Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

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8 May 2018

[redacted]

[redacted]

Dear [redacted]

RE Official Information Act request CDHB 9835

I refer to your email dated 4 April 2018 to the Ministry of Health which was subsequently transferred to us on 16 April 2018 requesting the following information under the Official Information Act from Canterbury DHB.

1. **I am seeking a breakdown in reported assaults on staff and assaults on patients at all mental health facilities, including forensic facilities. I would like the numbers broken down on a monthly basis for each unit dating back to 2008.**

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.

Within the Specialist Mental Health Service, the managers and clinical leaders, alongside staff, the unions, and supported by Canterbury DHB health and safety, work hard to reduce the frequency and severity of incidents through strengthening clinical leadership, reviewing models of care, stabilising staff numbers and reducing the use of agency staff, environmental changes within buildings, reinforcement of induction and orientation procedures.

Since January 2015, the Canterbury DHB has collected data related to incidents through an electronic reporting system. While this makes data obtained during this time easier to access and collate, it also means that data recorded prior to this date, requires a significant amount of research in order to present similar results.
We are therefore declining to provide information between 2008 and 2014 under section 18(f) of the Official Information Act.

Data related to assaults on consumers, and staff members, is collected under three separate categories:

Assault – reporting on a person who has assaulted another (all persons including consumers and staff).
Assaulted – reporting on a person who has been the victim of an assault (not including staff).
Physical Assault – Reporting on staff members who have been assaulted.

For the period January 2015 – March 2018, (within SMHS Inpatient Facilities) there were 2972 reported incidents of "Assault", 680 of "Assaulted", and 1921 of "Physical Assault". Additionally, for the same period, reported incidents from outpatient teams, and non-clinical areas, were 26 of "Assault", 4 of "Assaulted", and 39 of "Physical Assault.

Please refer to **Appendix 1 (**attached) for reported incidents, per unit, on a monthly basis for the following Specialist Mental Health Services:

Table one:	Assessment, Treatment & Rehabilitation
Table two:	C-Ward
Table three:	CAF Day Unit
Table four:	Child and Adolescent Unit
Table five:	East Inpatient
Table six:	North Inpatient
Table seven:	PSAID Inpatient
Table eight:	Seager Clinic
Table nine:	South Inpatient
Table ten:	Te Whare Hohou Roko
Table eleven:	Te Whare Manaaki
Table twelve:	Te Whare Mauri Ora
Table thirteen:	Tupuna
Table fourteen:	West Inpatient
Table fifteen:	Outpatient and Non-clinical areas

2. **I would like to get a similar breakdown on the number of times Police were called to assist or intervene in any incident.**

The Canterbury DHB does not record data concerning the number of times the Police were called to assist or intervene in any of the incidents, to do so 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.

Since the adoption of the Safety First reporting system, we have encouraged a strong reporting culture for all types of adverse incidents. With all incidents, staff are entitled to make a complaint with the Police.

Please find attached as **Appendix 2** – the Canterbury DHB Health Safety & Wellbeing Policy; as **Appendix 3** – Canterbury DHB's Incident Management Policy and as **Appendix 4** – Canterbury DHB's Complaint to police (Staff Complaint) Policy.

I trust that this satisfies your interest in this matter.

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.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website.

Yours sincerely

Carolyn Gullery
General Manager
Planning, Funding & Decision Support

Appendix 9835

Table one: Assessment, Treatment & Rehabilitation

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 February	22	10	3
2015 March	20	15	8
2015 April	22	6	7
2015 May	31	9	12
2015 June	9	4	3
2015 July	16	3	7
2015 August	18	4	9
2015 September	22	7	11
2015 October	16	2	6
2015 November	21	5	12
2015 December	21	2	15
2016 January	11	3	8
2016 February	18	3	9
2016 March	17	3	13
2016 April	25	4	22
2016 May	15	2	11
2016 June	22	4	16
2016 July	21	3	16
2016 August	19	2	16
2016 September	18	4	14
2016 October	11	3	7
2016 November	15	4	7
2016 December	17	3	8
2017 January	23	10	13
2017 February	14	9	4
2017 March	30	14	12
2017 April	16	3	6
2017 May	27	14	9
2017 June	32	4	22
2017 July	23	6	16
2017 August	15	2	10
2017 September	17	4	10
2017 October	10		6
2017 November	8		8
2017 December	3		3
2018 January	6		6
2018 February	9	2	5
2018 March	13	6	4

Table two: C-Ward

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	1		
2015 June	3		1
2016 October	1		1
2017 October	1		1
2018 January	1		
2018 February		1	
2018 March	1		

Table three: CAF Day Unit

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 June	1		
2015 August	1	1	
2015 September	4	1	4
2015 October	2		2
2015 November	4		4
2015 December	2		2
2016 February	1		1
2016 March	2		2
2016 May	1	1	
2016 July	1		
2016 August	10	1	
2016 September	4	2	1
2016 November	1	1	1
2017 March	1		
2017 May	1		
2017 July	8		6
2017 August	11	4	3
2017 September	7	2	2
2017 October	1	1	
2017 November	2		
2017 December	4		3
2018 February	3		3
2018 March	1		1

Table four: Child and Adolescent Unit

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	8	1	
2015 April	8	1	3
2015 May	6		2
2015 June	4		1
2015 July	7	1	6
2015 August	10	5	6
2015 September	2		1
2015 October	5		3
2015 December	10		8
2016 January	11	1	5
2016 February	4	2	1
2016 March	20	5	9
2016 April	31	8	9
2016 May	30		9
2016 June	4		1
2016 July	2		
2016 August	6	1	2
2016 September	3	1	1
2016 October	2		1
2016 November	9		9
2016 December	15	2	7
2017 January	10		5
2017 February	1	2	
2017 March	44	2	32
2017 April	15		10
2017 May	16	1	9
2017 June	5		4
2017 July	8	1	5
2017 August	9	3	5
2017 September	13	1	12
2017 October	14	4	13
2017 November	12		9
2017 December	4		2
2018 January	15	1	11
2018 February	22	2	19
2018 March	11	1	8

Table five: East Inpatient

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	2		
2015 April	1		
2015 July	4		2
2015 August	4	2	4
2015 September	1		1
2015 October	4	1	1
2015 November	12	4	9
2015 December	6		3
2016 February	1		1
2016 March	4	3	
2016 April	9	5	6
2016 May	2	3	2
2016 June	5	3	4
2016 July	3	4	2
2016 August	6	1	2
2016 September	2		
2016 October	4	2	1
2016 November	8		8
2016 December	3	1	2
2017 January	5	1	4
2017 February	2	1	1
2017 March	5	3	3
2017 April	5	3	3
2017 May	2		2
2017 June	5	1	5
2017 July	8	2	6
2017 August	3		2
2017 September	3	1	1
2017 October	6	4	4
2017 November	4		3
2017 December	3	4	1
2018 January	13	2	12
2018 February	5	2	3
2018 March	9	1	5

Table six: North Inpatient

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	6		
2015 April	1		
2015 June	2	3	
2015 July	7	1	3
2015 August	13	2	6
2015 September	2	3	
2015 October	22	4	9
2015 November	5	1	2
2015 December	14	1	12
2016 January	3		3
2016 March	2		2
2016 April	3	1	
2016 May	4		2
2016 June		1	
2016 July	4		
2016 August	6	2	3
2016 September	8	1	5
2016 October	24	9	17
2016 November	4	2	4
2016 December	2		1
2017 January	3		1
2017 February	3	1	3
2017 March	3		3
2017 April	7	4	2
2017 May	4	1	3
2017 June	8	4	6
2017 July	2		2
2017 August	6		6
2017 September	6	3	4
2017 October	6	1	4
2017 November	4	1	1
2017 December	2	1	
2018 January	10	4	6
2018 February	23	5	12
2018 March	20	8	6

Table seven: PSAID Inpatient

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 February	9	2	4
2015 March	11	4	9
2015 April	7	3	4
2015 May	14	1	13
2015 June	35	7	27
2015 July	6	1	5
2015 August	6		6
2015 September	14	1	13
2015 October	9	3	5
2015 November	10	4	9
2015 December	4		4
2016 January	16	7	12
2016 February	14	4	10
2016 March	21	8	20
2016 April	21	6	15
2016 May	17	1	13
2016 June	11		11
2016 July	4	2	4
2016 August	25	5	18
2016 September	21	2	16
2016 October	15	3	11
2016 November	27		26
2016 December	12		12
2017 January	8	2	5
2017 February	15		14
2017 March	13	4	11
2017 April	10	1	10
2017 May	10		8
2017 June	15	3	10
2017 July	8	4	3
2017 August	7	1	3
2017 September	9		9
2017 October	13	2	12
2017 November	8	4	7
2018 January	10	4	3
2018 February	7	1	5
2018 March	4		2

