

21 February 2020



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

PO Box 25496
Wellington 6146
New Zealand

T: +64 4 901 6040
F: +64 4 901 6079
E: info@hqsc.govt.nz
W: www.hqsc.govt.nz

Tēnā koe [REDACTED]

Re: Official information request – adverse events – unauthorised access to restricted areas

Thank you for your OIA request dated 10 February 2020.

To provide some context to the answers below, the Health Quality & Safety Commission (the Commission) uses the following definitions:

- Adverse event – an event which results in harm or has the potential to result in harm to a consumer while they are receiving health and disability services.
- Incident – an event that involves the health and safety of staff, volunteers, contractors, and visitors within health and disability service providers. These should be managed under health and safety legislation and policies.
- Near miss – an event which, under different circumstances, could have caused harm to a consumer but did not, and which is indistinguishable from an adverse event in all but outcome.

Request 1:

Would it be accurate to say that any event which occurred at a DHB and which had a risk of causing harm to a patient, employee or member of the public would be considered an "adverse event", "incident" or "near miss", which would require reporting? This would include, but not be limited to actions which have a risk of causing physical harm or emotional harm, such as deliberate actions which delayed diagnosis or breached patient privacy.

Our reply:

Yes. The Commission only receives reports involving adverse events and some near misses, as set out in the [National Adverse Events Reporting Policy 2017](#). Incidents are reported via different mechanisms.

Request 2:

Would you be able to direct me to a comprehensive list or description of what is considered "adverse events", "incidents" or "near misses" by the HQSC?

Our reply:

The [severity assessment code \(SAC\)](#) describes how to rate the severity of adverse events, and the [SAC examples](#) give examples of adverse events. The SAC examples are not exhaustive, and events are rated based on the actual harm to the consumer, which means that the same event

may be rated differently for different consumers, based on the harm that occurred. Because of this, there is no one comprehensive list of adverse events.

Request 3:

Would unauthorized access, by a member of the general public, to restricted areas such as a surgical theatre or medical laboratory, where bio-hazardous materials are kept and diagnostic testing conducted, be considered an "adverse event", "incident" or "near miss" and if so, please either describe or provide the protocol that DHB's are required to follow if such an event were to occur.

Our reply:

This would be considered an incident. Adverse events are events that cause harm to someone that is receiving healthcare. The Commission does not hold any information on specific protocols that DHBs are required to follow in such an event. As a result, I am refusing your request under section 18(g) of the Official Information Act 1982, as no official information is held by the Commission.

Request 4:

Please provide me with the number of reported incidents, for each individual DHB, in which a member of the public gained access to a surgical theatre without authorization or having been accompanied by a DHB employee, for each of the years from 2016 to 2019, inclusive, and the outcomes of these incidents.

Our reply:

The Commission does not collect this information. As a result, I am refusing your request under section 18(g) of the Official Information Act 1982, as no official information is held by the Commission. Individual DHBs may hold this information and the website of each DHB can be found [here](#).

Request 5:

Please provide me with the number of reported incidents, for each individual DHB, in which a member of the public gained access to a medical laboratory, where bio-hazardous materials are kept and diagnostic testing conducted, without authorization or having been accompanied by a DHB employee, for each of the years from 2016 to 2019, inclusive, and the outcomes of these incidents.

Our reply:

The Commission does not collect this information. As a result, I am refusing your request under section 18(g) of the Official Information Act 1982, as no official information is held by the Commission. Individual DHBs may hold this information and the website of each DHB can be found [here](#).

Request 6:

In the event that a DHB had reported unauthorized access to a surgical theatre or medical laboratory, what category of "adverse event" or "incident" would they be reported under in a DHB's Learning from Adverse Events report?

Our reply:

Such events would not be classified as adverse events, therefore I am refusing your request under section 18(g) of the Official Information Act 1982, because no official information is held by the Commission.

Request 7:

Please provide me with the steps taken by each DHB to mitigate the risk of unauthorized access to surgical theatres and medical laboratories.

Our reply:

The Commission does not collect this information. As a result, I am refusing your request under section 18(g) of the Official Information Act 1982, as no official information is held by the Commission. Individual DHBs may hold this information and the website of each DHB can be found [here](#).

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.

Ngā mihi

Dr Janice Wilson
Chief Executive

