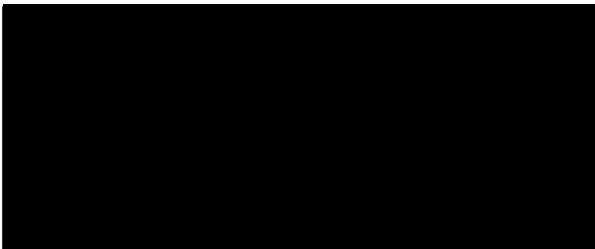


26 February 2021



Re: Official Information Act request – Correspondence re closed system devices – ADHB Ref: 20210104-753

Sarah McMahon spoke to you a couple of weeks ago about our providing a summary of Datix incidents regarding closed systems.

We apologise for the delay. The information requested is set out below.

Our colleague who reviewed all the possible incidents commented: "I have reviewed the DATIX and also received the assistance of ES NUM haematology and SCD haematology utilising her expertise. We have identified six incidents which relate to closed systems or the absence of closed systems. These include 5 spiking issues (not required in a closed system), and 1 line disconnection – (is not physical feasible in a closed system). The remainder of the incidents are equipment failure not solved by closed systems and still feasible with a closed system."

1. Unseen hole in bag caused on drop of fluid to drip onto the back of the nurse's gloved hand. No administration of the medication had started.
2. It was noticed that air was being drawn into the line. Nurse went to stop the infusion when some cytotoxic fluid from the inside the chemo bag splattered on to their hands and wrists.
3. When spiking the chemotherapy drug in glucose 5%, bag was accidentally spiked through. There was no leakage, however, the drug could no longer be used and was discarded appropriately.
4. Patient was having chemotherapy administered and the nurse heard a dripping noise and found that four drops of chemotherapy had leaked from the connection to the patient's chair. When the nurse tried to secure the contactor a few more drops got on the floor.
5. During training a staff member accidentally pierced the chemotherapy bag when spiking it and 2 - 3 drops of chemotherapy leaked out onto the floor. Leak identified immediately.
6. Nurse administering chemo accidentally spiked the bag and around 5-10 mls leaked onto the ground.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully



Ailsa Claire, OBE

Chief Executive of Te Toka Tumai (Auckland District Health Board)