ACT Government | Canberra Health Services

Our reference: **FOI20-13**

Dear

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on **Wednesday 20 May 2020**.

This application requested access to:

> *'I am seeking documents under the Freedom of Information Act 2016 from Canberra Health Services regarding illicit substances at the Adult Mental Health Unit.*
> *Specifically, I am seeking:*
> *1. All reports by staff of illicit substances found and confiscated at the Adult Mental Health Unit between 1 Jan 2019 and today*
> *2. All reports made to police of illicit drugs found on a person at the Adult Mental Health Unit*
> *3. All reports by staff of a person being removed from the Adult Mental Health Unit due to the discovery of an illicit substance*
> *4. Any reports of persons supplying illicit substances within the Adult Mental Health Unit*
> *5. Incident reports of a person overdosing with an illicit substance in their system.'*

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Friday 19 June 2020**.

I have identified 6 documents holding information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to grant partial access to 6 documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Partial Access
I have decided to grant partial access to 6 documents at references 1-6.

Public Interest Factors Favouring Disclosure
The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2.1 (a) (ii) contributes to positive and informed debate on important issues or matters of public interest.

Public Interest Factors Favouring Non-Disclosure
The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2.2 (a) (ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004.*

On balance, I determined some of the information identified is contrary to the public interest as it contains personal health information and I have decided not to disclose this information.

Charges
Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9829 or email HealthFOI@act.gov.au.

Yours sincerely

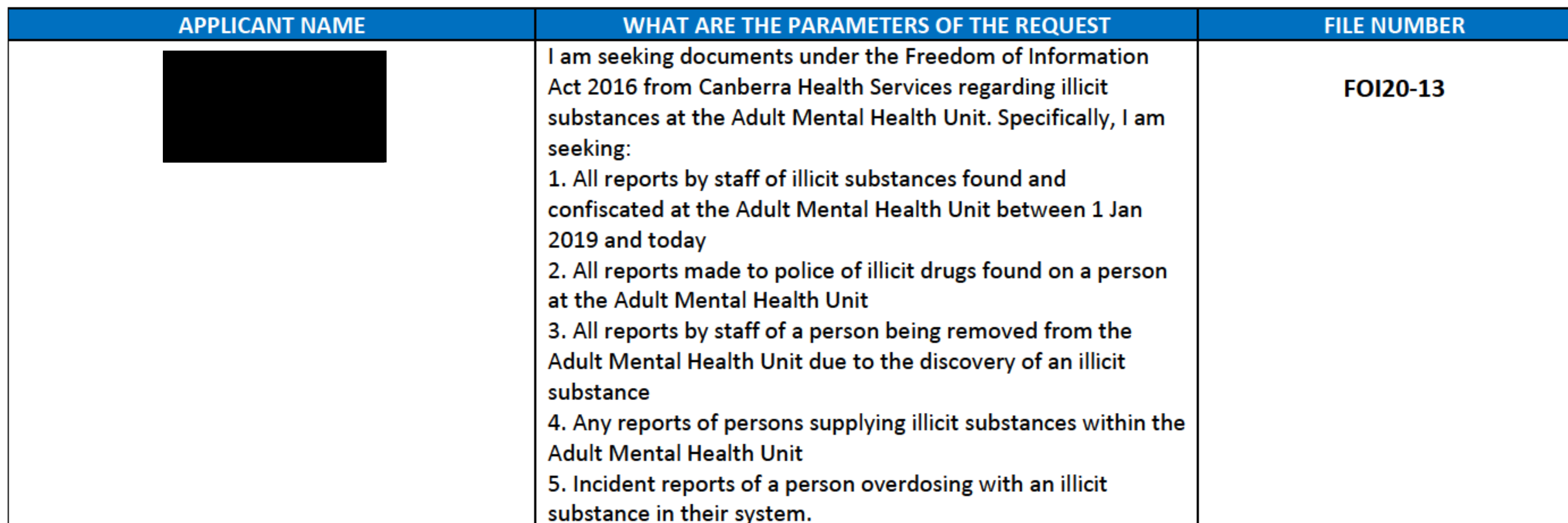
Karen Grace
Executive Director
Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS)

12 June 2020

Canberra Health Services

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at:
http://www.health.act.gov.au/public-information/consumers/freedom-information



APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
	I am seeking documents under the Freedom of Information Act 2016 from Canberra Health Services regarding illicit substances at the Adult Mental Health Unit. Specifically, I am seeking: 1. All reports by staff of illicit substances found and confiscated at the Adult Mental Health Unit between 1 Jan 2019 and today 2. All reports made to police of illicit drugs found on a person at the Adult Mental Health Unit 3. All reports by staff of a person being removed from the Adult Mental Health Unit due to the discovery of an illicit substance 4. Any reports of persons supplying illicit substances within the Adult Mental Health Unit 5. Incident reports of a person overdosing with an illicit substance in their system.	**FOI20-13**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	RM889538	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
2.	RM867316	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
3.	RM892945	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
4.	RM820755	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
5.	RM912679	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
6.	RM934478	RISKMAN report	N/A	Partial release	Section 12 - Contains personal health information and access to this information cannot be provided as the FOI Act does not apply to information held in a health record	Y
Total Number of Documents						

Clinical Incident ID: 889538

Who did the Incident Happen to?

