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28 March 2019

[redacted]

Re Official Information Act Request – Information about critical incident reports

I refer to your Official Information Act request of 27 February 2019 regarding the following information:

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

The investigations of incidents occurring between Oct-Dec 2018 will not yet be complete and, as such, are not available for release.

Adverse events are often complex and require investigation and review. This takes time. Care and attention to detail is needed to support on-going improvement and quality control.

Our duty of care to the patient includes a thorough review of our processes including recommendations arising from investigations into adverse events.

Auckland DHB, along with all DHBs is required to report adverse events to the Health Quality and Safety Commission which compiles a yearly report of Adverse Events reported by all DHBs.

The annual HQSC adverse events report is the official source of information and provides data for the preceding financial year to enable time for finalisation of investigative processes.

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

The Adverse Events learning programme aims to improve consumer safety by supporting organisations to report review and learn from adverse events that occur in health and disability services.

In the event of a potential event, a full evaluation is undertaken to establish if it fits the national criteria for reporting to HQSC as a serious adverse event. The investigation process often takes several months and involves independent expert clinical advice.

An investigation considers all aspects of the case including and an important consideration is informed choice by the patient and their close involvement in all decisions affecting them.

The most recent HQSC report was published in December of 2018 and included Auckland DHB data for 2017/2018. For 2017-2018, 92 adverse events were reported compared with 95 for the previous year.

https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/adverse-events-2017-18-DHB-figures.PDF

The report noted that DHBs reporting is steadily improving and more events are being reported and reviewed each year.

Auckland DHB is committed to quality improvement and learning from adverse events to improve the service we provide to patients in our community of care which includes more than 530,000 residents in the Auckland district and a commitment to providing national services for New Zealand.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive