



# Procedure: Serious and Sentinel Event Review

**Procedure Facilitator:** Manager Quality and Clinical Risk

**Classification:**

Administration and Clinical Manual

**Authorised by :** Chief Executive Officer

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## 1. Purpose of Procedure

The purpose of this procedure is to specify Waikato District Health Board's requirements for the analysis and follow-up of serious and sentinel events with a clinical impact. These requirements are **in addition** to those specified in the Waikato District Health Board (DHB) Incident / Accident / Near Miss Notification and Management Policy.

The primary aim of serious and sentinel event reviews is to learn from serious and sentinel events by:

- Identifying their contributory factors and root causes
- Identifying systems and processes that require improvement.
- Identifying strategies to prevent or minimise risks of future recurrence of serious and sentinel events.

Where the object of a Waikato DHB serious and sentinel event review is to improve the practices or competence of registered health practitioners by assessing the health services they perform, the review will be a Protected Quality Assurance Activity as specified in the Health Practitioners' Competence Assurance Act 2003. **In order to comply with this Act, all information arising solely from the review – whether verbal or written – must be treated as confidential and must not be used or disclosed except for review purposes. Refer to the Waikato DHB Protected Quality Assurance Activities Policy.**

Where information arising from a review is not protected in this way, it may be used to initiate a competence review where appropriate. As far as possible, this should occur **after** the Serious / Sentinel Event Review process has been completed.

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## 2. Competency

Serious / Sentinel Event Reviews shall only be conducted by staff who have been trained to conduct such reviews or have been authorised to do so by Waikato DHB.

## 2. Definitions:

(From Waikato DHB Incident / Accident / Near Miss Notification and Management Policy)

**Sentinel Event** An event which involves one or more of the following. It:

- has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the consumer's illness / underlying condition / pregnancy/ childbirth
- is a major system failure
- has the potential for serious adverse media attention
- has resulted in potential or actual harm to a group of consumers
- is one of the following (even if the outcome was not death or major permanent loss of function):
  - suicide of a consumer while in intensive psychiatric care
  - patient abduction or discharge to wrong family
  - invasive procedure or intervention on the wrong patient or wrong body part
  - attempted or alleged sexual abuse or rape
  - errors of omission or commission that result in significant additional treatment or are life threatening e.g. medication errors, iatrogenic injury, recall of patients.

**Serious Event** An event which involves one or more of the following. It:

- has the potential to result in a sentinel event
- is a suicide of a Mental Health outpatient;
- is a serious assault of a patient, staff member, contractor or visitor;
- involves a high risk patient missing;
- is any other event which the organisation or division deems to be serious. This may include serious complaints, ACC claims, an event resulting in recommendations made by a coroner or the Health and Disability Commissioner.

**Service User** Term used in Mental Health and Addictions Service to refer to patient or consumer of the service.

### 3. Procedure

**Note:** The Police may carry out their own investigation which is separate from the organisation's review.

**Note:** At all steps in this procedure, it is important to ensure that protected information arising from PQAA reviews retains appropriate protection.

| Action   | Rationale   |                                       |                   |                     |
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| <i>Immediate Actions and Notification of Serious / Sentinel Event</i>  |   |                                       |                   |                     |
| <p><b>Manager / CNL / Team Leader</b> ensures all actions specified in the Waikato DHB Incident / Accident / Near Miss Notification and Management Policy have been taken e.g.</p> <ul style="list-style-type: none"> <li>• Immediate actions taken to prevent further harm</li> <li>• Event has been reported to their immediate manager and also to the Manager Quality and Clinical Risk (by phone or email)</li> <li>• Manager informs Service Manager and relevant Clinical Director</li> <li>• Event has been reported on Waikato DHB Incident / Accident / Notification Form</li> <li>• Incident form number and description of incident have been recorded in the patient's clinical record</li> <li>• Notification of the patient and where relevant the patient's family / whānau where patient harm has occurred or may occur in future, has occurred</li> <li>• Staff advised of support available to them.</li> </ul> | <ul style="list-style-type: none"> <li>• The Serious Event Procedure <b>does not replace</b> the requirements of the Waikato DHB Incident / Accident / Near Miss Notification and Management Policy</li> <li>• To ensure staff are aware of support available e.g. Waikato DHB Employee Assistance Programme, Waikato DHB Critical Incident Stress Management Policy</li> </ul> |                                       |                   |                     |
| <p><b>For Mental Health and Addictions Service ONLY:</b></p> <ul style="list-style-type: none"> <li>• <b>The Service Manager</b> will notify the WDHB Legal Advisor, General Manager, Clinical Services Director, Director of Area Mental Health Services (DAMHS), Professional Advisors, Senior Consumer Advisor and significant others (e.g. Cultural Workers – as appropriate).</li> <li>• <b>The DAMHS</b> or responsible delegate notifies the District Inspector - within 24 hours, as far as reasonably practicable.</li> <li>• <b>The Administrator DAMHS</b> enters details of the event onto the Mental Health and Addictions Service database and informs the</li> </ul>  | <ul style="list-style-type: none"> <li>• All appropriate people are informed of the incident.</li> <li>• Legal requirements are met.</li> </ul>   |                                       |                   |                     |
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| <p>Ministry as directed by the DAMHS.</p> <ul style="list-style-type: none"> <li>• <b>The Key Worker/Team Leader:</b> <ul style="list-style-type: none"> <li>• <b>Informs</b> the service user and where relevant their family / whānau and significant others, including Non Government Agencies (NGOs) who provide care to the service user, that an event has occurred</li> <li>• <b>Offers support</b> (counselling by keyworker or liaison and referral to appropriate services) either verbally or in writing. All contacts or efforts to make contact are documented in the service user's file.</li> <li>• <b>Identifies</b> other service users who may be affected by the incident and offers additional support.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Support is provided to service user and their family/whānau and appropriate NGOs and others affected by the incident.</li> </ul> |