Incident Involved: Mental Health Consumer
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander:
ACTPAS Aboriginal/Torres Strait Islander:

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 17:20
Notification Date: [redacted]

Mental Health ACT

Registered MHJHADS Consumer?: [redacted]
Legal Status of Consumer: [redacted]
Treating Team Last Contact Date: [redacted]
Last Contact Type:
Last MDT Clinical Review Date: [redacted]
ARC Score: [redacted]
Consumer Leave Status: [redacted]
Discharged from Psych Inpt Care In Last 7 Days?: [redacted]
Discharge Date:
Discharge Time:
Incident Reportable to Director of MHJHADS: Not an Incident Reportable to the Executive Director of MHJHADS

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit [redacted]

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No
Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:
Bio Medical Rating:

Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No
Has this pressure injury been correctly classified?: No
Care plan completed & interventions implemented?: No
Interventions & management reviewed as per procedure?: No
Does the patient have an acute critical illness?: No
Is the patient terminally ill?: No
Has patient refused or cannot maintain repositioning?: No
Does patient lack mental capacity and / or refused assessment and is non-compliant?: No
Does the patient have signs of palliative skin changes?: No
Is the pressure injury palliative (>12 months): No
Has patient co morbidity / skin condition contributed to increased risk?: No
Review completed by CNC/CMC: No
Review completed by TVU/Nurse Practitioner: No
Was pressure injury:

What happened in the Incident?

Summary: ███ was found with a tobacco pouch on the ward which had cannabis in it.
Details: ███ returned from leave and ███ reported ███ has smoked cannabis, ███ declined having any prohibited items ███ showed ███ pockets to author and author took matches and filters. ███ room smelt of smoke later that afternoon, ███ again denied having any smoking items and denied smoking in ███ room, author advised it is illegal to smoke inside. ███ was later spotted by author rolling a cigarette outside, ███ handed over ███ tobacco pouch, a lighter, papers and filters. Author opened tobacco pouch to find estimated 20 grams of cannabis, reported this to TL, ███, and pouch stored in medication cupboard on ward.
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: ███
Reporter's Position: Registered Nurse / Midwife
Contact Phone: ███
Reviewed By:
Reviewed By Name:
Responsible Manager:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings:
Investigated By:
Controls Implemented:
Transfer Required:
Coroner Notified: No
Date of Death:
Autopsy performed: No
Time Of Death:
Next Of Kin Notified: No
WorkSafe ACT Notification Date:
WorkSafe ACT Notification Method:
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1 Name: ███
Person #1 Position: Registered Nurse / Midwife
Person #2 Name:
Person #2 Position:
Admitting Specialist: ███
VMO: No
Primary Care Team: Adult Mental Health Unit (AMHU)
Secondary Care Team:

Code Blue/MET?: No
CARE Call?: No
Outcome: Insignificant
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Behavioural | Behavioural | Non-Compliance

Other Body Part:

CARE Call

Field	Value	Field	Value
Date Activated:			
Time Activated:		Time Response Commenced:	
Time of completion:			
CARE Responder:		Specify Other Responder:	
CARE Caller:		Specify Other Caller:	
Primary CARE Reason Activation:		Specify Primary CARE Reason:	
Additional Activation Information:			
MEWS On Arrival:			
Treating team notified prior to activation:	No		
T/L Notified prior to activation?:	No		
Initial Outcome:		Specify Other Initial Outcome:	
24hr Outcome:			
Long Term Outcome:		Date of Hospital Discharge:	
Time of Radiation Oncology Event:		Location of Radiation Oncology Event:	
TMT Site:			
Planned Dose:		Planned Fractions:	
Planned Energy:		Number of Fractions Affected:	
Reflection/Comments from reporting staff:			
Pathway Classification:		Dosimetry Error:	
Consequence Level:			

Is this patient fall:

Field	Value	Field	Value
A current inpatient:	No		
Non inpatient:	No		
Was the 'falls screen/assessment' completed on admission?:			
Was patient 'at risk' of falls prior to the fall?:			
Did the patient have the cognition screen completed on Care Plan? (inpatients only):	No	Details if yes:	
Details of other:			
Was the patient identified with cognitive impairment ?:	No		
Was the fall witnessed by staff?:			
Was the patient on anticoagulant Medication at the time of fall?:			
Has this been documented in the care plan?:	No		
Was the patient checked within the last hour prior to the fall (hourly rounding):	No		
If at risk what falls prevention/management strategies were implemented PRIOR to the fall:	Patient Education		
(Falls Prevention) Other:			
If at risk has any type of restraint (chemical or physical) been used?:	No		
If 'at risk' what management was in place PRIOR to the fall? (non inpatient) :			
(Falls At risk) Other Details:			
Has there been a medical review following fall?:			
If at high risk of falls what falls culprit drugs is the patient on?:			
Was there any tests/imaging the patient has to undergo due to the fall?:			
Did patient suffer any injuries?:			
If yes, list...:		Details of Other:	
Was there a huddle reveiw following the fall?:			
Has carer/family been notified?:			

Has fall been documented in the clinical notes?:

How long before the fall was patient last seen?:

If at Risk has a medication review been completed BEFORE the fall?:

Have falls prevention interventions been modified following the fall?:

Are you aware of the Falls Prevention and Management Procedure?:

Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:

FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Follow-Up Status (NOK):

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No

Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Documents

No Attached Documents.

- End of Record -

Clinical Incident ID: 867316

Who did the Incident Happen to?

