Re: Westmead ED MH Pod concerns

Sent: November 18, 2022 9:52 AM

From: Nick Howson (Western Sydney LHD)

To: Steven Westbrook Sr (Western Sydney LHD);

2 Attachments

image001.jpg (28 KB); image003.png (181 B);

I'm here. Happy to have a chat. I've been hearing from nurses as well.

Nick Howson

A/Clinical Nurse Consultant | **WSLHD Acute Services**
Nursing Administration, Building 35, Cumberland Hospital
[redacted] | Teams Chat | [redacted]

From: Steven Westbrook Sr (Western Sydney LHD) [redacted]
Sent: Friday, 18 November 2022 09:50
To: Nick Howson (Western Sydney LHD) [redacted]
Subject: FW: Westmead ED MH Pod concerns

In strict confidence, please take a look at the below. I'm on my way to Cumberland and would like to have a chat with you about this if you are free

Kind Regards

Steven Westbrook Sr AICGM, AFASIAL, CHSS

Work Health & Safety Coordinator | **People & Culture | Work Health & Safety**

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From: Steven Westbrook Sr (Western Sydney LHD)
Sent: Thursday, 27 October 2022 2:21 AM
To: Mark Palmer (Western Sydney LHD) [redacted]; Jenifer Benny (Western Sydney LHD) [redacted]
Cc: Christine Dictado (Western Sydney LHD) [redacted] Darren Penney (Western Sydney LHD) [redacted]; Jason Carr (Western Sydney LHD) [redacted] Paul Giovenali (Western Sydney LHD) [redacted]
Subject: Westmead ED MH Pod concerns
Importance: High

Good Morning

Thank you for getting the updates on the staff involved in the recent incident (**INC555204)** in the MH pod of the Westmead ED. If not done already, please coordinate with the ED Num so that the IMS report can be updated to reflect. As discussed in the MHS morning huddle, I ventured over there yesterday to have a look at things. Very glad I did as I now have more clarity as to what is going on and the difficulties you and staff there have and face daily.

I was able to determine that the ultrasound machine was not in the MH pod area at the time. The patient left their bed area, walked over the adjacent ED area, grabbed the ultrasound machine and attempted to use it as a weapon. That clarifies the unnecessary equipment questions that were raised, but there are still housekeeping/sanitising issues within the MH pod area that need to be addressed. Other areas to consider are the staffing at the time of the psych consult. As we have previously had dangerous incidents during consults, was there adequate staff on hand for the task? Also with the distance the patient walked to get to the ultrasound machine there may have been sufficient time for redirection or other steps to contain the incident.

I also observed and noted other areas of concern. I have already briefed Wade Norrie on these and he has asked me to inform you of them so that we can begin to work collaboratively to resolve the issues. Understanding that this is the Westmead ED's space and they are actually and ultimately the primary responsible party for them, but I believe that as a service the MHS team should initiate dialog on this so that you can get the levels of service and safety that have been agreed on and are expected for patients and staff. Please also consider that most of these issues were discussed and included in the consultations for the RA conducted as operations within the MH pod began. I have attached the recommendations submitted by the Violence Prevention and WHS teams on 21 July 2022

Pease note that while there talking with the nurse one duty, there was a near miss incident(**patient attempted to suicide using the wall mounted Oxygen valves and her shoe laces as a ligature point-WM ED MH Pod Pic**). That incident is a **NEAR MISS** and should have a detailed review or RCA so that findings can be made and improvements/changes to reduce/eliminate further instances occurring. As a potentially dangerous incident, this possibly fits the criteria as a SafeWork NSW notifiable incident. Further discussions on this will be held once the IMS report is generated and reviewed.

In no order of importance these are the issues I found by observation and discussion with staff. Most are direct WHS concerns, while others are clinical but if not addressed affect patient acuity and could evolve into violence and aggression issues that again are WHS concerns. I have also included some recommended actions to be considered for

each. These are thoughts off the top of my head. Further detailed discussions will need to be held with our wider audience to develop a comprehensive strategy for each.

- **Faulty fixed duress alarm button at entrance to office** -**WM ED Pod Blocked Duress Alarm Pic**
  1. AFM to be initiated-followed up with correspondence to maintenance to expedite the repairs

  2. Not confirmed but staff indicated that have raised this issues previously and since they have been working in the MH Pod space, early in its inception, the alarm has not been working.

  3. If true and there are no documented actions such as repair parts on order, system diagnostics reports, etc, this could be a violation of the WHS Act- Is management is not taking reasonable steps to ensure compliance with unsafe conditions?

  4. The sign placed on the wall advising staff to not use the button is insufficient. Meeting minutes, emails, safety huddles, memos and etc documenting the communication of this to all staff. In addition, documentation of orientation/induction briefings for new and causal staff need to be maintained

- **Potentially the MH pod is blind spot in the Wi-Fi coverage for the duress tags-Multiple times, multiple staff have activated their tags and none were successful at ring the alarm and support only came from passers-by hearing the commotion**.
  1. AFM to be initiated-followed up with correspondence to maintenance/health infrastructure to expedite the testing of tags and connectivity of the WAPs

  2. As a redundancy to the alarms, Security staff assigned to the MH Pod area should have a two way radio to raise the alarm for extra assistance

- **Lack of security support-Particularly Security B team(I observed both officers on shit at the time were congregating in one spot talking as opposed to positioning themselves at either end of the pod to monitor activities)**
  1. Matter to be raised with Westmead Hospital security manager/ Synergy security contract manager

  2) Are the MH pod security fixed to that area or are they back up response for other areas in the ED or hospital?