Table eight: Seager Clinic

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	10	3	1
2015 April	5	3	2
2015 May	9	2	3
2015 June	1	1	
2015 July	6	2	3
2015 August	4	2	1
2015 September	9	1	3
2015 October	3		1
2015 November	4	2	1
2015 December	5	2	
2016 January	2	1	1
2016 February	4	1	2
2016 March	5	2	1
2016 April	7	2	5
2016 May	2	1	2
2016 June	4	1	2
2016 July	4	3	1
2016 August	8	5	4
2016 September	8	4	5
2016 October	32	11	6
2016 November	39	11	13
2016 December	11	3	6
2017 January	6	4	1
2017 February	5	2	3
2017 March	10	2	8
2017 April	6	1	1
2017 May	5	3	2
2017 June	7	1	4
2017 July	2	1	1
2017 August	5	3	3
2017 September	9	2	3
2017 October	8		6
2017 November	3	3	2
2018 January	5	3	4
2018 February	6	2	4
2018 March	8	6	3

Table nine: South Inpatient

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	1		
2015 May	1		
2015 June	1	1	1
2015 July	6	1	5
2015 September	2		
2015 October	4	1	2
2015 November	2		2
2015 December	18	3	14
2016 January	3		3
2016 February	1		1
2016 March	1		1
2016 May	1		
2016 June	1	1	
2016 July	9	2	3
2016 August	4	2	2
2016 September	1		
2016 October	4	1	2
2016 November	2	2	
2016 December	2		2
2017 January	2		
2017 March	4	2	1
2017 April	5	2	3
2017 May	14	2	7
2017 June	12	5	5
2017 July	5	2	5
2017 September	5	1	3
2017 October	4		4
2017 November	8	2	5
2017 December	5	3	3
2018 January	14	1	10
2018 February	9	3	5
2018 March	3		3

Table ten: Te Whare Hohou Roko

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 April	1		1
2016 July	2		2
2016 August	3	1	2
2017 April	1		1
2017 October		1	
2017 December	1	1	

Table eleven: Te Whare Manaaki

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	3	2	1
2015 April	1	1	
2015 May	2		2
2015 June	3		2
2015 July	1	1	
2015 August	2	1	1
2015 September	2		1
2015 October	8	3	6
2015 December	2		2
2016 January	5		5
2016 February	3		3
2016 April	1	1	
2016 May	3		3
2016 June	7		6
2016 July	3		2
2016 August	3	2	2
2016 September	2	1	2
2016 October	6	1	4
2016 November	7	4	3
2016 December	1		1
2017 January	3		3
2017 February	5	1	4
2017 March	1		1
2017 April	3	1	1
2017 May	4	2	2
2017 June	4		4
2017 July	3		3
2017 August	4		4
2017 September	4		4
2017 October	3	1	2
2017 November	6	1	5
2017 December	4		3
2018 January	2		2
2018 February	2	1	1
2018 March	4	1	3

Table twelve: Te Whare Mauri Ora

Month/Year	Assault	Assaulted - Consumer	Assaulted - staff
2017 December	1	1	-

Table thirteen: Tupuna

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 February	6		2
2015 March	9	1	5
2015 April	10	1	6
2015 May	12		9
2015 June	4	1	3
2015 July	7	2	5
2015 August	3		2
2015 September	1		1
2015 October	6	1	2
2015 November	3		1
2015 December	6	1	2
2016 January	5		3
2016 February	3	1	1
2016 March	3	1	3
2016 April	5	2	3
2016 May	4		3
2016 June	1		1
2016 July	3		1
2016 August	2		2
2016 October	2	1	1
2016 December	1		1
2017 January	5	1	4
2017 March	5		5
2017 April	3		2
2017 May	11		8
2017 June	7	2	5
2017 July	12	2	8
2017 August	5		5
2017 September	10	1	9
2017 October	10	2	8
2017 November	3		3
2017 December	4		4
2018 February	5		5
2018 March	7		7

Table fourteen: West Inpatient

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 March	4		3
2015 April	1		1
2015 May	17	1	11
2015 June	14		6
2015 July	9	1	7
2015 August	4	4	1
2015 October	4	1	2
2015 November	1		1
2015 December	7	2	7
2016 January	6	2	3
2016 February	1		1
2016 March	6	3	3
2016 April	6	1	4
2016 May	6	1	2
2016 June	1		
2016 July	2	3	2
2016 August	10		8
2016 September	2	1	1
2016 October	10	1	6
2016 November	2	1	1
2016 December	9	4	7
2017 January	7	3	7
2017 February	2	1	2
2017 March	7	1	6
2017 April	1	1	
2017 May	1		1
2017 June	10	1	8
2017 July	3	1	2
2017 August	2		1
2017 October	5	2	5
2017 November	5		5
2017 December	7	2	5
2018 January	5	6	4
2018 February	3		3
2018 March	9	1	7

Table fifteen: Outpatient and Non-clinical areas

Month/Year	Assault	Assaulted - Consumer	Assaulted - Staff
2015 February	1		
2015 April		1	
2015 June	1		
2015 July	1		
2016 February	1	1	
2016 March	2		
2016 April	1		
2016 June	1		
2016 July	1		
2016 September	1	1	1
2016 October	1		1
2017 January	1		1
2017 April	1		
2017 June	2		
2017 August	2		
2017 September	2		
2017 October	1		
2017 November	2	1	
2017 December	2		1
2018 February	1		1
2018 March	1		

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

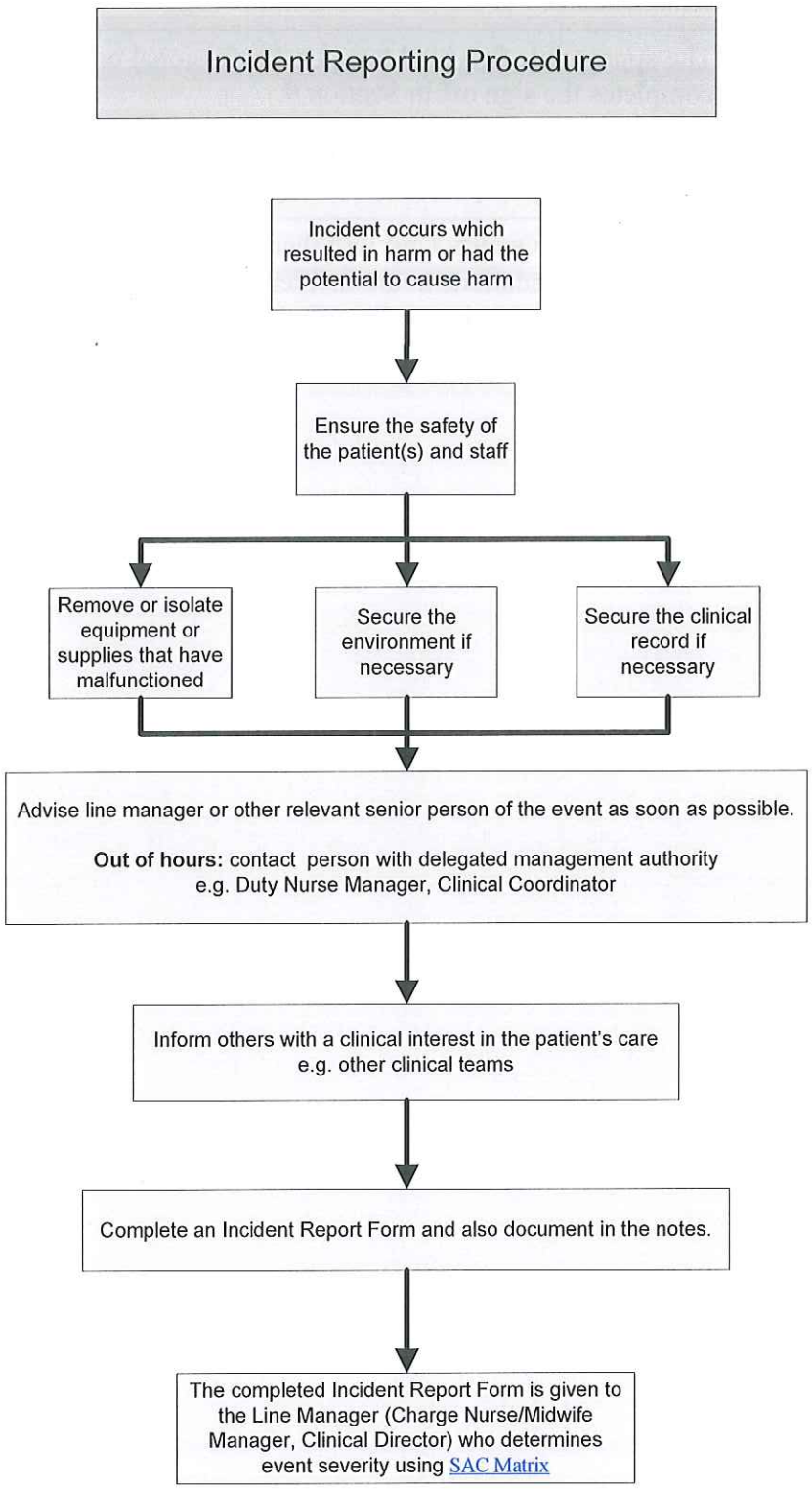
Step	Action
1	Staff directly or indirectly involved in an incident which resulted in harm or had the potential to cause harm. The first priority is to ensure the safety of the patient(s) and staff. As required and with the assistance of the area Charge or Coordinator • provide immediate care and comfort 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.

