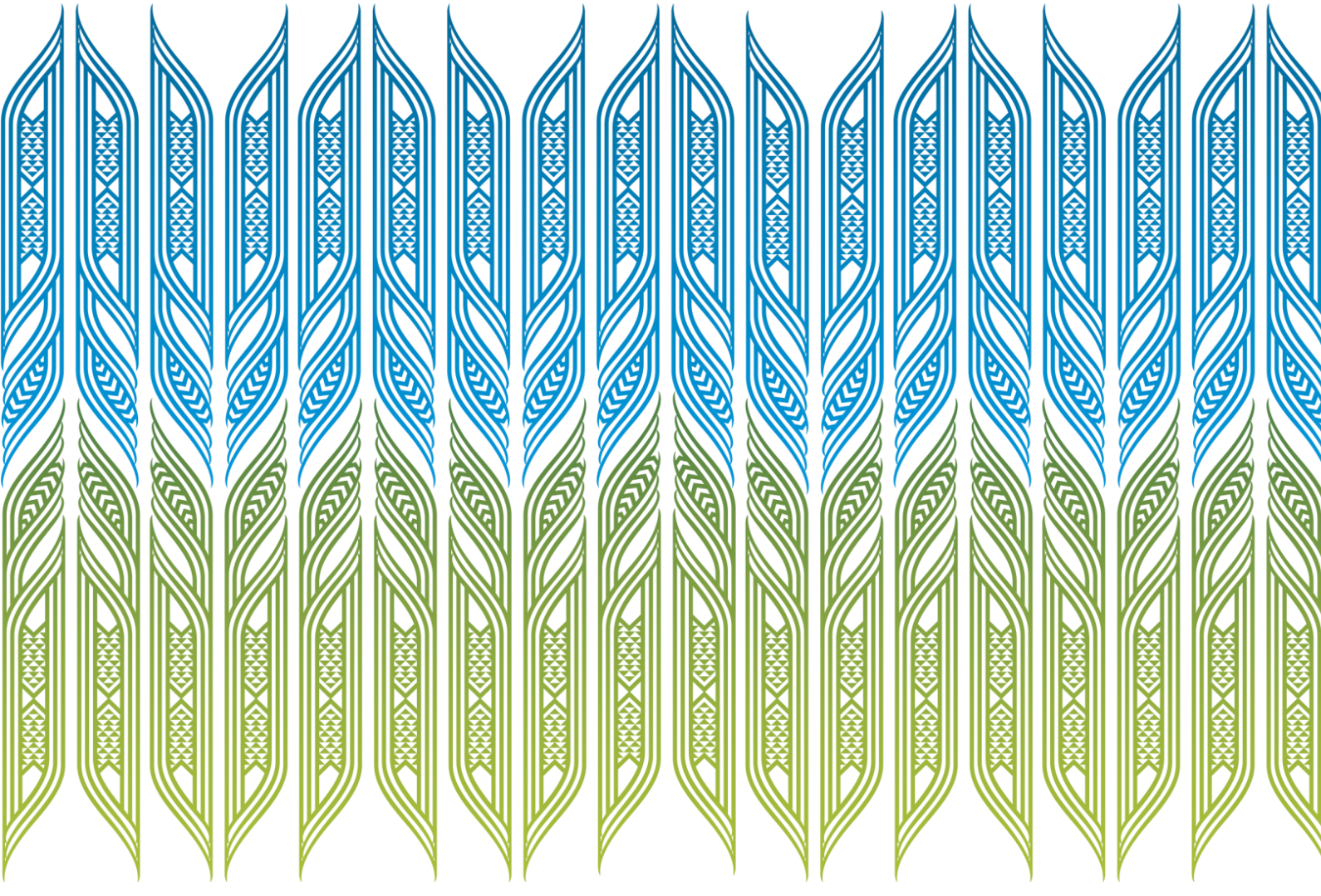
Te Tāhū Hauora
Health Quality & Safety Commission

Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023

Policy user guide | Aratohu kaupapa here

Revised version June 2025



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Te Kāwanatanga o Aotearoa
New Zealand Government

Introduction | He kupu whakataki

Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) first released the national reportable events policy in 2012 and then reviewed it in 2017. During 2022 Te Tāhū Hauora undertook extensive co-design to review the policy, which involved engaging with representatives from across the health sector to create the third revision of this policy. It is now titled Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023 (the 2023 policy).

