Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

28 August 2018

Cody

Email: fyi-request-8471-ce7ab0c7@requests.fyi.org.nz;

Dear Cody

RE Official information request CDHB 9919

We refer to your email dated 9 August 2018 requesting the following information under the Official Information Act from Canterbury DHB regarding Health & Safety control systems for violence against staff at Hillmorton Hospital. Specifically:

- **Please provide the policies and procedures, documents, risk registers, all practicable steps, etc., that are used for the prevention of violence against staff (including architectural / layout, emergency planning, training and other security measures).**

We believe that it would take in excess of 20+ hours to provide the detailed level of information requested and we are therefore declining your request under section 18(f) of the Official Information Act i.e. "……*The information cannot be made available without substantial collation or research".*

Everything we do on a daily basis is about the health, safety and wellbeing of our patients and staff; and all our staff work extremely hard to maintain a safe environment across our services. We can provide you with the following Canterbury DHB policies:

Please find attached as Appendices:
Appendix 1 – Health and Safety at Work Policy
Appendix 2 – Managing the risk of workplace violence
Appendix 3 – Complaint to Police (Staff complaint)
Appendix 4 – Incident Management.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek an investigation and review of our decision from the Ombudsman.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website ten working days after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Health and Safety at Work Policy

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Purpose

To enable our people to be and stay well so they, in turn, can improve the health and wellbeing of people living in the West Coast and Canterbury.

To comply with the Health and Safety at Work Act 2015 (HSWA 2015).

Policy

The West Coast District Health Board (WCDHB) and Canterbury District Health Board (CDHB) ensures, so far as is reasonably practicable, that the health and safety of its workers and others is not put at risk while at work.

Scope

All WCDHB and CDHB workers and volunteer workers.

Definitions

Worker:

- an employee; or
- a contractor or subcontractor; or
- an employee of a contractor or subcontractor; or
- an employee of a labour hire company who has been assigned to work in the business or undertaking; or
- an outworker (including a homeworker); or
- an apprentice, a student or a trainee; or
- a person gaining work experience or undertaking a work trial; or a volunteer worker.

Volunteer Worker:

- means a volunteer who carries out work in any capacity for WCDHB or CDHB;
- with the knowledge or consent of the WCDHB and CDHB; and

- on an ongoing and regular basis; and that is an integral part of the WCDHB or CDHB.

Roles and Responsibilities

All workers:

- Take reasonable care for their own health and safety.
- Ensure that their actions do not adversely affect the health and safety of other persons.
- Be aware of and follow instructions and procedures aimed at managing the health and safety risks.
- Report any concerns or incidents.

Managers:

- Identify and assess the health and safety risks in the department or unit and implement control measures.
- Escalate any issues that require the next level up decisonmaking.
- Ensure that workers are aware of the control measures and follow safe working procedures.
- Make sure that risk control measures are effective and a robust system is in place for ongoing review of the control measures and their effectiveness.
- Investigate reported incidents, determine root causes and implement corrective measures to prevent reoccurence.
- Provide workers with reasonable opportunities to share their views, raise work health or safety issues, and contribute to the decision-making process.

WCDHB/CDHB Boards and CEO:

- Understand risks associated with WCDHB and/or CDHB operations.
- Ensure that WCDHB and/or CDHB uses appropriate resources and processes to eliminate or minimise risks to health and safety of workers ond others.
- Ensures that WCDHB and/or CDHB has appropriate processes to receive, consider and respond to incidents in a timely manner.
- Ensures that WCDHB and/or CDHB implements processes to comply with the HSWA 2015.
- Ensures provision of the resources necessary for CDHB to comply with its duty under HSWA 2015.

Associated Documents

- WCDHB/CDHB Fit to Work Policy
- WCDHB/CDHB Risk Management Policy
- WCDHB/CDHB Hazardous Substances Policy
- WCDHB/CDHB Managing the Risk of Workplace Violence Policy

Measurement and Evaluation

- Number of workplace near-miss incident reports
- Lost time injury frequency rates
- Proportion of completed audits and inspections
- Proportion of corrective actions completed on time
- Proportion of trained health and safety representatives
- Proportion of workplace incidents investigated and resolved

References

- Health and Safety at Work Act (2015).

Managing the Risk of Workplace Violence Policy

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Purpose

Describe the risks of physical and mental harm faced by health care workers in residential, social service, and community settings.

Outline ways of managing the risk and protecting workers from harm resulting from violence and aggression.

