Incident/Harm Event Reporting, 2023

Introduction

It is an expectation that health care providers document adverse, unplanned, or untoward events including shortfalls in service delivery such as short staffing to identify and manage risks, and improve services (Standards New Zealand, 2021). The aim of Te Tāhū Hauora Health Quality and Safety Commission's (Te Tāhū Hauora) Healing, Learning and Improving from Harm/Te Whakaora, Te Ako Ee Te Whakapaiake I Te Kino policy (2023) is to 'support organisations to heal, learn and improve' the services they provide when harm has occurred, in order to improve consumer and health care worker safety. Incident reports that describe actual events or "near misses" are an effective way to improve quality and safety for patients and staff and are key to NZNO's Healthy Workplaces Strategy.

When an incident or harm event occurs, it is important to take the time to fill out an incident report. Incident reports create a record and provide supporting information when you are trying to campaign for change. Reports should be filled out as soon as possible after the incident/harm event occurs.

Management should make reports available on the type of incidents/events that have occurred and what action has been taken to reduce the risks, thus improving the quality of the service.

When should you complete an incident form?

> When there has been an error or omission that has or could potentially have affected patient care (a "near miss").
> When there has been an incident or accident involving a patient (e.g., a medication error, a fall).
> When nurses consider staffing levels are unsafe on their ward or unit
> When an event has threatened the health and safety of staff, e.g., abusive patients or visitors, or unsafe staffing.
> When there has been a harm event, i.e., there has been permanent harm or death as a result of an incident.

The incident report should include:

> Your name and designation.
> The name of the ward/area in which the incident occurred.
> Date and time of incident.
> The client/patient's full name and client/patient number.
> The events leading up to the incident.
> A description of what you observed.
> Details of observations/recordings taken.
> Actions you took in response to the recordings, e.g. rang for a registered nurse (RN) or doctor or initiated the early warning score protocols.
> A list establishing the order and time of what you did for the client/patient, following the incident.

> A list of all those notified at the time and what action was taken.
> An objective description of contributing factors.

Reports should be filled out as soon as possible after the incident, while events are still clear in your mind. This can be very difficult, especially if it has been a serious event, or if you are not familiar with the reporting system (e.g. electronic) or if you are very tired at the end of a difficult shift. It is important you get support from somebody else on the ward/unit.

If you think that an incident may reflect poorly on your competence or standards of practice, you are advised to seek NZNO advice early. Phone 0800 28 38 48

Incident reports are part of the quality improvement system, not the client/patient record. Any information recorded in an incident report should also be recorded separately in the client/patient notes.

Staff should always document incidents in a way that would satisfy themselves and observers if the staff member or their documentation were to be examined in court. Remember, all information and documentation may be requested if there is an investigation.

Some incident reports (particularly the electronic systems in most district health boards (DHBs) have a field for the staff member to rate the severity of the incident – the Severity Assessment Code or SAC, and to identify contributing factors to the incident. Staff should have been provided with training from the employer on how to do this effectively. This system can take time to use but it is critical that staff report events.

Safe Staffing Incidents

Incidents that should be reported related to nursing or midwifery staffing include:

> not enough staff (number/ratio)
> not enough staff with the right skills (skill mix)
> too many patients with complex needs to be managed safely (care capacity)

The Nursing Council guideline on direction and delegation (www.nursingcouncil.org.nz) requires nurses to report when systems are unsafe. In fact, it is vital to record short staffing, if that was a contributing factor to the incident. The Nursing Council Code of Conduct for Nurses (Standard 8.4) requires nurses to report "...your concerns if you believe the practice environment is compromising the health and safety of health consumers".

Clause 6 of the DHB/NZNO MECA requires DHBs to involve NZNO delegates in the investigation and resolution of incidents involving short staffing. This cannot happen without incident reports. Employers and NZNO need information that can be measured, quoted and reported, in order to request change. In aged-care and private providers, staff should seek support from delegates. If a staff member works in a workplace where there are no delegates, s/he should involve their peers or contact NZNO. If staff are concerned incident reports are being ignored in their workplaces, or they are not getting feedback about reports they have written, they should keep a note of the details of the report, including date and time, a summary of the issue and the number of the incident report.

Request a meeting with the manager to review the incident reports submitted and the actions that resulted from the reports.

Categorising harm events

A **harm event** is considered to have occurred when a patient requires unexpected additional treatment, is life-threatening or has led to a major loss of function for the patient and includes unanticipated patient death. These types of incidents are subject to a significant incident review process (SIRP).

A SIRP is held within the organisation and should use a 'learning review' process. to try to determine any systems issues that may have contributed to the error, and to make any recommendation for improvements. If there are issues relating to individual performance or competence, these must be investigated separately.

Get NZNO advice early!
Phone the Membership Support Centre on 0800 28 3 848

References

Standards New Zealand. (2021). *Ngā paerewa health and disability services standard* NZS. 8134:2021. https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards/nga-paerewa-health-and-disability-services-standard

Health Quality & Safety Commission. (2023). Healing, learning and improving from harm: National adverse events policy. https://www.hqsc.govt.nz/assets/Our-work/System-safety/Adverse-events/Publications-resources/National-adverse-events-policy-2023_English_final_WEB.pdf

Nursing Council of New Zealand. (2012). Code of Conduct for Nurses. Available: www.nursingcouncil.org.nz

Check www.nzno.org.nz for further and specific information on other topics related to incident reporting, making statements, the HDC, significant incident reviews etc.

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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.