During the co-design process, Te Tāhū Hauora worked to fulfil its obligations under Te Tiriti o Waitangi by weaving a worldview from te ao Māori throughout the 2023 policy. To do so, we first undertook a critical Te Tiriti policy analysis to evaluate the 2017 national adverse events policy. This analysis used the critical Tiriti analysis paper 'Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy'. The paper provides direction for policy makers wanting to improve Māori health outcomes and include Māori engagement, leadership and substantive authority in the policy process. It offered an approach to analysing policy that is simple to use and, inherently, a tool for advancing social justice. We then used the 2017 analysis to inform the changes in the 2023 policy and performed the same analysis on the new policy before finalising it.

During the 2023 policy co-design process, we worked closely with te ao Māori experts within Te Tāhū Hauora. We ensured that the working rōpū co-chairs reflected both tangata whenua and tangata tiriti and asked each organisation represented on the working rōpū to include feedback from both groups.

Len Hetet of Baked Design Limited created the policy design work in April 2020 as part of research by Te Tāhū Hauora into *Ngā Taero a Kupe: Whānau Māori experiences of in-hospital adverse events*.[1]

This user guide summarises the new principles and processes required to enact the 2023 policy. For additional resources for each of the 2023 policy's principles, see the web-based user guide. The resources were developed with the help of a variety of subject matter experts and focus groups from across the sector.

In line with recent changes in systems safety thinking, Te Tāhū Hauora has moved towards a 'learning together' framework that incorporates restorative approaches when dealing with harm. He toki ngao matariki Aotearoa (the practice of resilient health care) at Te Tāhū Hauora understands the challenges of addressing complexity and varying perspectives. In complex adaptive systems such as health care, the knowledge required for decision-making is imperfect and incomplete. It depends on each person's perspective, placing at the centre the consumer and whānau along with the wellbeing of the health care workers, with the aim of healing, learning and improving from harm for all. The 2023 policy supports a nationally consistent approach to healing, learning and improving from harm or potential for harm. The aim therefore is to meet the needs of all people within the health system, creating a culture of learning.

[1] Health Quality & Safety Commission. 2021. *Ngā Taero a Kupe: Whānau Māori experiences of in-hospital adverse events*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/nga-taero-a-kupe-whanau-maori-experiences-of-in-hospital-adverse-events.

Updating language

Since publication of the policy in 2023, Te Tāhū Hauora has encouraged the health and disability sector to be mindful of the use of language. From 1 July 2025 we will be using the term ‘harm event’ instead of 'adverse event'. This will better enable the application of the policy across all areas of harm, without implying harm levels. We have made the change effective in this user guide and encourage the sector to change their use of the language.

The following are two of the key changes that support the approach of the 2023 policy.

- In February 2022 the Ngā Paerewa Health and Disability Services Standard came into effect. Following the national adverse events reporting policy was a criterion within this standard:

  > 2.2.5 Service providers shall follow the national adverse event reporting policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.

  Health and disability service providers with obligations under the Health and Disability Services (Safety) Act 2001, and those who voluntarily comply with it, are expected to follow the 2023 policy. Their obligations are to: (a) notify Te Tāhū Hauora of harm that meets the criteria as Severity Assessment Code (SAC) 1, SAC 2 or Always Report and Review (ARR); and (b) provide Te Tāhū Hauora with findings and recommendations from their review of these events to enable national learning.
- In August 2022 Te Tāhū Hauora launched the ‘Code of expectations for health entities’ engagement with consumers and whānau’ (the code). The code sets the expectations for how health entities must work with consumers, whānau and communities in planning, designing, delivering and evaluating health services. The Pae Ora (Healthy Futures) Act 2022 required the development of the code, which is underpinned by the health sector principles. All health entities must follow the code and report annually on how they have applied it.

