Clinical/ Human Resources: Violence
Proactive Release: 28 March 2019

13 March 2019

[redacted]

Dear [redacted]

Official Information Act (1982) Request

I write in response to your Official Information Act request, dated 31 January 2019. You requested the following information:

Please provide any statistics or data about the number and nature of violent incidents in hospitals within your DHB within the last five years.

If possible, please provide a breakdown by:

1. **Annual number of incidents**
2. **Type or nature of incident:**
3. **The type of service they occur in (e.g. emergency departments, mental health units, other wards).**
4. **Who was the victim (patient, staff, visitor, etc.) and who perpetrated the violence?**
5. **When did the incident happen, and at what point in the hospital experience (e.g. 2 p.m., Sunday 4 Feb 2017, at the time of admission).**
6. **Where the patient was the perpetrator of a violent incident, how many incidents are reported within 48 hours of that patient being placed in seclusion or restraint**
7. **Were there any other factors or circumstances that may have contributed to the incident?**

Before responding, we believe the following may provide you with useful context.

CM Health services provide health services to in excess of 569,400 people residing in South Auckland, both in hospital and community settings. Obviously, many of these people are acutely unwell and/or in distress when they require care and that can result in behaviours that our staff members need to manage and respond to.

We have primarily derived the information provided for you from our staff Incident Reporting System (RiskPro). However, there are limitations in the ability to extract concise details for the incident reporting that you are seeking.

In particular, we note that the RiskPro reporting system is intended to enable DHB staff to report on any incidents in their workplace, and to have these investigated and resolved. However, this can mean there can be issues with data 'uniformity' and interpretation, and we cannot always directly extract information across all incidents logged.

Each incident is counted as a unique file, and we use coding themes to guide the allocation of incidents, along with narrative text that provides extended details, but this is not as easily coded. While there are 'nominated' codes for types of incidents reported, these may not always be consistently interpreted by everyone. In addition, there will be a range in the severity of incidents within the same code group.

We employ over 7,000 staff, and are constantly working to create a safe work environment. We are clear that it is unacceptable for anyone to experience violence and abuse while working in or receiving care from our services.

We acknowledge that there has been an increase in reported incidents of violence (including physical and verbal), but believe this is due to a range of factors, including increasing staff awareness of the importance of formally reporting all types of incidents (both against staff and patients), rather than simply an increase in incidents of physical violence as we deliver services to more people each year. Further, in preparing this response we note that this data shows reported incidents per annum, but accept that will not be the totality of the cases where staff deal with aggression or verbal abuse.

Different services will have different numbers of incidents, and have different resources available and clinical skill levels to deal with these types of situations, that can affect reporting. We provide all staff with opportunities for training to learn risk assessment, de-escalation and effective communication techniques that aim to reduce the number of such incidents, and the adverse impacts that can result. All incident reports are automatically sent to managers for investigation and follow–up. If appropriate, we will support individuals who need to work with Police, as they pursue investigations.

We have implemented a range of service-specific initiatives in clinical areas of greatest need, including the Emergency Department, Mental Health, and with our security and orderly staff, to further enhance their ability to report, debrief and prevent issues of violence against staff and/or patients. These initiatives include use of CCTV, personal alarms, input from specialist staff, and enhanced training. In addition, we have used social media and other messaging with our wider Counties community about living our CM Health values, and treating others with respect.

We note that this incident report system information should be interpreted with caution. Given the differences in reporting systems, and in the DHB sizes and services, comparisons between DHBs may also be misleading.

In response to your questions, we can provide the following details:

1. **Annual number of incidents reported across the CM Health services (including hospital, community and outpatient settings:**

Year	Total
2014	504
2015	431
2016	463
2017	474
2018	527
Grand Total	**2,399**

Notes:
The following Specific Incident Types are included in these numbers are:

- assault - physical
- behaviour - aggressive/threatening
- assault - verbal/gesture
- behaviour - violent
- hit/bitten/scratched by person
- assault - sexual
- abuse verbal
- abuse gesture

In addition, as of October 2018, the CM Health Emergency Department uses a different reporting system (Code Orange) for the logging of violent incidents against staff. This process commenced as a pilot in June 2018, so the data is not able to be interpreted as a trend or compared to prior years. The intention of Code Orange is to provide Emergency Department staff with easy means to report all incidents, provide early clinical and de-escalation assistance and ensure staff wellbeing.

Situations that may require a *Code Orange Call* have slightly different criteria from the incident reports (and a wider classification), being:

- Intimidating or manipulative behaviour from patient, whaanau or visitor
- Aggressive/intoxicated or suicidal patient / visitor
- Event or behaviour in which staff member feel uncomfortable or compromised
- Unwelcome visitor
- Patients, whaanau or visitors refusing to be sensitive to, or respect the rights of others to privacy
- Extremely stressed patient, whaanau or visitors

At this point, we have logged the following Code Orange reports per month

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Total incident	10	21	5	44	50	46	20	27

2. Type or nature of incident (for the four year period):

Specific Incident Type	Total 2014-2018
Assault - physical	1,079
Behaviour - aggressive/threatening	759
Assault - verbal/gesture	234
Behaviour - violent	146
Hit/bitten/scratched by person	136
Assault - sexual	39
Abuse verbal	5
Abuse gesture	1
Grand Total	**2,399**

Notes:
The incident type "hit/bitten/scratched by person" is typically used for incidents where the victim was unintentionally hit, bitten or scratched.

3. The type of service they occur in (e.g. emergency departments, mental health units, other wards).

Service/Area	Total 2014-2018
Mental Health	1,338
Emergency, Acute Care Services	256
Surgical	194
Medicine	184
Adult Rehab/ Health of Older People	143
Women's Health	79
Kidz First (Children)	64
Primary Health & Community	56
Middlemore Central	36
Facilities	14
Clinical Support	14
Central Clinical Services	11
Non-Clinical Support	9
Ko Awatea	1
Grand Total	**2,399**

Notes:
The following Specific Incident Types are included in these numbers:

- assault - physical
- behaviour - aggressive/threatening
- assault - verbal/gesture
- behaviour - violent

- hit/bitten/scratched by person
- assault - sexual
- abuse verbal
- abuse gesture

As mentioned under point 1 above, as of October 2018, the Emergency Department started using a different reporting system (Code Orange) for the logging of violent incidents.

4. Who was the victim (patient, staff, visitor, etc.) and who perpetrated the violence?

Limitations in the RiskPro reporting system mean it is difficult to consistently identify victims/ perpetrators. This detail is sometimes included in the narrative free-text of incident reports, but is not automatically extractable.

When the person affected is stated to be an employee, it is not possible to consistently discern whether the perpetrator was a patient/s, a family member/ visitor or a member of the public (again this detail may only be in the free-text narrative description).

Completing a manual review of all reports over the timeframe requested to isolate this level of detail would take considerable time.

5. When did the incident happen, and at what point in the hospital experience (eg, 2pm, Sunday 4 Feb 2017, at the time of admission)?

Limitations in the RiskPro reporting system mean the exact time of the incident (as distinct from the time of reporting) are only captured in the free-text narrative. In general, we consistently capture the date of an incident, but it is not a mandatory field to include the time of incident. Single incident reports may include multiple incident types (e.g. abuse, hitting and violent behaviours) escalating over a period of time by a single individual.

6. Where the patient was the perpetrator of a violent incident, how many incidents are reported within 48 hours of that patient being placed in seclusion or restraint?

We do not hold this information in a way that can be easily collated. Decisions to use seclusion and restraint always trigger the immediate use of a clinical incident reports and ongoing documentation. The use of restraint and seclusion is considered a last resort intervention, to be used only where there is clinically assessed concern that there may be harm to other people, and that its use is in line with organisation policy and procedures. All such incidents are debriefed/ reviewed, to ensure appropriateness on action and outcomes.

For any incident that was reported as a General Employee incident (such as assault by a patient), it is not consistently possible to relate to a specific patient, except by manual review of the free-text component of incidents reports, and further cross-referencing to security and clinical logs.

7. Were there any other factors or circumstances that may have contributed to the incident?

The following list of factors was logged as contributing to incidents, noting that more than one factor may contribute a single incident, and that multiple reports on a single incident may identify different factors.

Contributing Factors	Total 2014-2018
Action/ behaviour of patient	944
Agitated	809
Current/ pre-existing diagnosis/ condition	624
Combative	392
Confused/ disoriented	270
Communication difficulties/ deficit	211
Action/behaviour of visitor/ public	153
Provoked	121
Human factors	117
Substance abuse/ intoxication	116
Environment - arrangement/ design	90
Awkward position/ posture	62
Medication/ sedation	55
Action/behaviour of employee/ affiliate	47
Staff - availability/ skill mix	44
Action/behaviour of relative/ caregiver/ visitor	42
Assistance unavailable	39
Supervision/ monitoring inadequate	36
Job factors/ work arrangement/ organisation	33
Procedure/ policy not followed	30
Grand Total	**4,235**

I trust this information satisfactorily answers your query. Please contact us should you wish to further understand any elements of our response. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

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

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive