New Zealand Nurses Organisation

Submission to Communio Pty. Ltd.

on the

New Zealand Health and Disability Sector Safety Improvement Programme's Draft Policy for the Management of Healthcare Incidents

June 25, 2008

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EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes this opportunity to comment on the New Zealand Health and Disability Sector Safety Improvement Programme's Draft Policy for the Management of Healthcare Incidents. We particularly wish to thank Communio, the agency responsible for preparing the policy and handling the submissions, for the time extension which has allowed NZNO to participate in this consultative process. We note with concern, however, and notwithstanding the urgent need for a nationally consistent reporting system, the very short time allowed for submissions and the fact that we did not find out about the draft policy paper until two days before submissions were due. We have reviewed our communications systems and have not identified any error, but, as incident reporting is a serious issue and one we believe we can make a constructive contribution to, we trust we will be kept involved and informed from here on in.
2. NZNO is unaware of any *nursing* representation on the group developing the draft policy and consider that this is a gap that could be addressed. Nurses are the largest body of health professionals in the country and also the group which will be reporting the majority of incidents. We believe our participation this group would be helpful particularly with implementation. We also note in the NZ Incident Management Newsletter Issue 1 (May 08) that a faculty selected for expertise will be brought together to develop the curriculum for education to support this policy. Expertise can be provided in this capacity through our organisation
3. NZNO strongly supports the purpose of the policy to provide a nationally consistent approach to the management of healthcare incidents to increase public safety, reduce errors and ensure health professionals are operating in a safe environment.
4. We applaud the principles on which the policy is based and believe that establishing a coherent reporting system that nurtures learning and sharing

rather than naming and blaming is consistent with some aspects of the Health Practitioners Competence Assurance Act 2003 (HPCAA) , for example in supporting HPs to gain competencies they may be lacking. However it is not consistent in practise and does not provide sufficient protection for HPs who are unlikely to be encouraged to report incidents which may subsequently implicate them and affect their ability to practise. Under the Act, *regulated* HPs are personally responsible through their Practising Certificate, for adverse incidents, regardless of systemic or contributing issues; there is simply insufficient legislative protection for health practitioners to be confident that a 'no-blame' culture prevails. We note that Protected Quality Assurance Activities (PQAA) do not seem to be widely used; there is widespread confusion around the roles and responsibilities of regulated and unregulated healthcare workers; and any written reports are fully recoverable as evidence in reviews of HP practise. This policy does not take these factors into account.

5. It is particularly pleasing to see that the same reporting system and requirements will apply to both private and public institutions, since there are numerous occasions where NZNO has pointed out the inconsistency of reporting in, for example, private aged care facilities. Similarly, ensuring that the same system is used for both paper and electronic reporting, sensibly allows some degree of latitude for individual preference, training and the availability of resources in the inevitable transition to digital reporting. NZNO is aware that even where electronic reporting has been made mandatory, inadequate access to computers and training, user 'unfriendly' software and lack of time have impacted negatively on incident reporting.
6. We are pleased that the Severity Assessment Code (SAC) sensibly aligns with the Triage code, with number 1 denoting the highest level of severity.
7. The process for assessing incidents currently varies with and within each District Health Board (DHB), yet it is the quality of the assessment and how it is handled which is critical to establishing the right 'culture' and to

determining good outcomes. NZNO suggests that more defined and robust processes be established for training and credentialing assessors. It is not sufficient to leave it to general management; there needs to be clinical input and the assessor must enjoy the confidence of practitioners as well as the public.

8. Specific comments on the draft document are made below and for your consideration we append an alternate and excellent Incident Report Form developed by Roxanne McKerris which has been used to great effect at Canterbury DHB (Appendix 1) .