The 2023 policy is effective from 1 July 2023. It covers all events of harm reported on or after 1 July 2023. It is expected that health and disability service providers will modify their practice and operationalise changes associated with the 2023 policy during the 2023/24 transition year. Te Tāhū Hauora recognises that capacity and capability for restorative practice and hohou te rongo will take longer to develop so there will be a transition period of five years to embed these practices.

Policy principles | Ngā mātāpono o ngā kaupapa here

The 2023 policy contains eight principles (up from six in the previous policy):

1. consumer and whānau participation
2. culturally responsive practice
3. equity
4. open communication
5. restorative practice and hohou te rongo (restorative responses)
6. safe reporting
7. system accountability
8. system learning.

Each principle has a set of criteria to guide providers in understanding the expectations of Te Tāhū Hauora.

The national working rōpū focused on ensuring that the principles explicitly emphasises:

1. engaging with the consumer and whānau in a way that meets their needs and follows their tikanga in all steps in the process
2. having an initial discussion with the consumer and whānau to discuss the harm before giving it a SAC rating so that their opinions can inform the SAC rating
3. strengthening the expectations around involving the consumer and whānau throughout the review process
4. considering equity following harm and as part of the review process (evaluating for and proposing solutions to inequities)
5. preventing harm from compounding for all people in the system (consumers, whānau and health care workers)
6. moving the focus away from blame and towards system safety, recognising that human error is most often a consequence of system issues
7. expecting health and disability service providers to have processes to support consumers, whānau and health care workers involved in harm
8. understanding the concept of ‘work as done’ and how the system enables health care workers to ‘do the right thing’
9. expecting providers to share learning locally, regionally and nationally
10. clarifying the suggested review methodologies available – the ‘learning review’ is the preferred method of Te Tāhū Hauora
11. prioritising healing, learning and improving from harm to build trust and gain insight into how to minimise risk in the system
12. extending our reporting timeframes for part A (to 30 working days) and part B (to 120 working days).

The process of healing, learning and improving from harm | Te huarahi hei mahu, hei ako, hei pikinga ora i te pāmamae

The following process applies when harm or the potential for harm is reported by health care workers or consumers. The provider responsible for the care of the consumer(s) involved undertakes this process.

- Assess the report and ensure immediate safety actions have been implemented.
- With the consumer and whānau, discuss the harm and their immediate needs. (Consider appropriate tikanga for engaging with consumers and whānau.) If they are not ready to engage, respect their wishes but provide them with a contact they can use for future engagement if they choose.
- Use this discussion to inform your decision on the SAC rating (level of harm) for the event. Create a provisional SAC rating.
- Engage with the consumer, whānau and health care worker(s) to find out if a restorative response or hohou te rongo would meet their needs.
- Choose a review methodology for the harm that has occurred and conduct that review. The preferred method promoted by Te Tāhū Hauora is the learning review because it is specifically designed for complex adaptive systems like health.
- If the harm rating is **SAC 3 or SAC 4**:
  - manage the harm event through your local processes
  - collect information on trends and review them as clusters
  - develop learning and sustainable actions for improvement.
- If the harm rating is **SAC 1, SAC 2 or ARR**:
  - notify the appropriate local governance group and manage the event in line with local processes
  - where appropriate, review clusters of similar events together (eg, falls, pressure injuries or a series of ARR events)
  - complete and submit part A to Te Tāhū Hauora within 30 working days.
- Where a wider system review (learning review) is required (eg, for a SAC 1 or SAC 2 event):
  - complete terms of reference in line with the requirements for your organisation
  - throughout the review, engage regularly with the consumers, whānau and health care worker(s) involved in the event so that the review meets their needs
  - to review pressure injuries or falls, you can use local standardised review templates that evaluate at a system level or use the ones provided in the kete
    - https://www.hqsc.govt.nz/resources/resource-library/pressure-injury-review-template-2024/
    - https://www.hqsc.govt.nz/resources/resource-library/falls-review-template-2024/
  - choose the review facilitators
  - allocate a key contact for the consumer and whānau (where possible, get consent from the consumer before involving whānau)
  - undertake a review that meets the eight principles of the 2023 policy
  - develop learning opportunities and recommend actions for sustainable system improvement

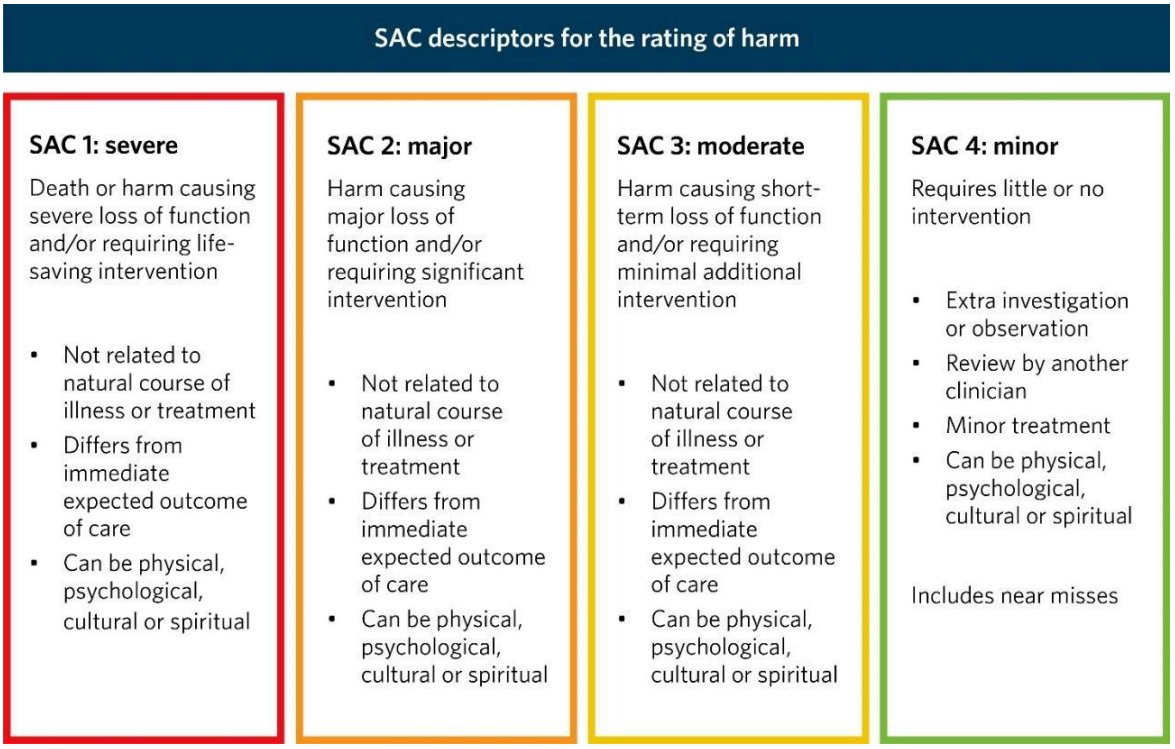
    - share the draft report with consumers, whānau and health care worker(s) for feedback before finalising the report
    - finalise the learning opportunities and recommended actions for improvement within the local governance process
    - decide on a final SAC rating based on the harm experienced rather than on the learning opportunities and recommended actions for improvement.
- SAC 1 and SAC 2: Share anonymised learning opportunities, as well as regular updates on progress in taking actions for improvement:
    - with consumer, whānau and health care workers
    - locally and regionally
    - nationally where appropriate or among professional forums.
- Complete the shared learning template provided by Te Tāhū Hauora if you discover specific learning opportunities that would be useful to share nationally.
- Close the loop: Evaluate the actions for improvement to establish that they are creating sustainable change without significant unintended consequences.
- Complete the part B template and submit it with the final anonymised report to Te Tāhū Hauora within 120 working days.
- Complete the Event of harm review tool prior to submitting Part B
    - https://www.hqsc.govt.nz/resources/resource-library/event-of-harm-review-tool-2025/

Templates | Ngā anga

Templates are available to support providers in meeting the criteria within the 2023 policy. Using these templates is not mandatory. Their purpose is to encourage national consistency in the way harm is reviewed and reported.

