Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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3 July 2018

[redacted]

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RE Official information request CDHB 9867

We refer to your email dated 30 May 2018 requesting the following information under section 12 of the Official Information Act (the 'Act') from Canterbury DHB.

1. **The number of assaults of hospital staff by patients reported to the DHB over the last five years. If this could please be broken down into number of cases each year for 2013, 2014, 2015, 2016, and 2017.**
2. **I would also like obtain the number of these assaults that were then reported to the police. I would also like to know the types of assaults these were. These do not need to be broken down into how many of each but just a list of the types of assault.**

The wellbeing and safety of our patients and staff is extremely important to us and staff work extremely hard to maintain a safe environment across our services.

Canterbury DHB implemented a centralised electronic incident reporting system in January 2015. As at 7th June 2018, there were 3278 incidents recorded with the mechanism of harm *'physical assault'* from January 2015 until June 2018 [865 in 2015, 1004 in 2016, 1021 in 2017 and 388 up to 6th June 2018].

For the event type, *'verbal abuse'*, 1182 [232 in 2015, 311 in 2016, 392 in 2017 and 247 up to 6th June 2018] incidents were recorded over the same period. The Canterbury DHB records the division and area for an incident, not the hospital or department.

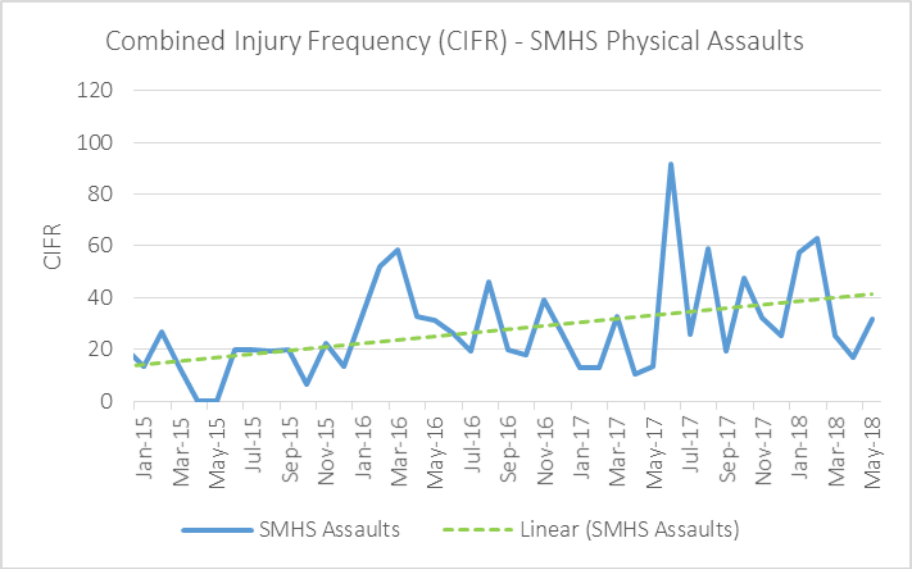
To provide the information requested prior to 2015 would require substantial collation and research; we are therefore declining to provide information for 2013 and 2014 under section 18(f) of the official Information Act. If you disagree with our decision to withhold information you may, under section 28(3) of the Act, seek an investigation and review of our decision from the Ombudsman.

Of the 3278 incidents recorded, 656 [112 in 2015, 190 in 2016, 243 in 2017 and 111 up to 6th June 2018] were accepted as ACC claims with a mechanism of harm *'being hit, struck or bitten by person'*.

194 of the accepted claims were from Specialist Mental Health Service. (SMHS) The physical severity of an incident is estimated by the amount of lost time accrued. For Canterbury DHB, 141 of these injuries resulted in no lost time [i.e. no time off work], 97 injuries resulted in 20 lost days or less and 39 injuries resulted in greater than 20 lost days.

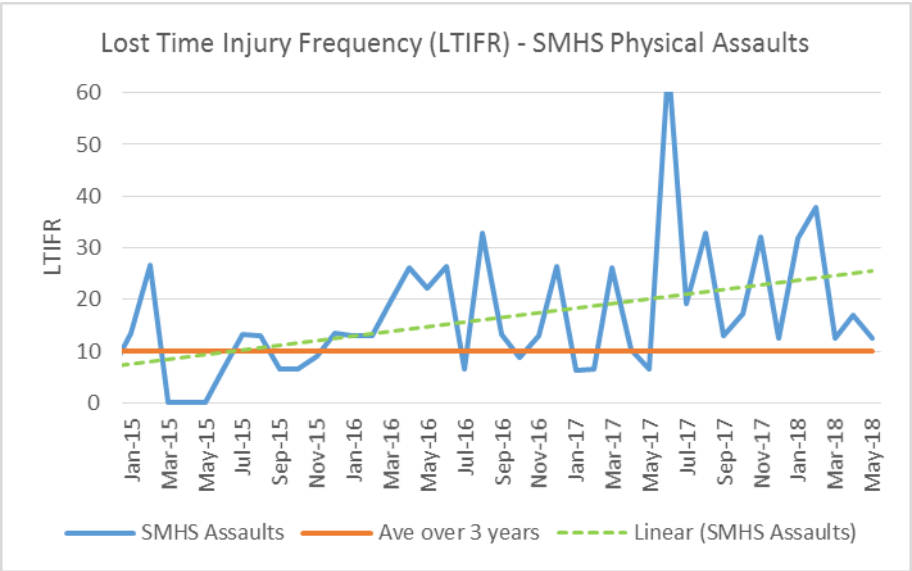
Note: over the last five financial years and despite the unprecedented level of demand across the service, combined injury frequency [ratio of all accepted medical treatment claims per million hours work] for Specialist Mental Health Service (SMHS) has risen slightly, which while concerning is a testament to the skill of our staff **[fig. 1].**

Figure 1 – Combined Injury Frequency SMHS



Over the same period, lost time injury frequency [number of lost time injuries per million hours worked] for SMHS has also increased **[fig 2.].** This increase is due to a spike in lost time injuries in August 2016 and in June 2017. SMHS staff, management and clinical leaders, unions, and supported by Canterbury DHB Health and Safety, work together to reduce the frequency and severity of incidents through actively addressing issues, strengthening clinical leadership, reviewing models of care, stabilising staff numbers and reducing the use of agency staff, making environmental changes within buildings, where we can, and strengthening induction and orientation procedures.