9. NZNO notes that this draft policy marks the beginning of a suite of activities supporting the implementation of a New Zealand Incident Management System (IMS) outlined in its launch (23rd June) and which include the "establishment of the VA patient safety programme, upon which most of the New Zealand system will be based" (NZQIP, 2008). There have been a number of incident reporting systems introduced in various DHBs which, for various reasons, including lack of proper resourcing, have not delivered the functionality required. For this reason NZNO has strong reservations about investing in an imported IMS, which will require extensive training and resourcing unless it has been adequately trialled in the New Zealand health sector. We seek assurance that it will be an effective tool, one that is culturally appropriate, and can be benchmarked against systems used extensively in Australia such as the Accident and Incident Management System (AIMs) and Riskpro . Trans Tasman mobility of HPs is very high and it makes sense both economically and for safety reasons that we work towards commonality with Australia. We also note that AIMS is used by the ACC for injury caused by medical misadventure. NZNO would like to be satisfied that due process has been followed in the selection of the VA patient safety programme as the basic tool for a NZ Incident Management System.

10. NZNO reiterates its strong interest in supporting this policy and commitment to educating our 43,000 members about responsible incident reporting. We

draw your attention to the DHB Multi Employer Collective Agreement which includes a clause whereby NZNO undertakes to review incident forms. We believe that successful implementation will only occur with widespread publicity, education and engagement and, in line with both bi-partite and tri-partite agreements with the government and DHBNZ, we would be very happy to assist with this process. We recommend a central role for Clinical Nurse Educators to disseminate information and provide guidance for nurses.

RECOMMENDATIONS

11. The New Zealand Nurses Organisation recommends that you:

- **note** our support for a nationally consistent incident management system;
- **note** our support for a culture of open disclosure;
- **agree** that nurses as the largest group of health professionals should be involved in the future development and implementation of a national incident management system;
- **note** NZNO's willingness to participate in the above and our identification of clinical nurse educators as key agents for education/implantation;
- **note** that some aspects of this policy are inconsistent with the requirements of the HPCAA;
- **note** our concern at the lack of distinction between regulated and unregulated health professionals;
- **agree** that this policy offers little protection to regulated health professionals;
- **agree** that all incidents need some level of individual review not just more serious events;
- **agree** that assessors need to be well trained and accredited

- **agree** that the development and implementation of a national incident reporting system is integral to the work of the Safe Staffing/Healthy Workplaces Unit
- **agree** that due process is followed in the selection of and education for an incident management tool, which should ideally have some reciprocity with Australian reporting systems; and
- **note** the Canterbury DHB incident report form appendix 1, and agree that it is a useful model.

ABOUT THE NEW ZEALAND NURSES ORGANISATION

12. NZNO is a Te Tiriti o Waitangi based organisation. It is the leading professional body and nursing union in Aotearoa New Zealand, representing over 43 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Te Runanga o Aotearoa NZNO comprises Māori membership and is the arm through which our Treaty based partnership is articulated.
13. The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.
14. NZNO has consulted its members in the preparation of this submission in particular NZNO staff (Management, Professional Nursing Advisors, Policy Analysts, and Industrial Advisors) and NZNO members (Colleges and Sections, Board Members and other health care workers)..

DRAFT POLICY FOR THE MANAGEMENT OF HEALTHCARE INCIDENTS

15. **Section 1. Introduction** The intent of the document and key points are clearly articulated. We note:

- *1.3 Context and Direction*: refers to clinical governance but does not provide a definition which would be useful.
- *1.4 Diagram Policy Education & Training Information System*: includes managers but excludes clinicians. Clinical leaders in particular should be integral to this model.
- *1.5 Principles*: Open disclosure. NZNO supports the principle of open disclosure but this section does not refer to or consider the admission of guilt or the possible impact that would have on a health worker. Regulated health professionals would be advised to seek advice from their professional body/insurer prior to any meeting with patients or families.. We note that open disclosure is not an established culture in the health sector and that considerable effort and education will be needed to encourage it.
- Accountability. This is a somewhat grey area since responsibilities are not always clearly defined or understood. In particular what is the individual accountability of the unregulated health care assistant. Is a regulated nurse responsible for tasks delegated to an HCA? Second level nurses – Enrolled Nurses and Nurse Assistants share competencies but not scopes of practice and this continues to lead to confusion amongst employers, other health professionals and the public. Further, basic minimum standards voluntarily agreed to by the sector in the NZ Standards *Indicators for Safe Aged-Care and Dementia-Care for consumers* (2005) are rarely met (see NZNO, 2005) in the privatised aged care sector, so the concept of individual accountability without, for instance, safe staffing levels, is neither fair nor appropriate. NZNO recommends that accountability needs to be defined in a balanced way that encompasses individual, government, corporate and professional responsibility.
- *1.6 Scope* NZNO notes that the *Easy Guide to Effective Healthcare Incident Management & Prevention* is still under development and would appreciate involvement and/or commenting on draft when this is available.

- *1.7 Safe reporting culture*: We do not consider "free lessons" appropriate language. Similarly, "Knowing where the edge is until patients and/or staff fall over it" is potentially offensive. The term "near miss"**,** is used elsewhere in the document and included in the definitions. We suggest revising the second sentence to read: "*Without a detailed analysis of mishaps, incidents and near misses, there is no mechanism for identification of issues, which may result in catastrophic incidents and systemic failures."*
- *1.8 Requirement to implement:* We support this directive, and recommend inclusion of "both private and public " at the end of the first sentence. It is not clear that individual organisations will still need their own policy defining their own organisational system which will be part of the "one local policy". This section needs rewording to reflect that.

Section 2. Definitions of Terms – NZNO suggests this may be better positioned as a glossary at the end of the document for ease of access.

- *Clinician* – this definition is grossly misleading, contradictory and counter - intuitive. New Zealand does not have a Health Registration Act. Presumably what is meant by this reference is the HPCAA in which case the distinction should be between regulated and unregulated health workers. Unregulated health care workers require no training, and are not subject to police checks, professional codes of practise or anything which the general public is likely to consider intrinsic to the role of a clinician. The actual examples given – medical practitioners, nurses and allied health professionals are all regulated. The distinction should be preserved and another name found for those who may assist and work in a healthcare environment but carry none of the professional responsibility or liability that a regulated HP does. We note too that midwives should be included in the list of examples. A suggested alternative definition from the a report commissioned by the Clinical Leaders Association of New Zealand (CLANZ) may be useful: "A broad definition of 'clinician' was

used to include any person with a health professional training, who has (usually) qualified and been involved in direct practice with individuals, groups or communities"(Jones et al, 1999).

- *Incident investigation* - Replace *undesirable* with *unexpected* or *adverse*
- *Open disclosure* – refer previous comments Section 1 1.5
- *Root Cause analysis* – consider revision to "a *method to investigate and analyse incidents, required to be used for SAC 1..."* This is a valuable objective tool and NZNO suggests it should have wider application than SAC 1 & 2 .

Section 3 The Incident Management Process

- *Step 3 Incident notification* – Anonymity of notification is difficult to achieve with electronic systems which require users to be logged. What measures will be put in place to ensure anonymity and will they be consistent with, or override, the HPCAA?
- Patient/ carer/ family/whanau reporting incident. Incident reporting is a tool for the healthcare provider and there are practical and technical difficulties in accessing electronic reporting. Client reports of an incident could be managed as a complaint .
- A notifier giving an opinion of what could have been prevented will require significant education with regard to effective documentation and ensuring that the account remains objective. There are potential issues with consumers giving their opinion at this time in this format – they need an avenue to be supported in their concerns but NZNO has reservations that this is the best way of engaging with them.
- We note too that incident reports written immediately can be very emotive and initial thoughts about causation can be pre-emptive and professionally damaging. This underlines the need for training to develop the skills needed to write effective incident reports which focus on systems failures and avoid using comments that apportion blame.

- *Step 3.2 Incident notification - by the manager. S*ignificant support will need to be put into place for managers to discuss *every* variation to SAC code that is likely to be made through this system. For clinical events (SAC 1 or SAC2); the Clinical Leaders in the Service or Speciality should also be notified.
- *Step 3.3 Notification to the patient (open disclosure)* Note our earlier comments regarding open discosure. Regarding an apology for harm at the time, we note that as well as supporting clients, support should also be given to staff member(s), particularly if inexperienced or junior staff are involved. Such situations can be challenging even for experienced clinicians.There must be an advocate for staff at all levels. In view of the HPCAA, we also suggest there is an urgent need for a flow chart or similar so that HPs are aware of getting timely professional support from their professional organisation/insurer.
- *Step 4. Prioritisation* –We note that rating by more than one person is suggested as a means of providing a more uniform yardstick. We believe that a uniform yardstick is important which makes it imperative that the (second) assessment is carried out by someone qualified to do so. A clinician may rate an incident quite differently from someone with a management perspective, for instance. Proper education and accreditation of assessors would be useful.
- Paragraph four – Replace “close calls” with “near miss”
- *Step 4.1 Severity Assessment code scoring process*. NZNO cautions that apportioning a SAC score on the potential outcome/ consequence/severity of an incident rather than actual severity will cause inaccuracy with reporting of data. Is it suggested that near misses are reported separately or within the system? If reports can be run separately for potential versus actual consequence, this would be more valuable.
- *Step 5-Investigation of the Incident* NZNO supports the focus on systems issues related to the incident and not on matters of individual competence