***Review of Serious / Sentinel Event***

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| <p><b>Manager Quality and Clinical Risk (Q&amp;CR):</b></p> <ul style="list-style-type: none"> <li>• decides whether the event is to be reviewed as a Serious / Sentinel Event, in consultation with the relevant Clinical Director, relevant Service Manager, Clinical Services Director/ Director of Area Mental Health Services (DAMHS), Chair of the Clinical Board, GM Health Services or Chief Executive as necessary.</li> <li>• Decides whether the review will be a PQAA, in consultation with the Corporate Solicitor as necessary.</li> </ul> | <ul style="list-style-type: none"> <li>• To ensure organisational consistency of approach to S/SE Review.</li> <li>• To provide the legislative protection available to staff where appropriate.</li> </ul> |
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| <p><b>Manager Quality Q&amp;CR:</b></p> <ul style="list-style-type: none"> <li>• allocates a Quality and Risk Systems Support (Q&amp;RSS) person to conduct the S/SE Review. This person involves a senior clinician / clinical expert to assist with the review where appropriate.</li> <li>• Where appropriate, an external consultant may be engaged to conduct the S/SE Review.</li> <li>• If the number of S/SE Reviews at any one time exceeds the availability of Q&amp;RSS resource to conduct the reviews, the reviews will be prioritised using Waikato DHB's Risk Assessment Tool.</li> </ul> | <ul style="list-style-type: none"> <li>• To ensure the review is conducted by an appropriately qualified person.</li> <li>• To ensure S/SE Reviews are completed in priority order.</li> </ul> |
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| Action   | Rationale  |
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| <ul style="list-style-type: none"> <li>Every effort will be made to complete the S/SE Review within one month.</li> </ul>  | <ul style="list-style-type: none"> <li>To ensure timeliness of review.</li> </ul>  |
| <p><b>Q&amp;RSS</b> informs the relevant Service Managers and Clinical Directors that the review will be undertaken.</p>   | <ul style="list-style-type: none"> <li>To ensure relevant line managers and clinical directors remain informed.</li> </ul>   |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>obtains patient’s clinical record (or copy if the record remains in use) and any other physical evidence related to the event e.g. policies, clinical protocols, equipment</li> <li>retains a list of all documents and items held</li> <li>accesses expertise of appropriate others within the organisation</li> <li>researches best practice if necessary.</li> </ul>  | <ul style="list-style-type: none"> <li>To inform the review.</li> <li>To identify the approved processes relating to the event</li> <li>To ensure tracking of documents used during the review.</li> </ul>                                   |
| <p><b>Q&amp;RSS</b> identifies, in consultation with others as necessary, the staff members who can provide information required to review the event.</p>  | <ul style="list-style-type: none"> <li>To ensure those closest to the event, and those with knowledge of local systems and processes are involved in the review.</li> </ul>  |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>sets up a meeting(s) of relevant staff members, and if appropriate the patient / family / whānau, to identify the sequence of events leading to the S/SE Event</li> </ul> <p><b>NB: It will not be appropriate to include external persons where the review is a PQAA.</b></p> <ul style="list-style-type: none"> <li>the focus of the meeting is to learn from the event, not to apportion blame</li> <li>informs staff members they may bring a support person (which may be a Union / MPS representative or lawyer) to the meeting if they wish.</li> </ul> <p><b>Note:</b> Q&amp;RSS will keep the relevant Service Manager(s) informed of staff needs for support. It is the Service Manager’s responsibility to provide the appropriate levels of support. Where the review is a PQAA, any communication outside the review group must accord with the PQAA requirements for protection of review information.</p> | <ul style="list-style-type: none"> <li>To identify the facts of the event.</li> <li>To ensure staff attending the meeting have access to appropriate support.</li> <li>To facilitate a ‘learning from adverse event’ environment.</li> </ul> |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>facilitates the S/SE Event Review meeting(s)</li> </ul>  | <ul style="list-style-type: none"> <li>To establish the ‘facts’ of the event – what, where, how, when, who, why.</li> </ul>  |