Figure 2 – Lost Time Injury Frequency SMHS

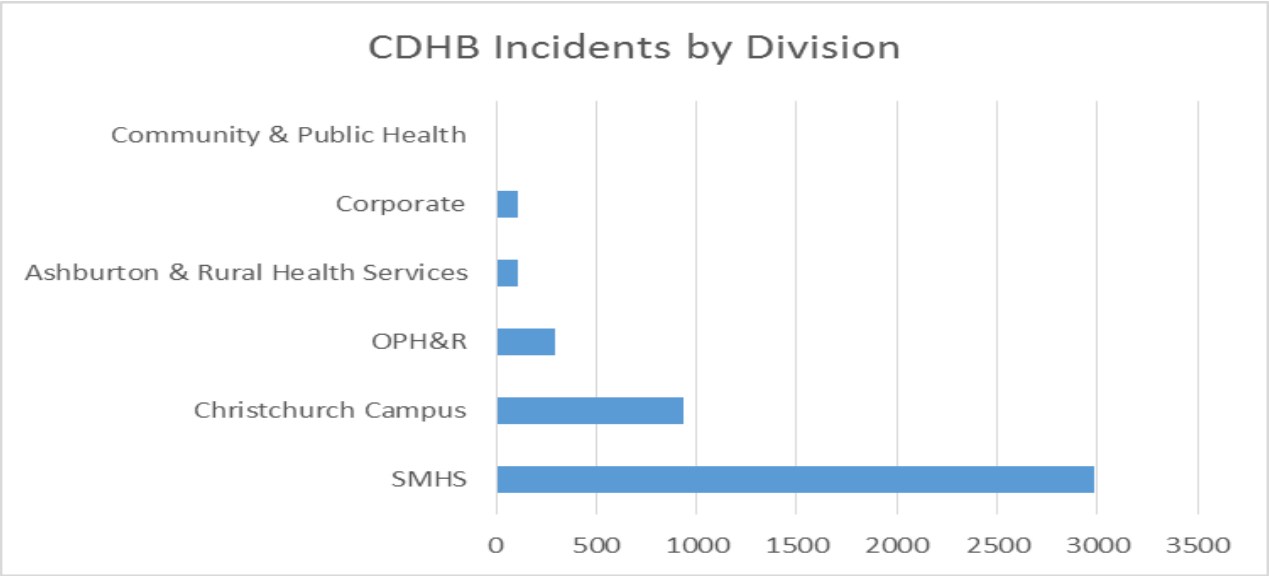


Of the 3278 incidents reported, 2988 incidents were reported by SMHS **[fig. 3]** (overleaf). **Note:** 2250 of the reported incidents in SMHS were reported as a physical injury. In comparison, across all Canterbury DHB divisions 1028 of the reported incidents were reported as a physical injury. This may indicate we have a positive and proactive reporting culture in SMHS that supports the promotion of a safe working environment.

We do not record incidents by severity as this would be too subjective because what one person considers minor might have a more serious impact on another, either physically or psychologically.

Since the adoption of the Safety First reporting system, we have developed a strong reporting culture for all types of adverse incidents. Staff are entitled to make a complaint with the Police but the incident reporting system does not hold data concerning the number of times the Police were called to assist or intervene in any of the incidents. To retrieve this would require use of substantial public resources to undertake research and collation of data against each individual patient file. We are therefore declining this question under section 18(f) of the Official Information Act. Our 'Complaint to Police (Staff Complaint) Policy' **(Appendix 1** attached) outlines the process for a staff member who wishes to lay a complaint with Police, following an incident for example, an assault.

Figure 3 – Specific Events Reported *'physical assault'* CDHB Division [January 2015 – June 2018]



SMHS - Assessment, Treatment and Rehabilitation [AT&R], Te Awakura and PSAID Inpatient and are the SMHS units with the highest incident reporting rates **[fig. 4]:**

- AT&R [8 beds] – 631 incidents reported, 540 were reported as a physical injury.
- Te Awakura [64 beds] - 783 incidents reported, 509 were reported as a physical injury.
- PSAID Inpatient [14 beds] – 389 incidents reported, 369 were reported as a physical injury.

Figure 4 – Specific Events Reported '*physical assault*' SMHS Unit

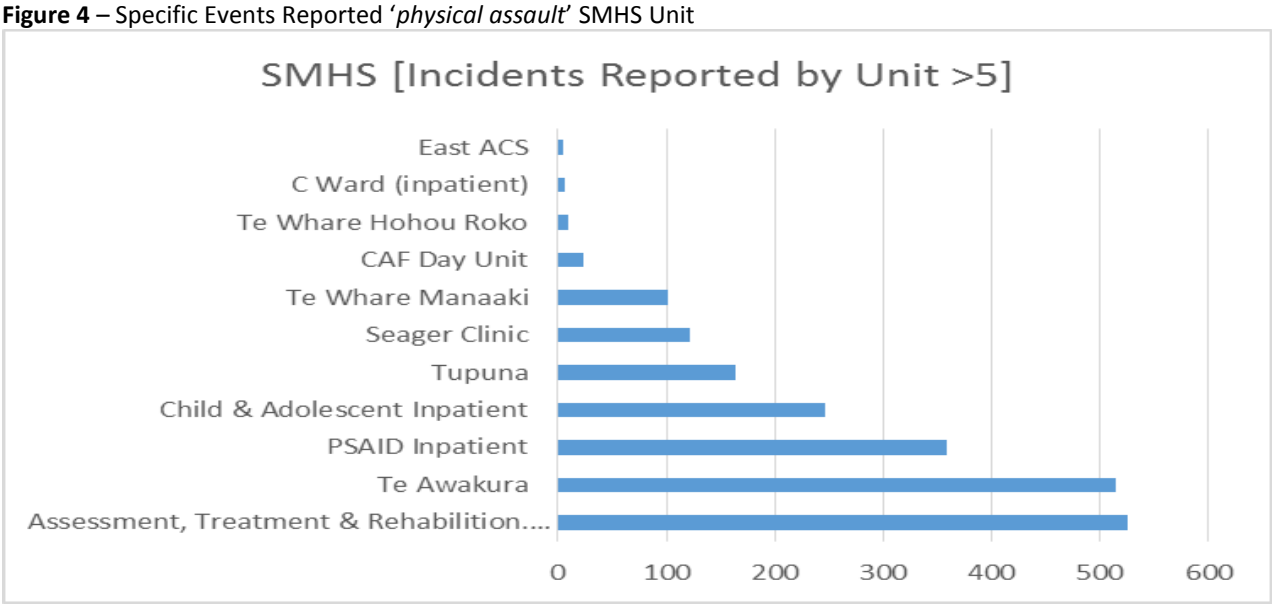


Figure 5 Christchurch Campus – Emergency Department reported 368 incidents, 180 did not result in injury.