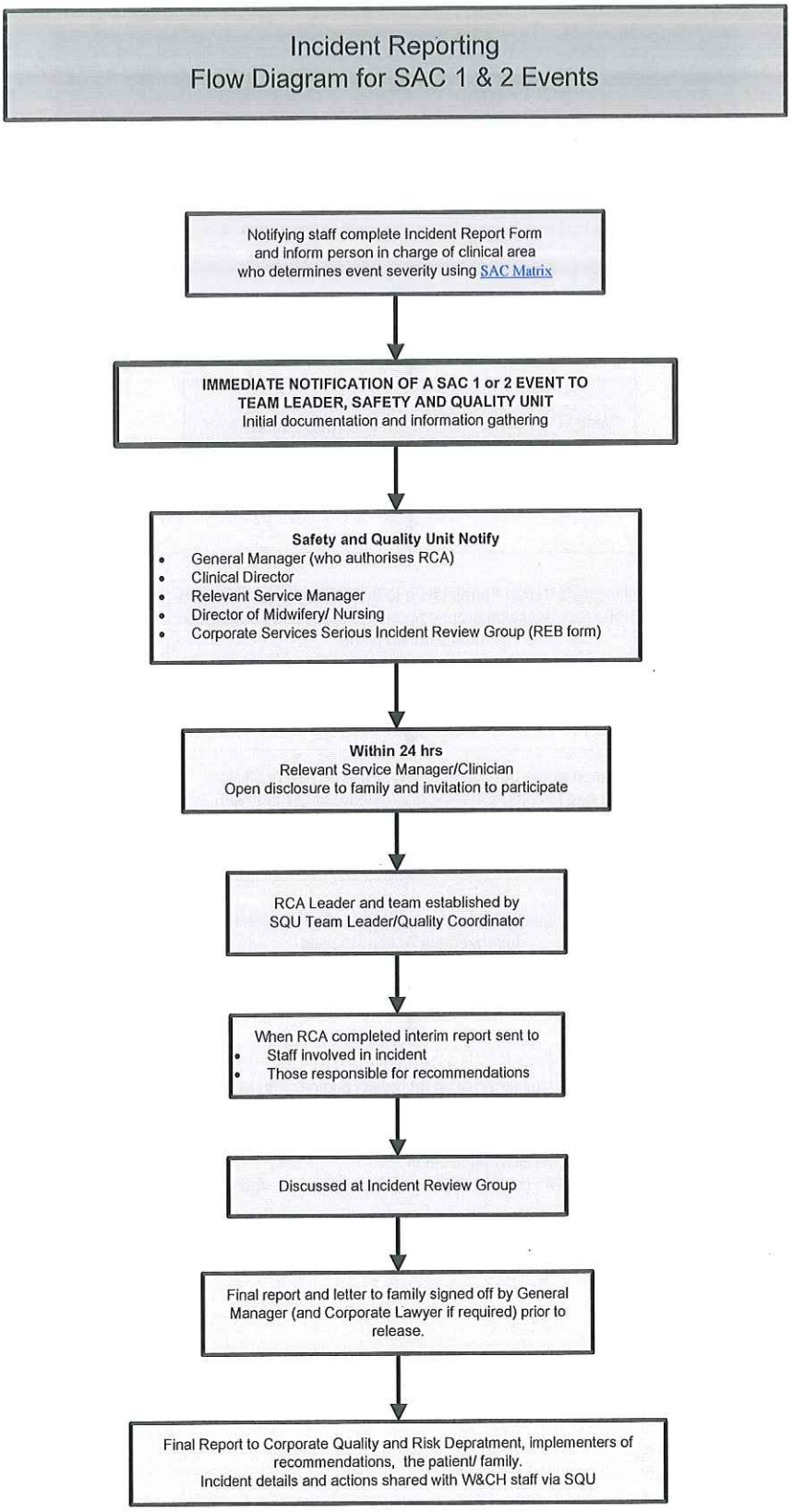
SAC Matrix

SAC Matrix

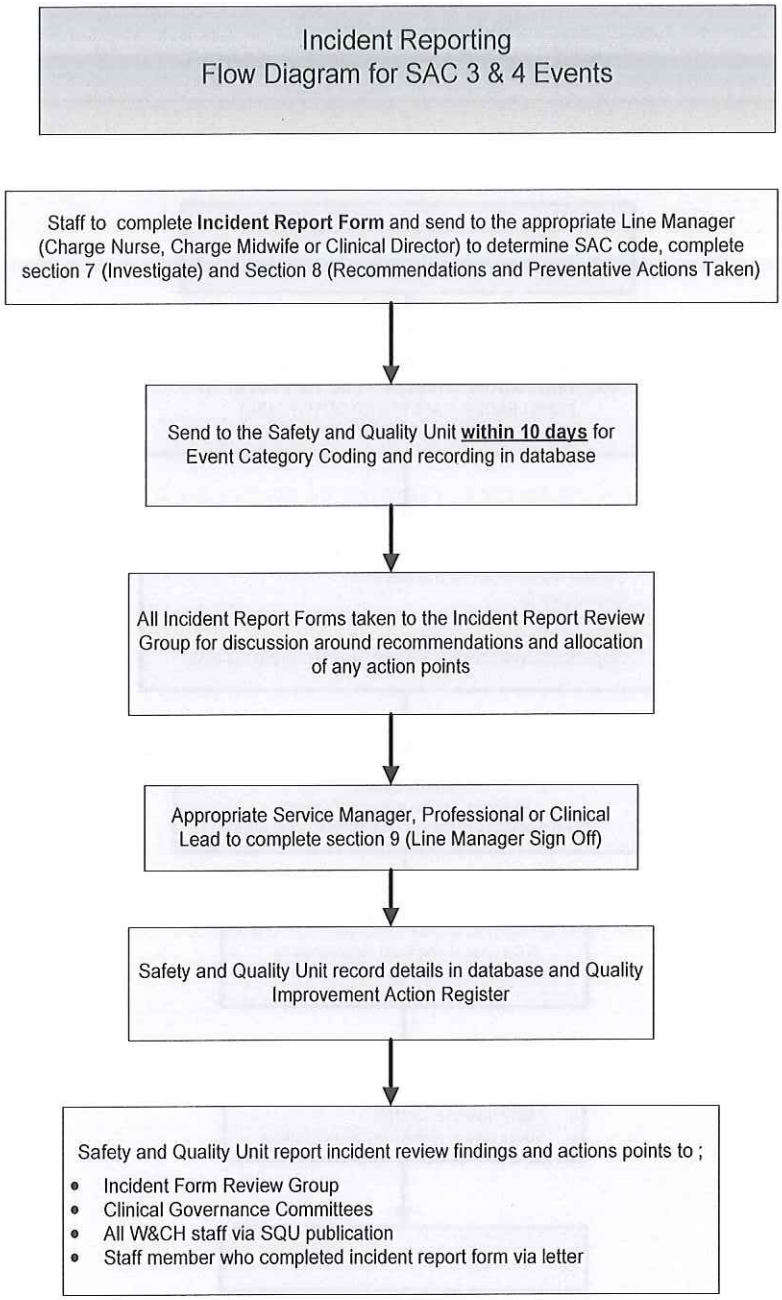
Incident Reporting Procedure



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

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.