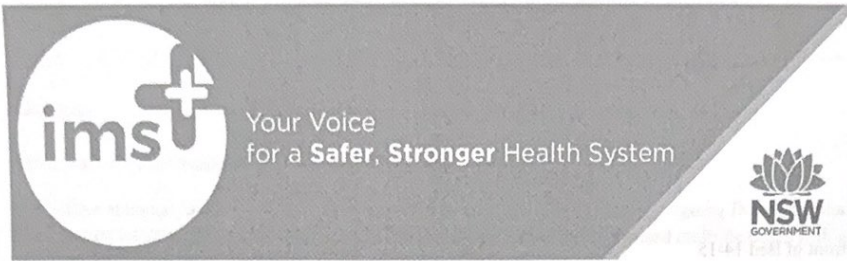


Incidents



eHealth

To view the NSW Health policies page click [HERE](#).

If you require any assistance, please view user guides and videos [HERE](#).

INC559198 | Security and Safety

Incident Overview

Details and Status

Reference ID	INC559198
Name of primary person affected	
Reported date (dd/mm/yyyy)	01/11/2022
Reported time (hh:mm)	12:16
Incident status	Finalised

Incident Details

Incident Details

Who or what was **most** affected? **No Person**
 This refers to the primary person affected, not the person who caused it

Incident Details

Incident date (dd/mm/yyyy) **01/11/2022**
 Incident time (24 hrs) (hh:mm)
 Is the time estimated?

Incident Details

What type of NSW Health organisation do you work for? **Local Health District (LHD) / Hospital or Specialty Health Network**

Health Service

Health Service

2/14/24, 2:22 AM

DCIQ:

Health/Ambulance service where the incident occurred NSW / WSLHD / WSLHD / Westmead Hospital / WM Emergency Mental Health Pod

Service responsible for clinical care/support

Please type in and search for the Ward/Department/Station first, then select the location with the correct LHD/Organisation in the name. If you can't find your location please see Help Text for examples.

Additional details about Location (e.g., corridor, hallway, community address) Infront of Bed 14-15

What Happened? (or could have happened)?

Principal incident type is meant to capture incidents, near misses and hazards.

What Happened? (or could have happened)?

Details Code Black alert button does not work consistently. Was tested this morning by Security and pressed for >3seconds as per "Note sign" and did not communicate with the alert system. It continues to not notify via the pagers for security, nor the overhead alert screens throughout the Emergency department, further to this when this button is pressed it does not alert the NUM or the Communication hub in FOH

What Happened? (or could have happened)?

Principal incident type Security and Safety

What Happened? (or could have happened)?

Please categorise this incident type further Emergency code

What Happened? (or could have happened)?

Additional details Code Black - Personal Threat

Was the emergency code raised in the State Health Emergency Management System (SHEMS)? No

No Was any equipment involved in the incident?

Outcome / Responses

Initial Assessment

Initial Impact of incident Threat to safety and security of patients, staff, service

Initial Care and/or treatment required following incident/near miss No response required

2/14/24, 2:22 AM

DCIQ:

Initial Harm Score 4

Responses

Responses

Have you told your manager? Yes

Immediate action(s) taken Enter action taken at the time of the incident. Maximum character limit is 32766 including spaces. Staff continue to wear the Duress alarms, ongoing IM's to be placed daily until error fixed, Safe work informed as this issue has been raised multiple times with no fix.

Contributing Factors and Prevention

What things could have contributed to the incident? A faulty Code Black button

Was the use of virtual care (i.e., telehealth, video conferencing, store & send or remote monitoring) involved in this incident or near miss? No

What could be done to prevent similar incidents? Have the alarm fixed in an appropriate amount of time given it has been broken and known about for almost 2 months

Feedback to the Notifier

Use this section to detail any specific feedback to the notifier.

Feedback to notifier Maximum character limit is 32766 including spaces.

Incidents



eHealth

To view the NSW Health policies page click [HERE](#).

If you require any assistance, please view user guides and videos [HERE](#).

INC786351 [REDACTED] Concerning Behaviour

Incident Overview

Details and Status

Reference ID	INC786351
Name of primary person affected	[REDACTED]
Reported date (dd/mm/yyyy)	20/10/2023
Reported time (hh:mm)	05:10
Incident status	Finalised

Incident Details

Incident Details

Who or what was most affected? Patient
 This refers to the primary person affected, not the person who caused it

Incident Details

Incident date (dd/mm/yyyy) 20/10/2023
Incident time (24 hrs) (hh:mm) 04:20
Is the time estimated? No

Incident Details

What type of NSW Health organisation do you work for? Local Health District (LHD) / Hospital or Specialty Health Network

Health Service

Health Service

2/14/24, 2:23 AM

DCIQ:

Health/Ambulance service where the incident occurred NSWH / WSLHD / WSLHD / Westmead Hospital / WM Emergency Department ED

Service responsible for clinical care/support

Please type in and search for the Ward/Department/Station first, then select the location with the correct LHD/Organisation in the name. If you can't find your location please see Help Text for examples.

