AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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[redacted]

Re Official Information Request- incidents relating to equipment not being sterilised properly

I refer to your official information request of 6 March 2019 to the Ministry of Health and subsequently transferred to the Auckland DHB on 22 March 2019 for the following information:

> ***A detailed breakdown of any and all incidents relating to equipment not being properly sterilised by District Health Boards in 2018 and 2019.***

The information you have requested is enclosed below:

Sterility Related Incidents Reported January 2018 – March 2019

During the time period 01 January 2018 – 31 March 2019, Auckland DHB CSSD cleaned and sterilised 5,846,451 reusable surgical instruments. Of these, 27 potential sterility breaches were reported. These potential breaches can be categorised as: water [1], wet instrument load [2], foreign matter (debris, cement, bone fragments, hair) [18], instruments not separated/disassembled [2], holes in wrapping [2], container not correctly sealed [1]; expired instruments [1].

This number includes events where foreign matter was found with processed surgical instruments. (Noting that there is a body of opinion that feels these are not a breach of sterility, research has suggested there is no risk to the patient when hair or bone has been through an adequate sterilisation process (American Journal of Infection Control, 2013)[1]). If these 18 foreign matter events are excluded, the total number of potential sterility breaches is reduced to nine out of over 5 million processed instruments, just under 0.0002%.

Auckland DHB takes all potential sterility-breach related events very seriously. All events are reported on the electronic Safety Management System (SMS) Datix incident reporting system. **No harm was reported to any patients**. All events were classed as SAC 4, that is, no increased level of care or length of stay was required. In all events where potential sterility breaches are reported, the Operating Room (OR) Charge Nurse and Central Sterile Supplies Department (CSSD) are notified and these notifications are followed up with the staff involved. CSSD management ensures strategies are put in place to prevent the re-occurrence of avoidable events.

I trust this information answers your questions.

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