Incident Involved: Patient / Client
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander:
ACTPAS Aboriginal/Torres Strait Islander:

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 12:30
Notification Date: [redacted]

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit (AMHU)

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No
Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:
Bio Medical Rating:
Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No
Has this pressure injury been correctly classified?: No
Care plan completed & interventions implemented?: No
Interventions & management reviewed as per procedure?: No
Does the patient have an acute critical illness?: No
Is the patient terminally ill?: No

Has patient refused or cannot maintain repositioning?: No

Does patient lack mental capacity and / or refused assessment and is non-compliant?: No

Does the patient have signs of palliative skin changes?: No

Is the pressure injury palliative (>12 months): No

Has patient co morbidity / skin condition contributed to increased risk?: No

Review completed by CNC/CMC: No

Review completed by TVU/Nurse Practitioner: No

Was pressure injury:

What happened in the Incident?

Summary: Found small amount of greenleafy substance in patients belongings, during property search.

Details: .

SI Details:

Incident Outline:

Date R.O.I. Received:

Date R.O.I. Prepared:

Outline Prepared By:

Origin of Incident Report:

Reporter's Name: [redacted]

Reporter's Position: Registered Nurse / Midwife

Contact Phone: [redacted]

Reviewed By:

Reviewed By Name:

Responsible Manager:

Treatment Given:

Steps Taken By:

Steps Taken: Removed substance, spoke with CNC, signed prohibited substance chart, informed Pharmacy who advised to contact police, same attended. Police number issued - P-1760748

Investigations/Findings:

Investigated By:

Controls Implemented:

Transfer Required:

Coroner Notified: No

Date of Death:

Autopsy performed: No

Time Of Death:

Next Of Kin Notified: No

WorkSafe ACT Notification Date:

WorkSafe ACT Notification Method:

Police Notified?: No

Date of Notification to Insurer:

Insurer Notif Mode:

<u>Personnel Involved</u>

Person #1 Name:

Person #1 Position:

Person #2 Name:

Person #2 Position:

Admitting Specialist: [redacted]

VMO: No

Primary Care Team: Adult Mental Health Unit (AMHU)

Secondary Care Team:

Code Blue/MET?: No

CARE Call?: No

Outcome: Insignificant

Significant Incident Level:

Significant Incident Type:

<u>Contributing Factors</u>

<u>Classification</u>

Behavioural	Criminal Activity (Referred to the Police)	
Behavioural	Substance Abuse	Illicit Drug / Paraphernalia Found on Health Directorate Premises

Other Body Part:

CARE Call

Date Activated:

Time Activated:

Time Response Commenced:

Time of completion:

CARE Responder:

Specify Other Responder:

CARE Caller:

Specify Other Caller:

Primary CARE Reason Activation:

Specify Primary CARE Reason:

Additional Activation Information:

MEWS On Arrival:

Treating team notified prior to activation: No
T/L Notified prior to activation?: No
Initial Outcome:
Specify Other Initial Outcome:
24hr Outcome:
Long Term Outcome:
Date of Hospital Discharge:
Time of Radiation Oncology Event:
Location of Radiation Oncology Event:
TMT Site:
Planned Dose:
Planned Fractions:
Planned Energy:
Number of Fractions Affected:
Reflection/Comments from reporting staff:
Pathway Classification:
Dosimetry Error:
Consequence Level:

Is this patient fall:

A current inpatient: No
Non inpatient: No
Was the 'falls screen/assessment' completed on admission?:
Was patient 'at risk' of falls prior to the fall?:
Did the patient have the cognition screen completed on Care Plan? (inpatients only): No
Details if yes:
Details of other:
Was the patient identified with cognitive impairment ?: No
Was the fall witnessed by staff?:
Was the patient on anticoagulant Medication at the time of fall?:
Has this been documented in the care plan?: No
Was the patient checked within the last hour prior to the fall (hourly rounding): No
If at risk what falls prevention/management strategies were implemented PRIOR to the fall:
(Falls Prevention) Other:
If at risk has any type of restraint (chemical or physical) been used?: No
If 'at risk' what management was in place PRIOR to the fall? (non inpatient)
:
(Falls At risk) Other Details:
Has there been a medical review following fall?:
If at high risk of falls what falls culprit drugs is the patient on?:
Was there any tests/imaging the patient has to undergo due to the fall?:
Did patient suffer any injuries?:
If yes, list...:
Details of Other:
Was there a huddle reveiw following the fall?:
Has carer/family been notified?:
Has fall been documented in the clinical notes?:
How long before the fall was patient last seen?:
If at Risk has a medication review been completed BEFORE the fall?:
Have falls prevention interventions been modified following the fall?:
Are you aware of the Falls Prevention and Management Procedure?:

Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:

FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Open Disclosure Status (Pt/Client):

Debriefing Date (Pt/Client):

Open Disclosure Date (Pt/Client):

Debriefing Time (Pt/Client):

Open Disclosure Time (Pt/Client):

Pt/Client Debriefed By:

Disclosure completed by (Pt/Client):

Open Disclosure Comments (Pt/Client):

Follow-Up Status (NOK):

Open Disclosure Status (NOK):

Debriefing Date (NOK):

Open Disclosure Date (NOK):

Debriefing Time (NOK):

Open Disclosure Time (NOK):

Next Of Kin Debriefed By:

Disclosure completed by (NOK):

Open Disclosure Comments (NOK):

Follow-Up Status (Carer):

Open Disclosure Status (Carer):

Debriefing Date (Carer):

Open Disclosure Date (Carer):

Debriefing Time (Carer):

Open Disclosure Time (Carer):

Carer Debriefed By:

Disclosure completed by (Carer):

Open Disclosure Comments (Carer):

Follow-Up Status (Family):

Open Disclosure Status (Family):

Debriefing Date (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Debriefing Time (Family):

Family Debriefed By:

Disclosure completed by (Family):

Open Disclosure Comments (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No

Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Documents

No Attached Documents.

- End of Record -

Clinical Incident ID: 892945

Who did the Incident Happen to?

Incident Involved: Patient / Client
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander:
ACTPAS Aboriginal/Torres Strait Islander:

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 15:00
Notification Date: [redacted]

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit [redacted]

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No
Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:
Bio Medical Rating:
Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No
Has this pressure injury been correctly classified?: No
Care plan completed & interventions implemented?: No
Interventions & management reviewed as per procedure?: No
Does the patient have an acute critical illness?: No
Is the patient terminally ill?: No
Has patient refused or cannot maintain repositioning?: No
Does patient lack mental capacity and / or refused assessment and is non-compliant?: No

Does the patient have signs of palliative skin changes?:	No	Is the pressure injury palliative (>12 months):	No
Has patient co morbidity / skin condition contributed to increased risk?:	No	Review completed by CNC/CMC:	No
Review completed by TVU/Nurse Practitioner:	No		
Was pressure injury:			

What happened in the Incident?

Summary: Contraband found on consumer.

Details: Consumer was about to be sent on leave to LDU when staff noticed ███ jacket pockets were bulging. Staff asked consumer to empty ███ pockets but when ███ did there was nothing in ███ pockets. Staff asked the security guard to attend so as to search ███, when the security guard arrived, consumer agreed and emptied the inner pockets of ███ jacket. In ███ pocket ███ had ███████. Consumer also had a tobacco bag which was full of green leaf substance not tobacco, ███ also had rolling papers and a pencil sharpener on ███ person.

SI Details:			
Incident Outline:			
Date R.O.I. Received:			
Date R.O.I. Prepared:			
Outline Prepared By:			
Origin of Incident Report:			
Reporter's Name:	███	Reporter's Position:	Registered Nurse / Midwife
Contact Phone:	███		
Reviewed By:		Reviewed By Name:	
Responsible Manager:			
Treatment Given:			
Steps Taken By:			
Steps Taken:			
Investigations/Findings:			
Investigated By:			
Controls Implemented:			
Transfer Required:			
Coroner Notified:	No		
Date of Death:		Autopsy performed:	No
Time Of Death:			
Next Of Kin Notified:	No		
WorkSafe ACT Notification Date:		WorkSafe ACT Notification Method:	
Police Notified?:	No		
Date of Notification to Insurer:		Insurer Notif Mode:	

Personnel Involved

Person #1 Name:		Person #1 Position:	
Person #2 Name:		Person #2 Position:	
Admitting Specialist:	███	VMO:	No
Primary Care Team:	Adult Mental Health Unit (AMHU)	Secondary Care Team:	
Code Blue/MET?:	No		
CARE Call?:	No		
Outcome:	Insignificant		
Significant Incident Level:		Significant Incident Type:	

Contributing Factors

Classification

Behavioural	Substance Abuse	Illicit Drug / Paraphernalia Found on Health Directorate Premises

Other Body Part:

CARE Call

Date Activated:			
Time Activated:		Time Response Commenced:	
Time of completion:			
CARE Responder:		Specify Other Responder:	
CARE Caller:		Specify Other Caller:	
Primary CARE Reason Activation:		Specify Primary CARE Reason:	
Additional Activation Information:			
MEWS On Arrival:			
Treating team notified prior to activation:	No		
T/L Notified prior to activation?:	No		

Initial Outcome:
Specify Other Initial Outcome:
24hr Outcome:
Long Term Outcome:
Date of Hospital Discharge:
Time of Radiation Oncology Event:
Location of Radiation Oncology Event:
TMT Site:
Planned Dose:
Planned Fractions:
Planned Energy:
Number of Fractions Affected:
Reflection/Comments from reporting staff:
Pathway Classification:
Dosimetry Error:
Consequence Level:

Is this patient fall:

A current inpatient: No
Non inpatient: No
Was the 'falls screen/assessment' completed on admission?:
Was patient 'at risk' of falls prior to the fall?:
Did the patient have the cognition screen completed on Care Plan? (inpatients only): No
Details if yes:
Details of other:
Was the patient identified with cognitive impairment ?: No
Was the fall witnessed by staff?:
Was the patient on anticoagulant Medication at the time of fall?:
Has this been documented in the care plan?: No
Was the patient checked within the last hour prior to the fall (hourly rounding): No
If at risk what falls prevention/management strategies were implemented PRIOR to the fall:
(Falls Prevention) Other:
If at risk has any type of restraint (chemical or physical) been used?: No
If 'at risk' what management was in place PRIOR to the fall? (non inpatient) :
(Falls At risk) Other Details:
Has there been a medical review following fall?:
If at high risk of falls what falls culprit drugs is the patient on?:
Was there any tests/imaging the patient has to undergo due to the fall?:
Did patient suffer any injuries?:
If yes, list...:
Details of Other:
Was there a huddle reveiw following the fall?:
Has carer/family been notified?:
Has fall been documented in the clinical notes?:
How long before the fall was patient last seen?:
If at Risk has a medication review been completed BEFORE the fall?:
Have falls prevention interventions been modified following the fall?:
Are you aware of the Falls Prevention and Management Procedure?:
Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:

FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Open Disclosure Status (Pt/Client):

Debriefing Date (Pt/Client):

Open Disclosure Date (Pt/Client):

Debriefing Time (Pt/Client):

Open Disclosure Time (Pt/Client):

Pt/Client Debriefed By:

Disclosure completed by (Pt/Client):

Open Disclosure Comments (Pt/Client):

Follow-Up Status (NOK):

Open Disclosure Status (NOK):

Debriefing Date (NOK):

Open Disclosure Date (NOK):

Debriefing Time (NOK):

Open Disclosure Time (NOK):

Next Of Kin Debriefed By:

Disclosure completed by (NOK):

Open Disclosure Comments (NOK):

Follow-Up Status (Carer):

Open Disclosure Status (Carer):

Debriefing Date (Carer):

Open Disclosure Date (Carer):

Debriefing Time (Carer):

Open Disclosure Time (Carer):

Carer Debriefed By:

Disclosure completed by (Carer):

Open Disclosure Comments (Carer):

Follow-Up Status (Family):

Open Disclosure Status (Family):

Debriefing Date (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Debriefing Time (Family):

Family Debriefed By:

Disclosure completed by (Family):

Open Disclosure Comments (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No

Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Documents

No Attached Documents.

- End of Record -

Clinical Incident ID: 820755

Who did the Incident Happen to?

Incident Involved: Mental Health Consumer
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander:
ACTPAS Aboriginal/Torres Strait Islander:

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 12:50
Notification Date: [redacted]

Mental Health ACT

Registered MHJHADS Consumer?: [redacted]
Legal Status of Consumer: [redacted]
Treating Team Last Contact Date:
Last Contact Type:
Last MDT Clinical Review Date:
ARC Score: [redacted]
Consumer Leave Status: [redacted]
Discharged from Psych Inpt Care In Last 7 Days?: [redacted]
Discharge Date:
Discharge Time:
Incident Reportable to Director of MHJHADS: Not an Incident Reportable to the Executive Director of MHJHADS

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit (AMHU)

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No
Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:

Bio Medical Rating:
Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No

Has this pressure injury been correctly classified?: No

Care plan completed & interventions implemented?: No

Interventions & management reviewed as per procedure?: No

Does the patient have an acute critical illness?: No

Is the patient terminally ill?: No

Has patient refused or cannot maintain repositioning?: No

Does patient lack mental capacity and / or refused assessment and is non-compliant?: No

Does the patient have signs of palliative skin changes?: No

Is the pressure injury palliative (>12 months): No

Has patient co morbidity / skin condition contributed to increased risk?: No

Review completed by CNC/CMC: No

Review completed by TVU/Nurse Practitioner: No

Was pressure injury:

What happened in the Incident?

Summary: Consumer was found with [redacted] partner [redacted]. in the courtyard attempting to smoke an unknown substance with a glass pipe. Pipe was taken from consumer and [redacted] partner was escorted out of the unit.

Details: .
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: [redacted]
Reporter's Position: Registered Nurse / Midwife
Contact Phone: [redacted]
Reviewed By:
Reviewed By Name:
Responsible Manager:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: [redacted] - CNC to discuss with RN [redacted] (nurse who witnessed). Ongoing.
Investigated By: [redacted]
Controls Implemented: [redacted] - Advised RN [redacted] of potential implications of documenting unwitnessed incidents. Will have similar conversation with RN [redacted].
Discussion with the two nursing staff regarding search policy and expectations of visitors.
No Further
Transfer Required:
Coroner Notified: No
Date of Death:
Autopsy performed: No
Time Of Death:
Next Of Kin Notified: No
WorkSafe ACT Notification Date:
WorkSafe ACT Notification Method:
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1 Name:
Person #1 Position:
Person #2 Name:
Person #2 Position:
Admitting Specialist: [redacted]
VMO: No
Primary Care Team: Adult Mental Health Unit (AMHU)
Secondary Care Team:

Code Blue/MET?: No
CARE Call?: No
Outcome: Minor
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Behavioural	Behavioural	Non-Compliance

Behavioural	Substance Abuse	Illicit Drug / Paraphernalia Found on Health Directorate Premises

Other Body Part:

CARE Call

Date Activated:			
Time Activated:		Time Response Commenced:	
Time of completion:			
CARE Responder:		Specify Other Responder:	
CARE Caller:		Specify Other Caller:	
Primary CARE Reason Activation:		Specify Primary CARE Reason:	
Additional Activation Information:			
MEWS On Arrival:			
Treating team notified prior to activation:	No		
T/L Notified prior to activation?:	No		
Initial Outcome:		Specify Other Initial Outcome:	
24hr Outcome:			
Long Term Outcome:		Date of Hospital Discharge:	
Time of Radiation Oncology Event:		Location of Radiation Oncology Event:	
TMT Site:			
Planned Dose:		Planned Fractions:	
Planned Energy:		Number of Fractions Affected:	
Reflection/Comments from reporting staff:			
Pathway Classification:		Dosimetry Error:	
Consequence Level:			

Is this patient fall:

A current inpatient:	No		
Non inpatient:	No		
Was the 'falls screen/assessment' completed on admission?:			
Was patient 'at risk' of falls prior to the fall?:			
Did the patient have the cognition screen completed on Care Plan? (inpatients only):	No	Details if yes:	
Details of other:			
Was the patient identified with cognitive impairment ?:	No		
Was the fall witnessed by staff?:			
Was the patient on anticoagulant Medication at the time of fall?:			
Has this been documented in the care plan?:	No		
Was the patient checked within the last hour prior to the fall (hourly rounding):	No		
If at risk what falls prevention/management strategies were implemented PRIOR to the fall:			
(Falls Prevention) Other:			
If at risk has any type of restraint (chemical or physical) been used?:	No		
If 'at risk' what management was in place PRIOR to the fall? (non inpatient) :			
(Falls At risk) Other Details:			
Has there been a medical review following fall?:			
If at high risk of falls what falls culprit drugs is the patient on?:			
Was there any tests/imaging the patient has to undergo due to the fall?:			
Did patient suffer any injuries?:			
If yes, list...:		Details of Other:	
Was there a huddle reveiw following the fall?:			

Has carer/family been notified?:
Has fall been documented in the clinical notes?:
How long before the fall was patient last seen?:
If at Risk has a medication review been completed BEFORE the fall?:

Have falls prevention interventions been modified following the fall?:

Are you aware of the Falls Prevention and Management Procedure?:
Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:
FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Debriefing Date (Pt/Client):
Debriefing Time (Pt/Client):
Pt/Client Debriefed By:
Open Disclosure Comments (Pt/Client):

Open Disclosure Status (Pt/Client):
Open Disclosure Date (Pt/Client):
Open Disclosure Time (Pt/Client):
Disclosure completed by (Pt/Client):

Follow-Up Status (NOK):
Debriefing Date (NOK):
Debriefing Time (NOK):
Next Of Kin Debriefed By:
Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):

Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Follow-Up Status (Family):
Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No
Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Date/Time	Journal Entry		Reference	Cost
Journal Type:	General Comments			
Created by:	Incident Classifier, 2			
21 Jan 19 15:23:00	Can the reporter please complete the MHJHADS extension within the notification? Thank you, Incident Management Team.			
	Sent To:		Sent Date:	
	Actioned:	No	Mail Sent On:	
	Linked Document Path:			

Documents

No Attached Documents.

- End of Record -

Clinical Incident ID: 912679

Who did the Incident Happen to?

Incident Involved: Mental Health Consumer
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander:
ACTPAS Aboriginal/Torres Strait Islander:

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 13:45
Notification Date: [redacted]

Mental Health ACT

Registered MHJHADS Consumer?: [redacted]
Legal Status of Consumer: [redacted]
Treating Team Last Contact Date:
Last Contact Type:
Last MDT Clinical Review Date:
ARC Score: [redacted]
Consumer Leave Status: [redacted]
Discharged from Psych Inpt Care In Last 7 Days?: [redacted]
Discharge Date:
Discharge Time:
Incident Reportable to Director of MHJHADS: Not an Incident Reportable to the Executive Director of MHJHADS

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit [redacted]

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No
Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:
Bio Medical Rating:

Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No
Has this pressure injury been correctly classified?: No
Care plan completed & interventions implemented?: No
Interventions & management reviewed as per procedure?: No
Does the patient have an acute critical illness?: No
Is the patient terminally ill?: No
Has patient refused or cannot maintain repositioning?: No
Does patient lack mental capacity and / or refused assessment and is non-compliant?: No
Does the patient have signs of palliative skin changes?: No
Is the pressure injury palliative (>12 months): No
Has patient co morbidity / skin condition contributed to increased risk?: No
Review completed by CNC/CMC: No
Review completed by TVU/Nurse Practitioner: No
Was pressure injury:

What happened in the Incident?

Summary: Consumer was suspected of smoking in the room, consumer declined, after being searched found marijuana, lighters and cigarette butts

Details: When author conducted environment check at approximately 1345 hrs, noticing very strong smell smoke in room [redacted] which is consumer allocated room. the room was searched and found a few cigarette butts on the bench in [redacted] allocated room. Consumer was uncooperative, argumentative and denied smoking in [redacted] room. Consumer was [redacted], wards man and [redacted] nurse , after being searched by [redacted] nurse , found 2 lighters , a pack cigarette butts and a pack of marijuana. Marijuana kept in DD cupboard , lighters and a pack cigarette butts were disposed by STL.

SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: [redacted]
Reporter's Position: Registered Nurse / Midwife
Contact Phone: [redacted]
Reviewed By:
Reviewed By Name:
Responsible Manager:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: Incident occurred on the [redacted]
Green leafy substance suspected of being marijuana located on consumer.
Retrieved and kept in drug safe.
Investigated By: [redacted]
Controls Implemented: Police to be contacted to have cannabis removed, contacted again [redacted] - job logged to collect. [redacted]
Transfer Required:
Coroner Notified: No
Date of Death:
Autopsy performed: No
Time Of Death:
Next Of Kin Notified: No
WorkSafe ACT Notification Date:
WorkSafe ACT Notification Method:
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1 Name:
Person #1 Position:
Person #2 Name:
Person #2 Position:
Admitting Specialist: [redacted]
VMO: No
Primary Care Team: Adult Mental Health Unit (AMHU)
Secondary Care Team:
Code Blue/MET?: No
CARE Call?: No
Outcome: Minor
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Behavioural	Behavioural	Non-Compliance
Behavioural	Substance Abuse	Illicit Drug / Paraphernalia Found on Health Directorate Premises
Non Clinical/Facility	Hazards	

Other Body Part:

CARE Call

Date Activated:

Time Activated:

Time Response Commenced:

Time of completion:

CARE Responder:

Specify Other Responder:

CARE Caller:

Specify Other Caller:

Primary CARE Reason Activation:

Specify Primary CARE Reason:

Additional Activation Information:

MEWS On Arrival:

Treating team notified prior to activation: No

T/L Notified prior to activation?: No

Initial Outcome:

Specify Other Initial Outcome:

24hr Outcome:

Long Term Outcome:

Date of Hospital Discharge:

Time of Radiation Oncology Event:

Location of Radiation Oncology Event:

TMT Site:

Planned Dose:

Planned Fractions:

Planned Energy:

Number of Fractions Affected:

Reflection/Comments from reporting staff:

Pathway Classification:

Dosimetry Error:

Consequence Level:

Is this patient fall:

A current inpatient: No

Non inpatient: No

Was the 'falls screen/assessment' completed on admission?:

Was patient 'at risk' of falls prior to the fall?:

Did the patient have the cognition screen completed on Care Plan? (inpatients only): No

Details if yes:

Details of other:

Was the patient identified with cognitive impairment ?: No

Was the fall witnessed by staff?:

Was the patient on anticoagulant Medication at the time of fall?:

Has this been documented in the care plan?: No

Was the patient checked within the last hour prior to the fall (hourly rounding): No

If at risk what falls prevention/management strategies were implemented PRIOR to the fall:

(Falls Prevention) Other:

If at risk has any type of restraint (chemical or physical) been used?: No

If 'at risk' what management was in place PRIOR to the fall? (non inpatient) :

(Falls At risk) Other Details:

Has there been a medical review following fall?:

If at high risk of falls what falls culprit drugs is the patient on?:

Was there any tests/imaging the patient has to undergo due to the fall?:

Did patient suffer any injuries?:

If yes, list...:

Details of Other:

Was there a huddle reveiw following the fall?:

Has carer/family been notified?:

Has fall been documented in the clinical notes?:

How long before the fall was patient last seen?:

If at Risk has a medication review been completed BEFORE the fall?:

Have falls prevention interventions been modified following the fall?:

Are you aware of the Falls Prevention and Management Procedure?:

Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:

FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Open Disclosure Status (Pt/Client):

Debriefing Date (Pt/Client):

Open Disclosure Date (Pt/Client):

Debriefing Time (Pt/Client):

Open Disclosure Time (Pt/Client):

Pt/Client Debriefed By:

Disclosure completed by (Pt/Client):

Open Disclosure Comments (Pt/Client):

Follow-Up Status (NOK):

Open Disclosure Status (NOK):

Debriefing Date (NOK):

Open Disclosure Date (NOK):

Debriefing Time (NOK):

Open Disclosure Time (NOK):

Next Of Kin Debriefed By:

Disclosure completed by (NOK):

Open Disclosure Comments (NOK):

Follow-Up Status (Carer):

Open Disclosure Status (Carer):

Debriefing Date (Carer):

Open Disclosure Date (Carer):

Debriefing Time (Carer):

Open Disclosure Time (Carer):

Carer Debriefed By:

Disclosure completed by (Carer):

Open Disclosure Comments (Carer):

Follow-Up Status (Family):

Open Disclosure Status (Family):

Debriefing Date (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Debriefing Time (Family):

Family Debriefed By:

Disclosure completed by (Family):

Open Disclosure Comments (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No

Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Date/Time	Journal Entry		Reference	Cost
Journal Type:	General Comments			
Created by:	Incident Classifier, 1			
13 Jan 20 12:03:00	Can the reporter please complete the MHJHADS extension within the notification? Thank you, Incident Management Team.			
	Sent To:		Sent Date:	
	Actioned:	Yes	Mail Sent On:	
	Linked Document Path:			

Documents

No Attached Documents.

- End of Record -

Clinical Incident ID: 934478

Who did the Incident Happen to?

Incident Involved: Patient / Client
Medical Record #: [redacted]
First Name: [redacted]
Surname: [redacted]
Date of Birth: [redacted]
Age: [redacted]
Gender: [redacted]
Street: [redacted]
Suburb/City: [redacted]
Postcode: [redacted]
Country:
Diagnosis/Presenting Problems:
Patient Status:
Transferred From:
Aboriginal/Torres Strait Islander: [redacted]
ACTPAS Aboriginal/Torres Strait Islander: [redacted]

When did the Incident Occur?

Admission Date:
Incident Date: [redacted]
Incident Time: 15:00
Notification Date: [redacted]

Where did the Incident Occur?

Work Unit (incidents): HCHS 62240
Division (incidents): Mental & Justice Health, Alcohol & Drug Services
Section (incidents): Adult Acute Mental Health Services
Sub section (incidents): Adult Mental Health Unit (AMHU)
Physical Location: Adult Mental Health Unit [redacted]

Is this one of the following common Incident Types

Wound?:
Fall?: No
Medical Devices?: No
Sterilising Services?: No
Radiation Oncology?: No

Medical Devices

Has the equipment/consumables been isolated?: No

Has the environment been isolated?: No
Has the BME been called to investigate (Phone 62 443043): No
patient/environment: No
Equipment Name:
GMDN Number:
GMDN Description:
Asset/Control Number:
Manufacturer/Brand Name:
Model Number:
Serial Number:
Purchase Date:
Description of the fault of the device:
Bio Medical Rating:
Blank (Drop down list):
Blank (Free text):

Tissue Viability / Nurse Practitioner / CNC Review

If significant facility acquired, has clinical review been completed?: No
Has this pressure injury been correctly classified?: No

Care plan completed & interventions implemented?: No
Interventions & management reviewed as per procedure?: No
Does the patient have an acute critical illness?: No
Is the patient terminally ill?: No
Has patient refused or cannot maintain repositioning?: No
Does patient lack mental capacity and / or refused assessment and is non-compliant?: No

Does the patient have signs of palliative skin changes?: No

Is the pressure injury palliative (>12 months): No

Has patient co morbidity / skin condition contributed to increased risk?: No

Review completed by CNC/CMC: No

Review completed by TVU/Nurse Practitioner: No

Was pressure injury:

What happened in the Incident?

Summary:

A few minutes after arrival, due to suspicion of intoxication and previous history of having contraband, staff performed a search on [redacted] had not left the de-escalation area or had contact with any other persons. permission obtained from Dr L.