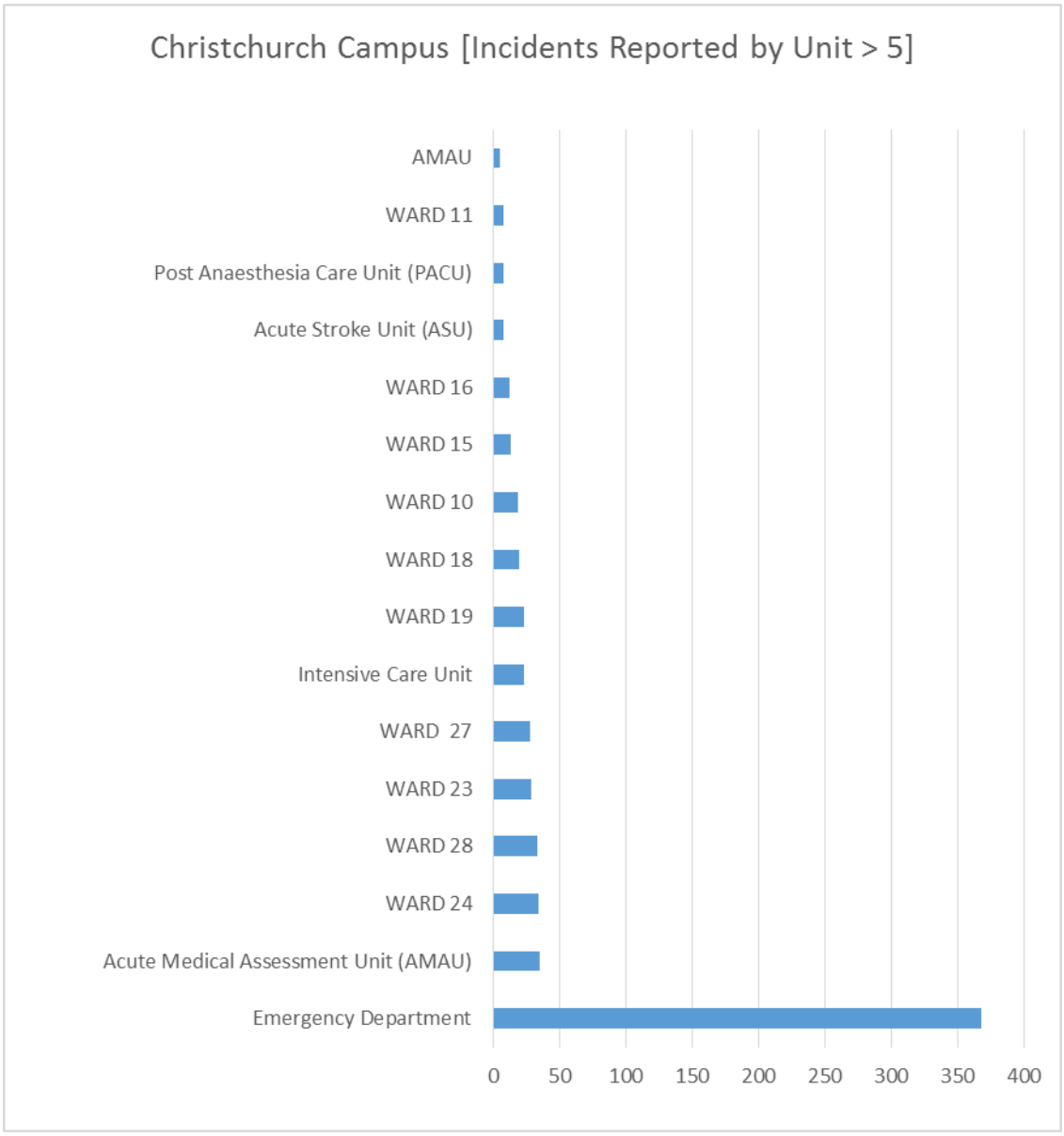
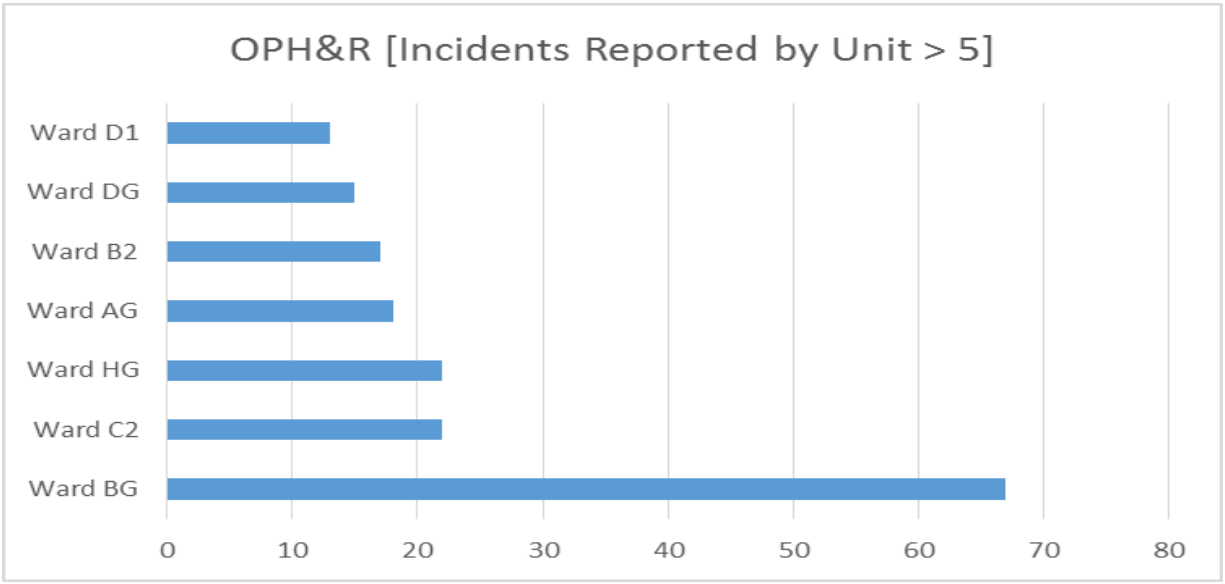


Figure 6 OPH&R – Ward BG reported 67 incidents, 24 did not result in injury.



