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

11th February 2021

[redacted]

By email: [redacted]

Dear [redacted],

Official information request for copies of all reports submitted by Waikato DHB between 1 January 2019 and 1 January 2021

I refer to your official information request dated 17 January 2021 for copies of all reports submitted by Waikato DHB between 1 January 2019 and 1 January 2021 in accordance with the New Zealand Health and Disability Services – National Reportable Events Policy 2012, as well as a complete list of the Central Repository (HQSC) classification codes (beyond those listed on page 10 of the Policy) and the description of those codes.

Part of the information you have requested is attached as an appendix to this letter, as well as a link to our current policy, released in 2017. However, we have decided to refuse your request for information which relates to reports submitted by Waikato DHB between 1 January 2019 and 1 January 2021 under section 9(2)(a) of the OIA.

Section 9(2)(a) states withholding of information is where*:*

- The withholding of information is necessary to "*protect the privacy of natural persons, including that of a deceased natural persons"*, and
- This interest is not *"outweighed by other considerations which render it desirable, in the public interest, to make that information available"*.

Additionally, the Commission have an obligation of confidence between the supplier of the information (Waikato DHB) as the agency receiving the information. The Commission regard the information as confidential and there is knowledge on the part of Waikato DHB that the information was imparted in confidence. Releasing this confidential detailed information would break confidentiality for the subjects of these reports as well as the Commission's obligation of confidence. The work that would be required to anonymise all the reports we have received between the dates requested are beyond the scope of our resources and the Commission has no obligation to.

We have decided to grant your request in part, namely information which relates to coding applied to our adverse events. The codes we apply to each event are listed in the appendix attached to this correspondence.

We encourage you to seek the information we have been unable to provide you with the Waikato DHB directly. You can contact them using this link https://www.waikatodhb.health.nz/contact-us/.

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 the Commission publishes some of its OIA responses on its website, after the response is sent to the requester. The responses published are those that are considered to have a high level of public interest. We will not publish your name, address or contact details.

If you wish to discuss this decision with us, please feel free to contact [redacted]

Yours sincerely

Dr Janice Wilson
Chief Executive ll Health Quality & Safety Commission

Appendix one

Codes and classifications applied to adverse events as of January 2021

WHO Coding

WHO Category	WHO code
Clinical administration	01
Clinical process/procedure	02
Documentation	03
Healthcare associated infection	04
Medication/IV fluids	05
Blood/blood products	06
Nutrition	07
Oxygen/gas/vapour	08
Medical device/equipment	09
Behaviour	10
Consumer accidents	11
Falls	12
Infrastructure/building/fittings	13
Resources/organisation/management	14

Clinical management report class – applied to WHO coded events highlighted above in categories 1, 2 and 14

Clinical management event classification	Description example (hypothetical)
Adverse outcome	Unexpected consumer death or outcome
Assessment and diagnosis	Initial assessment did not find the key clinical issue
Clinical process	Incomplete process during care (eg, consent, coordination of care)
Complication	Complication of treatment or procedure (eg, stroke following surgery)
Delayed diagnosis or treatment	Issue in referral process results in delay seeing specialist or receiving treatment
Deterioration	Consumer deterioration not recognised or managed in expected timeframe
Monitoring	Inadequacy of monitoring (eg, breathing rate after morphine given)
Other	Security issue
Pressure injury	Pressure injury from insufficient position change/nutrition, etc
Resources/organisation/management	Insufficient clinic, equipment, staff or appointments to meet demand

Retained item	Item left inside the body beyond expected time
Transfer	Harm related to transfer of care between services or providers
Treatment	Allergic reaction to products used for treatment
Wrong consumer/site/side	Wrong consumer in procedure room/theatre
Total	

Coding of mental health adverse events

Code used in HQSC database	Meaning of code
AWSIPS	Suspected suicide of an inpatient on unapproved leave
AWSOSH	Self-harm by an inpatient on unapproved leave
IPB	Inpatient adverse behaviour
IPBRI	Inpatient behaviour, restraint injury
OPB	Adverse behaviour by a patient in the community
SIPS	Suspected suicide of an inpatient
SIPS*	Suspected suicide of an inpatient while on approved leave
SISH*	Self-harm by an inpatient while on approved leave
SISH	Self-harm by an inpatient
SOPS	Suspected suicide of a patient in the community
SOSH	Self-harm by an patient in the community

Always Report and Review codes - detailed in link below

https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/Always-report-and-review-list-2018-19-Final.pdf

Current Adverse Events policy and supporting documentation

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