Serious and Sentinel Events

The purpose of this fact sheet is to outline the rights and responsibilities of nurses and midwives who may be involved in serious and sentinel event investigations.

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 (Health Quality and Safety Commission, 2010). A sentinel adverse event is life threatening or has led to major loss of function or an unanticipated death (Health Quality and Safety Commission, 2010). DHBS 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.[1]

A significant incident review process (SIRP) or serious and sentinel event investigation is a different forum to a Morbidity and Mortality review (M&M). M&M reviews are "Protected Quality Assurance Activities"[2]. 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 and midwives 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 nurses and midwives have a good understanding of the procedures and processes involved.

This fact sheet outlines the rights and responsibilities of members who may find

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[1] The most recent report was published in 2010 (Health Quality & Safety Commission, 2010).

[2] A quality assurance activity (QAA) is defined in section 53 of the HPCA Act as an activity that is undertaken to improve the practices and competence of health practitioners by assessing the health services provided by them. A 'protected' QAA protects the confidentiality of information that becomes known solely as a result of such activities as well as documents brought into existence solely for the purposes of such activities. It also gives immunity from civil liability to persons who engage in such activities in good faith (Ministry of Health, 2004).

themselves involved in an investigation into a serious or sentinel event. This fact sheet should be read in conjunction with the NZNO *Fact Sheet: Investigations – your rights and responsibilities* (NZNO, 2011) available separately.

Background

Most people who require health care receive it safely and appropriately (Health Quality and Safety Commission, 2010). For a small minority of people, events may occur while receiving care that may cause or have the potential to cause serious harm or even death.

In the 2009/2010 fiscal year DHBs reported the following statistics:

> 374 people treated in their hospitals were involved in a serious or sentinel event that was actually or potentially preventable
> 127 people died during admission or shortly afterwards, though not necessarily as a result of the event. Half of these deaths occurred through suicide
> falls (34%), clinical management problems (33%) and suicides (17%) were the three most commonly reported serious and sentinel events.

(Health Quality and Safety Commission, 2010, p.v)

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 (Quality Improvement Committee, 2009). The overall aim is to improve the safety of people receiving health care.

The Significant Incident Review Process (SIRP)

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. International research indicates that most harm caused to patients can be attributed to problems in the health care system itself rather than an individual (Canadian Nurses Association & University of Toronto Faculty of Nursing, 2004). 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, the question is to explore the system factors that may have contributed to the person making the error or misjudgment. 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 DHBs are 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:

> Firstly the group defines the incident and sequence of events leading up to it – a timeline is created.

Step two:

> The review group attempts to understand what happened.
> This is likely to include interviewing all those involved – remember any statement you make is discoverable (this means it can be used in a court of law). Please see the NZNO Fact Sheet: Investigations – your rights and responsibilities (NZNO, 2011) for detailed information on how to make a statement.
> Points where a barrier could have changed the course of events are identified.
> The relevance of each piece of information is assessed.

Step three:

> A cause and effect diagram is developed that assists in analysing the relationships between the event and its causes.
> The diagram identifies the primary causes that directly preceded the event.
> The root cause and contributing factors are analysed.

Step four:

> A causation statement is developed - a causation statement is a statement that identifies the link between the identified cause of an event and event itself.

The SIRP or serious and sentinel event investigation process should enable the implementation of steps to address the root systemic cause of the event in order to prevent it from occurring again.

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* (NZNO, 2010) 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 pamphlet on *Documentation* (NZNO, 2010a), provides clear guidelines on documentation.

Other

While SIRP and serious and sentinel event investigation processes differ across DHBs, it is vital that any member who thinks they may be involved in a serious or sentinel event get in touch with their NZNO organiser as soon as possible. The organiser will refer the member to a NZNO lawyer. 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 even 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 free 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 their NZNO organiser as soon as possible. The organiser will refer the member to a NZNO lawyer.

References

Canadian Nurses Association & University of Toronto Faculty of Nursing. (2004). Nurses and patient safety: a discussion paper. Ottawa, Ontario: Canadian Nurses Association.

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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.