1. The **terms of reference template** is designed for those organisations that are new to the 2023 policy and are looking for guidance on developing terms of reference for SAC 1 and SAC 2 events that require a wider system review.
2. **Rating and process tools** are diagrammatic representations of the processes involved in healing, learning and improving from harm. Two options are available – please choose the one that best suits your needs.
3. The **learning review report template** has been designed to support you in following the learning review process, which is the preferred method of Te Tāhū Hauora for reviewing SAC 1 and SAC 2 events. You can use the learning review template in combination with the following additional information available within our user resources:
    - a written guide to a learning review
    - an online learning review e-learning module
    - the learning from harm programme
    - worksheets from the System Engineering Initiative for Patient Safety (SEIPS), with a user-centred design based on human factors, which help with visualising all the interactions and interconnections (the people, tasks, tools, culture, and internal and external environments) within the system when evaluating an event of harm or designing solutions.
4. The **shared learning template** is designed for use when you discover nationally significant learning to share through Te Tāhū Hauora. It may be an innovative solution designed from a SAC 1 or SAC 2 event, or learning that came from a cluster of SAC 3 or SAC 4 events, which has led to sustainable change that is relevant to other organisations. This would then be considered, with the potential to be tabled at the National Quality Forum for consideration and agreed action. You could also use this form to escalate through your organisation.
5. The **implementation assessment tool** is a maturity assessment checklist that you can use not only to review your operational documents but also, through the process of a review, to assess where you are at with implementing the new criteria within the 2023 policy.
6. The **Falls and pressure injuries template** assist the analysis, findings and opportunities for improvement. The review is undertaken according to the organisation's review of harm principles, reflecting the national policy.
7. The **event of harm** review tool intended to be used by those writing learning reports following events of harm, to inform the development of the written report.

Severity Assessment Code (SAC) ratings | Ngā tatau o te waehere aromatawai taumaha



For the 2023 policy, we revised the definitions for the Severity Assessment Code (SAC) ratings as follows to reflect the new approach and to promote greater consistency nationally.

Questions have been raised around the rating of psychological, spiritual and cultural harm. While this is difficult to rate, all reviews of harm should consider the impact of harm from these perspectives, as part of working to understand the consumer and whānau experience and their needs from a review. When rating psychological, cultural or spiritual harm, it is important to incorporate a worldview from te ao Māori, considering the impact of such harm on the consumer's ability to function in the way they did before the event.

To support health and disability professionals to apply the new codes consistently, we have co-designed or revised a series of specialty guides with SAC examples. This series includes guides for:

- general hospital and specialist services (HSS)
- maternity
- mental health and addictions
- healthcare-acquired infections
- primary care
- aged residential care
- ambulance and air services (prehospital services)
- assisted reproductive technology (ART) services
- disability residential services
- home and community support services
- hospice services
- disability support services.

More guides may be added to the series overtime in collaboration with different specialties.

Learning together | Te ako tahi

As part of the 2023 policy, Te Tāhū Hauora has revised our supporting education programme, now called the learning from harm education programme (previously named the adverse event learning programme, AELP).

Learning from harm education offers a mixture of online modules combined with either a virtual or in-person workshop that follows through the learning review process. The modules support the implementation of the various principles within the 2023 policy. Dates are available on our website and released each financial year. See: www.hqsc.govt.nz/our-work/system-safety/adverse-events/education/learning-from-harm-education/.

