REACTION from New Zeeland:

Dear Victoria and Anna
In advance of the upcoming workshop in Copenhagen at EPSO, here is some background on the NZ context.
While now based in Europe, I am still involved in some projects in NZ and keep close ties with former colleagues at the Ministry of Health and Health Quality Safety Commission.

Apologies for the tardiness in getting this to you (I note the 6th April deadline)

We would be very grateful if you could also gather some information for us in preparation for the day.

1. We are interested in how your country classifies/defines safety incidents. Is there a scale from most serious to least serious? Is there differentiation between preventable errors and non-preventable errors
   *There is a severity assessment rating based on outcome and corresponding code from SAC4 (Minor/minimal) to SAC1 (Severe). *ref www.hqsc.govt.nz/our-programmes/adverseevents/publications-and-resources/publication/2937). NZ uses the WHO taxonomy of classifications for patient safety. There is no distinction between preventable and non.*

2. Do you cascade safety guidance from central bodies to hospitals? If so, how do you ensure compliance with it and what are the consequences if services don't comply?
   There are three main avenues for this – the Health and Disability Commissioner (with right of sanction) (www.hdc.org.nz/decisions/latest-decisions/)and the Health Quality Safety Commission who take an active role in education and monitoring – through a quality improvement lens https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2933/ . See attached 'learning from Adverse events report 2016/2017' There is an additional national agency / the ACC (Accident Compensation Corporation) who cover claims for treatment injury and who publish treatment injury case studies.

3. How many safety incidents do you have each year and has this gone up or down in recent years?

*refer report. In some areas, the volume has increased (pressure sores reported from Hospitals, in other areas it has decreased over the last 3 years (e.g. falls)

4. What they do when a safety incident occurs/ what is the expectation on hospitals? Is a root cause analysis completed, is there a central reporting requirement etc.

There is a protocol defined for this involving a root cause analysis and corrective steps action plan and corresponding notification to central agencies.

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

Hope this is of some help and look forward to seeing you in Copenhagen.
Best wishes

- Andrew