We take the health, safety and wellbeing of our workforce very seriously, in addition to the information provided in this response we have a range of wellbeing initiatives underway across the Canterbury DHB which we would be happy to share with you if you are interested.

Please find attached as Appendices:
Appendix 1 – Complaint to Police (Staff complaint)
Appendix 2 – Wellbeing, Health and Safety Policy
Appendix 3 – Incident Management

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website five working days after your receipt of this response.

I trust that this satisfies your interest in this matter.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Complaint to police (Staff complaint)

Purpose

To outline the process for a staff member who wishes to lay a complaint with the police.

Policy

SMHS acknowledges the right of a staff member to lay a complaint with the police.

In order to protect staff from the possibility of threats or danger, staff members' personal addresses and phone numbers will not be given or recorded on any communication with the police.

Scope

This policy applies when a staff member, while on duty, has been adversely affected by an incident or their property damaged or lost.

Supporting documentation

Legislation and standards

Health & Safety in Employment Act, 1992

Mental Health (Compulsory Assessment & Treatment) Act 1992

Guidelines for Reducing Violence in Mental Health, Ministry of Health (1995)

NZ Standard, Health and Disability Services (General) Standard. NZS 8134: 2008

CDHB Policies and Procedures

Legal and Quality manual

- Incident Management

Associated forms

Letter of Complaint to Police (MHS0103)

Contact Details form for a Complaint to Police (MHS0107)

Incident Report Form (ref: 1077)

Staff Accident Report Form (ref: 0620)

Complaint to police process

Following an incident the safety, treatment and support needs of the consumer, staff members and others must be met. Usual reporting processes for incidents and accidents apply.

If, following a Clinical Incident Review a staff member wishes to complain to the police, the staff member completes a 'Letter of Complaint to the Police'.

If the clinical team considers that a complaint is warranted, they will encourage and support the staff member to complain to police.

If the staff member does not wish to complain or write a statement, the clinical team will not pursue the matter.

The Clinical Manager or Charge Nurse Manager will identify the staff member's support needs throughout complaint processes and ensure these are met.

The Clinical Manager or Charge Nurse Manager faxes the complaint letter to the police, then telephones to inform the police of the complaint and confirm receipt of the fax.

Consumer subject of a complaint to the police

Where a consumer's actions have resulted in harm to a staff member or, loss or damage to their property, the consumer will continue to be treated with the care and consideration while the allegation is investigated.

If a consumer is suspected, they must be clinically assessed and a Clinical Incident Review undertaken. Processes and outcomes will be documented in the clinical notes.

- Ideally the clinical assessment would be on the same day as the incident and undertaken by the Consultant Psychiatrist (or delegate, or Duty Registrar after hours) in consultation with multidisciplinary team.

- Community services will identify a clinician(s) to carry out the assessment if the consumer's Consultant Psychiatrist is not readily available. If the consumer refuses to undergo an evaluation, the nature and seriousness of the incident will determine the safest most appropriate course of action. For example, DAO (for Mental Health Act processes) or police assistance.

Responsibility for ensuring the consumer's support needs are identified and met will be appropriately delegated to a staff member.

The Clinical Manager, Charge Nurse Manager or their delegate informs the consumer that a complaint has been made to the police and sends the consumer a formal letter.

The consumer's family (with permission) must be informed if a complaint is made to the police.

The consumer must be advised about the advocacy services available and their right to legal representation. Staff assistance may be needed to ensure the consumer receives these services.

If the consumer is required to attend court, the Clinical Manager or Charge Nurse Manager will inform the Court Liaison Nurse before the appearance date.

Protecting the staff member's identity

Progress notes regarding the incident and complaint will not identify the staff member.

Staff making a complaint or those involved in a police investigation may make contact arrangements with the police as they feel appropriate including giving:

- The Clinical Manager or Charge Nurse Manager's work telephone number for in hours contact and,
- Duty Nurse Manager's work telephone number for after hours contact.

The staff member may give their home contact details if they wish but the Clinical Manager or Charge Nurse Manager must be advised.

To ensure that the police are able to contact the staff member at any time, the Clinical Manager or Charge Nurse Manager completes a "Contact Details" form and sends it to the Duty Nurse Manager.

The Duty Nurse Manager retains the form in the 'Complaint to Police' folder, which is stored in a locked filing cabinet in the Duty Nurse Manager's office.

The Clinical Manager or Charge Nurse Manager retains and securely stores the original forms for the duration of any investigation. When the complaint and investigation is complete the Clinical Manager or Charge Nurse Manager ensures that the Contact Details forms are destroyed.

Police investigation

Once a complaint has been made, the police will investigate and decide whether charges will be laid. The police may consider alternatives if the consumer is very unwell and may be adversely affected by a criminal charge. This will require discussion with senior staff including the Clinical Director of the area.

The Clinical Manager or Charge Nurse Manager will liaise with the police. Requests for information will be relayed by the Clinical Manager or Charge Nurse Manager.

The Clinical Manager or Charge Nurse Manager will ensure the staff member is informed of the outcome of the police investigation.

Court appearance

If a staff member is required to appear as a witness, they should use their work address and phone number rather than their personal details.

The Clinical Manager or Charge Nurse Manager advises the Court Liaison Nurse ahead of a court appearance.

The Clinical Manager or Charge Nurse Manager will ensure the staff member is accompanied to court and supported during and after their appearance. A formal debriefing will be offered after the court appearance.

When the complaint procedure and investigation are complete, the Clinical Manager or Charge Nurse Manager ensures that both copies of the 'Contact Details' form are destroyed.

The original letter of complaint is returned to the staff member involved.

Wellbeing, Health and Safety Policy

Policy

The Canterbury District Health Board [CDHB] provides and maintains an effective, Health and Safety management system for the organisation.

Purpose

To enable staff to be safe and well so they, in turn, can improve the health and wellbeing of people living in Canterbury.

To comply with legislation including:

- Health and Safety at Work Act (2015).
- Hazardous Substances and New Organisms Act [HSNO] [1996] and Amendments.
- Health and Disability Service Standards [2008].

Audience/Scope

CDHB managers, staff, visiting staff, volunteers, students and contractors.

Associated Documents

- Wellbeing, Health and Safety processes as published on the CDHB Wellbeing, Health and Safety staff intranet site.
- CDHB Risk Management Policy.

References

- Health and Safety at Work Act [2015].
- Hazardous Substances and New Organisms Act [1996].
- Hazardous Substances and New Organisms Act Amendments.
- Accident Compensation Act [2001].
- ACC Partnership Programme and Audit Standards [2002].
- AS/NZS 4801:2001 Occupational Health and Safety Management System: Specification with guidance for use [2001].
- Employment Relations Act [2000].
- Health and Disabililty Service Standard [2008].