Other education and resources under our learning together umbrella that support the approaches in the 2023 policy are:

- He toki ngao matariki Aotearoa (the practice of resilient health care) www.hqsc.govt.nz/our-work/system-safety/resilient-healthcare/about-us/
- Restorative practice micro-credentialling www.hqsc.govt.nz/our-work/system-safety/restorative-practice/education/
- Restorative practice accreditation framework www.hqsc.govt.nz/resources/resource-library/he-maungarongo-ki-nga-iwi-envisioning-a-restorative-health-system-in-aotearoa-new-zealand/
- Introductory human factors and ergonomics e-learning package www.hqsc.govt.nz/our-work/system-safety/resilient-healthcare/education/human-factors-and-ergonomics/
- Co-design e-learning www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/co-design/

How to submit a harm event to Te Tāhū Hauora | Te ara tuku pūrongo pāmamae

- Access information on how to submit, upload anonymised final reports, edit and view your notifications in the *User guide – Harm (adverse) events submission portal* *https://www.hqsc.govt.nz/resources/resource-library/user-guide-harm-adverse-events-submission-portal/*

Frequently asked questions | Ngā pātai auau

Following consultation with the sector, we received a series of questions as part of the feedback on the process of healing, learning and improving from harm. We have included those questions along with our answers here to improve understanding of the intent and context of the requirements under the 2023 policy.

Consumer involvement

What do you mean by engaging consumers at the beginning of the process to inform the decision on the provisional SAC rating?

The 2023 policy asks providers to allocate a SAC rating following an initial open discussion with the consumer and whānau (but we are not expecting this discussion to cover the SAC rating numbers specifically). You should use what the consumer and whānau raise in the initial discussion to inform the decision on what type of harm has occurred (SAC rating), following the SAC guide. Often the consumer experience of harm differs from the clinician's perspective of it. For this reason, we have extended the part A reporting time to 30 working days. However, we acknowledge that for some consumers and whānau, this engagement may not be possible.

What if a consumer doesn't wish to be involved?

It is important to value the needs of the consumer. If they are not ready to engage in a conversation or the review, respect this and document their decision. Give them contact details of a person they can contact at your organisation if they decide at a later stage they are ready to share their story. Offer the opportunity for ongoing open communication.

What if a consumer doesn't wish to engage with the terms of reference and sign-off?

What is most important in this process is that you have offered the consumer the opportunity to engage and respect their wishes if they are not in a space to do this.

How do consumers report harm?

The 2023 policy expects providers to establish a process that enables consumers and whānau to report harm. The purpose of this process is to engage consumers and whānau and to validate, document and address their needs. Co-designing a process with consumers will help to develop a process that is accessible to all and upholds the 2022 Code of expectations for health entities' engagement with consumers and whānau. Consumers and whānau may report harm that needs a review through the complaints or kōrero mai process.

How do we prevent confusion between the complaints process and reviewing harm?

For many consumers and whānau, the only avenue for expressing concerns of harm is through the complaints process. When you receive a complaint and it is clear an event of harm has occurred, you should manage it as a harm event and can close it within the

complaints system. Based on the discussion with the consumer, you apply a SAC rating and begin a restorative approach or a learning review process.

How can we keep the review process confidential when we involve an independent consumer, especially in small locations?

Independent consumers who your organisation employs are bound by the same privacy and confidentiality laws as the health professionals involved in a review. You must explain this to them before bringing them into a team. It may be that an independent consumer does not come from the immediate small community but lives in a neighbouring community where less is known about the harm event under review.

Review methods

Why does Te Tāhū Hauora promote the learning review method?

Compared with more traditional review methods, the learning review method is useful in that it better reflects complex adaptive health care systems, seeks to find system-level learning and addresses hindsight and outcome biases. Its developer, Ivan Pupulidy, was seeking a better way to review accidents and incidents, considering human factors, organisation resilience, social construction and complex adaptive systems.[2] The approach responds to the recognition that the more traditional methods were not keeping people safe and often compound harm for consumer (s) whānau and healthcare workers.[3]

The learning review challenges traditional models of safety by acknowledging that complex technological systems are inherently unsafe and that safety is generated through work at all levels of the organisation.[4] In addition to helping us explain how an adverse event occurred, this approach may enable us to identify solutions that better support safe care, initiated from the health care workers who provide the care. This method moves our mental model away from blame by taking a systemic approach to developing a learning culture and improving organisational resilience. It shifts the focus of the review process from what caused the event to how we can prevent similar events in future.