Policy

Canterbury DHB and West Coast DHB recognises that acts of violence and aggression are a threat to heath care workers and community service providers.

Violent acts can result in physical injury and threats or intimidating behaviour can cause profound damaging psychological effects, including loss of morale and confidence, and long-term psychological stress.

Although eliminating the risk of violence is unlikely due to the nature of care provided, practical steps can be taken to identify and manage the risks without compromising patient care.

Managing the risk of violence must take into account the:

- context of the particular workplace.
- effect on the quality of patient care.
- need to be consistent with good employment practice.

Scope

All health care workers i.e., employees, contractors and volunteers, who may be exposed to workplace violence, including:

- physical assault i.e., an assault that results in actual physical harm.
- physical threat i.e., an attempted assault that does not result in actual harm.
- any form of indecent physical contact, including sexual harassment or sexual assault.
- verbal abuse.
- threats, intimidation, and harassment e.g., a verbal or written communication where a worker feels that they or their property is at risk of harm.
- damage to property i.e., items that belong to a worker or the organisation are damaged.

Definitions

Workplace violence

- Incidents where workers are abused, threatened, or assaulted in circumstances related to their work.
- Includes incidents when commuting to or from work.
- Involves an explicit or implicit challenge to the worker's wellbeing or safety.
- May be instigated by a patient, another staff member, or a member of the public.

Roles and Responsibilities

All workers

- Be aware of the risk of violence and aggression to yourself and others and take steps to avoid it.
- Actively participate in procedures or initiatives aimed at preventing and managing violence and aggression.
- Report all violent or aggressive acts using Safety 1st – Employee form.

Department and unit managers.

- Make sure all workers are aware of the organisation's approach to managing violence and aggression.
- Encourage a team approach if workers become aware of a potential or actual violent or aggressive event i.e. stand back at a safe distance and wait until a number of other people can be summoned to provide assistance.

- If there is an incident involving violence, aggression, or intimidating behaviour:
    - identify contributing factors.
    - consult with the Wellbeing, Health and Safety team.
    - take steps to prevent further incidents.

Senior managers

Make sure:

- appropriate controls are in place to prevent and manage violence; and
- procedures are followed.

Associated Documents

Managing the Risk of Workplace Violence procedures

Measurement or Evaluation

Workforce incident and lost time injury data.

References

Wellbeing Health and Safety Policy

Complaint to police (Staff complaint)

Purpose

To outline the process for a staff member who wishes to lay a complaint with the police.

Policy

SMHS acknowledges the right of a staff member to lay a complaint with the police.

In order to protect staff from the possibility of threats or danger, staff members' personal addresses and phone numbers will not be given or recorded on any communication with the police.

Scope

This policy applies when a staff member, while on duty, has been adversely affected by an incident or their property damaged or lost.

Supporting documentation

Legislation and standards

Health & Safety in Employment Act, 1992

Mental Health (Compulsory Assessment & Treatment) Act 1992

Guidelines for Reducing Violence in Mental Health, Ministry of Health (1995)

NZ Standard, Health and Disability Services (General) Standard. NZS 8134: 2008

CDHB Policies and Procedures

Legal and Quality manual

- Incident Management

Associated forms

Letter of Complaint to Police (MHS0103)

Contact Details form for a Complaint to Police (MHS0107)

Incident Report Form (ref: 1077)

Staff Accident Report Form (ref: 0620)

Complaint to police process

Following an incident the safety, treatment and support needs of the consumer, staff members and others must be met. Usual reporting processes for incidents and accidents apply.

If, following a Clinical Incident Review a staff member wishes to complain to the police, the staff member completes a 'Letter of Complaint to the Police'.

If the clinical team considers that a complaint is warranted, they will encourage and support the staff member to complain to police.

If the staff member does not wish to complain or write a statement, the clinical team will not pursue the matter.

The Clinical Manager or Charge Nurse Manager will identify the staff member's support needs throughout complaint processes and ensure these are met.

The Clinical Manager or Charge Nurse Manager faxes the complaint letter to the police, then telephones to inform the police of the complaint and confirm receipt of the fax.

Consumer subject of a complaint to the police

Where a consumer's actions have resulted in harm to a staff member or, loss or damage to their property, the consumer will continue to be treated with the care and consideration while the allegation is investigated.

If a consumer is suspected, they must be clinically assessed and a Clinical Incident Review undertaken. Processes and outcomes will be documented in the clinical notes.

- Ideally the clinical assessment would be on the same day as the incident and undertaken by the Consultant Psychiatrist (or delegate, or Duty Registrar after hours) in consultation with multidisciplinary team.

- Community services will identify a clinician(s) to carry out the assessment if the consumer's Consultant Psychiatrist is not readily available. If the consumer refuses to undergo an evaluation, the nature and seriousness of the incident will determine the safest most appropriate course of action. For example, DAO (for Mental Health Act processes) or police assistance.

Responsibility for ensuring the consumer's support needs are identified and met will be appropriately delegated to a staff member.

The Clinical Manager, Charge Nurse Manager or their delegate informs the consumer that a complaint has been made to the police and sends the consumer a formal letter.

The consumer's family (with permission) must be informed if a complaint is made to the police.

The consumer must be advised about the advocacy services available and their right to legal representation. Staff assistance may be needed to ensure the consumer receives these services.

If the consumer is required to attend court, the Clinical Manager or Charge Nurse Manager will inform the Court Liaison Nurse before the appearance date.

Protecting the staff member's identity

Progress notes regarding the incident and complaint will not identify the staff member.

Staff making a complaint or those involved in a police investigation may make contact arrangements with the police as they feel appropriate including giving:

- The Clinical Manager or Charge Nurse Manager's work telephone number for in hours contact and,
- Duty Nurse Manager's work telephone number for after hours contact.

The staff member may give their home contact details if they wish but the Clinical Manager or Charge Nurse Manager must be advised.

To ensure that the police are able to contact the staff member at any time, the Clinical Manager or Charge Nurse Manager completes a "Contact Details" form and sends it to the Duty Nurse Manager.

The Duty Nurse Manager retains the form in the 'Complaint to Police' folder, which is stored in a locked filing cabinet in the Duty Nurse Manager's office.

The Clinical Manager or Charge Nurse Manager retains and securely stores the original forms for the duration of any investigation. When the complaint and investigation is complete the Clinical Manager or Charge Nurse Manager ensures that the Contact Details forms are destroyed.

Police investigation

Once a complaint has been made, the police will investigate and decide whether charges will be laid. The police may consider alternatives if the consumer is very unwell and may be adversely affected by a criminal charge. This will require discussion with senior staff including the Clinical Director of the area.

The Clinical Manager or Charge Nurse Manager will liaise with the police. Requests for information will be relayed by the Clinical Manager or Charge Nurse Manager.

The Clinical Manager or Charge Nurse Manager will ensure the staff member is informed of the outcome of the police investigation.

Court appearance

If a staff member is required to appear as a witness, they should use their work address and phone number rather than their personal details.

The Clinical Manager or Charge Nurse Manager advises the Court Liaison Nurse ahead of a court appearance.

The Clinical Manager or Charge Nurse Manager will ensure the staff member is accompanied to court and supported during and after their appearance. A formal debriefing will be offered after the court appearance.

When the complaint procedure and investigation are complete, the Clinical Manager or Charge Nurse Manager ensures that both copies of the 'Contact Details' form are destroyed.

The original letter of complaint is returned to the staff member involved.

Incident Management

Policy

CDHB Incident Management Policy

Purpose

To provide staff with information and guidance on the management of incident reporting including clinical incidents, significant or sentinel events.

Scope

Patient related incidents that occur within W&CH which resulted in harm or had the potential to cause harm such as ;

- Patient Falls
- Medication Errors
- Blood/food/fluid administration errors (including breast milk)
- Equipment Failures
- Adverse outcomes (unexpected deterioration or death)
- Resource issues (equipment, staffing etc)

The following issues **may** be reported on an Incident Form but do not come under the remit of this Incident Management Policy and **shall** be reported on the other relevant documentation:

- Health and Safety related incidents – staff and visitors (Staff Accident Report Form, Ref 620)
- Blood/Body Fluid Exposure (Staff Accident Report Form, Ref 620)
- Patient or Staff Complaints (Suggestions, Compliments and Complaints Form Ref 152)
- Incidents that clearly relate to health practitioner competency (letter format and sent to relevant professional lead).

Definitions & Acronyms

Clinical Incident:

Is any event that has either resulted in, or had the potential to cause unintended and/or unnecessary harm or death (near miss) not related to the natural course of the patient's illness or underlying condition. Refer to CDHB Incident Management Policy

Root Cause Analysis (RCA) :
A process analysis method, which can be used to identify the factors that contribute to adverse events. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events - notably, what happened, why it occurred, and what can be done to prevent it from happening again.

Root Cause Analysis Leader:
The person who leads the Root Cause Analysis team

Root Cause Analysis Team:
The staff chosen to participate in the Root Cause Analysis. Participants chosen will be based upon them having knowledge of the processes and systems being reviewed and /or them having decision making authority to affect necessary change to prevent recurrence of the event.

QCMS:

Quality and Complaints Management Systems (QCMS)

SAC Matrix:
Severity Assessment Code (SAC) grading matrix. A level 1 or 2 event can generally be described as a sentinel or significant event requiring a Root Cause Analysis.

Policy Statements

W&CH shall ensure that:

- All patient related incidents are adequately investigated and actioned as required to minimise recurrence
- SAC 1 & 2 incidents are reviewed using an RCA methodology and reported to Corporate Quality and Risk as per CDHB Incident Management Policy.
- All RCA shall be commenced and completed within 70 days.
- All staff involved in an incident are appropriately supported as required by having access to debriefing sessions, Employee Assistance Programme (EAP), mentorship, modification to work environment or hours
- All patient related incidents are reported using the Incident Report Form Ref: 1077
- All SAC 1 & 2 incidents shall be discussed in a multi-disciplinary

forum e.g. Incident Review Groups, Rolling Half Day etc.

- Incident trends are monitored and discussed regularly by SQU at Incident Review Groups and Clinical Governance Committees.
- Incident data is analysed and published quarterly with emerging issues and trends highlighted for action through Clinical Governance Committees

Associated Documents

Legislation:

Health Information Privacy Code 1994 (Revised in 2008)

Health Practitioners Competency Assurance Act 2003

Privacy Act 2003

Government Guidelines:

Ministry of Health Reportable Events Guideline 2001

CDHB Wide Documents:

CDHB Incident Management Policy

Legal & Quality Manual, Volume 2

- Tikanga Policy
- Health and Information Privacy Code 1994
- Incident Management
- Open disclosure policy

Health And Safety Manual, Volume 6

- Managing the Risk of Violence and Aggression in the Workplace.

Infection Control Manual, Volume 10

- Standard precautions Policy
- Blood/Body Fluid Exposure

Quality Strategic Plan 2007 – 2010

Quality and Complaints Management Systems (QCMS) Incident Users Guide

Incident Report Form, Ref: 1077

SAC Matrix

CDHB Corporate Quality and Risk Incident Management intranet

References

- National Policy for the Management of Healthcare Incidents, Working Draft (Communio Group)

Equipment

Nil.

Key Responsibilities

Quality Coordinator

- May take the role of Root Cause Analysis Leader
- Selects the people for the RCA team
- Plans and coordinates the RCA process
- Prepares the Root Cause Analysis summary report and disseminates accordingly
- Monitors implementation, reports progress to clinical governance committee and updates Corrective action register.
- Ensures a process of evaluating effectiveness of actions is in place

SMO's with the quality portfolio

- Where applicable works in conjunction with the SQU Team Leader or Quality Coordinator on incident inquiries
- May take the role of RCA Leader for incidents
- Evaluates effectiveness of actions

Service Managers

- Provides final approval for the completion of SAC 3 and 4 Events

Professional Leaders

- Assist the Service Manager with incident reviews on professional and clinical related issues
- Ensures staff involved in clinical incidents are offered and provided ongoing support

Clinical Directors and Charge Midwives or Nurse Managers

- Conduct an inquiry into the reported incident validating the reporters information and clarifying the sequence of events and identifying contributing factors
- Provide initial approval for the completion of SAC 3 and 4 Events.
- Refer SAC 1 & 2 events to the Safety and Quality Unit within 24 hours of discovery.

All staff

- All staff have a duty to report any incident they are involved in or are witness to immediately. This includes hazard concerns and near misses that have the potential to cause harm or loss
- Ensure that the policy of Open Disclosure to patient and relatives is implemented at the time of the incident
- Incident Report Forms should ideally be completed within 24 hours of discovery of the event and sent to the Charge Midwife/ Nurse Manager or Clinical Director (as appropriate)
- Reporters should ensure the written account of the clinical incident is factual, clearly describes the sequence of events and does not apportion blame to any individual
- Protect (from unnecessary handling or tampering) and retain evidence that may be relevant to a subsequent inquiry. Evidence may include but is not limited to documentation, equipment, a product, packaging or medication. Retain the evidence and present it to Charge Midwife/Nurse Manager or Clinical Coordinator who should then retain and secure the evidence until collected by the SQU team.

Incident Reporting Procedure

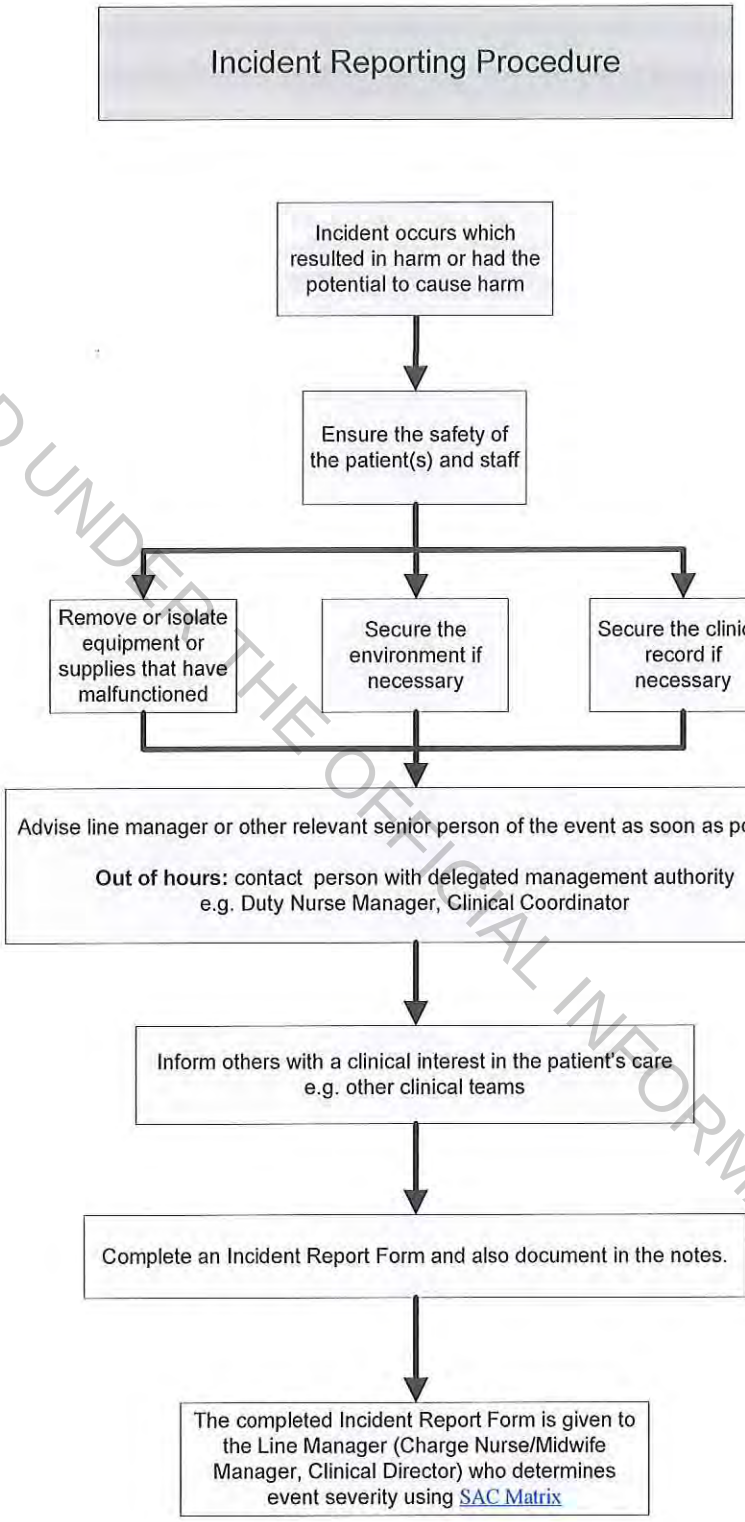
Step	Action
1	Staff directly or indirectly involved in an incident which resulted in harm or had the potential to cause harm. The first priority is to ensure the safety of the patient(s) and staff. As required and with the assistance of the area Charge or Coordinator • provide immediate care and comfort to individuals involved in the event (patient, staff or visitors) • make the environment safe • remove or isolate equipment or supplies that have or may have malfunctioned • secure the environment if necessary • secure the clinical record if necessary
2	Advise line manager or other relevant senior person of the event as soon as possible. **Out of hours**: Contact the person with delegated management authority for the hospital after hours e.g. Duty Nurse Manager, Duty Clinical Team Coordinator, Night Coordinator, Birthing Suite Clinical Coordinator, Associate Clinical Nurse Manager.
3	Inform others with a clinical interest in the patient's care e.g. other clinical teams
4	Complete an Incident Report Form before going home and also document the incident in the clinical records. It is helpful if all staff involved can write an account of the events and their involvement in them before leaving the shift. Attach these to the incident form.
5	Give the completed Incident Report Form to Line Manager, in most cases either a Charge Nurse or Midwife Manager or Clinical Director.
6	The Line Manager considers the severity of the incident and refers the matter directly to the Safety and Quality Unit Team Leader if they feel that the event is a SAC 1 or 2 event (refer to the SAC Matrix).
7	If the matter is a SAC 3 or 4 event, the Line Manager undertakes an initial investigation as to the circumstances of the incident and makes recommendations for implementation as required. This is documented on the reverse of the Incident Report Form
8	The Line Manager provides the Incident Report Form to the Safety and Quality Team within 10 days.
9	The Quality Coordinator reviews the incident and takes it to the Incident Review Group where, in consultation with the appropriate Professional

	and Clinical Leaders, the events, investigation and any recommendations made are reviewed. The Line Manager's review is either endorsed or further information sought.
10	The appropriate Service Manager, Professional or Clinical Lead completes the sign off in Section 9.
11	The Safety & Quality Unit will enter the details of the incident into QCMS and action points into the Quality Improvement Action Register.
12	The Safety & Quality Unit will then report on incident trends, actions and recommendations to the Incident Review Groups, Clinical Governance Committee, all staff via SQU publications and to the staff who completed the incident form via letter.

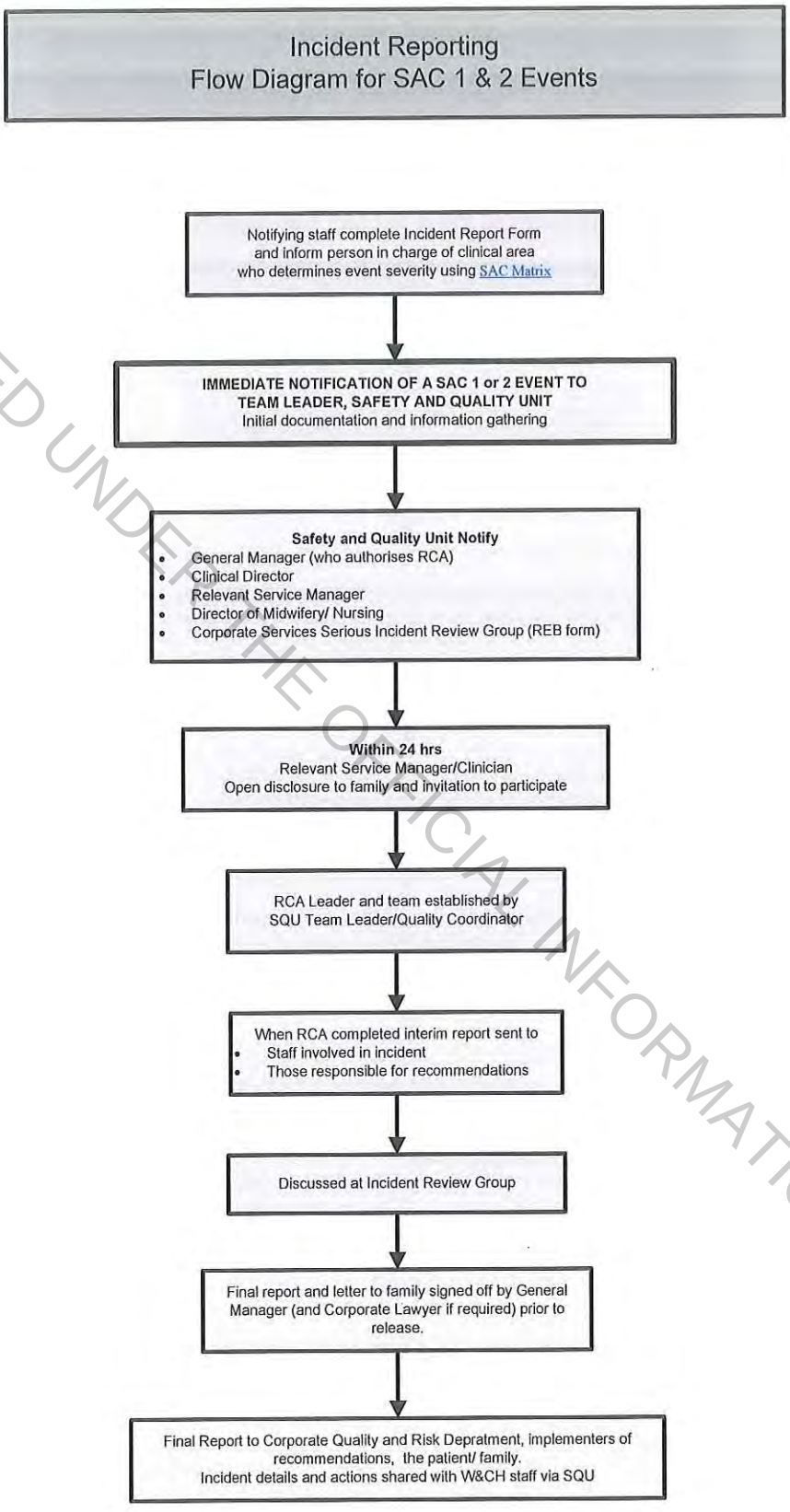
SAC Matrix

SAC Matrix

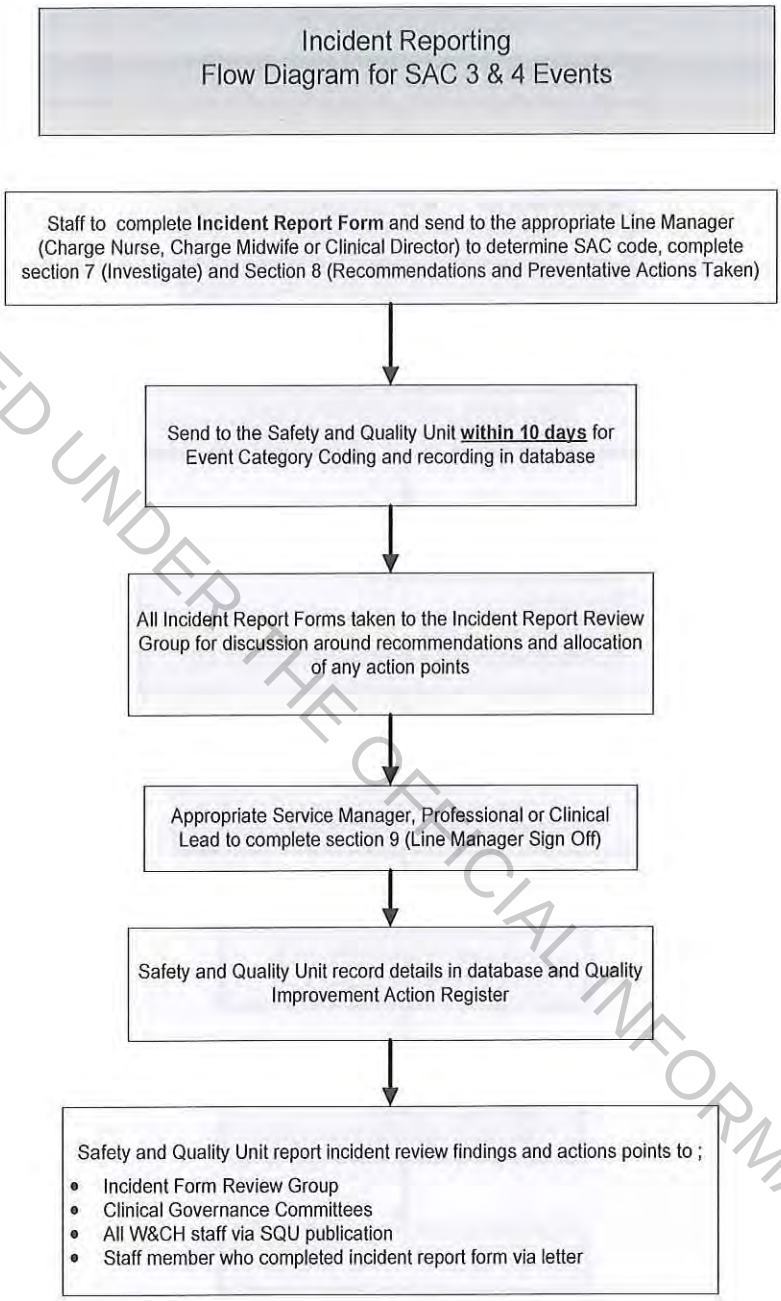
Incident Reporting Procedure



SAC 1 & 2 Events Procedure



SAC 3 & 4 Events Procedure



Root Cause Analysis (RCA)

The RCA methodology is used to assist the investigation of all incidents classified as SAC 1 or 2, except in cases of professional misconduct. It aims to focus on the event and systems rather than individuals and is conducted independent of any enquiry or investigation undertaken by Accident Compensation Corporation (ACC)

Objectives

- To have a positive impact in improving patient care, treatment and services and preventing sentinel events
- To focus attention on understanding the cause/s that underlie the event, and on changing the system and processes to reduce the probability of such an event in the future
- To increase the general knowledge about sentinel events, their causes and, and strategies for improving the safety culture

Goal

- To meet legal and statutory obligations
- To ascertaining the circumstances around significant/sentinel events and report on the factual circumstances surrounding the provision of care
- To highlight where services can be improved and remedial actions can prevent reoccurrence
- To ensure that factors that have been identified as contributing to a significant or sentinel event are discussed and utilised to promote learning and change practice
- To ensure that patient and staff confidentiality are respected throughout the RCA process
- To have a final report produced within 70 working days of commencement of the RCA

Accountability

- The General Manager, W&CH sanctions all RCA
- The RCA team reports to the Safety and Quality Unit Team Leader and to the General Manager W&CH, via the monthly Safety and Quality Unit report
- Following the recommendations of the RCA, action plans will be formulated by the services that are required to make improvements to a system or process

Responsibility

- The Lead Investigator will liaise regularly with the Safety and Quality Unit Team Leader on progress of the investigation and additional support that may be required
- SMO involved in an RCA is expected to dedicate the necessary priority required to complete RCA investigations in a timely manner
- The General Manager, W&CH and (if required, the CHDB corporate solicitor) will view RCA reports prior to distribution

RCA Lead

- Is required to have completed appropriate training in RCA investigations and may be a clinician or member of the Safety and Quality Unit.
- The Lead Investigator must be given the necessary time required to complete RCA investigations in a timely manner.

RCA Procedure

Step	Action
1	The Team Leader or Quality Coordinator approaches and appoints an appropriate RCA Lead and RCA team who conduct the remainder of these procedures.
2	Initial fact finding is undertaken, using the clinical records and the Incident Report Form to create a timeline of the events.
3	The timeline is used to determine what further information is required and to guide who should be interviewed.
4	Interviews of key staff are conducted by the team and written statements may be requested.
5	Complete the fact finding aspects of the review. This includes: • **What** happened • **When** did it happen • **Where** did it happen • **Who** was involved • **How** did it happen • **What** can be done to prevent recurrence
6	Once all the facts are learnt, the casual factors for the event are determined

7	The review team analyses the casual factors to determine the root cause(s). Ideally a single root cause should be determined.
8	The review team then draft recommendations for changes to practice that will help either minimise or prevent recurrence of the root cause to minimise future incidents.
9	The strength of recommendations should be considered in the context of the following hierarchy of the effectiveness of controls: 1. Elimination 2. Substitution 3. Creating redundancies or forcing functions 4. Developing policies, procedures and guidelines 5. Issuing protective equipment 6. Providing staff education 7. Accepting the consequences without taking any further action
10	In consultation with the staff responsible for implementation assign responsibilities and timeframes to the recommendations.
11	Provide feedback to staff involved in the event on the causal factors, root causes and proposed recommendations.
12	Submit a draft de-identified report to the General Manager (and Corporate Solicitor if required) for consideration.
13	Provide the final draft report to the Incident Form Review Group for endorsement of the findings and recommendations.
14	Provide the final report to the General Manager, W&CH for authorisation.
15	Distribute the final report to the Corporate Quality & Risk Department, CDHB Corporate Solicitor, those with responsibility to implement recommendations, the patient or family (if requested) and any others as required. Complete the REB and send to Corporate Services Serious Incident Review Group.
16	Ensure that the recommendations are included on the W&CH Quality Improvement Action Register for ongoing monitoring
17	SQU will update the Divisional SAC Log as required.

Performance Indicators/Benchmarks

- RCA reviews are completed within 70 days of the event;
- 90% of reported incidents are received by the Safety and Quality Unit within 10 days of the date that the incident occurred

Record/Evidence

- Incident Report Forms, maintained by the Safety and Quality Unit
- Quality and Complaints Management System (QCMS)
- Sentinel Event Review Files, maintained by the Safety and Quality Unit

Policy/Procedure Owner	Team Leader, Safety and Quality Unit
Date of Authorisation	Issue 1: 21 July 2009 Issue 2: 18th April 2011