- Ministry of Health Immunisation Handbook [2011].
- Guidelines for TB Control in New Zealand [2010].

Procedure

The CDHB develops and maintains a Health and Safety management system. This system includes the following processes:

Review, Planning and Implementation

- Continuous improvement occurs through ongoing review of wellbeing, health and safety policies and procedures, and development and implementation of wellbeing, health and safety goals/programmes.

Commitment to developing a health safety & wellbeing culture of shared responsibility and being proactive

- Demonstrates strong management commitment and promotion of wellbeing, health and safety, with an emphasis on shared responsibility.

Employee and Union Participation

- Employees and unions are consulted and participate in wellbeing, health and safety processes. This includes having robust communication pathways between senior management and employees.

Risk Management

- Hazards are identified, documented,risk assessed and controlled.
- Identified staff requiring health monitoring undergo a health monitoring programme.

Accident Reporting and Investigation

- Incidents or near misses are reported and recorded accurately and promptly, investigated, and where appropriate, corrective action is implemented.

Rehabilitation

- Ill or injured employees are assisted to remain at work, or return to work as soon as practicable.

Wellbeing Programmes

- Programmes promoting the wellbeing of employees are implemented.

Emergency Planning

- An effective emergency planning system is maintained.

Contractor Management

- An effective contractor management system to ensure the health and safety of contractors and their employees is maintained.

Training

- Employees and managers are trained in wellbeing, health and safety so they are able to perform their roles in a safe manner and meet their responsibilities.

Acting in Good Faith

- The parties involved with implementation of these processes work together, acting in good faith, according to the Employment Relations Act [2000].

Fulfilling Responsibilities

- Those under the scope of this policy have an awareness of, and meet their individual responsibilities regarding the implementation of the health and safety management system.
- Managers are responsible for managing their staff which includes the promotion and maintenance of a safe work environment.
- Employees are responsible for their wellbeing, health and safety at work.

Policy Owner	Manager, Wellbeing, Health and Safety
Policy Authoriser	CEO
Date of Authorisation	03 August 2016

Incident Management

Policy

CDHB Incident Management Policy

Purpose

To provide staff with information and guidance on the management of incident reporting including clinical incidents, significant or sentinel events.

Scope

Patient related incidents that occur within W&CH which resulted in harm or had the potential to cause harm such as ;

- Patient Falls
- Medication Errors
- Blood/food/fluid administration errors (including breast milk)
- Equipment Failures
- Adverse outcomes (unexpected deterioration or death)
- Resource issues (equipment, staffing etc)

The following issues **may** be reported on an Incident Form but do not come under the remit of this Incident Management Policy and **shall** be reported on the other relevant documentation:

- Health and Safety related incidents – staff and visitors (Staff Accident Report Form, Ref 620)
- Blood/Body Fluid Exposure (Staff Accident Report Form, Ref 620)
- Patient or Staff Complaints (Suggestions, Compliments and Complaints Form Ref 152)
- Incidents that clearly relate to health practitioner competency (letter format and sent to relevant professional lead).

Definitions & Acronyms

Clinical Incident:

Is any event that has either resulted in, or had the potential to cause unintended and/or unnecessary harm or death (near miss) not related to the natural course of the patient's illness or underlying condition. Refer to CDHB Incident Management Policy

Root Cause Analysis (RCA) :
A process analysis method, which can be used to identify the factors that contribute to adverse events. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events - notably, what happened, why it occurred, and what can be done to prevent it from happening again.

Root Cause Analysis Leader:
The person who leads the Root Cause Analysis team

Root Cause Analysis Team:
The staff chosen to participate in the Root Cause Analysis. Participants chosen will be based upon them having knowledge of the processes and systems being reviewed and /or them having decision making authority to affect necessary change to prevent recurrence of the event.

QCMS:

Quality and Complaints Management Systems (QCMS)

SAC Matrix:
Severity Assessment Code (SAC) grading matrix. A level 1 or 2 event can generally be described as a sentinel or significant event requiring a Root Cause Analysis.

Policy Statements

W&CH shall ensure that:

- All patient related incidents are adequately investigated and actioned as required to minimise recurrence
- SAC 1 & 2 incidents are reviewed using an RCA methodology and reported to Corporate Quality and Risk as per CDHB Incident Management Policy.
- All RCA shall be commenced and completed within 70 days.
- All staff involved in an incident are appropriately supported as required by having access to debriefing sessions, Employee Assistance Programme (EAP), mentorship, modification to work environment or hours
- All patient related incidents are reported using the Incident Report Form Ref: 1077
- All SAC 1 & 2 incidents shall be discussed in a multi-disciplinary

forum e.g. Incident Review Groups, Rolling Half Day etc.

- Incident trends are monitored and discussed regularly by SQU at Incident Review Groups and Clinical Governance Committees.
- Incident data is analysed and published quarterly with emerging issues and trends highlighted for action through Clinical Governance Committees

Associated Documents

Legislation:

Health Information Privacy Code 1994 (Revised in 2008)
Health Practitioners Competency Assurance Act 2003
Privacy Act 2003

Government Guidelines:

Ministry of Health Reportable Events Guideline 2001

CDHB Wide Documents:

CDHB Incident Management Policy
Legal & Quality Manual, Volume 2

- Tikanga Policy
- Health and Information Privacy Code 1994
- Incident Management
- Open disclosure policy

Health And Safety Manual, Volume 6

- Managing the Risk of Violence and Aggression in the Workplace.

Infection Control Manual, Volume 10

- Standard precautions Policy
- Blood/Body Fluid Exposure

Quality Strategic Plan 2007 – 2010
Quality and Complaints Management Systems (QCMS) Incident Users Guide
Incident Report Form, Ref: 1077
SAC Matrix

CDHB Corporate Quality and Risk Incident Management intranet

References

- National Policy for the Management of Healthcare Incidents, Working Draft (Communio Group)

Equipment

Nil.

Key Responsibilities

Quality Coordinator

- May take the role of Root Cause Analysis Leader
- Selects the people for the RCA team
- Plans and coordinates the RCA process
- Prepares the Root Cause Analysis summary report and disseminates accordingly
- Monitors implementation, reports progress to clinical governance committee and updates Corrective action register.
- Ensures a process of evaluating effectiveness of actions is in place

SMO's with the quality portfolio

- Where applicable works in conjunction with the SQU Team Leader or Quality Coordinator on incident inquiries
- May take the role of RCA Leader for incidents
- Evaluates effectiveness of actions

Service Managers

- Provides final approval for the completion of SAC 3 and 4 Events

Professional Leaders

- Assist the Service Manager with incident reviews on professional and clinical related issues
- Ensures staff involved in clinical incidents are offered and provided ongoing support

Clinical Directors and Charge Midwives or Nurse Managers

- Conduct an inquiry into the reported incident validating the reporters information and clarifying the sequence of events and identifying contributing factors
- Provide initial approval for the completion of SAC 3 and 4 Events.
- Refer SAC 1 & 2 events to the Safety and Quality Unit within 24 hours of discovery.

All staff

- All staff have a duty to report any incident they are involved in or are witness to immediately. This includes hazard concerns and near misses that have the potential to cause harm or loss
- Ensure that the policy of Open Disclosure to patient and relatives is implemented at the time of the incident
- Incident Report Forms should ideally be completed within 24 hours of discovery of the event and sent to the Charge Midwife/ Nurse Manager or Clinical Director (as appropriate)
- Reporters should ensure the written account of the clinical incident is factual, clearly describes the sequence of events and does not apportion blame to any individual
- Protect (from unnecessary handling or tampering) and retain evidence that may be relevant to a subsequent inquiry. Evidence may include but is not limited to documentation, equipment, a product, packaging or medication. Retain the evidence and present it to Charge Midwife/Nurse Manager or Clinical Coordinator who should then retain and secure the evidence until collected by the SQU team.

Incident Reporting Procedure

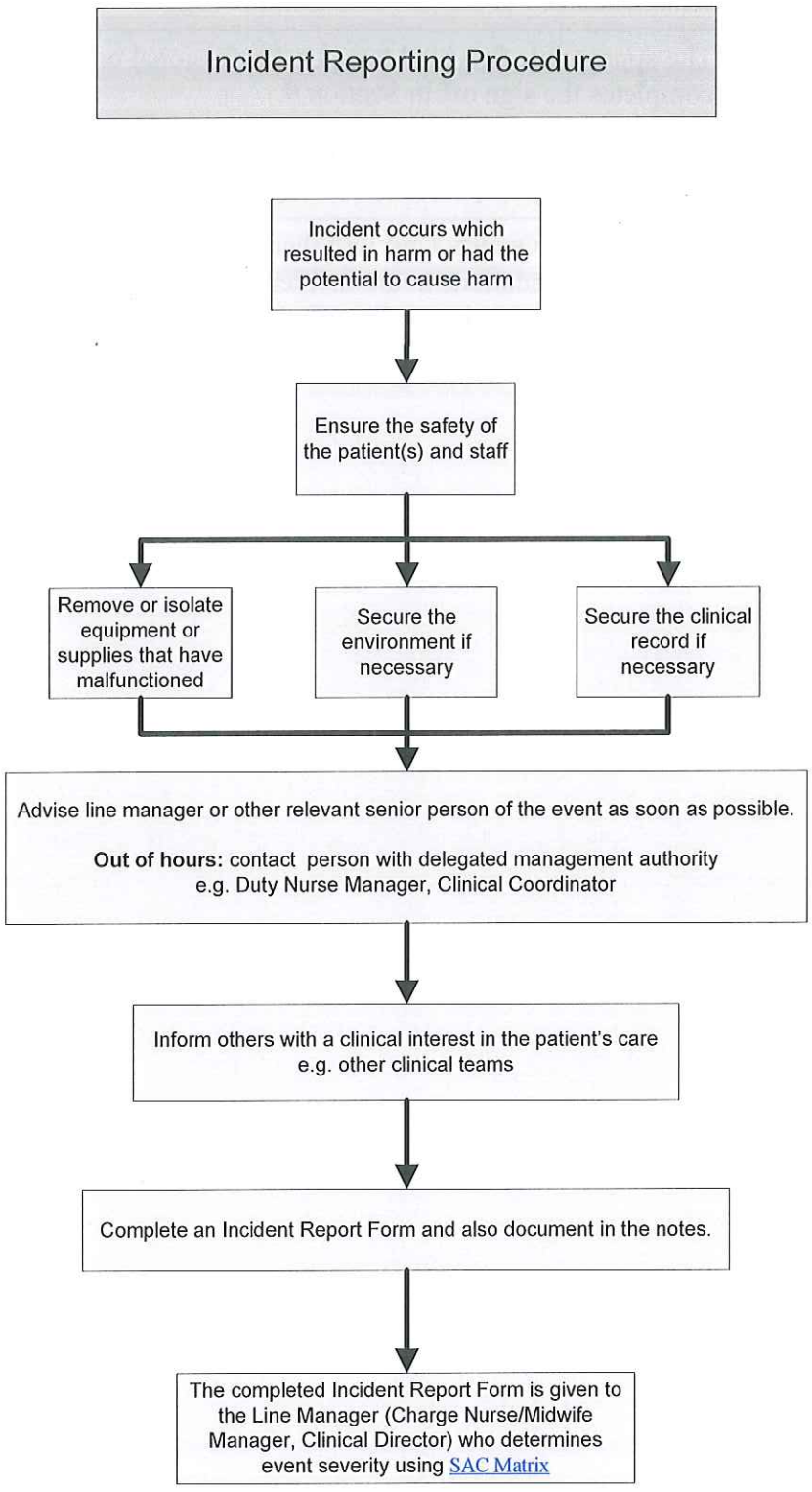
Step	Action
1	Staff directly or indirectly involved in an incident which resulted in harm or had the potential to cause harm. The first priority is to ensure the safety of the patient(s) and staff. As required and with the assistance of the area Charge or Coordinator • provide immediate care and comfort to individuals involved in the event (patient, staff or visitors) • make the environment safe • remove or isolate equipment or supplies that have or may have malfunctioned • secure the environment if necessary • secure the clinical record if necessary
2	Advise line manager or other relevant senior person of the event as soon as possible. **Out of hours**: Contact the person with delegated management authority for the hospital after hours e.g. Duty Nurse Manager, Duty Clinical Team Coordinator, Night Coordinator, Birthing Suite Clinical Coordinator, Associate Clinical Nurse Manager.
3	Inform others with a clinical interest in the patient's care e.g. other clinical teams
4	Complete an Incident Report Form before going home and also document the incident in the clinical records. It is helpful if all staff involved can write an account of the events and their involvement in them before leaving the shift. Attach these to the incident form.
5	Give the completed Incident Report Form to Line Manager, in most cases either a Charge Nurse or Midwife Manager or Clinical Director.
6	The Line Manager considers the severity of the incident and refers the matter directly to the Safety and Quality Unit Team Leader if they feel that the event is a SAC 1 or 2 event (refer to the SAC Matrix).
7	If the matter is a SAC 3 or 4 event, the Line Manager undertakes an initial investigation as to the circumstances of the incident and makes recommendations for implementation as required. This is documented on the reverse of the Incident Report Form
8	The Line Manager provides the Incident Report Form to the Safety and Quality Team within 10 days.
9	The Quality Coordinator reviews the incident and takes it to the Incident Review Group where, in consultation with the appropriate Professional

	and Clinical Leaders, the events, investigation and any recommendations made are reviewed. The Line Manager's review is either endorsed or further information sought.
10	The appropriate Service Manager, Professional or Clinical Lead completes the sign off in Section 9.
11	The Safety & Quality Unit will enter the details of the incident into QCMS and action points into the Quality Improvement Action Register.
12	The Safety & Quality Unit will then report on incident trends, actions and recommendations to the Incident Review Groups, Clinical Governance Committee, all staff via SQU publications and to the staff who completed the incident form via letter.

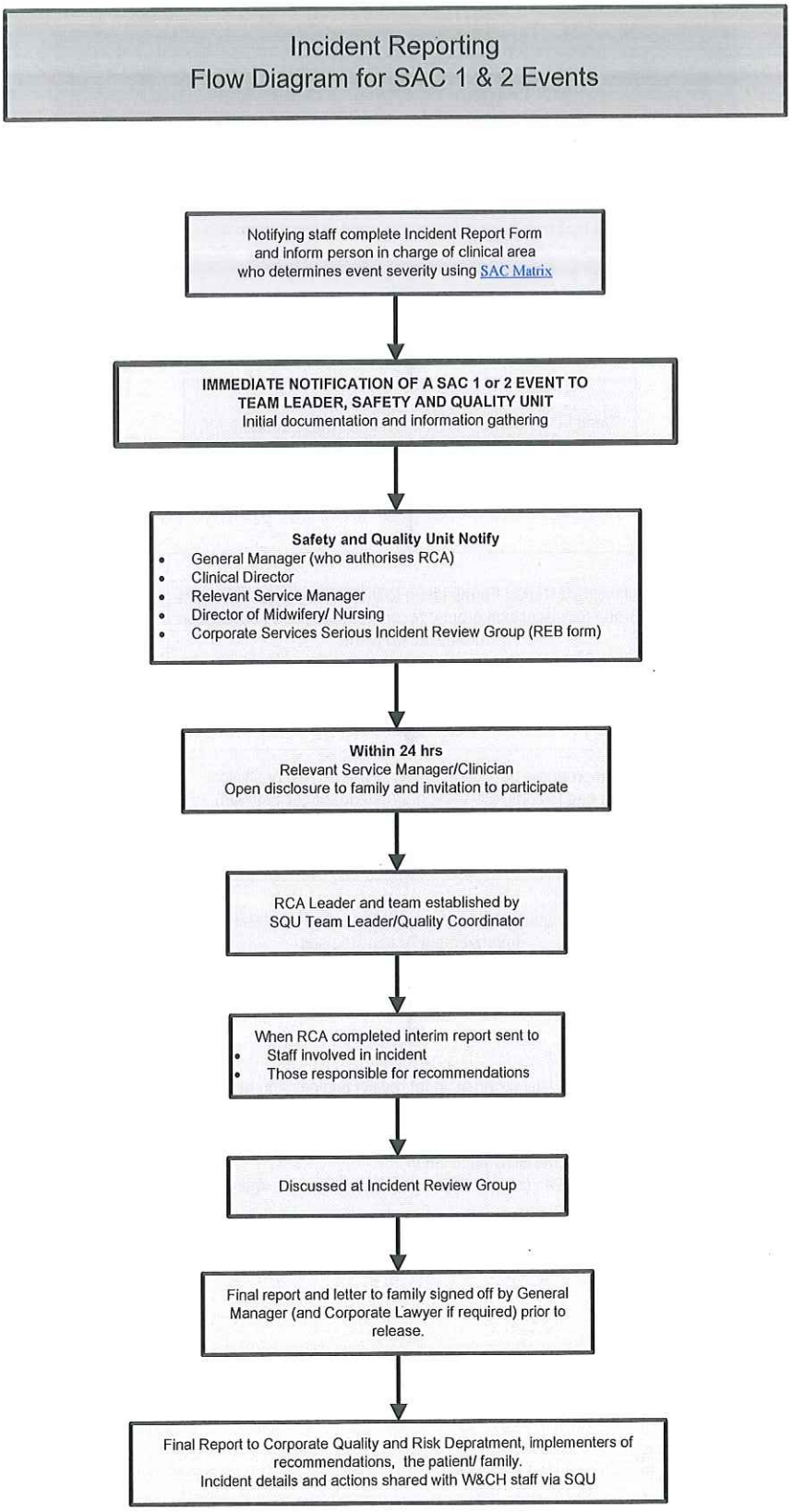
SAC Matrix

SAC Matrix

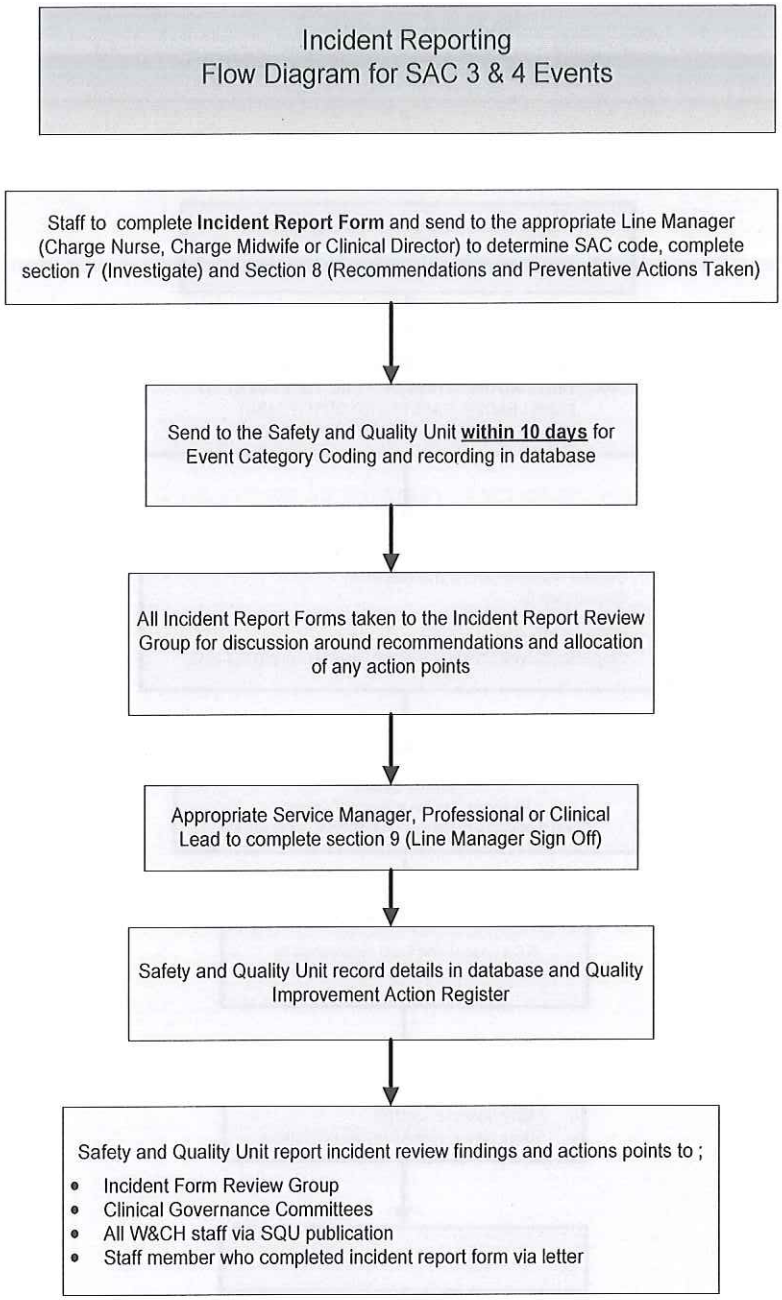
Incident Reporting Procedure



SAC 1 & 2 Events Procedure



SAC 3 & 4 Events Procedure



Root Cause Analysis (RCA)

The RCA methodology is used to assist the investigation of all incidents classified as SAC 1 or 2, except in cases of professional misconduct. It aims to focus on the event and systems rather than individuals and is conducted independent of any enquiry or investigation undertaken by Accident Compensation Corporation (ACC)

Objectives

- To have a positive impact in improving patient care, treatment and services and preventing sentinel events
- To focus attention on understanding the cause/s that underlie the event, and on changing the system and processes to reduce the probability of such an event in the future
- To increase the general knowledge about sentinel events, their causes and, and strategies for improving the safety culture

Goal

- To meet legal and statutory obligations
- To ascertaining the circumstances around significant/sentinel events and report on the factual circumstances surrounding the provision of care
- To highlight where services can be improved and remedial actions can prevent reoccurrence
- To ensure that factors that have been identified as contributing to a significant or sentinel event are discussed and utilised to promote learning and change practice
- To ensure that patient and staff confidentiality are respected throughout the RCA process
- To have a final report produced within 70 working days of commencement of the RCA

Accountability

- The General Manager, W&CH sanctions all RCA
- The RCA team reports to the Safety and Quality Unit Team Leader and to the General Manager W&CH, via the monthly Safety and Quality Unit report
- Following the recommendations of the RCA, action plans will be formulated by the services that are required to make improvements to a system or process

Responsibility

- The Lead Investigator will liaise regularly with the Safety and Quality Unit Team Leader on progress of the investigation and additional support that may be required
- SMO involved in an RCA is expected to dedicate the necessary priority required to complete RCA investigations in a timely manner
- The General Manager, W&CH and (if required, the CHDB corporate solicitor) will view RCA reports prior to distribution

RCA Lead

- Is required to have completed appropriate training in RCA investigations and may be a clinician or member of the Safety and Quality Unit.
- The Lead Investigator must be given the necessary time required to complete RCA investigations in a timely manner.

RCA Procedure

Step	Action
1	The Team Leader or Quality Coordinator approaches and appoints an appropriate RCA Lead and RCA team who conduct the remainder of these procedures.
2	Initial fact finding is undertaken, using the clinical records and the Incident Report Form to create a timeline of the events.
3	The timeline is used to determine what further information is required and to guide who should be interviewed.
4	Interviews of key staff are conducted by the team and written statements may be requested.
5	Complete the fact finding aspects of the review. This includes: • **What** happened • **When** did it happen • **Where** did it happen • **Who** was involved • **How** did it happen • **What** can be done to prevent recurrence
6	Once all the facts are learnt, the casual factors for the event are determined

7	The review team analyses the casual factors to determine the root cause(s). Ideally a single root cause should be determined.
8	The review team then draft recommendations for changes to practice that will help either minimise or prevent recurrence of the root cause to minimise future incidents.
9	The strength of recommendations should be considered in the context of the following hierarchy of the effectiveness of controls: 1. Elimination 2. Substitution 3. Creating redundancies or forcing functions 4. Developing policies, procedures and guidelines 5. Issuing protective equipment 6. Providing staff education 7. Accepting the consequences without taking any further action
10	In consultation with the staff responsible for implementation assign responsibilities and timeframes to the recommendations.
11	Provide feedback to staff involved in the event on the causal factors, root causes and proposed recommendations.
12	Submit a draft de-identified report to the General Manager (and Corporate Solicitor if required) for consideration.
13	Provide the final draft report to the Incident Form Review Group for endorsement of the findings and recommendations.
14	Provide the final report to the General Manager, W&CH for authorisation.
15	Distribute the final report to the Corporate Quality & Risk Department, CDHB Corporate Solicitor, those with responsibility to implement recommendations, the patient or family (if requested) and any others as required. Complete the REB and send to Corporate Services Serious Incident Review Group.
16	Ensure that the recommendations are included on the W&CH Quality Improvement Action Register for ongoing monitoring
17	SQU will update the Divisional SAC Log as required.

Performance Indicators/Benchmarks

- RCA reviews are completed within 70 days of the event;
- 90% of reported incidents are received by the Safety and Quality Unit within 10 days of the date that the incident occurred

Record/Evidence

- Incident Report Forms, maintained by the Safety and Quality Unit
- Quality and Complaints Management System (QCMS)
- Sentinel Event Review Files, maintained by the Safety and Quality Unit

Policy/Procedure Owner	Team Leader, Safety and Quality Unit
Date of Authorisation	Issue 1: 21 July 2009 Issue 2: 18th April 2011