Te Whatu Ora
Health New Zealand

26 January 2023

[redacted]

Tēnā koe [redacted]

Official Information Act request HNZ00008512

Thank you for your Official Information Act 1982 (the Act) request of 8 December 20222 for information relating to Adverse Events. Specifically:

1. *Number of adverse events at Auckland City Hospital in between 1st July 2021 and 30th June 2022*
2. *Of these adverse events the number or percentage of which led to reviews being completed and recommendations made*
3. *Of the adverse events where reviews were completed and recommendations made, the number or percentage of the adverse events where recommendations have been implemented*
4. *Of the adverse events where reviews were completed and recommendations made the number or percentage of the adverse events where consumers have updated on implementation progress*

Response
Adverse events in the New Zealand health system are classified in four categories. Te Toka Tumai Auckland holds data centrally on adverse events with Severity Assessment Code (SAC) scores of 1 and 2. Data on events with codes 3 and 4 are held in the various directorates and we this has presented us with a research and collation challenge.

This means that Te Toka Tumai Auckland has decided to decline part of your request as it applies to adverse events with a category of 3 and 4 under s18(f) Official Information Act substantial collation and research.

We have considered whether any of the following options would assist us in managing this work:

- charging for the work involved
- extending the timeframe for responding
- using a contractor to analyse and cross-collate the information.

However, due to the volume of work required, we have concluded that none of these options would assist us in providing the information as our own specialist staff would need to collate and review the records. This would take key staff away from their work and prejudice our ability to provide core services.

The following data for adverse events involving patients that have a Severity Assessment Code (SAC) score of 1 and 2. These definitions being set by the Health Quality & Safety Commission New Zealand and are:

SAC 1 Severe
Death or permanent severe loss of function:
- not related to the natural course of the illness

- differs from the immediate expected outcome of the care management
- can be sensory, motor, physiological, psychological or intellectual

SAC 2 Major
Permanent major or temporary severe loss of function
- not related to the natural course of the illness
- differs from the immediate expected outcome of the care management
- can be sensory, motor, physiological, psychological or intellectual

Common examples of SAC 2 incidents are pressure injuries of certain severity developing in the hospital, or a fall with injury within the hospital.

1) **Number of adverse events at Auckland City Hospital in between 1st July 2021 and 30th June 2022**

   81 in total, comprising 13 SAC 1 events and 68 SAC 2 events

2) **Of these adverse events the number or percentage of which led to reviews being completed and recommendations made**

   36 reviews have been completed, and 38 recommendations made (there may be more than 1 recommendation per review).

   There are 47 events currently under review that may lead to recommendations being made.

3) ***Of the adverse events where reviews were completed and recommendations made, the number or percentage of the adverse events where recommendations have been implemented***

   Of the 38 recommendations, 19 have been implemented with the remainder in progress

4) **Of the adverse events where reviews were completed and recommendations made the number or percentage of the adverse events where consumers have updated on implementation progress**

   This information is not collected and we are declining this part of your request, citing s18(f) Official Information Act – substantial collation and research.

   Note there is currently no formal requirement from external agencies for consumers to be updated on the status of the implementation process of recommendations, so this is not collected. We also note that consumers are invited/have the opportunity to be involved at several stages of the adverse event review process and updates to consumers about implementation progress on recommendations may be something that occurs on an individual basis, as agreed between the clinical service and consumer(s).

   We have considered whether any of the following options would assist us in managing this part of your request:

   - charging for the work involved
   - extending the timeframe for responding
   - using a contractor to analyse and cross-collate the information.

   However, due to the volume of work required, we have concluded that none of these options would assist us in providing the information as our own specialist staff would need to collate

and review the records. This would take key staff away from their work and prejudice our ability to provide core services.

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Te Whatu Ora may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available on our website.

Nāku iti noa, nā

Margaret Dotchin
Acting Interim District Director
Te Toka Tumai Auckland