During the search, [redacted] also had 2 zip lock bags (1 containing a substance that looks like cannabis) and a lighter down [redacted] underwear.

AFP Comms. Sgt H. informed by phone and email to AFP communications.
The same Patrol will be attended to collect the substance, [redacted].

Staff present:(see SI Details section)

Details:

SI Details: [redacted] Dr L.
AFP Comms. [redacted] = H.

Staff present:
[redacted] RN
[redacted] RN
[redacted] RN
[redacted] (wardsman)
[redacted] (wardsman)

Incident Outline:

Date R.O.I. Received:

Date R.O.I. Prepared:

Outline Prepared By:

Origin of Incident Report:

Reporter's Name: [redacted]

Reporter's Position: Registered Nurse / Midwife

Contact Phone: [redacted]

Reviewed By:

Reviewed By Name:

Responsible Manager:

Treatment Given:

Steps Taken By:

Steps Taken:

Investigations/Findings:

Investigated By:

Controls Implemented:

Transfer Required:

Coroner Notified: No

Date of Death:

Autopsy performed: No

Time Of Death:

Next Of Kin Notified: No

WorkSafe ACT Notification Date:

WorkSafe ACT Notification Method:

Police Notified?: No

Date of Notification to Insurer:

Insurer Notif Mode:

Personnel Involved

Person #1 Name:

Person #1 Position:

Person #2 Name:

Person #2 Position:

Admitting Specialist: [redacted]

VMO: No

Primary Care Team: Adult Mental Health Unit (AMHU)

Secondary Care Team:

Code Blue/MET?: No
CARE Call?: No
Outcome: Minor
Significant Incident Level: | Significant Incident Type:

Contributing Factors

Classification

Non Clinical/Facility	Facility - Security	[redacted] on Health Directorate Premises
Non Clinical/Facility	Hazards	Other

Other Body Part:

CARE Call

Date Activated:
Time Activated: | Time Response Commenced:
Time of completion:
CARE Responder: | Specify Other Responder:
CARE Caller: | Specify Other Caller:
Primary CARE Reason Activation: | Specify Primary CARE Reason:

Additional Activation Information:

MEWS On Arrival:
Treating team notified prior to activation: No
T/L Notified prior to activation?: No
Initial Outcome: | Specify Other Initial Outcome:
24hr Outcome:
Long Term Outcome: | Date of Hospital Discharge:
Time of Radiation Oncology Event: | Location of Radiation Oncology Event:
TMT Site:
Planned Dose: | Planned Fractions:
Planned Energy: | Number of Fractions Affected:
Reflection/Comments from reporting staff:
Pathway Classification: | Dosimetry Error:
Consequence Level:

Is this patient fall:

A current inpatient: No
Non inpatient: No
Was the 'falls screen/assessment' completed on admission?:

Was patient 'at risk' of falls prior to the fall?:
Did the patient have the cognition screen completed on Care Plan? (inpatients only): No | Details if yes:
Details of other:
Was the patient identified with cognitive impairment ?: No
Was the fall witnessed by staff?:
Was the patient on anticoagulant Medication at the time of fall?:

Has this been documented in the care plan?: No
Was the patient checked within the last hour prior to the fall (hourly rounding): No
If at risk what falls prevention/management strategies were implemented PRIOR to the fall:
(Falls Prevention) Other:
If at risk has any type of restraint (chemical or physical) been used?: No

If 'at risk' what management was in place PRIOR to the fall? (non inpatient)
:
(Falls At risk) Other Details:
Has there been a medical review following fall?:

If at high risk of falls what falls culprit drugs is the patient on?:
Was there any tests/imaging the patient has to undergo due to the fall?:
Did patient suffer any injuries?:
If yes, list...:
Details of Other:
Was there a huddle reveiw following the fall?:
Has carer/family been notified?:
Has fall been documented in the clinical notes?:
How long before the fall was patient last seen?:
If at Risk has a medication review been completed BEFORE the fall?:
Have falls prevention interventions been modified following the fall?:
Are you aware of the Falls Prevention and Management Procedure?:
Have you accessed the Falls Prevention and Management Procedure within the past 12 months?:
FOLLOWING CLINICAL REVIEW OUTCOME OF FALL (Committee use only):

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):
Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Open Disclosure Status (NOK):
Debriefing Date (NOK):
Open Disclosure Date (NOK):
Debriefing Time (NOK):
Open Disclosure Time (NOK):
Next Of Kin Debriefed By:
Disclosure completed by (NOK):
Open Disclosure Comments (NOK):
Follow-Up Status (Carer):
Open Disclosure Status (Carer):
Debriefing Date (Carer):
Open Disclosure Date (Carer):
Debriefing Time (Carer):
Open Disclosure Time (Carer):
Carer Debriefed By:
Disclosure completed by (Carer):
Open Disclosure Comments (Carer):
Follow-Up Status (Family):
Open Disclosure Status (Family):
Debriefing Date (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Debriefing Time (Family):
Family Debriefed By:
Disclosure completed by (Family):
Open Disclosure Comments (Family):

Refer to Patient Safety Team

Refer to Patient Safety Team: No
Date referred to Patient Safety Team:

Comments

Transfer data to SAIR Register:

Journal Entries

Date/Time	Journal Entry	Reference	Cost
Journal Type:	General Comments		
Created by:	Incident Classifier, 1		
08 Apr 20 17:04:00	[redacted] . Thank You IMT.		
	Sent To:	Sent Date:	
	Actioned: Yes	Mail Sent On:	
	Linked Document Path:		

Documents

No Attached Documents.

- End of Record -