



Safer together: recognising, reporting and responding to adverse events

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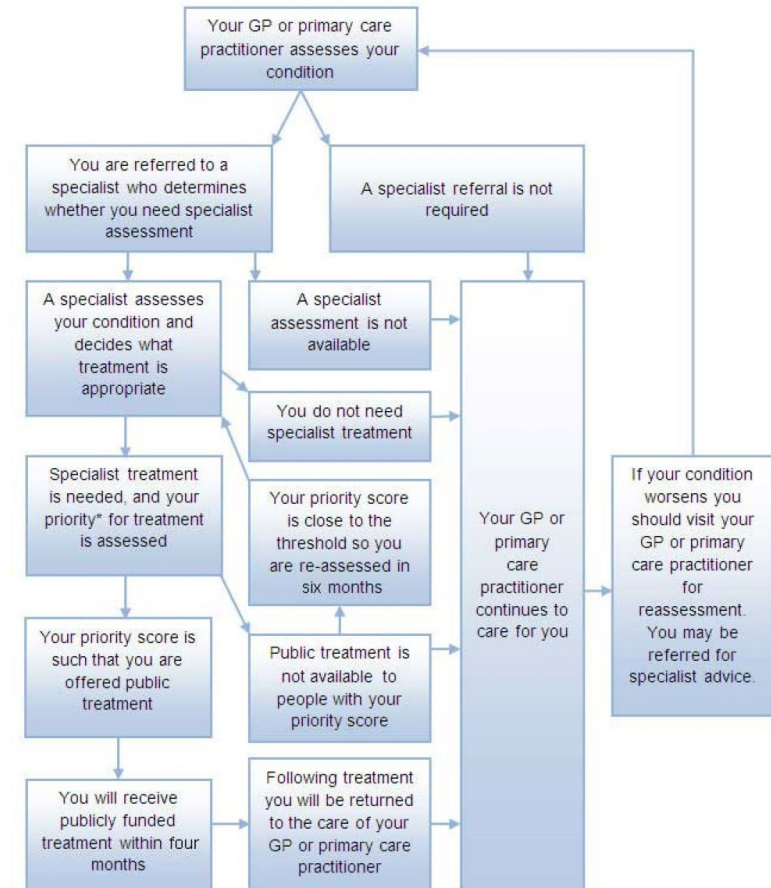
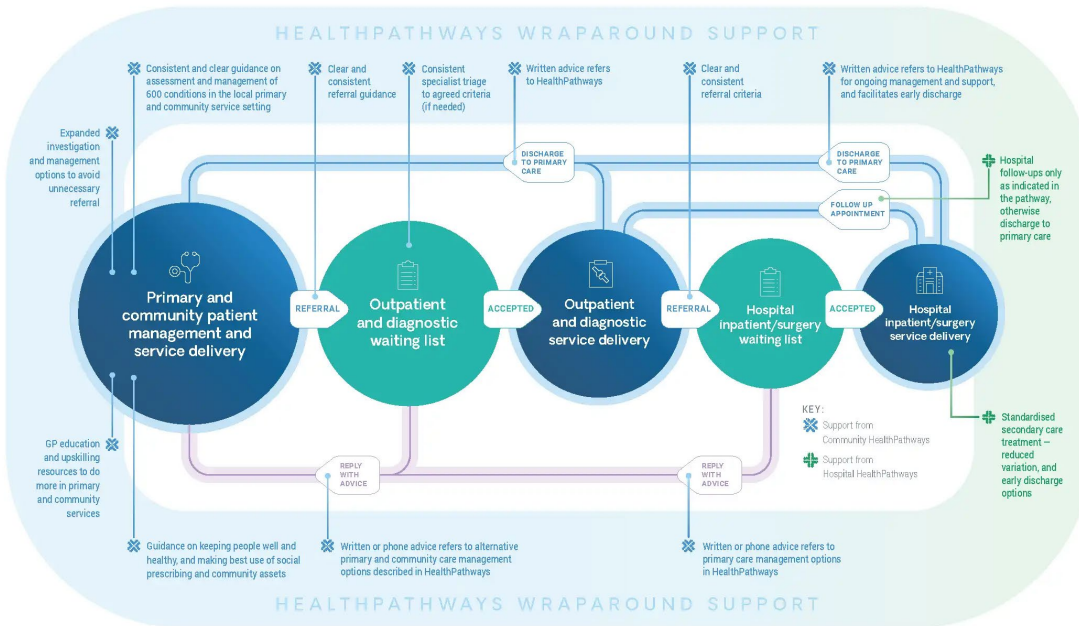
The sticky notes contain the following text:

- AE info reviews
MOS
daily meeting
Quality meetings
- we had the learning forum
the next day
- Informing appropriate
staff about AE
6
- each AE should
have
corresponding
education
- lack of feedback
about the outcome
of described AE
5
- Lack of feedback
about what is
done as a result
of AE report
1
- Unclear what
happens after
AE report
2
- I hope there is
an outcome from
AE reporting
1
- I don't know the
outcome of
AE reports
1
- Educator might
be an outcome
of AE reporting
1 & 3
of feedback 1
- Under
documentation
of previous
AE reports
1
- My manager doesn't
look about AE
reports regularly
3
- we don't all
share AE
learning would
be better
1
- Continue to find
out what
happened so
we share
knowledge
1
- Generally there is
a lack of
feedback after
AE reports
1
- we share info
about AEs
internally
(general)
1

Healthcare is a complex system

HealthPathways: Managing patient flows across the system

(Highly simplified model for conceptual purposes only)



<https://innovation.health.nz/projects/healthpathways/>

<https://www.tewhatoora.govt.nz/health-services-and-programmes/planned-care-services/how-the-planned-care-process-works>



Healthcare
workers are
human too

<https://www.saferack.com/glossary/drive-off/>



The study

Experiences of staff nurses and charge nurses when recognising, responding to, reporting and resolving **adverse events** in a New Zealand hospital setting



Qualitative mixed methods study



12 RN interviews




6 Charge Nurses focus group



Impact

“I didn’t want to harm him ... I felt so bad because I should have known”





Reporting

“I think the main idea of the information system is to prevent any further incidents rather than blaming anyone ... It’s more about rectifying or preventing the mistakes”

“When you have an error back home ... it’s your fault. It’s your fault – whatever you say, it’s going to be your fault – so if we’re going to investigate, we want to investigate because we want to verify that it was your fault”



Responding

“you’ve put a report in, you’ve been asked one or two questions, and that’s the end of it – you don’t really know the outcome of it”

“The most positive feedback I’ve had is when a few of my teams presented to the committee over a pressure injury, and when they then came back and presented it to the team ... they just were amazed that people above them, as they said – people above actually are listening”



Literature
review – still
relevant?

References

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