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District Health Board

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30 May 2022

Dear

Re: Official Information Act

I am responding on behalf of Taranaki District Health Board (DHB) to your OIA request of 5 April 2022, which was transferred to Taranaki DHB on 5 May 2022 by the Ministry of Health. You have requested the following information:

I would like to request access to each DHBs Risk Register as it stands at the 5 of April 2022.

Please find the information requested in the attached document - 2022-05 TDHB Risk Register.

I trust this information answers your OIA request.

Kind regards

Katy Sheffield
Acting Chief Operating Officer

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Taranaki DHB - Risk Register - As at April 2022 (Active Risks only)

Our reference	Title	Risk Type	Risk Subtype	Department/Location	Risk level (current)	Risk level (Target)	Risk review date	Concise summary of the risk	Controls in place
4309	Nikau and Kowhai Beds identified as potential ligature hazard	Health and Safety Hazards	Environmental	TDHB Te Puna Waiora	Extreme	Extreme	*TBC*	Clients are admitted to TPW for various reasons - one being acute suicidality. Often high risk clients are placed in Rimu until the acute risk for suicide has passed but a clients level of suicidality may increase/ decrease for various reasons. Nikau and kowhai have standard hospital beds in their bedrooms . It has been identified that these beds have multiple ligature points that clients could use as means to suicide , one of the possible outcomes is death	All clients are assessed regularly in terms of risk and the level of observation required . there is a range of observation levels ranging from 1-1 eyesight, arms length , to less frequent observation
3823	Transport event	Workforce	Health & Safety	TDHB Executive Management	Extreme	*TBC*	30/09/2021	Harm arising from work related travel and transport. Includes motor vehicle, air transport and risks arising from operation in and around a heliport	Programme of work yet to commence. Review required of current helicopter landing procedures, and driver training requirements
3818	Violence and Aggression	Workforce	Health & Safety	TDHB Executive Management	Extreme	Moderate	30/09/2021	Risk of suffering harm from physical, verbal or sexual assault	Security programme of work identified. Approval for consultant to provide security roadmap commencing early 2021.
3340	Transport Events	Health and Safety Hazards		TDHB Hospital Services Management	Extreme	Moderate	11/06/2020	Harm arising from work-related travel and transport. Includes motor vehicle, air transport and risks arising form helicopter operations	Driving Licence provided to Motor pool supervisor Vehicle maintenance plan Transport Services - information for vehicle users handbook Transport Policy - use of company vehicles
3724	Incorrect or outdated policies and procedures	Organisation Reputation/Governance	Communication and Information	TDHB Executive Management	Major	Moderate	27/07/2021	Events could occur that may cause harm, financial loss etc due to following incorrect or outdated policies and procedures	- Individual ownership of policy reviews - Selected staff able to publish onto WILSON reduced
3733	Privacy	Organisation Reputation/Governance	Compliance	TDHB Executive Management	Major	Major	29/07/2021	Privacy breaches from human error and/or unauthorised access leads to reputational damage or breach of obligations	Regular education including annual refresher
3571	Bed steering mechanism	Health and Safety Hazards	Equipment	TDHB Emergency Department (ED)	Major	Moderate	30/05/2022	Transfer nurse sustained back injury involving time off work. States steering mechanism broken on 'lots' of beds in ED which makes it very difficult to steer beds during transfer.	Where possible transfer patients on beds with steering mechanism and/or utilise an orderly to assist
4037	Access to MHSOP area - narrow and hindered by metal poles , sloping floor which are trip hazards	Health and Safety Hazards	Hazards	TDHB Te Puna Waiora	Major	Major	*TBC*	Sloping floors at multiple entry & exit points to the conservatory area between Rimu and MHSOP create a trip hazard to elderly patients. 2 station posts also create an issue when staff need to move patient beds, and also create a risk of further harm if someone falls and comes in to contact with the post during a fall. There could be an issue during medical emergencies with staff trying to get around the poles with the crash trolley - this could delay emergency treatment . Some clients are having regular ECT and the beds don't fit between the MHSOP doors due to the poles - in these cases , clients are taken in their beds via Rimu, which could be potentially unsafe due to the likelihood of having volatile/ unwell clients there (secure unit) Risk of injury from a fall by an elderly person is high and could result in admission to hospital for fractures or head injury	Beds can be wheeled through Rimu but this could be potentially unsafe due to potential of having acutely unwell / volatile clients. potential for staff and clients to be injured Hazard tape on uneven surfaces
2268	Hostel fire risk	Health and Safety Hazards	Hazards	TDHB Hostel/Accommodation	Major	Major	27/03/2019	The 3rd and 4th floors of the Barrett Building (Building 125A) is used as a Hostel for visiting Doctors, Nurses other staff and students. Although fitted with a fire alarm the building lacks any sprinkler system. Currently as many as 50 people can be sleeping in this facility. This is a serious fire risk. All other wards units where patient stay overnight in the Hospital are fitted with sprinkler protection systems but not the hostel where apparently it is not a legal requirement.	Fire alarms and some hose reels and fire extinguishers exist in the Barrett Block. Sprinklers requested but cost and budget have meant little prospect of being progressed. Also long term (to 2032) plans show hostel being demolished and replace by gardens and public car parking.
4038	Uneven Patient Floor Increases Fall Risk	Health and Safety Hazards	Hazards	TDHB Te Puna Waiora	Major	*TBC*	*TBC*	Floor in MHSOP bathroom is uneven and creates a risk of patient &/or staff fall. There is a an immediate incline slope at the entrance to the bathroom which them slopes of in the opposite direction. The installed handrail is design for sitting & standing assistance, There is no hand rail to assist with mobility.	*Remediation to be confirmed in due course.*

3973	A TDHB employee or visitor is harmed by a patient or visitor in ED	Workforce	Health & Safety	TDHB Emergency Department (ED)	Major	Moderate	12/02/2022	Potential causes: Public turning up to ED with MH conditions Public turning up to ED under the effect of Alcohol or drugs Restriction and delays to access into ED (related mainly to COVID-19) Frustration with waiting time Frustration with DHB processes and policies Dissatisfaction with service delivery Dissatisfaction with communication Perceived prejudice and organisational racism or micro-racism Head-injury/trauma	Access to MH treatment plans Access to MH ABC team Quick triage & designated MH assessment room Medical staff to conduct Section 109 Quick triage & designated assessment room Access to A&D case worker Increase staffing and guarding for large events Access to and response by Police ED Lockdown / Restrict access Communication strategy (signs on doors) Tracking of the TTT (time to triage) Tracking of the SSED (6 hour target) Re-direction to GP or afterhours providers Communication of any delays in treatment Communication strategy Documentation Health literacy Effective communication training (de-escalation) TDHB, the Treaty and Me Tikanga best practice Effectively engaging with Maori Access to Maori Health team and increased visibility within ED Clinical policies and guidelines Staff training and assessment skills Security Policy and related procedures in place. Security Guard service in place. staff Training and assessment skills
3424	Autistic/distressed/young-but-mobile children exiting ward unsupervised	Patient Safety	Health & Safety	TDHB Ward 2B Paeds	Major	Moderate	14/04/2023	Hazard: Handles on ward doors are within children's reach leading to Autistic / distressed / young-but-mobile children able to exit their room and walk freely on the ward. Potential consequence : these children may exit the ward/run away without notice, especially when ward is busy.	Mitigation/risk treatment plan: An engineering request was made 17th June 2020 for higher door handles to be installed in 2 rooms so we can have these kept specifically for patients who need extra safety.
3820	Contractor Management	Organisation Reputation/Governance	Health & Safety	TDHB Executive Management	Major	Moderate	3/11/2022	Risk of harm from breakdown or lack of contractor safety management	Contractor Health & Safety programme of work underway. Yet to develop pre-qualification and formalise audit process. Programme to be implemented throughout all areas of DHB
2544	Duress Alarms Risks	Workforce	Health & Safety	TDHB Te Puna Waiora	Major	Moderate	15/04/2021	Duress Alarm system can be inaccurate with location of emergency Duress Alarms Not Being Returned Duress Alarm Batteries going flat	All staff to be trained in use of duress alarms/fobs, on induction/orientation to the ward Individual alarms are checked weekly (Tuesday mornings), be aware that this occurs, however, also check that the alarms that activate on a Tuesday are due to checks and not due to staff requiring assistance Fobs need to have batteries regularly changed as soon as they start beeping with a low battery Alarms need to be placed correctly on the chargers Nurse call bells can be pressed three times to indicate the need for assistance and will also be more reliable to indicate location Be aware that the current system may not reflect on the monitor screen the exact location of the emergency, continue to respond to alarm until the location has been identified (there may be more than one alarm location if more than one incident is occurring) and all staff have been accounted for Alarms and fobs to be kept in locked cupboard in Nikau office - Coordinator to hold the cupboard keys Alarms in Rimu are counted at the end/beginning of each shift Staff to sign alarms in and out to ensure accountability and try to prevent shortage of alarms Batteries for fobs are kept in ward administrators office in a blue container on drawer cabinet Staff to check battery level of alarms when putting on for their shift
3822	Hazardous Substances	Workforce	Health & Safety	TDHB Executive Management	Major	*TBC*	30/03/2022	Risk of harm form exposure to; bulk hazardous substances, chemical reactions, acute or chronic handling exposures - fumes, vapours, gases asphyxiate / medical gases, diesel, petrol, flammable gases	Hazardous substances review underway. Working through completing hazardous substances register to assist in identifying training, storage and signage needs
3825	Lone Workers	Workforce	Health & Safety	TDHB Executive Management	Major	Moderate	30/09/2021	Risk of severity of harm being increased when an incident occurs to a loan or isolated worker	Lone worker programme included in general security review
3553	Risk of reduced service continuity related to Karisma	Service/Business Continuity	Information Systems	TDHB Radiology	Major	Moderate	30/09/2020	Multiple Karisma outages causing interruptions to workflows within the department Significant inefficiencies Associated patient safety risk if administrative or reporting functions are interrupted during outages.	Regional RIS/PACs team working with vendors to try and fix.
4055	Technology changes are unable to be implemented	Service/Business Continuity	Information Systems	TDHB ICT Services	Major	Moderate	14/10/2022	Technology changes are unable to be implemented in a timely manner due to resource constraints, architecture incompatibility or prioritisation	- Resource Allocation Planning - Resource succession planning - Prioritisation Process Business/ICT - Contractor resource - Recruitment process - Retention plans