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| Action   | Rationale   |
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| <ul style="list-style-type: none"> <li>identifies the sequence of events</li> <li>identifies the points at which this sequence differed from what 'should' have happened.</li> </ul> <p><b>NB This meeting will be as comprehensive as possible.</b></p>   | <ul style="list-style-type: none"> <li>To – as far as possible - prevent staff having to be interviewed more than once in relation to the same event.</li> </ul>  |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>develops the Draft Root Cause Analysis (RCA) using information obtained to date, and obtains further information if necessary.</li> <li><b>This RCA must be marked 'CONFIDENTIAL' and all staff involved in reviewing the RCA have a responsibility to protect its confidentiality, regardless of whether it is a PQAA.</b> This includes deleting it from all electronic mailboxes.</li> </ul>  | <ul style="list-style-type: none"> <li>To identify the sequence of events.</li> <li>To identify proximal and root causes.</li> <li>To protect the confidentiality of staff members involved in the event</li> <li>To meet the legal requirements for confidentiality of a PQAA.</li> </ul>  |
| <p><b>Q&amp;RSS</b> develops the Draft Action Plan to address each proximal and root cause.</p>  | <ul style="list-style-type: none"> <li>To ensure that each cause has an associated action identified to prevent its recurrence and / or reduce its severity.</li> </ul>   |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>sends the Draft RCA and Action Plan to all participants of the initial review meeting, plus other relevant individuals, including the relevant Service Manager and Clinical Director, requesting them to: <ul style="list-style-type: none"> <li>correct any factual errors</li> <li>comment on the recommended actions</li> <li>delete / shred all electronic and hard copies of the RCA and Action Plan when they have finished with them.</li> </ul> </li> </ul> <p><b>NB: If the review is a PQAA protected information must not be shared outside the review group.</b></p> | <ul style="list-style-type: none"> <li>To ensure factual accuracy of the RCA.</li> <li>To ensure the proposed actions, time frames and responsibilities are appropriate to address the causes.</li> <li>To identify what resources may be needed to implement the actions.</li> <li>To protect the confidentiality of the information.</li> </ul>   |
| <p><b>Q&amp;RSS:</b></p> <ul style="list-style-type: none"> <li>develops the Final Draft RCA and Action Plan taking into account the feedback received</li> <li>submits it to the Manager QCR for approval (may also be submitted to the relevant Service Manager / Clinical Director for approval if requested by them)</li> <li>sends it to the Q&amp;RSS who has the SE Portfolio</li> </ul> <p><b>NB Final draft contains no names, only</b></p>   | <ul style="list-style-type: none"> <li>To ensure the Final Draft RCA and Action Plan are as correct and appropriate as possible prior to being submitted to the SE Panel.</li> <li>To protect the privacy of individual staff members as far as possible</li> <li>To comply with PQAA requirements where relevant.</li> <li>To maintain a 'learning from error' environment by focusing on systems and processes rather than</li> </ul> |

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| Action   | Rationale  |
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| <p><b>designations, of staff members involved in the event being reviewed.</b></p>   | <p>individuals. Where the review is a PQAA and the focus is on individual competence and practice, a ‘learning from error’ focus must still drive the review process.</p>  |
| <p><b>Q&amp;RSS with SE Portfolio:</b></p> <ul style="list-style-type: none"> <li>• Sends copies of the Final Draft RCA and Action Plan to all SE Panel members at least one week prior to the SE Panel meeting (Administrator DAMHS will send copies to Mental Health and Addictions Service SE Panel)</li> <li>• Advises them to delete / shred all electronic and hard copies of the RCA and Action Plan when they have finished with them.</li> </ul>  | <ul style="list-style-type: none"> <li>• To ensure Panel members have time to read the documents prior to the meeting.</li> <li>• See Section 4 SE Panel below.</li> <li>• To protect the confidentiality of the information.</li> </ul> |
| <p><b>SE Panel and/or Mental Health and Addictions Service SE Panel</b> reviews the Final Draft RCA and Action Plan and advises of need for any changes.</p>   | <ul style="list-style-type: none"> <li>• To ensure the SE Panel endorses the actions proposed to address causes identified.</li> </ul>   |
| <p><b>Q&amp;RSS</b></p> <ul style="list-style-type: none"> <li>• makes any necessary amendments to finalise the RCA and Action Plan</li> <li>• if necessary checks with SE Panel members that it is correct</li> <li>• stores electronic version on Q&amp;R Shared Drive</li> <li>• sends hard copy to Q&amp;R Administrator to retain on central file and record on incident database</li> <li>• sends all documentation collected during the review to Q&amp;R Administrator to retain on central file</li> <li>• sends copy of Action Plan only to relevant Service Managers, Clinical Directors and individuals named in it as being responsible for actions to be taken.</li> <li>• For Mental Health and Addictions Service, copy of the Action Plan will be sent to Administrator DAMHS to: <ul style="list-style-type: none"> <li>• distribute appropriately within the Service</li> <li>• enter all recommendations onto the Service’s database.</li> </ul> </li> </ul> <p><b>NB The Action Plan must ensure that protected information arising from PQAA</b></p> | <ul style="list-style-type: none"> <li>• To ensure documentation retained by the organisation</li> <li>• To ensure Service Manager is informed of actions required to be taken</li> </ul>  |

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| Action   | Rationale   |
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| <b>reviews remains protected.</b>  |   |
| <p><b>Service Manager:</b></p> <ul style="list-style-type: none"> <li>• Incorporates Action Plan requirements into the Service Quality and Risk Plan</li> <li>• Reports monthly on progress in implementing the actions required. This information is included within the Service Manager's monthly report to their line manager and is copied to the Q&amp;RSS with the SE Portfolio.</li> <li>• For Mental Health and Addictions Service, the Service Manager informs the Administrator DAMHS who will forward this information to the Q&amp;RSS with the SE Portfolio and update the Service database.</li> <li>• All monthly reports from Service Managers are forwarded to the Service Development Unit monthly by the Personal Assistants to the GMHS and Manager Waikato and District Hospitals.</li> </ul> | <ul style="list-style-type: none"> <li>• To ensure Q&amp;R receives information about implementing the recommendations arising from SE reviews.</li> </ul>  |
| <p><b>Q&amp;RSS allocated to the Service(s) involved in the serious event:</b></p> <ul style="list-style-type: none"> <li>• records completion of actions on the electronic version of the Action Plan</li> <li>• when all actions have been completed, sends hard copy of the completed Action Plan to the Q&amp;R Administrator who: <ul style="list-style-type: none"> <li>• retains the hard copy on central file and</li> <li>• records on the incident database that all actions have been completed.</li> </ul> </li> </ul>   | <ul style="list-style-type: none"> <li>• To monitor that required actions are implemented.</li> <li>• To ensure the organisation retains a central record of actions taken.</li> <li>• To monitor completion of actions.</li> </ul> |
| <p><b>Q&amp;RSS with SE Portfolio</b> provides quarterly report to the Manager Q&amp;CR specifying:</p> <ul style="list-style-type: none"> <li>• actions to address S/SEs which have been completed during the previous quarter</li> <li>• actions to address S/SEs which remain outstanding / overdue for completion</li> </ul>   | <ul style="list-style-type: none"> <li>• To monitor implementation progress.</li> </ul>   |
| <p><b>Manager Q&amp;CR</b> presents this information to the Clinical Board and Senior Management Group quarterly.</p> <p><b>Clinical Services Director for Mental Health and Addictions Service</b> presents information relevant to that Service to the Clinical Board quarterly.</p>   | <ul style="list-style-type: none"> <li>• To ensure monitoring at the senior levels of the organisation.</li> </ul>  |

