Serious and Sentinel Events Investigation

The purpose of this fact sheet is to outline the investigation process, and the New Zealand Nurses Organisation – Toputanga Tapuhi Kaitiaki O Aotearoa (NZNO) support available of nurses, midwives and Kaiawhina who may be involved in serious and sentinel event investigations. This publication fits with the NZNO Maranga Mai strategy for building member power – supporting members industrially and professionally.

This fact sheet should be read in conjunction with the NZNO *Fact Sheet: Investigations – your rights and responsibilities* available separately from the NZNO website (https://www.nzno.org.nz/resources/nzno_publications).

Background

A serious adverse event is one that is not life threatening and has not resulted in major loss of function but requires significant additional treatment A sentinel adverse event is life threatening or has led to major loss of function or an unanticipated death (Health Quality and Safety Commission, 2021a). Health care organisations are required to provide information on serious and sentinel events so that this can be included in the annual serious and sentinel Events report published by the Quality and Safety Commission.

A significant incident review process (SIRP) or serious and sentinel event investigation is a different forum to a Morbidity and Mortality review. Morbidity and Mortality reviews are 'Protected Quality Assurance Activities'. In most cases, SIRP and serious and sentinel event investigation reports are not Protected Quality Assurance Activities, as the purpose is for shared learning. Therefore, meeting minutes, reports and recommendations are generally discoverable i.e. they can be used in other investigations.

Commonly, adverse incidents that require investigation through the SIRP or serious and sentinel event investigation process, may also be investigated by ACC via a consumer or HDC complaint, or by the Coroner. Findings from the SIRP or serious and sentinel event investigation process may also inform these investigations or an investigation by a regulatory body (e.g. the Nursing Council of New Zealand) if this is deemed necessary.

We recommend that if you are involved in a SIRP or serious and sentinel events investigation process, get advice early from NZNO.

Nurses, midwives and Kaiawhina may be involved in either a serious or sentinel event whether they are directly or indirectly involved in the care provided. It is important that all health care workers have a good understanding of the procedures and processes involved.

Most people who require health care receive it safely and appropriately however, for a small minority of people, events may occur while receiving care that cause or have the potential to cause serious harm including death. The total number of adverse events reported in the year from 1 July 2019 to 30 June 2020 was 975 and increase of 59 form the previous year.

This increase has been attributed to increased reporting. Key findings from this report include:

- Pressure injuries - 112, an increase of 42 from the previous year.
- Delayed diagnosis or treatment - 73, a decrease of 6 from the previous year.
- Deterioration - 55, a decrease of 9 from the previous year.
- Complications - 52, of which 27 were maternity events, a decrease of 2 from the previous year.
- Fall - 231, a decrease of 24 from the previous year.
- Healthcare associated infections - 13, a reduction of 5 from the previous year.
- Mental health and addiction services - 218, a reduction of 14 from the previous year.

(HQSC, 2020)

Learning from the occurrence of serious or sentinel events is essential if we are to continue to provide safe and effective care to people. The purpose of recording and investigating preventable adverse events is to try and understand why these events occurred in order to try and prevent similar events from happening in the future "through reporting and learning from all types of harm" (HQSC, 2023, p. 5). The overall aim is to improve the safety of people receiving health care while meeting the cultural needs of all involved parties.

The Significant Incident Review Process (SIRP)

The Health Quality and Safety Commission (HQSC) supports a national approach to reviewing serious and sentinel events. In order to improve the quality, safety and experience of health and disability services, the HQSC developed the Healing learning and improving from harm, Te whakaora, tea ko me te whakapai ake I te kino: National Adverse Events Policy (2023). This policy focuses on system safety and learning from adverse events and is underpinned by the following principles:

1. **Consumer and whānau participation/Whai wāhi a te kritaki me te whanau** – consumer, whanau and providers working in partnership to understand and learn from harm events.
2. **Culturally responsive practice/Kia aro kit e ahurea** – consideration, acknowledgement and support of each person's culture, beliefs, and values.
3. **Equity/Mana taurite** – review processes must take into account inequities that

exist and develop specific actions that take these into account.

4. **Open Communication/kia kōrerorero noa** – timely, transparent communication with health consumers and whānau when potential or actual harm has occurred is integral to the maintenance and restoration of the dignity or tapu of those involved.
5. **Restorative practice and restorative responses/Mahi haumanu, hohou te rongo** – restorative practice is involvement in a voluntary relational process that is supported and facilitated. Restorative responses us tikanga or specific practices to explore harm that has been caused. A meaningful apology is part of this process along with restoration of mana, power, authority and tapu.
6. **Safe reporting/Kia haumaru te tuku pūrongo** – The development of a safe culture of reporting that allows concerns to be raised and events to be reported without negative personal consequences.
7. **System accountability/Tā te pūnaha kawenga** – Service providers are accountable for the implementation of services that meet national expectations and recognize physical, psychological, cultural and spiritual harm.
8. **System learning/Tā te pūnaka ako** - a systems approach that is ethical, inclusive and respectful and includes examination of human factors should be used to provide meaningful analysis. Using a 'learning review' is the preferred method of achieving this.