3723	Business disruption through building damage caused by a natural disaster event	Service/Business Continuity	Infrastructure	TDHB Executive Management	Major	Major	3/11/2022	Business disruption through building damage caused by a natural disaster event	*Mitigation to be determined.*
3771	Medication safety issues on TPW	Patient Safety	Managing Service Delivery	TDHB Te Puna Waiora	Major	Moderate	*TBC*	increased risk of harm to patient from medication prescribing or administration errors.	Clinical Pharmacist ward visits (though now only 3 times a week due to resourcing issues), Nursing staff, Prescribers (although it has been identified that there are some training issues).
3732	Pandemic or Disaster disrupts the Business	Service/Business Continuity	Managing Service Delivery	TDHB Executive Management	Major	Moderate	28/07/2021	A Pandemic or Disaster which disrupts the Business will reduce the staff's capacity to manage that and continue with BAU.	- Up to date Disaster Management Plan
3731	Surgery priority orders realigned	Patient Safety	Managing Service Delivery	TDHB Executive Management	Major	Moderate	28/07/2021	Increased demand on resourcing for surgeries requires realignment of priority orders for waiting lists	active clinical review by surgeons. Threshold review to manage demand. planned care clinical manager in place
4183	Staffing Deficits	Workforce	People/Staff	TDHB Te Puna Waiora	Major	Major	12/05/2022	Currently 7.0 RN FTE short due to staff resignations, staff long term sickness, maternity leave & inability to recruit. Staff are working overtime/double shifts to cover shift gaps with risk of staff burn out and impact on client care.	1. Nikau numbers to remain within capacity. (extra beds removed) 2. Avoid the use of Rimu beds for voluntary clients to help reduce capacity. 3. Increase PA FTE with temp contracts while recruiting to RN FTE to support staffing in Rimu. (instead of 3 RN and 1 PA, 2 RNs and 2-3 PAs).
3725	Medication errors	Patient Safety	Process of Care	TDHB Executive Management	Major	Moderate	27/07/2021	High number of Medication errors may lead to adverse patient outcomes	- Medication Safety Committee (MSC)in place. - Pharmacology and Therapeutics Committees - Antimicrobial Stewardship Committee in place - E-medication reconciliation Quality & Safety Markers in place(HQSC) - Clinical Pharmacists in place.
4056	Strategy, planning and project management	Service/Business Continuity	Strategy/Development and Delivery	TDHB ICT Services	Major	Moderate	14/10/2022	Strategy, planning and project management is not to sufficient standard to move the department or organisation forward	- Project Management SOP - Annual planning - H&SS Digital Request Meetings - ICT Roadmap - Lifecycle Management
2082	Moving and Handling	Health and Safety Hazards			Major	Minimal/minor	1/12/2021	Risk of musculoskeletal injury from manual handling, static holds ans patient handling	Provision of lifting equipment Regular equipment maintenance program Staff are trained to : - use correct patient handling techniques as per ACC guidelines - use safe work practices for object moving and handling - correct use and maintenance of lifting / transferring aids - Report and action repair of malfunctioning equipment - Report incidents and accidents via Datix
2702	Chemical emmissions from heated thermoplastic splinting material	Health and Safety Hazards	Chemical	TDHB ART Team	Moderate	Moderate	*TBC*	Splinting material can emit chemicals when softened	-ensure handtherapy treatment room is well ventilated -avoid prolonged use of heat gun -soften thermoplastic in water bath prior to using heat gun when appropriate
2254	Chemical Exposure	Health and Safety Hazards	Chemical	TDHB LabCare Pathology Service	Moderate	Moderate	1/07/2021	Accidental exposure to hazardous chemicals during laboratory procedures	Staff training and competency program SOP's Use of fume hood PPE
2705	Chemical exposure from pool chemicals/ risk of infection	Health and Safety Hazards	Chemical	TDHB ART Team	Moderate	Moderate	*TBC*	Physiotherapy hydrotherapy pool is accessed by patients. Risk to skin or of infection if chemical levels incorrect	-daily monitoring of pool pH level -notify workshop staff if pH not at correct level -workshop staff responsible for chemical dosing of pool -monthly pool samples sent for biological testing -pre screening of patients for infection risk -pool stand down period of 48 hrs if patient has had diarrhoea or vomitting
2388	Chemotherapy medication	Health and Safety Hazards	Chemical	TDHB Oncology, Haematology & Medical OPD	Moderate	Moderate	1/05/2019	Potential staff exposure to chemotherapy medication when administering the drug to the patient. Potential chemotherapy spill or burst chemotherapy bags.	-Staff fully trained in chemotherapy management -Staff to take their time in chemotherapy preparation -PPE available eg. Nitrile gloves, chemotherapy gowns, eyewear and duck bill respiratory masks -Chemotherapy spill kit -Chemotherapy spill protocol
3000	Cytotoxic Drugs and Spills	Health and Safety Hazards	Chemical	TDHB Pharmacy	Moderate	Moderate	7/07/2021	Exposure to cytotoxic medications while handling, dispensing and delivering in the hospital	-Transportation of Cytotoxic done with 'Chemo Trolley' which contains spill kit. -Cytotoxic spill kit available in pharmacy department and use understood -All staff trained in cytotoxic spill kit procedure by DVD provided by baxters health care -Staff trained in handling and preparing cytotoxic drugs -Avoid susceptible staff -Appropriate PPE available
3438	Increase in the Number Of Section 29 (i.e. unlicensed in NZ) Medicines that we are having to Administer to Patients	Patient Safety	Compliance	TDHB Hospital Services Management	Moderate	Minimal/minor	1/02/2021	With current global medication supply chain issues due to COVID-19 the number of Section 29 medications that we are having to administer to patients has vastly increased. TDHB Section guideline requires that a doctor discusses the use of any Section 29 medication with the patient and gains verbal consent which is then written in the patient's clinical notes. With the vastly increased number of Section 29 medicines now being used, Doctors will not be aware of all of the medicines that require this consent, so it will not be obtained in all cases.	Pharmacy emails to 'Clinical' each time supply of a registered medicine is replaced by a Section 29 supply/brand
3267	Balcony on level 2 Surgical outpatients.	Health and Safety Hazards	Environmental	TDHB Surgical District Nursing	Moderate	*Not reviewed yet*	*TBC*	The balcony on Level 2 Surgical outpatients is too low. The NPDC Building regs state that it must be at least 1100mm if there is a risk of fall of up to 1.8 meters. Also the rails are horizontal which creates a good climbing platform for children.	*Mitigation to be determined.*

4318	Fire Hydrants - Base Hospital	Health and Safety Hazards	Equipment	TDHB Engineering Mtce	Moderate	Minimal/minor	22/04/2022	Fire and Emergency New Zealand (FENZ) had a call-out to old laundry building at Base Hospital, regarding sprinkler fault alarm. FENZ had difficulty in locating the hydrant, as this was not clearly marker per NZ standards. With FENZ safety advisor, reviewed this and other hydrants, noting similar issues (photos taken). One found to be covered in dirt and had to be dug out, majority not marked so difficult to locate, and two marked on layout map moved during construction phase but maps (NPDC and FENZ) not updated.	Hydrant outlets are inspected by Engineering Services. Following retirement of past staff member, inspections have not occurred. Remediation now underway via Emergency Manager.
2706	Risk of injury from unsafe use of gym equipment in physio gym	Health and Safety Hazards	Equipment	TDHB ART Team	Moderate	Minimal/minor	*TBC*	risk of crush injury from weights, recoil injury from wts machine or rower, musculoskeletal injury from incorrect use	-free weights placed in racks after use -regular checks of all equipment for structural integrity as per manufacturers specifications -orientation of new staff to area to include instruction on correct use of gym equipment -damaged equipment taken out of gym area or out of order sign attached, and damage reported to clinical leader or manager -regular engineering check for equipment -be aware of equipment location -put equipment away
2697	Stanley knife - risk of laceration	Health and Safety Hazards	Equipment	TDHB ART Team	Moderate	Moderate	TBC	Stanley knife used to cut splinting material for fabrication of splints	-safe technique -maintain equipment -lay material on flat surface when cutting -never hold knife vertical when scoring -put blade back in cover when done -dispose of old blades in sharps bin
3463	Moving and Handling	Health and Safety Hazards	Ergonomic	TDHB Sonograghers	Moderate	Minimal/minor	*TBC*	Ensure due to the nature of Ultrasound that staff can take breaks and can practice their stretching to help alleviate MSK issues caused by repetitive movements.	Time to allow sonographers to have a break and practice their stretches to mitigate MSK repetitive movement issues.
3200	Driver fatigue	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Moderate	Moderate	14/02/2021	Driving motor vehicles for more than 2 hours or extended hours working and driving.	Before trip - Investigate alternatives to travel - tele/video/WebEx conference attendance - Flying to location - Plan meeting taking into account travel time, time of meeting, how late the return drive will be - Request the meeting at a central location - Familiarise yourself with the route to be taken - Investigate car pooling options - good sleep prior to setting out on journey - plan workload for the next working day to take into account a long journey General - Avoid driving between midnight and 6am - consider the position of the risking and setting sun during the journey - Journeys >3hours each way consider breaking overnight - Adjust driving position before commencing journey - wear suitable comfortable clothing - bring sunglasses for journey - break journey for at least 10 mins every 2 hours. Get out of car at each break - Avoid excess caffine (more than 2 cups), high sugar and high fat foods prior to and during the journey - Pull over in a safe place if feeling sleepy - Nap for no longer than 20 mins if sleepy and ensure safety while asleep (lock doors) Consider training - Defensive driving course - low speed manoeuvres course.
2704	Drowning in physiotherapy pool	Health and Safety Hazards	Hazards	TDHB ART Team	Moderate	Minimal/minor	*TBC*	Patients perform supervised exercise programmes in the physiotherapy pool. There is a risk of drowning if the patient has a medical event or an injury when in the pool	- pts always supervised by a physio staff member while in the pool -barrier in place to prevent patients entering the pool when therapist not present -only 4 pts in the pool at any one time -Pool emergency evacuations practiced 6 monthly -emergency bells tested daily -pool room locked when not being utilised
3197	Innoculation injury (needlestick)	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Moderate	Moderate	1/04/2023	when preparing for, administering or disposing of equipment for vaccination.	Point of use sharps container use Staff training on - no recapping - no bending/ breaking or manipulating needles - sharps container use - vaccination safety Educate patient of process and potential discomfort use of standard precautions should patient bleed. preference for minimal sharps use e.g. pre drawn syringes rather then phials.
3900	Moss on footpath	Health and Safety Hazards	Hazards	TDHB Public Health Support Services	Moderate	Moderate	17/06/2022	Moss on the footpath in front of the Public Health Unit appears every year around winter season. This needs to be sprayed whenever it happens. It is a slipping hazard to staff and clients.	A requisition has been sent to the Engineering workshop advising to spray the moss.
3404	Radiation exposure	Health and Safety Hazards	Hazards	TDHB Radiology	Moderate	Minimal/minor	*TBC*	Risk of unnecessary Radiation exposure to staff due to nature of business.	In compliance with ORS, ESR and MoH, all guidelines are routinely reviewed and policies followed. Monitoring of staff are in place for all staff that work with radiation, with the use of personal monitoring devices.

2073	Slips, Trips & Falls	Health and Safety Hazards	Hazards		Moderate	Minimal/minor	30/06/2022	Injuries sustained from slips, trips and falls. Possible causes: - Wet floors e.g.due to water, spilt food or drink, urine or leaking soap dispensers - Dry floors e.g. due to dust or plastic wrapping - Stairs - Poor footwear choice - Electrical cords - Outside environment e.g. weather, uneven surfaces, lighting - Assisting unsteady patients	- Signage - Uniform Policy (specifying footwear) - Initial Assessment process for community visits - H&S Audit - Lights in car park - Electrical Policy
2699	Splint bath - risk of burns/scalds	Health and Safety Hazards	Hazards	TDHB ART Team	Moderate	Moderate	*TBC*	Splint bath used by handtherapists fabricating customised splints for patients. Risk of burns or scald to skin when using	-care when placing items in and out of splint pan -remove items with a spatula
2574	Staff working autonomously in the community	Health and Safety Hazards	Hazards	TDHB Renal Unit	Moderate	Moderate	10/06/2021	Potential risk to staff working in the community on their own eg. patient homes, satellite clinics or driving in the community.	- Staff are to ensure that when departing from DHB site telephonists are contacted regarding travel plan and location eg. Waitara rooms, Stratford. - Cell phones to be carried at all times. - Staff to be familiar with surroundings (contingency plan if situation arose) - Staff to notify telephonist if she is alone in a centre (safety).
2504	Security - violent/aggressive individuals	Workforce	Health & Safety	TDHB Te Puna Waiora	Moderate	Moderate	28/10/2022	Staff interaction with aggressive patients and/or visitors, inclusive of altercations between patients	Staff trained in de-escalation and SPEC, including appropriate use of Rimu/Pods/Seclusion Staff to attend regular refreshers in SPEC and de-escalation techniques at least every 18 months Staff trained in how to contact 111 through TDHB operators All staff trained in use of duress alarms and fobs - alarms/fobs must be worn while on duty Staff to carry out Risk Assessments of patients on arrival to ward and throughout admission. Clearly document any identified risks in patients care-plan/notes and verbally communicate these at shift handovers As per ward policy, search patients and their belongings on admission and on return from leave. Remove any items that could be of harm (eg Steel cap boots, Razor blades) Staff to be fully orientated to Rimu and to be aware of Rimu specific protocols Staff to report incidents both in client records and on Datix form - debrief to be encouraged Staff to be trained and actively use sensory modulation techniques and equipment to avoid aggressive behaviours exhibiting Staff know to: Report incidents/accidents and develop and implement control plan How to contact Police Secure access to all facilities out of hours Security officer on-site 24/7 Refer to: Security Policy Community Security Policy Restraint protocol Rimu specific Policies
3557	Data Migration	Service/Business Continuity	Information Systems	TDHB Radiology	Moderate	Minimal/minor	28/05/2021	Imaging has not been migrated over yet for the last 10 yrs. Only 2 yrs worth of imaging has been migrated onto new system. Lack of resources from vendors end has delayed this. Poses massive clinical risk for clinicians.	Local RIS/PACS team pull across imaging when requested by clinicians.
3554	Datix 90848 SMS incorrect information	Service/Business Continuity	Information Systems	TDHB Radiology	Moderate	Minimal/minor	30/09/2020	SMS in correct information being sent out during Lockdown. Confusing and upsetting for patients and staff alike.	RIS/PACS team able to check logs when issues occur.
2507	Duress Alarm system can be inaccurate with location of emergency	Service/Business Continuity	Information Systems	TDHB Te Puna Waiora	Moderate	Moderate	3/10/2022	Alarms alerting others to the need for emergency assistance can be inaccurate with the location that assistance is required	All staff to be trained in use of duress alarms/fobs, on induction/orientation to the ward Individual alarms are checked weekly (Tuesday mornings), be aware that this occurs, however, also check that the alarms that activate on a Tuesday are due to checks and not due to staff requiring assistance Fobs need to have batteries regularly changed as soon as they start beeping with a low battery Alarms need to be placed correctly on the chargers Nurse call bells can be pressed three times to indicate the need for assistance and will also be more reliable to indicate location Be aware that the current system may not reflect on the monitor screen the exact location of the emergency, continue to respond to alarm until the location has been identified (there may be more than one alarm location if more than one incident is occurring) and all staff have been accounted for update: 21.1.2021 System has been reviewed and location of sensors renamed to match areas more accurately.

2505	Risk of Fire	Financial	Infrastructure	TDHB Te Puna Waiora	Moderate	Moderate	3/10/2022	Use of TPW Use of electrical equipment Use and storage of oxygen cylinders and flammable liquids Use of cigarette lighters and matches, intentional lighting of fires by unwell clients Client/visitor smoking within hospital grounds/buildings	High standard of housekeeping - rubbish disposed of and removed regularly, rooms tidy, garden litter removed Security to patrol building and grounds All electrical equipment brought into the ward to be tested and certified before use, and retested annually. Equipment with frayed or damaged cords to be repaired or replaced Air conditioning system to be checked and vents cleaned Clothes dryer to be cleared of lint after every use Flammable liquids and gases stored appropriately and locked away Staff trained in use, risks and storage of cylinders If a client is having oxygen administered (eg for nebuliser) staff to constant client while this occurs Staff to monitor client activities and assess risk, if client has a history of arson, client to be on 15/60 obs (minimum) and any lighters or matches removed and kept in property drawer in office Emergency equipment - hose reels and portable extinguishers available and their positions marked Inspection of extinguishers to confirm they are present and in good condition Servicing and testing of extinguishers Staff to be trained in the use of fire hoses and portable extinguishers and selection of appropriate form of extinguisher Staff to be aware of automatic fire detection systems and how to activate the fire alarms (NB TPW are different to other areas as the alarms are key activated) Staff to be educated re evacuation procedures Fireboards to be kept up to date by night shift staff Smoking is not permitted on TDHB grounds or in buildings - if a client is covertly smoking in building, search client/property and remove lighters and tobacco (place in property drawer) Staff to educate clients about smoking restrictions and to encourage use of NRT to reduce cravings (and likelihood of covert smoking)
4053	Resourcing/knowledge capability	Workforce	Knowledge/Skills/Competence	TDHB ICT Services	Moderate	Moderate	14/10/2022	Resourcing/knowledge capability is unable to be obtained which puts critical functions or processes at risk of failing	Weekly resourcing meeting training/upskilling Annual planning Budgeting Strategic planning Recruitment Onboarding processes - Capabilities matrix - Contractors - Succession planning - standard operating procedures - Knowledge base - Project management - lists
3563	Aging equipment	Service/Business Continuity	Managing Service Delivery	TDHB Radiology	Moderate		30/09/2021	Radiology equipment at Base, Hawera, Waitara and Stratford is all over due replacement with the exception of a couple of pieces of equipment at Base (the angio suite, Room 2 and a couple of Ultrasound machines). The equipment ages range from 4 yrs old (angio and Rm 2)to 24 yrs old. Much of the equipment has surpassed its life expectancy. MRI is the oldest in the country, image quality is now classed as substandard, due to its age we can no longer upgrade the software. Parts are difficult to source.It is not efficient. It will not last until we move into the new build. Two Image intensifiers have both ready for replacement, the cost for repair, down time and knock on effects for theatre. The image quality is poor. These will not last until we move to the new build. Nuclear Medicine has reached end of service and will need to be replaced before we move into the new building. The x ray rooms need to be addressed, not only at Base but across the sites. Waitara now no longer has a service contract as it has expired. We need to be able to serve our community with fully functional, efficient equipment. Our oldest mobile x ray unit is 24yrs old.	Routine maintenance, annual QHP checks, QA performed as per the QHP requirements. CT and MR being replaced in June/July by new equipment
3354	Delay in reporting of x rays	Patient Safety	Managing Service Delivery	TDHB Radiology - General	Moderate	Minimal/minor	7/05/2021	Considerable delay in the reporting of a plain film x ray attributed to deficit in FTE for Radiologists.	Am able to visualise numbers of outstanding imaging requiring reporting across all modalities on Karisma, this is available to all Radiologists. The outstanding reporting is discussed with the HOD and additional out of hours reporting occurs for all modalities. Work that cannot be completed in a timely fashion is then outsourced.
3834	Hepatology/Gastroenterology service	Patient Safety	Managing Service Delivery	TDHB Oncology, Haematology & Medical OPD	Moderate	Moderate	30/05/2022	Delayed patient follow up due to service demands accross Gastroenterology and Hepatology.	Waitlists have been developed to make workload manageable for hepatology nurse.

3794	Mulitple Surgical leadership roles not filled leading to gaps in service provision	Workforce	Managing Service Delivery	TDHB Nursing Director	Moderate	Minimal/minor	16/06/2022	• Safe staffing - currently responsibility of Nurse Manager – Surgical Services as well as existing NM role. This is person dependant and unable to be rotated. Safe staffing programme should be implemented by June 2021 and curremt estimates are that we are 60% achieved. • Nurse Manager is reactive rather than pro actively managing Surgical issues with any depth. • Nurse Manager – OT – multiple reports due to lack of next line leadership role. The periopertative project is on-going. • We currently have no Director of Nursing and the ADONs are covering for this role and operational responsibilities.	See above. perioperative project on-going. Care Capacity Demand Management Nurse Manager role appointed into. DON role realigned - professional lead and workforce lead appointed. Perioperative project ongoing - leadership review underway NM Surgical appointed into temporarily
3419	St John Ambulance availability in South Taranaki for emergency maternal and neonatal episodes	Patient Safety	Managing Service Delivery	TDHB Hawera Maternity	Moderate	Minimal/minor	30/07/2022	St John availability in South Taranaki is dependent on logistics of where the vehicles in the district are at the time of the emergency and availability and safety of crew	Interhospital transfer protocol Training for Hawera staff for emergency situations and calls auditing of 777 calls 0800 My baby phone number that all pregnant women are given by their LMC's in case of emergency need if no credit on phone and importance of heading to Taranaki base and not Hawera Maternity if high risk women booked to birth at base or if antenatal and emergency situation such as APH St Joh 6 years ago that if women are high risk in community, LMC can advise of womans name number and address so this can be flagged and response teams see the urgency which will save delays and especially when women insist on going to Hawera ED or maternity
3730	Staff absenteeism	Workforce	Managing Service Delivery	TDHB Executive Management	Moderate	Minimal/minor	27/07/2021	Increased staff absenteeism could affect the quality of care delivered	- Daily MOPS meeting - Twice daily safety huddle with staff - Daily situational update to provided to Duty Managers and HLT - Prioritised recruitment of relief staff including Psychiatric - Assistants supported by specific induction training - Staff wellbeing sessions implemented. Safe staffing programme of work
3916	ongoing staff deficits, increasing staff fatigue	Workforce	People/Staff	TDHB Ward 3B Ortho	Moderate	Minimal/minor	10/07/2022	*3B recruited 100% to current budget* ward often not staffed to acuity with an inability for pool to cover requirements as multiple deficits hospital wide. Staff regularly phoned on days off - interrupting their rest time, or staff on duty asked to do 12 hour shifts. ward budget for 1 HCA, when acuity rises a 2nd HCA not always available due to increased number of close care patients hospital wide. staff are reporting fatigue, decreased job satisfaction, back pain.	1030 meetings - however often answer is to fill own gap, we do not have a supply of our own casuals and staff are entitled to uninterrupted breaks from work. encouraging team work, staying strong together. Annual FTE methodology as per CCDM Monthly TrendCare scorecard CNM often works on floor / backfills - short term control
3564	Reduced Radiologist FTE	Workforce	People/Staff	TDHB Radiology	Moderate	Minimal/minor	30/09/2021	Decreased Radiologists FTE, need too utilise outsourcing of reporting to reduce clinical risk. Department at times may have 1 Radiologist covering 2 modalities.	Have all radiologists on site. Limit leave to 2 Radiologists on leave at a time. Outsourcing out of hours reporting, utilising this for the day reporting too.
3357	Hepatatis B in Pregnancy Pathway adherence	Patient Safety	Process of Care	TDHB Maternity	Moderate	Minimal/minor	12/05/2022	Incidents 58024 and 89574 resulting in one baby becoming Hep B positive. Follow up on 58024 has not resolved the complex steps /pathway for GP's, Midwives and specialists to follow in the few number of cases creating clinical risk	Staff have been given additional education on pathway Additional control (added 1/12/20) - MMR has been entered onto the new electronic whiteboard that is expected in maternity in Dec/ Jan. This will additionally prompt staff to consider MMR for babies
2779	Armed Hold up	Health and Safety Hazards	Staff Safety	TDHB Pharmacy	Moderate	Moderate	1/06/2021	Armed hold up/forced entry/hostage situation during the working day on wards or in pharmacy department. Risk to on-call pharmacist after hours	Staff trained in Armed Hold up procedures and how to access security Staff attend Police armed hold up education session Staff in front line areas or pivotal roles trained in critical Incident de-briefing Security staff trained in de-escalation and co-op procedure Security officer on site security officer available to escort on-call pharmacist during out-of hours Duress alarm Restricted access to pharmacy department
3474	Stress and Fatigue/ On Call Rooms	Health and Safety Hazards	Staff Safety	TDHB Theatre Suite	Moderate	Minimal/minor	1/12/2022	Risk of stress and fatigue reducing ability to work safely and effectively. Sleep loss or sleep deprivation has been shown to in pair judgement slow reaction times, affect concentration and negatively impact both mental and physical health. Emotional health also suffers. Poor quality interrupted sleep can contribute to fatigue, in turn resulting in lapses in concentration irritability compromised emotion and physical health. This directly affects staff turn over staff and patient health and safety.	-Roster guidelines -Availability of EAP -Stress work shops -Investigate and Manager are aware. -Cleaning schedule has been modified and equipment removed from area as was previously stored -trial of alternative facilities in the short term -long term alternatives being explored
2267	transport fleet vehicle safety	Health and Safety Hazards	Staff Safety	TDHB Stores/Purchasing	Moderate	Moderate	27/03/2019	TDHB operates a fleet of 106 vehicles, mostly in a general pool for use by hospital staff and other approved users for TDHB business related use. Safety of staff and other road users is paramount. Recent legislation makes any company vehicle part of the employees work space and subject to OSH regulations and the company is responsible for providing a safe workspace which includes company fleet vehicles. Also vehicles are risk to both users and the general public if driven badly can be a reputational risk to the organisation as well.	All vehicles sourced for the fleet at ANCAP 5 star safety rated and are serviced and maintained to manufacturers schedule and standard by the manufacturers local main dealership. All drivers are required to have a current valid New Zealand driving licence, a copy of which is kept on file in the Transport Department. The majority of the fleet are also tracked and can also be provided with a panic button when requested. Vehicle speed is monitored and staff breaking speed limits are reported to HR and line management as a driving safety improvement aid.

4036	Project delivery failure	Projects/Objectives	Strategy/Development and Delivery	TDHB ICT Services	Moderate	Moderate	6/10/2022	Projects fail due to insufficient resourcing, go over budget and/or don't deliver required benefits	- Project management methodology - Scoping - Budgeting - Reporting - Testing including user acceptance - Business prioritisation - Stakeholder engagement - Sponsor engagement - Oracle (budget) - Dev sites - Weekly resourcing meeting - PM meeting - Standups - Vendor engagement/management - Contract resourcing - Projects fully completed and reviewed against PID - Recruitment
2088	Compressed Gas cylinders	Health and Safety Hazards	*TBC*	*TBC*	Moderate	Moderate	1/06/2022	High pressure gas release can cause injury to staff and/or damage to property	- Cylinders are stored appropriately e.g. stored upright and secured to prevent falling - Education of staff and patients regarding flammability - Cylinders transported according to Hazardous Substances Regulations 2017
2085	Computers and Workstations	Health and Safety Hazards	*TBC*	*TBC*	Moderate	Minimal/minor	1/06/2022	Potential health issues related to computer use include: - physical discomfort, pain and injury - Fatigue	- Keyboard ergonomic audits completed at orientation and annually - All new staff using a computer workstation attend Discomfort, Pain and Injury training - Workstation assessments completed by the Health and Safety team as required - Early reporting of pain and discomfort via Datix encouraged
2084	Stress and fatigue	Health and Safety Hazards			Moderate	Moderate	1/06/2022	Risk of stress and fatigue reducing ability to work safely and effectively. Various causes can include - Work schedules e.g. hours of work and shift work - Sleep disruption - Environmental conditions e.g. climate, noise and vibrating tools. - Physical and mental work demands - Emotional well-being	- Rostering guidelines - Availability of EAP - Attention to scheduled tea/meal breaks - Stress and resilience workshops
2573	Working autonomously in the community	Health and Safety Hazards		TDHB Cardiology Clinic	Moderate	Moderate	10/06/2022	Potential risk to staff working in the community eg. patients homes, satellite clinics or driving in community	- Staff to ensure when departing from DHB site that telephonists are contacted regarding travel plan and location - Cell phone to be carried at all times - Nurse to be familiar with surroundings (contingency plan if situation arose) - Nurse to notify telephonist if she is alone in a centre (safety)
3439	Blood, Body Fluids, Spills	Health and Safety Hazards	Biological	TDHB Radiology	Minimal/minor	Minimal/minor	1/04/2021	* Performing IV Cannulation * Handling of blood/body fluids * Falls * Fractures * Bruises * Cuts * Dislocations * Concussion	* Correct IV Cannulation method * Use of PPE * Standard Precautions * Correct disposal * reporting adverse events immediately in Datix * Developing and implementing control plan * warning signs (Wet floor)
2494	Surgical cautery/diathermy plume	Health and Safety Hazards	Biological	TDHB OPD	Minimal/minor	Minimal/minor	10/06/2023	Exposure to diathermy plume in the biopsy clinic and colposcopy clinic (whereby Human Papilloma Virus is still active in the diathermy plume)	-PPE eg. mask, apron, gloves -Use of direct suction to excision/cautery site during procedure -Overhead air extraction unit in colposcopy room to be used for all cautery/diathermy procedure. Also internal filtress filter to be replaced annually and documented on appropriate form and external filter to be discarded after 15 uses as per identification boxes on filter. -Covidien rapid vac smoke evacuation unit to be used in biopsy clinic -Air ventilation grid in colposcopy room door to assist fresh air flow
2698	Acetone - risk of combustion	Health and Safety Hazards	Chemical	TDHB ART Team	Minimal/minor	Minimal/minor	*TBC*	Acetone used in fabrication of splints by handtherapists. Risk of combustion	-keep lid on bottle -store in cupboard away from heat gun
2519	Access to activities equipment	Health and Safety Hazards	Environmental	TDHB Te Puna Waiora	Minimal/minor	Minimal/minor	3/10/2022	Access to equipment used for activities which can include but are not limited to sharp items, strings/yarn, needles, paints, solvents and electrical equipment	Client risk to be assessed prior to access to Art room Equipment that could be used to cause serious harm such as guillotine, building tools etc to be locked in storeroom in Art room and only used by staff. If risk has been determined to be low with a specific client, and that client is closely supervised, that client may be given limited access Consideration to be given to what type of equipment is left in the Art room and whether this could be used as a weapon All clients access to Art room is to be supervised by staff at all times. When not in use, the Art room door is to be locked
4241	Extremely strong Mould smell	Health and Safety Hazards	Environmental	TDHB CACC - Child & Adolescent Centre	Minimal/minor	Minimal/minor	*TBC*	From the instant you walk in to The Child and Adolescent Centre you can smell mould. This is extremely strong in the hallway and office by the large meeting room and kitchen area. 2 staff members experience Headache and nausea from this, another has asthma flare ups and another burning eyes	Doors and windows open

3460	MRI scanner	Health and Safety Hazards	Equipment	TDHB Radiology	Minimal/minor	Minimal/minor	*TBC*	Due to the nature of the MRI scanner, projectiles are not permitted anywhere near the magnet as can cause severe injury/death to either staff or patients.	Safety checks in place by qualified and trained MRI staff. Limited access to the MRI scanner through the 3rd and 4th zones. MRI staff do an annual MRI Safety study day. Signs up in MRI area warning of dangers. Safety questionnaire filled out by all staff and pt.'s prior to entering the magnet. All staff and pt.'s checked prior to entering the magnet.
2703	Risk of injury from moving equipment in community vehicles	Health and Safety Hazards	Equipment	TDHB ART Team	Minimal/minor	Minimal/minor	*TBC*	risk of mobility equipment etc moving in cars when being transported to patients	-use vehicles with barriers installed -pack equipment safely and securely -drive safely/cautiously
2701	Risk of thumb sprain when cutting thermoplastic splinting material	Health and Safety Hazards	Equipment	TDHB ART Team	Minimal/minor	Minimal/minor	*TBC*	Thermoplastics can be difficult to cut and require some force. this poses risk of thumb injury	-avoid using scissors to cut thermoplastics of a thickness greater than 1.6mm
2263	Stores meeting Australasian clinical storage standards	Health and Safety Hazards	Equipment	TDHB Stores/Purchasing	Minimal/minor	Minimal/minor	27/03/2019	Main stores aims to meet Australasian Clinical storage standards. . There is a further requirement to air condition the store to 20 air changes per hour standard. (this has been planned for a number of years but the financial situation has so far ruled out compliance in that area.	All wooden shelving and shelf decking has been replaced by Steel racking with pressed steel shelves (use of wood in a clinical store is banned as it generates dust and is also a fire hazard). All shelving is Para-bolted to the concrete floor (to mitigate earthquake risks and the floor is painted with a 2 coat epoxy paint to reduce dust.Shelving has been updated to meet standard. Request for air conditioning is outstanding and on hold due to cost and need to meet other higher priorities across site.
2782	Rimu Fixed Furniture	Health and Safety Hazards	Ergonomic	TDHB Te Puna Waiora	Minimal/minor	Minimal/minor	*TBC*	Potential for physical strain and/or injury from making up beds in Rimu due to not being able to height adjust or move them.	Slim fit mattresses that are lightweight Fitted sheets
3194	Agression/Violence/Security of Staff and others	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Minimal/minor	Minimal/minor	1/04/2023	Complaint management sees people who are in a heightened emotional state. Staff have been verbally abused and threatened.	- Duress alarm available and tested weekly. process in U drive - Walk-ins discouraged (other areas advised to phone ahead and not send people into CGSU, appointments to be made - Other staff in area made aware when volatile person in area. - Check-in plans in place - Risk assessment to occur before meeting a person alone - Location board used for staff whereabouts. - Unit to be secured out of hours - If staff member in unit out of hours switchboard to be notified. added following staff meeting review: - All staff to complete CALM training -Communication has occurred with ward management re roles and responsibilities -Patient information pamphlets will be reviewed to ensure alignment with safe practice for staff. Risk assessment procedure to be reviewed to incorporate learnings from a recent incident. -staff area secured with swipe-card access for staff only 24 hrs
3196	DPI/OOS/RSI	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Minimal/minor	Minimal/minor	12/04/2021	repetitive tasks e.g. filing or working at a computer or desk increases risk of repetitive strain injury.	- Keyboard/ergonomic assessment completed at orientation and annually - Staff to attend discomfort pain and injury training which covers - Taking regular breaks - Varying of tasks - Adjusting of workstations - How to request review of workstation - early discomfort reporting - investigation of reports of strain/pain - Ergonomic consideration of equipment at time of purchase
2727	Falling or objects that are moving	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Minimal/minor	Minimal/minor	1/04/2023	Three and four drawer filing cabinets can fall or move with drawers open or during an earthquake. Bookshelves can move during an earthquake.	- Secure cabinets higher than two filing drawers to the wall. - Any cabinet that is higher than it is wide is a higher risk of falling in an earthquake event. - Staff trained not to overfill file drawers and to only open one drawer at a time. - Close cabinet drawers. - Decrease the number of old style high filing cabinets - Increase paper lite service. - avoid storing heavy items up high
3744	Hazardous Substance	Health and Safety Hazards	Hazards	TDHB Theatre Suite	Minimal/minor	Minimal/minor	9/12/2022	Hazardous substance knowledge and identification	Theatre Audit to identify Hazardous substance. Formalin spill kit to be ordered
2261	Hazchem products in store	Health and Safety Hazards	Hazards	TDHB Circulating Stores	Minimal/minor	Minimal/minor	3/11/2022	Some Stores items have a Hazchem rating (typically alcohol based hand rubs and hand washes). These should not be stored in bulk in the main store but transferred after booking in to the Dangerous Goods Store (Site building 103), a small quantity for immediate picking and packing use is kept in an OSH approved inflammable liquids cupboard in the goods inwards area adjacent to the roller doors (where the fire service can get to it and pull from the building in the event of a major fire incident.	Hazchem rated goods transferred to Dangerous Goods Store, small on hand picking stock kept in OSH rated inflammable goods cabinet by Goods Inwards main roller doors.
2669	Heavy traffic flow driving around the port & large trucks & equipment	Health and Safety Hazards	Hazards	TDHB Public Health Regulatory Services	Minimal/minor	Minimal/minor	9/06/2020	Heavy traffic flow at the port - logging trucks with large loads and large log moving equipment.	Staff awareness of the hazards.
2258	Lifting	Health and Safety Hazards	Hazards	TDHB Circulating Stores	Minimal/minor	Minimal/minor	3/11/2022	Lifting,manual handling,carrying goods. Basic lifting of packages, boxes, cartons, loading of cargons and trolleys for onwards distribution and loading stores and unit shelving with stock	Best practice safe lifting (straight back, lift from knees, safe grip check safe weight i.e. <16kg) Posters in place in stores. Walkie Stacker, Sack Barrows, trolleys and pallet lifters available to use for items over 16kg

3199	Manual handling of items and equipment	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Minimal/minor	Minimal/minor	15/03/2021	- Any task that requires lifting heavy or awkward loads - Incorrect techniques involved with lifting, carrying, pushing and pulling. - When Handling lever arch files and health and safety files.	- Assess tasks where manual handling is required - correct lifting technique - team lifts - use devices for manual handling e.g. trolleys Train staff in safe work practices - use of trolley and manual handling devices - store heavy items approximately between knees and shoulders - keep load close to the body - organise work so that loads are lifted between mid-thigh and shoulder heights - Use steps rather than lifting above shoulder heights - Sore only light, less used items over shoulders - sit while filing on lower shelves - Remove excess files from shelves - Reduce amount of files in folders - minimise printing of documents and store electronically where possible. Manual handing training included in 2-yearly refreshers
2300	Manual Handling with lifting 25kg salt bags, boxes of dialysis fluid	Health and Safety Hazards	Hazards	TDHB Renal Unit	Minimal/minor	Minimal/minor	10/06/2021	-Potential risk to staff when lifting boxes of dialysis fluid from store room, moving heavy equipment eg. dialysis machines, placing salt into water softener reservoir and assisting patients onto the dialysis chairs as necessary.	-Manual handling refresher course and Ko Awatea e-learning site -Ensuring wheels on dialysis machine are well maintained. -Emptying boxes of fluid bags as necessary, prior to transporting to another area within the unit -Stock palette to be located closer to store room -x2 staff to lift slat bag together -Use scooper to transfer salt to reservoir
3712	Moving car awareness	Health and Safety Hazards	Hazards	TDHB COVID Testing	Minimal/minor	Minimal/minor	1/12/2022	Staff members and members of the public moving in and around moving vehicles. Risk of injury to staff member or public.	One way traffic management flow. Cones, signs and barriers to direct traffic. Drivers requested to turn engines off while stationery where staff working People instructed to remain in vehicles Site advertised as drive in collection point for Rapid Antigen Testing Members of public who walk in are chaperoned by staff through to safe area Staff to remain under scaffolding to work Speed reduction sign in place on entering hospital grounds Traffic management called in when testing demands and traffic increased
3195	Slip/Trip/Fall	Health and Safety Hazards	Hazards	TDHB Clinical Governance Support	Minimal/minor	Minimal/minor	1/04/2023	Multiple risks for injury, - damaged to surfaces of flooring - Cords on floor and around surfaces - Items or debris on floor	- frayed carpet has tape to prevent any lifting at edges Staff training on - wearing non-slip footwear - ensure area is well lit - reporting of damaged surfaces - timely repair/replacement - regular environmental inspections to ensure all surfaces safe and intact - Position equipment to avoid cords on floor - tidy environment to avoid obstacles on floor
2805	Transportation of Oxygen Cylinders in the Community	Health and Safety Hazards	Hazards	TDHB Public Health Nursing	Minimal/minor	Minimal/minor	26/06/2022	The uncontrolled release of gas under pressure may cause physical harm. Unsecured cylinders can cause injury.	Education of staff Guidelines for Oxygen Cylinder Safety
2260	Vehicle Unloading and Loading	Health and Safety Hazards	Hazards	TDHB Circulating Stores	Minimal/minor	Minimal/minor	3/11/2022	We operate a very active vehicle unloading docking area and we handle a wide variety of vehicles carrying all manner of goods. unloading can be dangerous and we provide equipment to assist in getting goods into the hospital safely.	Staff using lifting equipment should have current OSH approved training and attend 2 yearly refresher courses. For which the receive a licence card to prove currency in training. We have one dock fitted with a Tiecos608H dock leveller to deal with vehicles whose decks do not match our dock height and a variety of pallet handling equipment including pallet handlers and a Crown Walkie stacker forklift. We also have folding ramps and checker plates to bridge gaps and cover damaged decks for wheeled items.
4126	Wet Moping Floors	Health and Safety Hazards	Hazards	TDHB Alcohol and Drug Svces	Minimal/minor	Minimal/minor	30/11/2022	Cleaner wet mops floors during busy times in the AOD service. Staff and clients to be made aware that floor is wet and slippery.	Signs are put up when floor is being wet mopped. Cleaner usually advises people that floors are wet.
3114	(Cow) Computer on wheels	Workforce	Health & Safety	TDHB Theatre Suite	Minimal/minor	Minimal/minor	9/12/2022	Inappropriate cleaning of IT equipment in theatre	Cleaning wipes Keyboard covers
2506	Risk of harm to staff/client from items brought into the ward	Workforce	Health & Safety	TDHB Te Puna Waiora	Minimal/minor	Minimal/minor	3/10/2022	Clients bringing in, concealing or being provided with items which could be harmful eg Blades, illicit substances, stockpiled medications	Follow admission protocols re searching clients and their belongings on admission, removing any potentially dangerous items. NB Full body searches are NOT routinely performed Wear disposable gloves when searching patient property/rooms. Do not place hands into areas that cannot be seen and which may conceal sharps, gently top contents out to check or ask client to remove them If illicit substances are found, place these in CD safe (make entry in green folder) and contact Police to dispose of these If suspicion has been raised that a client is bringing in harmful items from leave, conduct a search on return from leave as per protocols If suspicion exists that visitors may be bringing in illicit substances or dangerous items, carry out a search on arrival unless the visitor prefers to leave Report any incidents where items are brought into ward in patient notes and on Datix

3578	Delays in maternity patients being seen	Service/Business Continuity	Infrastructure	TDHB Maternity	Minimal/minor	Minimal/minor	30/11/2021	Non acute, non ANC maternity patients - not in labour or requiring acute assessment and care are delayed in being seen. Causes of this are: Non acute being seen in acute area No dedicated midwifery resource available No appropriate physical location for the patients to be seen No referral process consistently followed	Book used to record patients ANC coordinator daily check to reschedule to ANC where appropriate Management and educators pulled to floor to manage acuity Raised at LMC monthly forum Increased rostering to manage presentations NOTE: Added 12/1/21 - Additional 0.4 FTE has been added to ANC to remove AN reviews from labour ward - To assess in 11/21
3855	Dispensing Error causing harm to patient	Patient Safety	Managing Service Delivery	TDHB Pharmacy	Minimal/minor	Minimal/minor	29/04/2022	Possible causes: - lack of knowledge/experience/training - staffing deficit - environmental factors eg. Interruptions, multi-tasking, poor lighting, noise and a significant workload - look alike /sound alike medicines - lack of automation - ambiguous prescription - poor user interface with ePharmacy/Medchart - human error - dual systems - poor environmental layout - rushing - Stock put away in the incorrect place - high work load within short timeframes - poor environmental/physical layout of the chemotherapy room - communication breakdown with organising high risk medicines - preparation errors - accidental exposures (eg. To cytotoxics, or pregnant and exposed to teratogenics)	- Orientation to department at commencement of employment - Use of Casual staff - Increasing staffing levels (employ more FTE) - Double check before stock released - Administrator to answer/screen calls - Increase administrator FTE to cover all opening hours - Roster extra dispensing staff - Roster other tasks away from dispensary - Training - Feedback to Medsafe & Manufacturer - Differentiating stock via changing where/how stored - manual profiling from electronic script - Medchart (esp of prescribe by protocol or quicklist) - Clinical Pharmacist screening charts prior to dispensing - Write prescription clearly - double check with prescriber before releasing item - Regular breaks - Roster 2 hour slots - Self checking - Roll out Medchart to all areas - Door opener in dispensary - Internal self pacing - Ask for help - communication white board in pharmacy - dispensary diary - chemotherapy diary - Elastomeric diary
4067	Disruption to business	Service/Business Continuity	Managing Service Delivery	TDHB Pharmacy	Minimal/minor	Minimal/minor	20/04/2022	Possible causes: - pandemic - staff sickness - natural disaster - strikes - courier strikes - Pharmaceuticals compounding services delays to chemotherapy/antimicrobial/TPN/eyedrops delivery - access to pharmacy area eg. Due to fire or gas leak	- Policy documents for emergencies and disasters that describe the reporting lines, and roles and responsibilities of the workforce - training documents relating to the management of emergencies and disasters, including evacuation and emergency drills - business continuity plan or emergency and disaster management plan - disaster recover plan
4069	Inability to procure medicines in a timely fashion, resulting in changes in medicines and practices.	Service/Business Continuity	Managing Service Delivery	TDHB Pharmacy	Minimal/minor	Minimal/minor	20/10/2022	Possible causes: -natural disaster -delay of made to order products from Baxters pharmaceuticals (eg Chemotherpy, monoclonal antibodies, Total Parenteral Nutrition, elastomerics), which can harm a patient from delays to administration. -poor weather (delivery problems as sometimes reliant on flights in to New Plymouth) -global incident eg. Pandemic -Lack/shortage of drugs (due to break of stock, high staff turnover, failure to report restocking needs, or deficient inventory management), that depending on its importance may cause sever adverse events in the patient. -Labelling of Medicines not meeting NZ standards (Section 29 Medicines), causing confusion and could result in patient harm -Supplier issues -	- Pharmacists - Pharmacy Technicians - Ordering in advance of need (where expiry of product allows this) ie get product in the day before its needed - check new brands as they arrive - overlabel with English labels - obtain registered stock where possible (its usually not) - communication with Pharmac and Medsafe

3934	Medication failure due to incorrect storage	Service/Business Continuity	Managing Service Delivery	TDHB Pharmacy	Minimal/minor	Minimal/minor	22/07/2022	•human error (putting medicine in the incorrect place or are expired) •excessive temperature inside top drawer of pyxis machine •medication room too hot (poor ventilation) / aging building •aging pyxis equipment •lack of knowledge/experience/training •not following cold chain policy/procedure or lack of accreditation •refrigeration equipment failure •aging fridge equipment •fridge manual temperature monitoring •human interference •transport issues •power failure •human error (storing chemotherapy in wrong place ie. Confusion between storing in fridge or at room temperature)	Training self checking rolling stock take replace equipment (pyxis machines) store medicines stable to 30 degrees in top drawer monitor temperature with datalogger air conditioning cloud based monitoring manual temperature monitoring replace equipment (pyxis machines) regular servicing replace equipment Review of manual records for deficits twin bird Controlled drugs provided to patient care units in a safe and secure manner emergency generator
3523	Multiple processes for recording patient information	Patient Safety	Managing Service Delivery	TDHB Sexual Health Clinic	Minimal/minor	Minimal/minor	16/09/2022	SHC staff are using a combination of paper based and electronic systems for clinical records and results. In addition there is a system of numbers used ,not NHIs. This has risk of results not being linked correctly with paper notes and no effective recall system can be used. Other Clinicians who may be in contact with patients post visit to clinic do not have access to problem list or treatment which may compromise their own treatment plan .eg in emergency situation.	Extra time given to staff to work through this manual system to ensure accurate records are maintained.
3550	Paediatric ID Assesment wait list	Workforce	Managing Service Delivery	TDHB CACC - Child & Adolescent Centre	Minimal/minor	Minimal/minor	29/09/2022	Current waiting list for Paediatric referrals accepted for ID assessments is not able to managed within acceptable time frames. The children and families are at risk of not receiving support available to them as they may be dependant on the outcome of the assessment.	Finalised contract with outside provider to complete a number of assessments. Have employed Psychologist on 6/12 contract to complete ID assessments. Considering electronic solutions to make assessment process more efficient.
3441	Decreased avaliability of Radiologists on site	Workforce	People/Staff	TDHB Radiology	Minimal/minor	Minimal/minor	17/07/2021	CT had to stop scanning on Friday 17/07/20 due to a lack of Radiologists in Radiology. Are not able to continue scanning using contrast without a DR available. Hospital Dr's all busy. Scanning stopped for 30 minutes until a radiologist was in the department. Radiologists remote reporting. Delay's caused due to down time. Staff managed to complete some non contrast scans whilst waiting.	CT staff aware no Radiologist in department, escalated to me, asked advise. Told to stop any contrast scan until Radiologist available.
2763	Dental Ergonomics	Health and Safety Hazards	People/Staff	TDHB Community Oral Health	Minimal/minor	Minimal/minor	11/06/2020	Injury to staff when treating patients.	Train all staff in safe work practices including to: •Take regular breaks •Practice micro pauses •Spread patient workload evenly throughout the day •Complete patient records after each patient •Vary tasks each day •Report early signs of aches/pains, requesting a professional review of individual work environment as necessary •Complete an annual ergonomic audit making recommendations to manager to action •Report incident/accidents and implement control plan
3577	Hawera Maternity Staffing	Workforce	People/Staff	TDHB Hawera Maternity	Minimal/minor	Minimal/minor	30/06/2022	Inability to recruit to FTE in Hawera Maternity Unit due to national RM shortage, means shifts are not able to be staffed. Current RM staff are restricted in their ability to take leave	RN's are utilised where available to cover the night shifts with an RM on call to support When a RM can not cover the on call or the shift - patients are re routed/ re admitted to Base Maternity unit Base Maternity unit will support with additional RM's if able
2778	Hazardous substances: Dry Ice	Health and Safety Hazards	Physical	TDHB LabCare Pathology Service	Minimal/minor	Minimal/minor	1/07/2021	Handling of dry ice Dry Ice can cause burns and asphyxiation	Specialised training for those packing and handling of dry Ice. Adequate ventilation PPE available
2489	Moving and Handling - Standing hoist	Health and Safety Hazards	Physical	TDHB OPD	Minimal/minor	Minimal/minor	14/05/2023	Potential harm/injury to staff or patient with standing hoist through incorrect harnessing, incorrect positioning of sling, potential crushing of fingers when hooking harness to hoist	- staff to be trained/familiar with use of hoist - correct harness positioning - protecting staff backs through correct "stance/body alignment" when positioning harness beneath patient. - ensuring that surroundings are free of clutter for clear transfer of patient
3852	Moving and handling of patients	Health and Safety Hazards	Physical	TDHB Te Puna Waiora	Minimal/minor	Minimal/minor	2/05/2022	A lack of equipment to assist staff in moving and handling patients with mobility deficits safely, for both the patients and the staff.	1. A moving and handling gap analysis has occurred on 24/3/2021. 2. A list of equipment to assist with moving and handling has been made with OT, and costing obtained. 3. A capex to purchase equipment is planned. 4. Training for staff in the use of equipment is planned.
2490	Noise	Health and Safety Hazards	Staff Safety	TDHB OPD	Minimal/minor	Minimal/minor	14/05/2023	On-going Staff/patient exposure to high decibels when removing POP or fibreglass plasters with plaster saw	- PPE eg. staff/patients to wear ear muffs/ earplugs to diminish high decibel exposure - Staff hearing test programme through OHN
2646	Paper recycling bins	Health and Safety Hazards	Staff Safety	TDHB Public Health Support Services	Minimal/minor	Minimal/minor	16/05/2021	Risk of injury to staff members while moving paper recycling bin.	Staff advised to not overfill the recycling bins and place in a position which makes it easier to access and move.