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| Action   | Rationale   |
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| <p><b>Service Manager / Clinical Director / Clinical Unit Leader</b> for each service:</p> <ul style="list-style-type: none"> <li>• is responsible for monitoring trends / actions taken to address S/SEs in their service at least quarterly.</li> <li>• Minutes of the Service Quality Meetings need to reflect that this monitoring has occurred and that actions to address issues of concern have been instigated / taken and have been monitored for effectiveness.</li> </ul>   | <ul style="list-style-type: none"> <li>• To ensure that the review of S/SEs results in changes which minimise risk of recurrence and/or harm.</li> </ul>              |
| <p><b>Q&amp;RSS with SE Portfolio:</b> Provides documented anonymised learnings from S/SEs to be shared through the following mechanisms:<br/> <b>Chair of Clinical Board</b> includes learnings in Medical Staff newsletter<br/> <b>Member of Clinical Board</b> presents learnings at Grand Round at least annually<br/> <b>Director of Nursing</b> presents learnings at Nursing Grand Round at least annually<br/> <b>Manager Q&amp;CR:</b></p> <ul style="list-style-type: none"> <li>• Informs CNLs, Team Leaders, Operational Managers of learnings</li> <li>• Ensures learnings inform the annual Quality and Risk Planning process</li> <li>• Informs other DHBs of learnings as appropriate</li> </ul> | <ul style="list-style-type: none"> <li>• To ensure sharing of the learnings from S/SEs occurs within and beyond the organisation</li> </ul>                           |
| <p><b>Manager Q&amp;CR:</b></p> <ul style="list-style-type: none"> <li>• conducts annual review to evaluate effectiveness of actions taken to address S/SEs to assess whether recurrence has been prevented</li> <li>• reports on review findings to Clinical Board, SMG and ECG</li> </ul>  | <ul style="list-style-type: none"> <li>• To evaluate outcomes of S/SE review processes.</li> </ul>  |
| <p><b>Clinical Director / Service Manager:</b></p> <ul style="list-style-type: none"> <li>• Informs all staff who were interviewed as part of the Serious / Sentinel Event process, of the outcomes of the review. This information must be generic and not mention staff names.</li> </ul>  | <ul style="list-style-type: none"> <li>• To ensure staff members involved in the event review are informed of the outcomes.</li> </ul>                                |
| <p><b>Clinical Director of Service involved in the patient's care where harm has occurred:</b></p> <ul style="list-style-type: none"> <li>• Informs the patient and/or their family / whānau / support person of the outcome of the Serious / Sentinel Event Review in general terms i.e. without mentioning staff</li> </ul>  | <ul style="list-style-type: none"> <li>• To ensure the patient / family / whānau / support person is informed of the organisation's response to the event.</li> </ul> |

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| Action  | Rationale |
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| names, provides information re actions planned to be taken to prevent recurrence / severity of a similar event. |           |

#### 4. Serious Event Panel

- Refer to attached:
  - Waikato DHB Serious / Sentinel Event Panel Terms of Reference
  - Mental Health and Addictions Service Serious / Sentinel Event Panel.
- It is essential for the integrity of the serious event review process that the Serious / Sentinel Event Panels involve the relevant clinical leaders and staff.
- To this end managers, clinical leaders and staff members requested to attend a Panel meeting must do so. If they are unable to attend, they must inform Quality and Risk or the Administrator DAMHS as appropriate so that another date may be set, or other individuals may attend on their behalf.
- If any person wishes to dispute the recommendations made by the Waikato DHB Serious / Sentinel Event Panel, they must contact the Manager Quality and Clinical Risk who will arrange for an appropriate clinical leader to follow up the concerns raised. Any changes to the Serious / Sentinel Event Panel's recommendations must be approved by the Chair of the Panel.
- If any person wishes to dispute the recommendations made by the Mental Health and Addictions Serious / Sentinel Event Panel, they must contact the Clinical Services Director / DAMHS. Any changes to the Panel's recommendations must be approved by the Clinical Services Director / DAMHS.

#### 5. References

- Health and Disability (Safety) Act 2001
- Health Practitioners' Competence Assurance Act 2003
- *Reportable Events Guidelines* Ministry of Health 2001
- SNZ HB 8152:2001 *Sentinel Events Workbook*

#### 6. Associated Documents

- Waikato DHB Incident / Accident / Near Miss Notification and Management Policy
- Waikato DHB Protected Quality Assurance Activities Policy
- Quality and Risk Service Root Cause Analysis and Action Plan Format
- Waikato DHB Serious / Sentinel Event Panel Terms of Reference
- Mental Health and Addictions Service Serious / Sentinel Event

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Panel Terms of Reference

- Waikato DHB Employee Assistance Programme Policy
- Waikato DHB Māori Health Policy
- Waikato DHB Tikanga Recommended Best Practice Guidelines
- Waikato DHB Critical Incident Stress Management Policy

## 7. Authorisation

Authorised by:

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Brent Wiseman  
Acting Chief Executive  
Waikato DHB

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Date

| <b>Waikato District Health Board PROCEDURE: Serious and Sentinel Event Review</b> |                                  |                                       |                   |                      |
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