  3) Is there an appetite for recruiting and hiring HSAs to perform this role?. They would be inhouse NSW staff and this would offer consistency in training and familiarity with the task required to be performed

- **Lack of training/briefing with security- In most cases they are directionless, looking at their phones or otherwise not providing the level of service needed**
  1) Matter to be raised with Westmead Hospital security manager/ Synergy security contract manager.

  2) SOP to be developed outlining the duties and expectations of assigned staff- This also includes SOPs for clinical staff permanent/causal/transient on their duties

  3) Personnel assigned briefed on SOPs before commencement of assigned shifts

  4) Nursing staff to be trained and briefed that the security role is **CLINCALLY LED**. THEY are allowed and well within their rights to provide direction and reasonable request to the security officers within the context of the job for assigned security staff

- **AINs from Westmead ED are assigned to shift as the co staff for the MHS Nurse**
  1. During the consultation for the RA, this was discussed and it was communicated that they do not provide AINs. Highlighted as an area that need to be part of the RA for future compliance

  2. MHS has allocated funding for there to be RNs to be on the shift

3. It is out of their scope of practice for AINs to perform the roles they are being tasked to do. Danger to themselves, patients and other staff

4. Rosters and staffing both from the MHS and ED need to be scrutinized and managed to ensure appropriate staffing is maintained

- **Access to medications- not having and RN to be partnered with you have to seek out the same and MOs for access and support to be able get required medications. Can take 20 -45 mins to get them**
  1. Unsafe and inefficient as Nurse has to leave patients in need, alone to get needed medications

  2. Mental health patients in the pod deserve same levels of care as general medicine patients within the ED- Someone presenting with and diagnosed as being in severe pain would promptly be given appropriate medications to assist. Someone presenting with an acute psychotic episode similarly needs timely access to medications

  3. Ties in with the identified staffing concerns raised

- **Possible patient ratio/NHPPD issues-MHS Nurse in Pod is 1:6 vs other ED staff are 1:4**
  1. Totally out of my purview but I am aware that it is a very contentious issue and could if not resolved or deemed to be within accepted standards lead to industrial relations issues and actions as well as staff burnout(Nurse that I spoke to was doing a double shift)

  2. This issue is exacerbated if paired with an AIN

- **MH Pod rooms not sanitized of unnecessary equipment- WM ED MH Pod Pics 2 and 3**
  1. Discussed at length during consultations for the RA

  2. If not remedied, you are providing access to means for patients to harm themselves or others

  3. Removal of ligature points- As best as possible the ED MH Pod spaces should be treated the same as any other MH ward space

- **Fixed duress button on wall blocked by MOW and other items**
  1. Discussed during the RA consultations as dangerous and needed to be remedied.

  2. Could be a violation of the WHS Act- Is management not taking reasonable steps to ensure compliance with unsafe conditions

  3. Needs to be communicated to staff. Signage as well as meeting minutes, emails, safety huddles, memos and etc documenting the communication of this to all staff. In addition, documentation of orientation/induction briefings for new and causal staff need to be maintained

- **Staff sitting with patient and MOW in front of door to nurse's station.**
  1. Prohibitive and dangerous for staff entering/exiting the door

  2. Potentially not therapeutic for the patient with the number of interruptions presented by passing by. (In this case observed, the patient had left their allocated bed and was sitting and talking with the staff. Positive outcome as they needed personal engagement and conversation, but none the less this practice, in the area in question has safety concerns)

- **Inadequate or no adherence to search policy**
  1. In the incident that occurred while I was there in the Pod, a patient that had been in the Pod for a few hours already, still had access to their shoe laces and was able to use them to attempt to suicide using the oxygen valves on the wall as a ligature point

  2. Consistent adherence to approved search policy should be upheld. The ED in general and with MH patients specifically there is a clear and present danger for patients and staff in not taking reasonable steps to safeguard against potentially dangerous weapons, drugs or contraband being introduced into our facilities

- **Consistent models of care to be adopted**
  1. General Medicine within the ED and Mental Health have fundamental differences in many areas, such as the use of mechanical restraints on patients. Tempering safety and security concerns with trauma informed care strategies needs to be had. In the same manner as seclusion is viewed, a consistent approach of least restrictive practices should maintained. There is a middle ground that can be reached to provide for better outcomes for the patients and a safer environment for all.

  2. Staff to be trained and briefed on models of care and care plans for patients

- **Clear and defined lines of escalation**
  1. With the mix of personnel and space ownership there is an unclear direction as to who owns incidents and how they are to be escalated

  2. Needs to be clarified and communicated to all staff

  3. As with most of the Non Cumberland MHS wards, staff feel disconnected as the HDCs are not always readily available except by phone and there is a perception of not being supported

I have cc'd to this email some relevant stakeholders and or personnel that will be able to provide support for assisting you in resolving the issues raised.

To show the importance of these matters and how small things can quickly escalate and spiral out of control with serious ramifications, I have included a copy of a recent SafeWork NSW Enforceable Undertaking that occurred for the SLHD in one of their facilities EDs.

The WHS, and Violence Prevention teams are here to assist you with this and other matters as you move forward.

Have a good day and be safe.

Kind Regards

Steven Westbrook Sr AICGM, AFASIAL, CHSS

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