Waitemata
District Health Board

Best Care for Everyone

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13 March 2019

[redacted]

Dear [redacted]

Re: OIA request – serious adverse event reports

Thank you for your Official Information Act request received received 27 February 2019 seeking the following of Waitemata District Health Board (DHB):

- *Copies of all critical incident reports last three months of 2018 – October 1st to December 31 2018.*
- *Details of each critical incident report including: date of incident, description of event, review findings and recommendations/actions.*

Upon receipt of your request, Waitemata DHB sought clarification of your use of the term 'critical incident'. In reply, you provided a web link to a Ministry of Health form used to report adverse events arising in the care of forensic patients with intellectual disabilities.

When Waitemata DHB queried whether your request was specific to this group of patients, you replied: *"I mean all critical incident reports from all departments. Waitemata DHB may call them 'serious adverse and sentinel events' or 'adverse events'? As said, I understand all DHBs are required to report such events to the Health Quality and Safety Commission, which compiles a yearly report on adverse events reported by all DHBs."*

This response is provided consistent with your clarification.

Waitemata DHB cares for the largest population of any district health board in New Zealand, currently standing at more than 630,000 people. In addition to providing care for our own resident population, we are the Northern Region provider of forensic mental health services and child disability services. Further, Waitemata DHB is the metro Auckland provider of community alcohol and drug services and child community dental services.

Waitemata DHB mantains a strong focus on patient safety and we foster an open culture of reporting potential adverse events in order to learn, improve and ensure the best outcomes for our patients.

We have robust quality assurances processes in place to minimise the risk of avoidable adverse events affecting patients during the course of their care. Our DHB has one of the lowest standardised rates of hospital mortality and treatment injury in New Zealand.

When treatment results in a potential adverse outcome for a patient, a detailed investigation begins to establish whether the event fits the national criteria for reporting to the Health Quality & Safety Commission (HQSC) as a serious adverse event.

The investigative process around each event usually takes several months and needs to consider the complexity of each individual's clinical situation and, where appropriate, seek independent expert clinical review.

The fact a patient outcome is being investigated does not automatically mean that the harm caused was avoidable, or related to the provision of healthcare. Where a known risk exists, Waitemata DHB always seeks to explain this to the patient in advance in order for them to make an informed choice about their treatment.

When an event is found to meet the HQSC's criteria for a serious adverse event , this is confirmed to the HQSC for inclusion in its annual report, which is publicly available online:

https://www.hqsc.govt.nz/our-programmes/adverse-events/

The HQSC's annual *Learning from Adverse Events* report is the official record of care which has been fully investigated and found to have resulted in unintended, unexpected or unplanned outcomes for patients. The HQSC's 2017/18 report commended Waitemata DHB for our strong focus on reporting and for our culture of learning (see page 13).

The report is published in December each year and provides data for the preceding financial year in order to allow a window of time for the finalisation of investigative processes. Even with this window, many investigations will not have been completed.

Waitemata DHB data for 2017/18 is already publicly available via our website:

http://www.waitematadhb.govt.nz/assets/Documents/serious-adverse-events/Waitemata-DHB-Serious-Adverse-Events-FY-2017-2018-Report-F.pdf

There are no completed investigations into events occurring between October and December 2018 at Waitemata DHB. Therefore, there are no completed reports to provide. However, we can advise there were 10 potentially serious adverse events during this time which have been notified to the HQSC.

Once Waitemata DHB has completed an adverse event investigation, the investigation report is approved by our Adverse Events Committee and the event is then confirmed with the HQSC. Sometimes, the investigation will identify that the adverse event was not as serious as first suspected and does not meet the criteria of a serious adverse event that is reportable to the HQSC (using an agreed HQSC rating matrix).

Waitemata DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Andrew Brant
Chief Medical Officer and Deputy Chief Executive Officer
Waitemata District Health Board