI across the health sector
- increased accountability to governance mechanisms through more comprehensive standardised reportingMitigating risk of liability.

Reporting

Incidents and near misses are a fact of life in any business and team members must be encouraged to report any incident (or near miss) to learn and improve health and safety in the practice.

Reporting and follow-up are essential quality improvement activities that enable the use of actual or near-miss event learning to support the implementation of safe practice, to reduce risk and improve systems and processes within the practice.

Adverse event reporting, follow-up and management are all part of the process to reduce risk and promote best practice processes.

Reporting adverse drug reactions

Reporting adverse drug reactions (ADR) is a clinical responsibility that enables national monitoring of medication reactions by the New Zealand Pharmacovigilance Centre.

This includes several monitoring agencies such as CARM (Centre for Adverse Reactions Monitoring), Psychoactive Substances, Recreational Substances and Legal Highs. Reporting to these agencies can be done via several methods – online and hardcopy.

Reporting of serious adverse events (SAC 1 or 2 rated serious harm to patients)

Reporting of adverse events and near misses is guided by the National Adverse Events Reporting Policy 2017 (the policy).

The Policy supports a nationally consistent approach to reporting, review and learning from adverse events and near misses. Under the Policy, health and disability service providers with obligations under the Health and Disability Services (Safety) Act 2001, and those who voluntarily comply, are expected to (a) notify the Health Quality & Safety Commission ('the Commission') of serious adverse events and (b) provide the Commission with findings and recommendations from review of these events to enable national learning.

The Commission's national Policy supports nationally consistent reporting, review and learning across the whole health and disability sector, including a single policy and reporting process for events that occur in different parts of the sector and therefore reporting is encouraged.

It's a good idea to work with the PHO/network when significant incidents occur. This can enable support with the investigation and management of incidents while providing learning into and out of the practice to improve patient safety across the health sector.

Register of adverse events and near misses

The practice's incident management register can be used to manage and record adverse events.

Adverse events and near misses need to be recorded, investigated and followed up. Write down any details and findings in an adverse event register, and any follow-up required.

Links to resources

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National Adverse Events Reporting Policy 2017

- HQSC: adverse events 2017

- 2023 Healing, learning and improving from harm: Adverse Events Policy and guidance

- 2023 Adverse Events Policy Primary Care Severity Assessment Code (SAC) guide

- Centre for Adverse Reactions Monitoring