Human Resources: Staff disciplinary
Proactive Release: 13 December 2018

15 November 2018

[redacted]

E-mail: [redacted]

Dear [redacted]

Official Information Act (1982) Request

I write in response to your Official Information Act request, dated 01 November 2018. You requested the following information:

- **The number of patients at Middlemore Hospital who have left or absconded from Middlemore Hospital while under watch over the past two years.**

- **Please provide copies of all incident forms (Riskpro/ Datex or any other incident forms) in this regard.**

We have used the CM Health Incident Reporting System (RiskPro), which is electronic, to extract incidents within the scope of your request from all areas of Counties Manukau Health, including Inpatients, Outpatient and Community services, including Mental Health. There are 21 incident reports that matched your request.

For context, Counties Manukau Health Services provide health services to more than 550,000 people residing in South Auckland, both in hospitals and community settings. Obviously, many of these people requiring our services are acutely unwell and / or in distress when they require this care and that can result in inappropriate or challenging behaviours being exhibited, which many of our staff members need to manage and respond to in carrying out their work.

As you'll appreciate Watches and 1:1 Carer/Trackers are allocated to many patients each day in our Hospitals and Services, for a variety of reasons. Typically, we deploy in excess of 80 FTE staff to provide this additional care to patients who are at greater risk of harm while in hospital, due to their condition or capacity. There are very few circumstances where we can reasonably detain patients against their will. So whilst a Watch or Tracker can provide additional assurance, ultimately if patients want to leave our services, we cannot usually stop them. We do have agreed procedures for staff to enact if a patient absconds, including notification to Family members, Clinicians, the Security team and Daily Operation Unit, and if appropriate NZ Police.

A summary of the incidents logged by staff from 01 November 2016 to 01 November 2018 is provided here (**Table 1**), using the incident reporting system and the search parameters as noted below. This summary includes detail of the incident date, location and type of patient, and the incident type.

We believe this is sufficient detail for your request, and in providing this information we are balancing the public interest in this matter against the privacy of affected individuals, including patients and family members. We are not providing full copies of reports, and we do this under section 9(2)(a) of the Act.

As part of our commitment to working in partnership with NZNO, we are willing to arrange viewing of a fuller excerpt from the relevant incident reports listed above (on a confidential basis), but believe that there are countervailing requirements for us to maintain the confidentiality of this information at this time.

The Specific Incident Type was listed in the incident reporting system (RiskPro) as one of the following:

- Specific Incident Type equal to awol
- Specific Incident Type equal to awol - Category A
- Specific Incident Type equal to awol - Category B
- Specific Incident Type equal to awol - Category C
- Specific Incident Type equal to discharge against medical advise
- Specific Incident Type equal to discharged/self-discharged against advice
- Specific Incident Type equal to patient left before recommended time
- Specific Incident Type equal to patient left against medical advice
- Specific Incident Type equal to patient left without being seen
- Specific Incident Type equal to patient self removal
- Specific Incident Type equal to self discharge

This extract was then reviewed / searched for the short description of the incidents for the following keywords: *'watch'*, *'escort'*, *'tracker'*, *'HCA'*. Incidents included in the list described a situation where a patient absconded while being watched by a watch (typically an HCA) or tracker, or if they were mental health patients being escorted by staff members at the time they absconded.

File ID	Incident Date	Service	Person Classification	Specific Incident Type
114115	06/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL
114329	11/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL
114344	12/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL
116206	06/05/2017	EMERGENCY DEPARTMENT	IN-PATIENT	Patient Left Against Medical Advice
117207	06/06/2017	CORE MENTAL HEALTH ADULT SERVICES	IN-PATIENT	AWOL
121062	22/09/2017	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL
121489	06/10/2017	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL
123517	10/12/2017	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL
124899	22/01/2018	GYNAECOLOGY	IN-PATIENT	Patient Left Against Medical Advice
124928	26/01/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice

File ID	Incident Date	Service	Person Classification	Specific Incident Type
126614	17/03/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice
126592	17/03/2018	STROKE WARD	IN-PATIENT	AWOL
126590	17/03/2018	STROKE WARD	IN-PATIENT	AWOL
129083	31/05/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Without Being Seen
129126	01/06/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Without Being Seen
132377	04/09/2018	CORE MENTAL HEALTH ADULT SERVICES	IN-PATIENT	AWOL
132483	07/09/2018	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL
132703	12/09/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice
133121	23/09/2018	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL
134402	29/10/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL
134442	30/10/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL

We expect staff to immediately report all clinical incidents, and these reports are automatically sent to service managers for investigation and follow-up. This may include a review of direct patient care in place, but also identify requirements for additional staff development and training.

In the reporting system, which is available to all staff, there is a mixed set of category data points, and also free-text fields for narrative. There are some limitations to this repository, including that the system enables multiple staff to log multiple incident reports on the same event, that the self-selection of the 'specific incident type' by the reporting staff member can result in misallocation, and that there can be different ways that patients are supervised and directed (e.g. going outside with a watch) in different areas.

I trust this information satisfactorily answers your query. 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