Investigations – Your Rights and Responsibilities

The purpose of this fact sheet is to outline the rights and responsibilities of nurses, midwives and Health Care Assistants (HCAs)/kaiāwhina who may be involved in investigations into their or another health professional's practice.

Background

NZNO is seeing an increase in the number of members seeking assistance following a complaint against their practice or if the nurse is involved in an investigation, including an increase in the reporting of serious and sentinel events which are part of Te Whatu Ora annual reporting. This trend is also reflected in an increasing number of complaints being laid with or referred to the Nursing Council. For example: in 2016, 220 nurses were referred to the Nursing Council; in 2019, 268 nurses were referred; and in 2020, 272 nurses were referred. This shows a steady increase in the numbers of nurses being referred to the Nursing Council (Nursing Council of New Zealand, 2016, 2019, 2020).

Members of society expect to receive health care that is timely, safe, ethical, of high quality, and that meets the legal requirements of the profession. While nurses and midwives have always been accountable and responsible for their practice, given increasing health demands and expanded areas of practice, they are more likely to become subject to investigations into their practice.

Any recipient of health care or their family has the right to complain about the care they receive under the Code of Health and Disability Services Consumer Rights (1996). Any provider of health care services, whether regulated or not, may find themselves the subject of such complaints and any subsequent investigation.

Investigations may involve an internal process such as a sentinel incident review or may require external review. In some cases, one incident/adverse event or complaint may give rise to multiple pathways of investigation.

The following agencies can scrutinise the practice of nurses and midwives:

> serious and sentinel events/significant incident review (internal employer review)
> the Nursing Council of New Zealand
> the Midwifery Council of New Zealand
> the Health Practitioners Disciplinary Tribunal (HPDT)
> the police
> a coroner
> District Inspectors (Mental Health Act)
> the Health and Disability Commissioner (HDC)
> the Privacy Commissioner
> the Director of Proceedings
> the Director General of Mental Health
> ACC
> private/civil legal challenges

> Human Rights Commission Te Kahui Tika Tangata

Nurses, midwives and HCAs/kaiāwhina may find themselves involved in any one of these investigations, either as providers of direct care or being called on to provide additional information. This fact sheet outlines the rights and responsibilities of members who may find themselves subject to an investigation into their practice or being asked to provide witness statements and provides information on how to manage interviews. This fact sheet should be read in conjunction with the NZNO fact sheet: Serious and sentinel events (NZNO) available separately.

A brief outline of the Acts and Codes that set parameters around the practice of health professionals is helpful in understanding your rights and responsibilities if you are involved in an investigation.

Coroners Act (2006)

Coroners investigate cases of death where:

> the cause is unknown
> in the case of suicide or unnatural or violent death
> for which no doctor's certificate is given
> if the death occurs as a result of a medical, surgical or dental procedure, or while under anaesthetic or while a woman was giving birth
> for people who are under compulsory care or custody, no matter what they die of.

Health Practitioners Competence Assurance Act (HPCA) Act (2003)

The HPCA Act (2003) is designed to protect the health and safety of the public by providing mechanisms to ensure continued competency of health practitioners. A number of titles are protected under the Act, and only health practitioners who are registered under the Act are entitled to use such titles. Registered professions include nursing, midwifery, medicine, pharmacy, physiotherapy, and a range of other allied health professions. Under the HPCA Act these professions must demonstrate their fitness and competence to practice. Health care workers such as health care assistants, mental health support workers, phlebotomists and physician's assistants are not covered by the Act, and there are no legal requirements surrounding the competency of these individuals under the HPCA Act. However, they are expected to work within other legislative requirements such as the Code of Health & Disability Services Consumers Rights (1996) and the Health and Disability Services Standards (2022).

The Health Practitioner Disciplinary Tribunal is responsible for hearing and determining disciplinary proceedings brought against nurses and midwives under the HPCA Act, however any of the agencies listed above may also investigate the practice of nurses. Findings made by one agency may result in a referral to, and investigation by another agency.

Code of Health and Disability Services Consumer Rights (1996)

The code outlines the rights of consumers who are accessing health or disability services and the duties of every provider of health and disability services. These include the right to:

> be treated with respect and privacy
> fair treatment; and to be free from discrimination
> dignity and independence
> services of an appropriate standard
> effective communication
> be fully informed
> make an informed choice and give informed consent
> support
> hold rights in respect of teaching and research
> complain

Where a breach of the Code may have occurred, a complaint may be laid with the Health and Disability Commissioner (HDC). The HDC may choose to initiate an investigation themselves, or they may refer the complaint to an advocacy service. The HDC may then investigate further and may make recommendations for further action including to the Nursing Council and Health Practitioners Disciplinary Tribunal (HPDT). Investigations may take place months or even years after an incident, as it may take some time for the complainant to formalise their complaint. Maintaining excellent clinical documentation will assist in such investigations (discussed later).

It is important to note that in the case of a potential breach of any of these rights, the onus is on the health care provider to show that they took reasonable steps to comply with the rights of the code. Both the nurse/midwife and the employer have responsibilities in this regard.

Making a Statement – Your Rights

Health professionals are frequently asked to make a statement regarding their involvement in an incident or in the care of a patient and may also be asked to attend an interview.

If you are asked to make a statement that is to be used in an internal or external investigation, especially if it is for the employer, police, coroner, HDC or ACC you have a number of rights including:

> You have the right to seek advice prior to making any statement. NZNO strongly recommends that you seek advice from NZNO prior to making a statement. To do this phone the NZNO Membership Support Centre on 0800 28 38 48. They will be able to support you and refer you for advice from the NZNO professional/legal team prior to making any statement if required.
> You have the right to NOT feel “pressured to have to talk” right then or to make a statement straight away.
> If you want to provide information, say that you are prepared to help BUT need to seek professional/legal advice first.
> Review relevant documentation/patient notes before and/or during the making of your statement.
> If you are not able to do this, make a note in your statement that you have not been able to view the documentation/patient notes.

In addition to the points above, your rights when dealing with the police are:
> You are generally not under any obligation to talk to the police.
> Other than your name, address, age and occupation you do not have to tell them anything.

> Some organisations have a formal arrangement with the police indicating they will assist with police investigations – check your organisation's policy first.
> You are entitled to get legal advice before you meet the police and to have a lawyer with you during the meeting. Unless you are under arrest you may also have another support person (non- lawyer) with you.
> You can suggest a venue – maybe work or home.
> Unless you are under arrest, you are not obliged to go to the police station.
> Pick a time that suits you.
> Do not assume that the police have medical or nursing knowledge.
> You can adjourn the meeting to seek advice (either from an advisor who is with you at the meeting or somebody else).
> If the meeting is going on for a long time, you can ask for it to be adjourned to a later date.
> We advise that you are better to answer questions rather than to volunteer information.
> When answering questions, ask for clarification or questions to be repeated if you don't fully hear or understand what you are being asked
> If you're not sure of an answer say you are unsure or don't know
> Try to avoid giving opinions or speculating - stick to your area of expertise.
> Try to avoid commenting on what you have heard. Comment only on what you have personal knowledge of.
> Try to avoid absolutes like 'always' or 'never'.
> The police will record the questions and answers you give.
> Check the information carefully – ask for changes to be made (corrections/additions/deletions) if you disagree with what the police have written or what is recorded is not what you intended to say.
> Ensure you ask for a copy – do this at the time you are interviewed, obtaining these at a later date can be problematic.
> You can talk to the police but you do not have to sign a statement.

Making a written statement:

> You may be able to provide a written statement instead of an interview or you may be asked to write a statement.

> Advantages of making a written statement include:
  - You only provide the information that you want to.
  - You can put information in the order/way that you want it to be.
  - It gives you and your adviser more time to consider your response.
  - It can be less stressful than a meeting/interview.

Ensure you contact NZNO before you write or send a statement.

When sending a written statement for review write "for the purpose of obtaining legal advice" on it – it can then be subject to legal professional privilege.

Your Responsibilities

Nurses and Midwives have an obligation to provide safe, competent and ethical care to the people they nurse and may be considered negligent if they fail to meet their professional responsibilities in the provision of nursing care. HCAs/kaiāwhina have an obligation to provide care that meets relevant standards.

The Health and Disability Commissioner investigates a range of cases each year and examples of these pertaining to nurses can be found on their website (https://www.hdc.org.nz/decisions/).

Ensuring excellence in documentation will assist nurses to demonstrate they meet their obligations and responsibilities. The NZNO Guideline - Documentation provides clear guidelines for excellence in documentation and is Available on the NZNO website (https://www.nzno.org.nz/resources/nzno_publications).

Employer Responsibilities

Employers have an obligation to provide the necessary resources and support to help nurses meet the required standard of practice. In 2007 the Health and Disability Commissioner released findings on an inquiry into the care of five patients at North Shore Hospital (Health and Disability Commissioner, 2007, HDC case 07HDC21742).

The Commissioner concluded that:

> Patient care was compromised by inadequate systems and the failure of the District Health Board (DHB) to resolve overcrowding and staff shortages.
> Whilst sympathetic to the difficulties the DHB faced in trying to meet the needs of a rapidly growing population, the DHB had not acted with sufficient urgency, early enough.
> It was not enough for a Board simply to "toll the bell of scarce resources" to excuse itself from liability under the Code.
> Regardless of the problems facing the DHB, its patients were entitled to an appropriate standard of care.
> The DHB's Board and its senior management were accountable for the failures in the patients' care.

A key feature of the inquiry was the degree to which the nursing care was compromised by workload. The Health and Disability Commissioner (2007) noted that: "The nurses didn't have time to care" (p.4). Further, the DHB "had inadequate planning and systems of nursing staffing, particularly in relation to the need to match staffing levels with patient numbers" (p.58). The Commissioner found that the professional leadership structure was not effective to give nurses authority over daily practice or to enable a meaningful partnership between clinical directors and management. The predictable result was: "an unsystematic approach to nursing care; poor planning, assessment and monitoring; inadequate supervision; failings in communications and documentation; and a general lack of patient focus" (Health and Disability Commissioner, 2007, p.58).

Professional liability is increased where there is inappropriate staffing and resourcing liability. The International Council of Nurses (2018, p.1) notes that:

> *"Safe nurse staffing is a critical issue for patient safety and the quality of care in hospitals, community and all settings in which care is provided. Inadequate or insufficient nurse staffing levels increase the risk of care being compromised, adverse events for patients, inferior clinical outcomes, in-patient death in hospitals and poorer patient experience of care"*

While employers have a substantial obligation to support nursing staff, this does not remove the accountability of nurses to provide safe care. Where circumstances indicate that safe care cannot be provided due to instances of inadequate staffing, this must be clearly and adequately documented in client notes and in an incident form reported using your organisations. The incident form must be completed in order to establish the one episode, as well as emerging patterns of inadequacies being identified. Like any documentation, if it isn't recorded then it is (very) difficult to confirm it is happening or ensure the risk is mitigated.

Support from NZNO

If you are involved in a serious or sentinel event investigation the NZNO fact sheet: Serious and Sentinel events will be helpful.

NZNO provides a range of services to assist members who are subject to coroners, NC & HDC investigations. This includes legal advice and representation in relation to professional practice matters. The earlier a member seeks support from NZNO, the better it is for both the nurse and NZNO to manage the situation.

NZNO members who find themselves subject to a complaint or are subject to an investigation into their practice must seek support and advice from NZNO as soon as possible.

NZNO recommends that nurse managers advise nurses who may be involved in an investigation of the importance of seeking guidance/support from their professional body.

References

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Mission statement
NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.