or performance. However, if during the investigation process such issues are identified, this document should include reference to processes of referral for professional review.

- *SAC 1 incidents* – NZNO notes the 70 day prescribed window during which time the incident must be investigated and the report completed. However there is no consideration given to the rights of HPs to seek professional advice with regard to providing statements that might be used in an investigation. If named in the report or if reference has been made to actions that they have taken, HPs should have a right to see the report before it is sent to the MOH and seek advice as appropriate.
- Investigating several similar incidents together is useful for identification of themes, but NZNO recommends that all incidents should be subject to individual review. The process need not be as complex as the review for SAC 1 &2 but must be robust enough to ensure that the incident has been accurately classified and does not require escalation to a higher rating. There is often much value to be gained from review of a less severe incident that provides information that can prevent a recurrence of a similar incident with more serious consequences.
- It should also be clear to what extent information pertaining to each specific incident would be able to be recovered, should there be further investigation by, for instance, the Health & Disability Commissioner or Accident Compensation Corporation.
- *5.2- Investigations and individual performance*. This section does not clearly specify referral to regulatory bodies for the incidents described, yet in many cases, this is mandatory. Referral to DHB Chief executive and management through local human resources policy is too vague and not applicable in some cases. Midwives who have access agreements, for example, are not bound by DHB HR policies.
- *5.3 –Investigation of the incident*. A review across services /providers with clearly assigned responsibility for managing the review is a positive step in improving patient outcomes.

- *Step 6 - Classification* NZNO supports the introduction of a consistent classification system nationally to facilitate more effective bench marking between providers.
- *Step 7 – Analysis* While this summarises some important aspects and benefits of analysing the correlations/ causal factors for adverse incidents, it should be linked into existing understanding of risk factors in the health sector and especially around the seven elements of Safe Staffing/Healthy Workplaces (SS/HW) identified in the Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry(2006). The SS/HW Unit , a partnership between NZNO, and all DHBs, is supported by the Ministry of Health. It has been set up within DHBNZ to implement the recommendations of the report and it is evident that, to avoid further fragmentation and duplication, this incident reporting policy needs to be aligned with the Unit's work.
- NZNO also suggests that this section should include reference to staff being kept informed of actions being taken to improve situations that have led to incidents since a reason frequently given for not reporting minor incidents is that previous reports have elicited no response.
- *Step 8 - Improvement action* Midwives, a distinct professional group from nurses, should be included in the list of HPs at the end of the second paragraph.
- *Step 9- Feedback following investigation.*9.2 NZNO believes that individuals involved with specific incidents are entitled to be kept informed at all times of the progress of any investigation and the subsequent development of a report. They should be made aware of their right to seek professional support.

Section 4. Reportable event briefs (REB) For greater clarity add the italicised phrases to the following *4.2 REB Reporting Requirements*

- Retained instruments *following surgery/ procedure*.
- Unintended material *retained following a procedure*.

- We note that medication error leading to death is specified; and believe that medication error leading to significant harm but not resulting in death should also be specified.

Section 5. Responsibilities for incident management This section provides a good and clear summary of the responsibilities for incident management and it is particularly pleasing to see the leadership role of Ministry of Health defined.