Additional details about Location (e.g., corridor, hallway, community address) Bed 14 through Acute A to resus

Specific Service

Specific Service

Specific service involved Service / Mental Health - Emergency Department

What Happened? (or could have happened)?

Principal incident type is meant to capture incidents, near misses and hazards.

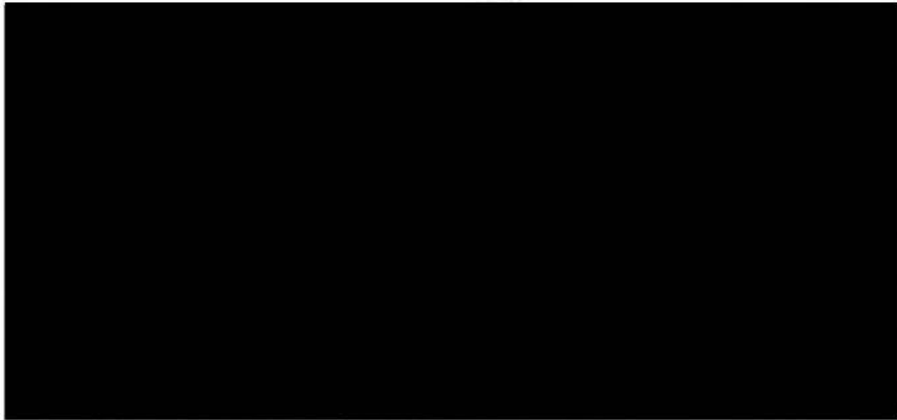
What Happened? (or could have happened)?

Details
Maximum character limit is 32766 including spaces.



2/14/24, 2:23 AM

DCIQ:



What Happened?
(or could have happened)?

Principal incident type

Concerning Behaviour

What Happened?
(or could have happened)?

Please categorise this incident type further

Aggression - both physical and verbal

What Happened?
(or could have happened)?

Additional details

Actual

No Was any equipment involved in the incident?

No Was a medication involved in the incident?

Code Black Response

Was a Code Black called?

Yes

Weapon Involvement

Weapon Involvement

Was a weapon involved?

No

Physical Aggression

Physical Aggression

Physical aggression displayed?

Intimidating/threatening/combative
Intrusive/disruptive
Slapping/punching/hitting/kicking

Verbal Aggression

2/14/24, 2:23 AM

DCIQ:

Verbal Aggression

Verbal aggression displayed?

- Harassing
- Intimidating (including physical gestures)
- Threatening (including death threats)

Instigator Details

Instigator Details

Who instigated the behaviour?
 Note: For suspected suicide incidents, please select the option of Person (above)

Person affected (noted below)

Other Affected Parties / Property

Other Affected Parties / Property

If other people and/or property were affected, select all that apply:

None of the above

Seclusion / Restraint

Seclusion / Restraint

Seclusion/restraint required?

Restraint

Involvement of Police

Involvement of Police

Were the police called/notified?

No

Outcome / Responses

Initial Assessment

Initial Impact of incident

Near miss (patient incident or accident avoided)

Initial Care and/or treatment required following incident/near miss

Not applicable

Initial Harm Score

4

Responses

Responses

2/14/24, 2:23 AM

DCIQ:

Open Disclosure

Has the patient/support person been informed? No

Open Disclosure

Why wasn't the patient informed? Patient unable to participate

Emergency Contact Notifications

Emergency Contact Notifications

Emergency contact notified? No

Contributing Factors and Prevention

What things could have contributed to the incident? Inadequate security presence in MH POD, security only 1 female guard who refused to escalate to code black on radio. Female guard inadequately trained in how to manage escalating pts Pt potentially under the influence of illicit substances. Known recent released from Long bay correctional facility 1/7 ago. Pt reported history of long standing Schizophrenia? as per NSWPF

Was the use of virtual care (i.e., telehealth, video conferencing, store & send or remote monitoring) involved in this incident or near miss? No

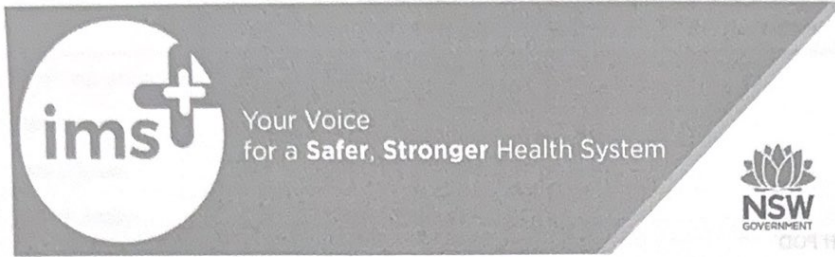
What could be done to prevent similar incidents? Proper security personal present in MH POD AT ALL TIMES. Appropriate EDMO r/v times. Pt should have been moved to Acute side of ED when sedated.

Feedback to the Notifier

Use this section to detail any specific feedback to the notifier.

Feedback to notifier Maximum character limit is 32766 including spaces.

Incidents



eHealth

To view the NSWH policies page click [HERE](#).

If you require any assistance, please view user guides and videos [HERE](#).

INC851425 | Security and Safety

Incident Overview

Details and Status

Reference ID	INC851425
Name of primary person affected	
Reported date (dd/mm/yyyy)	01/02/2024
Reported time (hh:mm)	00:47
Incident status	Investigation Complete

Incident Details

Incident Details

Who or what was most affected?
This refers to the primary person affected, not the person who caused it

No Person

Incident Details

Incident date (dd/mm/yyyy)	01/02/2024
Incident time (24 hrs) (hh:mm)	00:25
Is the time estimated?	No

Incident Details

What type of NSW Health organisation do you work for?
Local Health District (LHD) / Hospital or Specialty Health Network

Health Service

Health Service

2/14/24, 2:23 AM

DCIQ:

Health/Ambulance service where the incident occurred
Service responsible for clinical care/support

NSWH / WSLHD / WSLHD / Westmead Hospital / WM Emergency Mental Health Pod

Please type in and search for the Ward/Department/Station first, then select the location with the correct LHD/Organisation in the name. If you can't find your location please see Help Text for examples.

Additional details about Location (e.g., corridor, hallway, community address)

MH POD

What Happened?
(or could have happened)?

Principal incident type is meant to capture incidents, near misses and hazards.

What Happened?
(or could have happened)?

Details
Maximum character limit is 32766 including spaces.

Pt approached for r/v by Psych reg and security.
Irritable and demanding to leave to kill himself.
Refusing to appropriately engage with Psych reg for assessment.
Interview terminated due to pt escalation.
Pt then pacing in bed space having to be physically redirected and verbally redirect.
Pt administered PRN 10mg Olanzapine .
Pt then walked out of bed space and fronted with security physically coming in contact with their chest.
Duress alarm pulled however did not alarm for further 1-2minutes after being activated.
Pt physically restrained and moved back to bed space by x1 Security guard and x1 NS
Other security present in the ED sat on chairs not helping.
Pt then once back in his bed space attempting to grab machines off wall and dismantle bed.
Instructed firmly by NS and security to lay down and rest.
Pt has since complied.

What Happened?
(or could have happened)?

Principal incident type

Security and Safety

What Happened?
(or could have happened)?

Please categorise this incident type further

Alarm triggered

What Happened?
(or could have happened)?

Additional details

Duress alarm

Yes Was any equipment involved in the incident?

Alarms Triggered

Time alarm raised? (hh:mm)

00:25

Time appropriate personnel responded? (hh:mm)

00:30

2/14/24, 2:23 AM

DCIQ:

False alarm? No

Equipment

Item / equipment type	Duress
Brand name	AIRISTA
Manufacturer	AIRISTA
Model number	C4CB6B234AAF
Identification number(s) / marks	NIL

Outcome / Responses

Initial Assessment

Initial Impact of incident	Threat to safety and security of patients, staff, service
Initial Care and/or treatment required following incident/near miss	Monitor/review only
Initial Harm Score	4

Responses

Responses

Have you told your manager?	No
Immediate action(s) taken	Duress pulled.
Enter action taken at the time of the incident. Maximum character limit is 32766 including spaces.	Pt physically restrained in upright position and returned to bed space Advised EDNUM of complications regarding Duress not activating

Contributing Factors and Prevention

What things could have contributed to the incident?	Security need to actually respond specifically Synergy security who sat and did not come to assist. Duress alarms need to be re calibrated to effectively notify that there is an incident requiring assistance
Was the use of virtual care (i.e., telehealth, video conferencing, store & send or remote monitoring) involved in this incident or near miss?	No
What could be done to prevent similar incidents?	Security need to actually respond specifically Synergy security who sat and did not come to assist. Duress alarms need to be re calibrated to effectively notify that there is an incident requiring assistance

2/14/24, 2:23 AM

DCIQ:

Feedback to the Notifier

Use this section to detail any specific feedback to the notifier.

Feedback to notifier

WHS reopened this incident as the PST has not had the opportunity to review & comment.

Maximum character limit is 32766 including spaces.