The learning review sets out to value our frontline workers, including those involved in an event. It discusses how errors are often a product of the systems, rather than simply resulting from individuals making mistakes. It also identifies learning opportunities that can be translated into sustainable actions for improvement.

While Te Tāhū Hauora promotes the learning review, we also emphasise it is important to consider the extent of the information gathered before starting a review to minimise the risk of hindsight and outcome biases that then influence how an organisation conducts the learning review.

[2] Pupulidy IA. 2015. *The transformation of accident investigation: from finding cause to sense-making*. Tilburg, the Netherlands: Tilburg University.

[3] Moore J, Mello MM. 2017. Improving reconciliation following medical injury: a qualitative study of responses to patient safety incidents in New Zealand. *BMJ Quality & Safety* 26(10): 788–98. DOI: 10.1136/bmjqs-2016- 005804.

[4] Salmon P, Hulme A, Guy H, et al. 2023. Towards a unified model of accident causation: refining and validating the systems thinking safety tenets. *Ergonomics* 66(5): 644–57. DOI: 10.1080/00140139.2022.2107709.

Why does Te Tāhū Hauora no longer recommend more traditional review methods, such as root cause analysis?

There is growing recognition that embedded approaches to reporting and learning from adverse events have not reduced frequency and severity of harm as many had hoped.[5] The traditional methods of review do not cover the shared responsibility for safety that should span multiple, if not all, levels within the health system, up to and including regulatory bodies and government organisations.[6]

When do we use the learning review method?

The learning review is designed for those events where significant harm has occurred and a wider review of the systems involved is required. It is recommended for SAC 1 and SAC 2 events but can be used for SAC 3 and SAC 4 events when you need to conduct a cluster review. This review method can be used for both consumer harm and staff harm events.

How do we decide between a learning review and a restorative approach?

Your discussion with consumers and their whānau and the health care workers involved in the event of harm will help you to identify whether a restorative response would be appropriate. Restorative responses focus on the importance of human relationships, recognising these are fundamental to human wellbeing and implicated in our healing.[7] For some, the focus of healing, learning and improving will be best facilitated through a voluntary restorative or hohou te rongo approach. This approach should be available as an option as capacity and capability in facilitating it grow across the sector (which will occur over a five-year transition period). If you choose a restorative approach, those involved will agree on the learning and recommended actions for improvement. If you choose this option, **you do not** need to conduct a learning review as well.

Review process

What are the important first steps when starting a review?

If we are to shift to a culture of learning, it is essential that we change our mental models around reviews. To reduce the ‘blame culture’, it is important from the beginning of the review to clearly communicate to those involved that the intention in the final report is to create learning at a system level, not to find blame with individuals.

The steps within the learning review method focus on understanding the realities of everyday work. To achieve this understanding, we need to minimise the risk of hindsight and outcome biases by hearing the stories from those involved before gathering all the clinical documentation, records of policies and procedures and other data. In this method, the review team members are not ‘experts’ in the field but facilitators who build the narrative that

[5] Leggat SG, Balding C, Bish M. 2021. Perspectives of Australian hospital leaders on the provision of safe care: implications for safety I and safety II. *Journal of Health Organization and Management* 35(5): 550–60. DOI: 10.1108/JHOM-10-2020-0398.
[6] Salmon et al, 2023, *op. cit*.
[7] Initiatives in Health. URL: www.hqsc.govt.nz/resources/resource-library/he-maungarongo-ki-nga-iwi-envisioning- a-restorative-health-system-in-aotearoa-new-zealand/ (accessed 19 June 2023).

they present to focus groups for sense-making.[8] It is important to note that where a review uncovers clear criminal intent or performance management issues, these need to be dealt with separately under the Employment Relations Act 2000, not as part of the learning review.

Sense-making involves understanding interactions between the system components and the resulting emerging issues and how these are controlled (or not). This approach shows how Te Tāhū Hauora has moved away from the traditional approaches, such as root cause analysis, which have historically emphasised the role of equipment failure and human error at the 'sharp-end' of the system.[9] Learning reviews are designed to evaluate the system drivers behind the harm, not to blame individuals for their behaviours or actions.

Do we need to do a full review of all SAC events (1–4)?

SAC 1 and SAC 2 events require a formal review. However, where those events involve pressure injuries and falls, you can use standardised, system-focused review processes. Or the template s described in the section above. You do not need to conduct a full review for SAC 3 and SAC 4 events, but follow your local policy or you can review them as a cluster. It is important that we learn from near-miss and SAC 3 and 4 harm events to reduce the risk of more serious harm.

What does 'theming' of events under SAC 3 and SAC 4 mean?

Following discussion with different sector focus groups, we are aware that often our biggest system learning to minimise the risk of harm in the future comes from trends within SAC 3 and SAC 4 events. Therefore, in promoting 'theming' Te Tāhū Hauora is reinforcing that organisations do what they already do when they notice a trend or theme within event reports. That is, they should conduct a system review to consider the wider system factors that may be contributing to SAC 3 and SAC 4 events, and then share their findings locally, and where relevant regionally and nationally.

Why does Te Tāhū Hauora require the full anonymised report?

We require organisations to submit full anonymised reports so that we can undertake better thematic analyses across reviews and so share more insightful national learning. The full report provides context to the learning and recommended actions for improvement.

If we send in the full report, do we need to send in part B?

Yes. You need to provide a part A for each event you report to Te Tāhū Hauora and complete all the part B sections, at which point you upload the anonymised report.

Where you have reviewed a cluster of events together, you can attach one overarching completed report and enter all the details in **one** part B submission. For further information on submitting clusters refer to the User guide – Harm (adverse) events *portal (link)*

Who at Te Tāhū Hauora has access to the anonymised report, and how is it stored safely?

Only specified staff within Te Tāhū Hauora will have access to the anonymised reports, which are stored in a separate location from the part A and part B harm events.

[8] Te Tāhū Hauora, 2023 'Guide to a learning review' (available on the policy user guide website).
[9] Salmon et al, 2023, *op. cit.*

What mechanisms does a restorative approach have to keep staff safe?

Participating in a restorative or hohou te rongo response is voluntary. Restorative practice is based on a series of principles and upholding these principles is fundamental to the approach. As restorative practice is human centred and relational, the approach mitigates risk of compounded harm and maximises opportunities for all participants to heal, learn and improve.[10]

What is the difference between learning opportunities and recommended actions for improvement?

Learning opportunities are the opportunities that arise from the review focus groups that will make it easier for people to perform their work, or make the system safer, or provide greater insight into areas that may require further research or investigation. These learning opportunities are then crafted into recommended actions for improvement. Through a quality improvement process, these actions will help to change the system to meet the needs of the consumers, whānau, health care workers and the organisation.

Templates

What is the purpose of the shared learning template and when should we use it?

The shared learning template provides a method for highlighting learning or recommended actions for improvement from SAC events at any level that may have regional or national significance. Te Tāhū Hauora will then work with the organisation to publish relevant learning on our website. We do not expect that organisations will use it in managing all SAC 3 and SAC 4 events.

For pressure injuries and falls, is a local standardised review template acceptable?

Te Tāhū Hauora supports the use of localised templates to review falls and pressure injuries where the learning opportunities focus on improvements required within or to the system. Te Tāhū Hauora encourages reviewing clusters of events together to maximise the potential for learning how to improve the system.

[10] National Collaborative for Restorative Initiatives in Health, 2023, *op. cit.*