Section 6. Open disclosure – refer previous comments**.**

CONCLUSION

16. In summary NZNO strongly supports the development and implementation of a nationally consistent incident reporting model. We agree with the principles of open disclosure, and fostering a culture of learning and sharing to increase accident prevention and public safety and support health professionals. We have suggested modifications of the draft policy document and in particular draw your attention to fundamental inconsistency between the requirements of the HPCAA and an open reporting environment. Unless legislative protection is offered to HPs and/or adequate responsibility is taken for factors beyond individual HPs control, open reporting is unlikely to be normalised.
17. NZNO believes nurses should be involved in the subsequent development and implementation of this policy and are willing to facilitate this.

Marilyn Head

NZ Nurses Organisation

REFERENCES

NZQIP. 2008. New Zealand Incident Management System Newsletter, Communio Pty.Ltd. Issue 1.

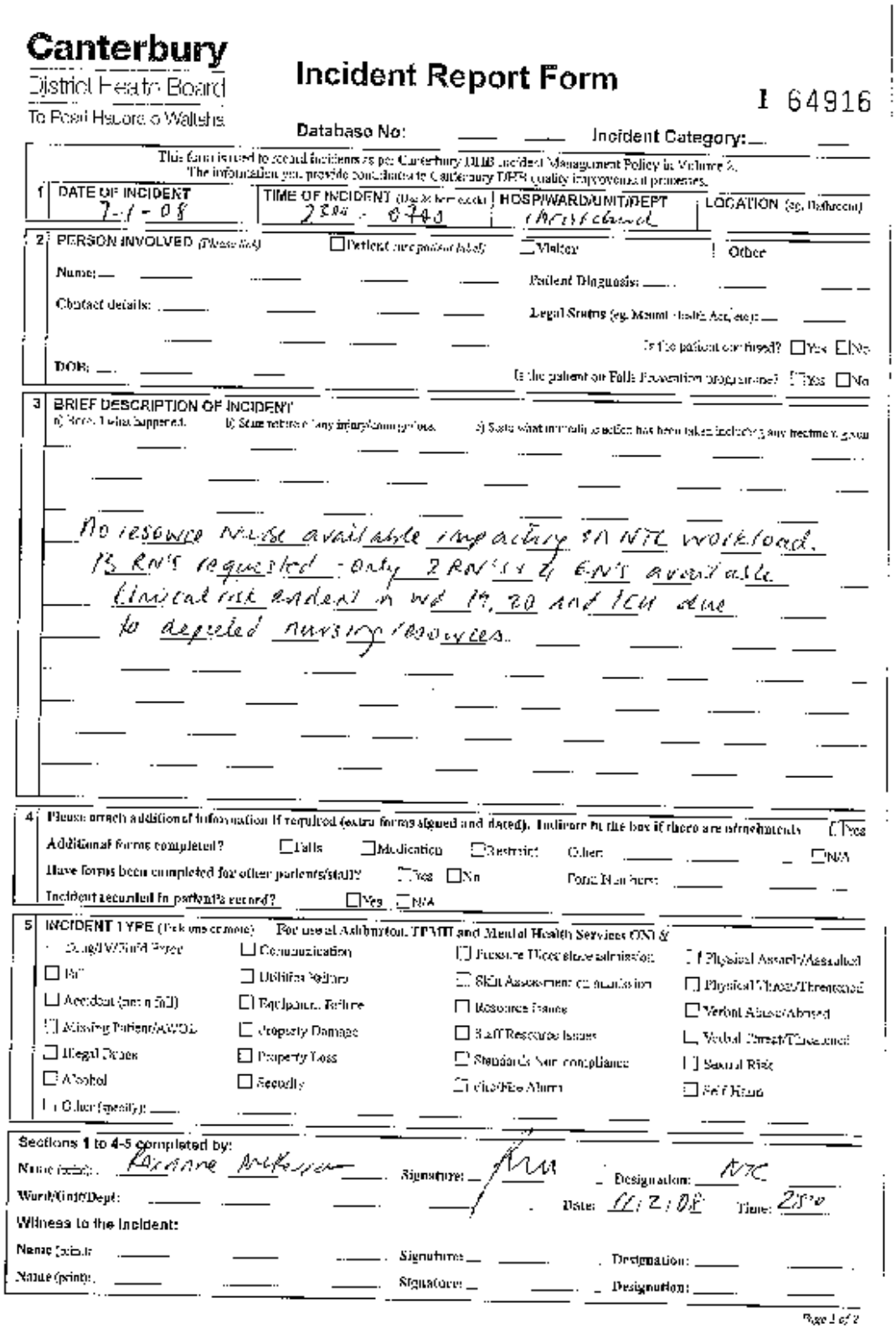
Jones, Shelley; Boyd, Mary-Anne; Raymont, Antony. 1999. *Clinicians in Management and Leadership Roles: an analysis of learning needs and an overview of learning strategies and resources.* Clinical Leaders' Association of New Zealand retrieved June 2008 from http://www.clanz.org.nz/downloads/index.cfm?recordid=3