Our reference	Title	Risk Type	Risk Subtype	Department/Location	Risk level (current)	Risk level (Target)	Risk review date	Concise summary of the risk	Controls in place
2594	Taranaki Base Hospital Emergency Heli Pad	Health and Safety Hazards	Staff Safety	TDHB Orderly Services	Minimal/minor	Minimal/minor	TBC	Helicopter Rotor Wash - Effecting the Café Umbrellas - Dust in eyes - Café Patrons - dust hazard Staff, Public, Contractors, Vehicles and Rubbish entering the Helicopter Operating Area Collision between Helicopter and Telecom mast Helicopter Emergency landing in car park ?	- TARANAKI BASE HOSPITAL EMERGENCY HELI PAD PROCEDURES ROTOR WASH EFFECTING CAFE UMBRELLAS - Close umbrellas prior to landing DUST IN EYES FROM ROTOR WASH - PPE Safety glasses to be warn - available to Orderly Staff - Warn Café patrons of Helicopter landing and of the DUST HAZARD STAFF, PUBLIC, CONTRACTORS, VEHICLES AND RUBBISH ENTERING THE HELICOPTER OPERATING AREA - Fencing and signage - Good situational awareness by Pilot, Crewman, Paramedic and Orderly Staff. COLLISION BETWEEN HELICOPTER AND TELECOM MAST - Pilot and Crew aware it is there in the first instance. - We will advise other operators re criteria and hazards. - Aircrew remain visual with the mast at all times during the approach and departure. HELICOPTER EMERGENCY LANDING IN CAR PARK ? - Allowing twin engine helicopter only - Mainly land on bottom Heli Pad and ambulance crew meet them.
3981	Theatre six floor	Health and Safety Hazards	Staff Safety	TDHB Theatre Suite	Minimal/minor	Minimal/minor	1/12/2022	-Risk of injury to staff due floor slippery. Staff complaining	Signs to be placed in area where floors are wet/recently mopped Mopping excess water when identified Nonslip flooring in place under scrub sinks Early identification and notification to HCA team for wet floor areas
2780	Cold rooms and Freezers	Health and Safety Hazards	*TBC*	TDHB LabCare Pathology Service	Minimal/minor	Minimal/minor	1/07/2021	Cold room set at 4 degrees Freezer room set at -20 degrees Plasma Freezer set at -50 degrees	Cold room and freezer room doors can be opened from the inside to avoid personal being trapped inside. Freezer room has a non slip mat inside to avoid slips. Plasma freezers PPE padded gloves to avoid cold burns.
2086	Blood/Body Fluid Exposure	Health and Safety Hazards			Minimal/minor	Minimal/minor	1/06/2022	Accidental staff contamination with blood or body fluids. Possible causes: - Needle stick injury - Splashes and spitting - Specimen handling, leaking specimens	- Appropriate PPE - Standard precautions - Correct disposal of sharps - Use of needleless systems where possible - Procedures for SC/IM administration - Staff vaccination program
2756	Burns	Health and Safety Hazards		TDHB OPD	Minimal/minor	Minimal/minor	10/06/2023	Risk of burns as a result of exposure to heat sources. Areas include: Phototherapy (NBUVB) Diathermy (electrical burns)	Staff trained in the use of equipment at orientation Correct use of PPE Maintenance of equipment
2761	Chemical exposure	Health and Safety Hazards		TDHB Renal Unit	Minimal/minor	Minimal/minor	10/06/2021	Risk of chemical exposure resulting in harm to staff. Chemicals/ work tasks involved: - Methylated spirits - Dialox - Janola - Riotane	New staff orientation includes training in chemical use 2 yearly refresher training Provision of PPE MSDS available staff aware of storage procedures
2762	Chemical Exposure	Health and Safety Hazards		TDHB Cardiology Clinic	Minimal/minor	Minimal/minor	10/06/2022	Risk of chemical exposure resulting in harm to staff. Chemicals / work tasks included: Isopropyl Alcohol Tristel wipe system - chlorine	New staff orientation Provision of PPE SDS available Staff aware of storage procedures
2759	Electricity	Health and Safety Hazards			Minimal/minor	Minimal/minor	1/06/2022	Risk of : - Burns - Electric shock - Fire Possible causes - Overloading sockets - Handling sockets or equipment with wet hands - Lack of equipment maintenance	- Taranaki DHB Electrical Policy - Test inspections for all electrical equipment used at TDHB - Unit specific orientations cover electrical equipment -
2077	Exposure to Infectious Diseases	Health and Safety Hazards			Minimal/minor	Minimal/minor	16/05/2022	Exposure when involved in the direct handling/care of patients with infectious diseases	Staff are trained in: - Infection control procedures - Identification of infectious patients - Use of appropriate PPE Staff have access to: - Guidelines explaining the correct process for dealing with infectious patients - Vaccination offered as per Staff Vaccination Protocol
2511	Risk of injury to staff moving beds	Health and Safety Hazards		TDHB Te Puna Waiora	Minimal/minor	Minimal/minor	3/10/2022	Risk of injury to staff as doorways in Nikau rooms 1 - 8 and 11 & 12 not wide enough to fit beds through	Assess clients who are allocated these rooms, if they have significant medical or mobility issues, allocate to a room with a wider doorway (rooms 9 and 10) Minimise risk by using trolley bed in Nikau treatment room if emergency transfer of a client is required
2087	Sharps	Health and Safety Hazards			Minimal/minor	Minimal/minor	1/06/2022	Risk of: - Puncture wound - Infection Possible causes: - Needle stick or sharp instrument injury - Handling of broken glass or porcelain	- Staff training - Apprioriate PPE - Safe disposal

3440	Ultrasound bed	Health and Safety Hazards	Ergonomic	TDHB Radiology Hawera	*TBC*	*TBC*	*TBC*	Ultrasound bed in Hawera does not go low enough or able to slowly raise the back of the bed up and down to aid with scanning. The bed that is in use is not suitable for ultrasound. Due to the inability to move the bed back up and down with out causing strain on the patient and sonographer, the bed should not be used. Inability to get bed at correct height is causing musculoskeletal injuries to the sonographers.	staff to take regular breaks as and when possible. This will not solve the height issue.
4263	Lack of SPEC trained staff	Workforce	Knowledge/Skills/Competence	TDHB Te Puna Waiora			29/07/2022	Due to staff shortage/recruitment deficits of RNS in TPW, the roster cannot support SPEC training. New staff unable to be SPEC trained. Depleted availability of SPEC trained staff to work in RIMU or participate in restraints within the unit.	Utilising more Psychiatric assistants in Rimu and reducing RN numbers as a last resort. Trying to keep capacity in RIMU from going over numbers. Using overtime/double shifts to provide cover in RIMU, leading to staff burn out.