The significant incident review process (SIRP) or a similar process of investigation is initiated by the employing organisation in response to a serious or sentinel event. A SIRP or serious and sentinel event investigation process takes a **systems approach** to determining the cause of the event rather than trying to apportion blame to an individual. Although an individual may have made an error or misjudgment, it is important that the system factors that may have contributed to that error or misjudgment be reviewed. HQSC provides links to the London Protocol and states that "the purpose of the London Protocol is to ensure a comprehensive and thoughtful investigation and analysis of a clinical incident" (HQSC, 2021b).

The London Protocol process incorporates all those who work within the healthcare system from management to front line clinicians, and looks at how they interact, communicate, work as a team and work to create "a safe organisation". This protocol can be used to do quick analysis to identify 'main problems' and 'contributing factors', or in-depth reviews of events. The protocol can also be used for teaching to introduce systems thinking and help staff understand the protocol. The process covers investigation, analysis and recommended actions (Taylor-Adams & Vincent, 2023).

In this framework the term 'care delivery problem' is used for unsafe acts. The term was chosen as it may be difficult to identify a single or specific unsafe act as issues often develop over time. Once the care delivery problem (CDP) has been identified the contributory factors including the conditions in which the error occurred and wider organisational context are revived. Contributory factors may precipitate errors (Taylor-Adams & Vincent, 2023).

Any concerns with individual performance/competence or potential disciplinary action should not be addressed in the SIRP or investigation process – these issues, if highlighted, should be addressed through other formal channels/processes. While other organisations may undertake a SIRP or serious and sentinel event investigation

process, only Te Whatu Ora/Health New Zealand is required to make any learning public in the Serious and Sentinel Event Annual Report.

Steps in the SIRP or serious and sentinel event investigation process

The following provides an example of a normal process that may be undertaken following a serious or sentinel event.

After the event has occurred and been identified as requiring investigation, a review panel with approximately three to five people on it is established. The review panel commonly consists of a Clinical/Technical Expert/Advisor (e.g. Clinical Director or Associate Director of Nursing), a manager (preferably not the manager of the unit where the incident occurred), a quality co-ordinator/ manager, and occasionally a consumer.

Step one: Identification and decision to investigate

- Incidents may be reviewed if they have had serious consequences for the patient and whanau or organisation, or there is potential learning to improve health care delivery.
- Immediate initial investigation may be required for serious incidents, others may be delayed.
- The most senior person present decides what initial action should be taken.
- Analysis should focus initially on the period of time when issues were most obvious.
- Your organisation should specify what circumstance should initiate an incident investigation

Step two: Select the people for the investigation team

- An investigation team should consist of 3-4 appropriate experts.
- Members should have multiple skills and be able to commit time to the process.

Step three: Organisation and Data Gathering

- Documenting the incident, including all facts, knowledge and physical items related to the incident.
- Statements from those involved can be a useful data source.
- Information can be obtained by interviewing those involved. These should take place in private away from the work environment. Interviewees should be asked if they would like a support person to be present (NZNO strongly recommends this).

Step four: Determine the Chronology of the Incident

- Establish a clear detailed timeline, narrative of chronology, time person grid or flow chart of the incident.
- Disagreement or discrepancies need to be clearly identified.

Step five: Identify CDPs

- Identify the care delivery problems.
- It may be useful to meet with all those involved in the incident to identify the care delivery problems so that they can identify what went wrong and why. This needs to be done in a supportive environment by a skilled facilitator.

Step six: Identify the Contributory Factors

- Analyse each CDP to identify the contributory factors.

Step seven: Making Recommendations and Developing an Action Plan

- A set of recommendations and improvement strategies is generated from the identified CDPs and contributing factors.
- An action plan is developed that prioritises safety; lists actions to address contributing factors; identify the timeframe and who is responsible for implementation of the action plan; identify resources required; provide evidence of completion of actions and identify a date for formal evaluation.

One of the key elements required for a successful SIRP or serious and sentinel event investigation is the accurate completion of incident reports – see the NZNO *Fact Sheet: Incident reporting* for complete guidance on how to complete an incident report.

Ensuring excellence in documentation will also assist nurses if they are involved in a SIRP or serious and sentinel event investigation process. The NZNO *Guideline: Documentation* provides clear guidelines on documentation.

Member Support

While investigation processes differ across healthcare organisations, it is vital that any member who thinks they may be involved in a serious or sentinel event get in touch with NZNO as soon as possible.

- It has been known for nurses to be asked to attend a serious or sentinel event review meeting with very short notice and with no support person.
- It has also been known for members to not receive a copy of recorded notes of a meeting or to see a draft report before it is finalised. This can be an issue when comments are attributed to the member and are not what the member intended or actually said.
- While it is important for members to engage in the SIRP and serious and sentinel event investigation process, this must be balanced with the need to protect oneself professionally. Seeking advice at the earliest possible stage is crucial to ensuring constructive outcomes.

NZNO provides a range of services to assist members who are subject to an investigation. This includes:

- Professional advice and support.
- Legal advice and representation in relation to professional practice matters.
- The earlier a member seeks support from NZNO, the easier 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.

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.

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