

Overview of the Hearing Screening Incident

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National Screening Unit

How were the NSU informed?

- Auckland DHB - 1 screener identified



The Incident

Screeners were identified as:

- Screening their own ears
- Screening one ear of the baby and one of their own ears
- Screening the same ear of the baby twice



Next steps

- Hutt Valley DHB - 1 screener identified
- All DHBs asked to review their screening data
- 6 more DHBs identified
- 12 screeners in total
- Incident Review Group and Technical Review Group formed
- Incident report finalised in December 2012
- 21 recommendations