New Zealand Nurses Organisation. 2005 A Snapshot of Staffing Levels in Aged Care Services. NZNO.

Safe Staffing Healthy/Workplaces Committee of Inquiry. 2006. *Report of the Safe Staffing Healthy/ Workplaces Committee of Inquiry.*Wellington.

Standards New Zealand. 2005. *New Zealand Handbook: Indicators for Safe Aged-care and Dementia-care for Consumers*, SNZ HB 8163:2005. Wellington, New Zealand Standards Council.

APPENDIX



Canterbury
District Health Board
Te Poari Hauora o Waitaha

Incident Report Form

I 64916

Database No: ____ ____ Incident Category: ____ ____

This form is used to record incidents as per Canterbury DHB Incident Management Policy in Volume 2.
The information you provide contributes to Canterbury DHB quality improvement processes.

1 DATE OF INCIDENT 7-1-08 | TIME OF INCIDENT (Use 24 hour clock) 2200 - 0700 | HOSP/WARD/UNIT/DEPT Christchurch | LOCATION (eg. Bathroom)

2 PERSON INVOLVED (Please tick) ☐ Patient (use patient label) ☐ Visitor ☐ Other

Name: ____ Patient Diagnosis: ____

Contact details: ____ Legal Status (eg. Mental Health Act, etc): ____

Is the patient confused? ☐ Yes ☐ No

DOB: ____ Is the patient on Falls Prevention programme? ☐ Yes ☐ No

3 BRIEF DESCRIPTION OF INCIDENT
a) Were Police Supported. b) State nature of any injury/damage done. c) State what immediate action has been taken including any treatment given

No resource nurse available impacting on NTC workload.
13 RN's requested - only 2 RN's & 6 NN's available
Clinical risk evident in wd 19, 20 and ICU due
to depleted nursing resources.

4 Please attach additional information if required (extra forms signed and dated). Indicate in the box if there are attachments ☐ Yes

Additional forms completed? ☐ Falls ☐ Medication ☐ Restraint Other: ____ ☐ N/A

Have forms been completed for other patients/staff? ☐ Yes ☐ No Point Number: ____

Incident recorded in patient's record? ☐ Yes ☐ N/A

5 INCIDENT TYPE (Tick one or more) For use at Ashburton, TPMH and Mental Health Services ONLY

- ☐ Drug/IV/Fluid Error
- ☐ Fall
- ☐ Accident (person hurt)
- ☐ Missing Patient/AWOL
- ☐ Illegal Drugs
- ☐ Alcohol
- ☐ Other (specify): ____
- ☐ Communication
- ☐ Difficult Patient
- ☐ Equipment Failure
- ☐ Property Damage
- ☐ Property Loss
- ☐ Security
- ☐ Pressure Ulcer since admission
- ☐ Skill Assessment or Education
- ☐ Resource Issues
- ☐ Staff Resource Issues
- ☐ Standards Non-compliance
- ☐ Code/Fire Alarm
- ☐ Physical Assault/Assaulted
- ☐ Physical Abuse/Threatened
- ☐ Verbal Abuse/Abused
- ☐ Verbal Threat/Threatened
- ☐ Sexual Risk
- ☐ Self Harm

Sections 1 to 4-5 completed by:
Name (print): Lorraine McKeown Signature: ____ Designation: NTC
Ward/Unit/Dept: ____ Date: 11/2/08 Time: 2330
Witness to the Incident:
Name (print): ____ Signature: ____ Designation: ____
Name (print): ____ Signature: ____ Designation: ____

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