HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
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28 November 2022

[redacted]

Re: **Prescription error harm**

Tēnā koe [redacted]

Official information request

You originally requested the following information:

> *How many people were harmed by those prescription errors over the past ten years? Of those, how many were seriously injured e.g., required hospital treatment? Displayed by year, and region?*

On Monday 14th November you responded to our request for clarification with:

I would like what you have described as medication error data please.

1. *How many people were harmed by medication errors over the past ten years? Of those, how many were seriously injured e.g., required hospital treatment? Displayed by year, and region?*

Table one: Medication errors reported to the Commission by year and organisation

	2015/16		2016/17		2017/18		2018/19		2019/20		2020/21		2021/22	
	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4	SAC 1 or 2	SAC 3 or 4
Auckland DHB	2				3	1	1	2			4		2	
Bay of Plenty DHB						1	4		1		1			
Canterbury DHB	4		1		2						1		1	
Capital and Coast DHB	2		1		1		1		7		6		5	
Counties Manukau DHB	2	1	5	1	1	1			1		6	2	3	
Hawkes Bay DHB	2		2		2			1	2		3		1	
Hutt Valley DHB	1						4				2		2	
Lakes DHB	2		1	1	1				1				1	
MidCentral DHB			1		1		1		1				1	
Nelson Marlborough DHB	4	1				1					1		1	
Northland DHB	4	1	2		1			2	1		2			
South Canterbury DHB				1			1							
Southern DHB	1		5		2		4		3		4		1	
Hauora Tairawhiti DHB					1			1						
Taranaki DHB			1					1						
Waikato DHB	1		2		3	1	1		2				2	
Wairarapa DHB			1											
Waitemata DHB					1	1			2		2		4	1
West Coast DHB											1			
Whanganui DHB									1				1	
Ambulance service			1		1	1								
Other: rural or private hospital						1	1							1
Total	**25**	**3**	**23**	**3**	**20**	**8**	**18**	**7**	**22**	**0**	**33**	**2**	**25**	**2**

Our regular reporting for medication errors begins with the 2015/16 year. The Commission only requires medication errors that result in severe harm (SAC 1 and 2) to be reported. The events rated SAC 3 and 4 in the table are only those that meet the criteria for the Commission's Always report and review criteria (ARR). All patients involved in the medication errors were either in an ambulance or within a hospital setting at the time of the event.

Please see the below Commission link for further information regarding SAC and ARR ratings. https://www.hqsc.govt.nz/our-work/system-safety/adverse-events/national-adverse-events-reporting-policy/

The Commission welcome increases in reporting rates, because rather than representing worsening rates of adverse events, we believe they represent more thorough and consistent reporting of the events that have always been a part of the system. This stronger reporting culture creates real opportunities for improvement across the system.

2. *Are HNZ aware of any deaths caused by errors in prescriptions in the past ten years? If so, when and where did these deaths occur*

Table two: Events where a medication error reported to the Commission potentially contributed to the death of a patient since the 2015/16 year.

Deaths by organisation	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Auckland						1	
Bay of Plenty							
Canterbury			1				1
Capital and Coast	1						
Counties Manukau						1	
Hawkes Bay	1				1		
Hutt Valley							
Lakes							
Mid Central							
Nelson Marlborough							1
Northland						1	
South Canterbury							
Southern			1	1			
Hauora Tairawhiti			1				
Taranaki							
Waikato	1	1					
Wairarapa							
Waitemata							2
West Coast							
Whanganui							1
Ambulance service							
Other							
Total	**3**	**2**	**2**	**1**	**1**	**3**	**5**

It is important to note that this is a snapshot from our adverse events database as once the final review findings are completed the SAC rating of events may change, or the events may be removed. Please note in the 2021/22-year organisations must complete all their formal reviews before it can be confirmed whether the medication error did or did not contribute to these deaths.

If you have any queries, please feel free to contact us at info@hqsc.govt.nz. If any additional factors come to light which are relevant to your request, please do not hesitate to contact us so that these can be considered.

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.

Ngā mihi

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Health Quality & Safety Commission