Austin ED Patient Safety Case Conference Worksheet

INCIDENT: An event or circumstance that could have resulted, or did result, in unintended or unnecessary harm to a person receiving care (ACSQHC, 2006).

- **ADVERSE EVENT**: An incident in which harm resulted to a person receiving health care (ACSQHC, 2006).
- **NEAR MISS**: An incident that did not cause harm (ACSQHC, 2006). Near miss encompasses incident that had potentia to cause harm but didn't, due to timely intervention and/or luck/chance.

CARE DELIVERY PROBLEM (CDP)- ie: when to initiate review

- ☐ Unexpected death. Reportable to coroner/ Chief Psychiatrist?
- ☐ Unexpected escalation of care (eg: ICU)
- ☐ Wrong patient/ patient ID issue
- ☐ Delay/error in triage
- ☐ Inappropriate observation/ monitoring
- ☐ Inappropriate patient supervision
- ☐ Delay/error in diagnosis (including lack of differential diagnosis)
- ☐ Delay/error in pathology
- ☐ Delay/error in radiology
- ☐ Abnormal pathology/radiology results not followed up/actioned
- ☐ Delay/error in drug prescription/administration
- ☐ Delay/error/complication of procedure/equipment use
  - ☐ Wrong patient/procedure/site (sentinel event)
- ☐ Inappropriate physical restraint/mechanical restraint/ seclusion
- ☐ Other____

IN ADDITION TO THIS CASE CONFENERENCE, PLEASE FILL IN A RISK-MAN FOR THE FOLLOWING CIRCUMSTANCES

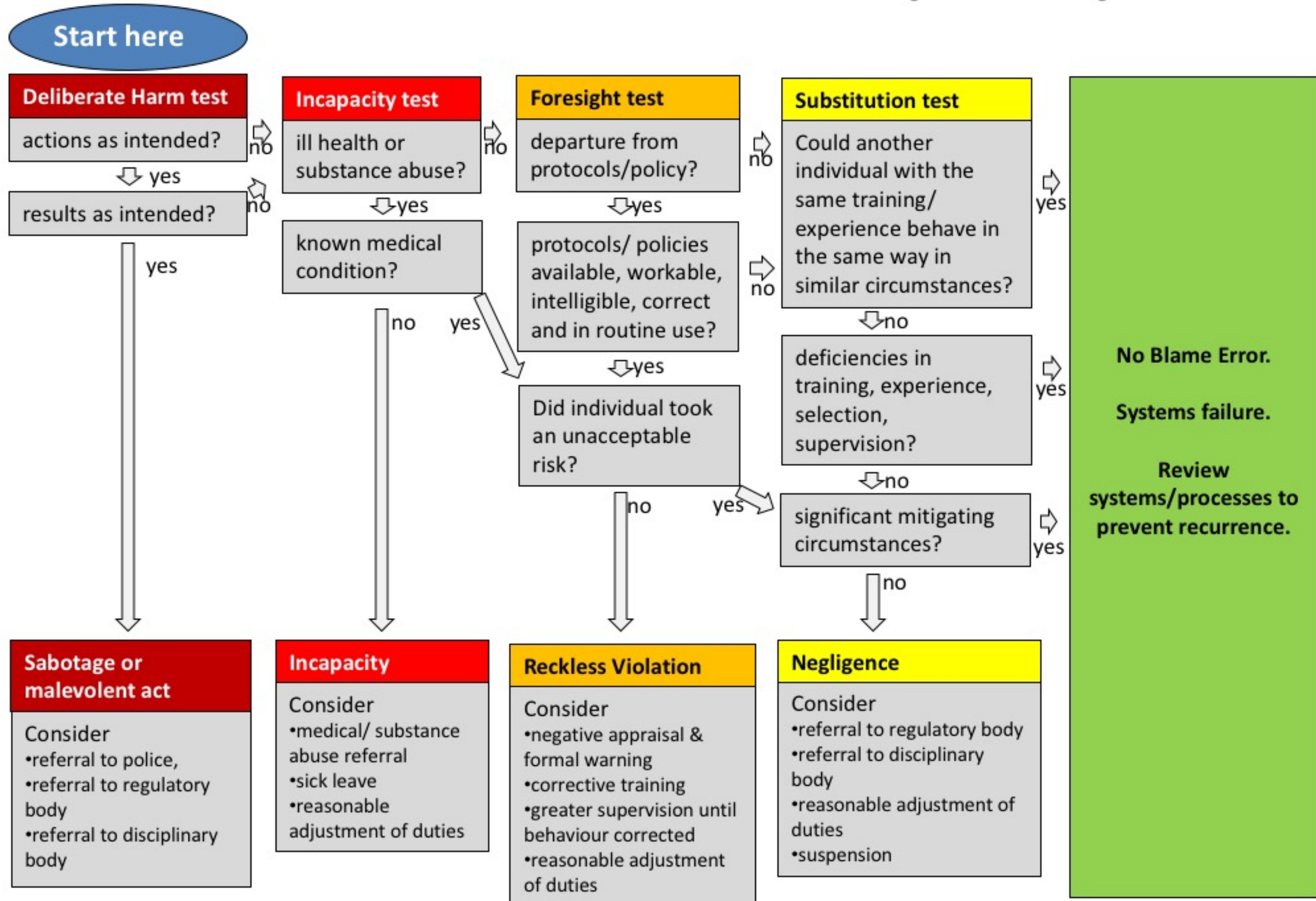
- ☐ ***ISR 1: Unexpected death/permanent injury harm***
- ☐ ***ISR 2: Temporary harm or reduction in functioning***
- ☐ ***ISR 3: Mild harm***
- ☐ ***ISR 4: Near miss event that resulted in no harm***

- *ISR 1 incidents receive formal RCA by the Quality & Safety Unit and the CSU Quality Coordinator*
- *ISR 2 get in-depth case review by management tier determined by QSU*
- *All ISR 3&4 are reviewed locally with aggregated and themed data presented by QC at the safety meetings and at the Executive*

What happened? (Brief chronology notes or flow chart)

This is a quality improvement document. Please do not identify any patients or healthcare providers.

James Reason's Just Culture culpability model



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(modified) London Protocol - Framework of Contributory Factors influencing Clinical Practice

Patient Factors

☐ Late presentation/ comorbidities
☐ Unable to communicate/poor historian
☐ Limited consumer engagemement/ non-compliance
☐ Advocate or carer lacking/ not consulted ☐
☐ Other?

No Fault factors

☐ Atypical presentation
☐ Rare or undiagnosable condition

Indiviudal (Staff) Factors. *please discuss with staff*

☐ Knowledge: inadequate prior experience?
☐ Skills/training: inadequate for task, ☐ uncredentialed
☐ Physical health issue_____________ ☐ previously known
☐ ψ-ologic/ψ-iatric issue___________ ☐ previously known
☐ Decision fatigue- interruptions, Hungry, Angry, Late, Tired {OT/recall/no breaks},
☐ Cognitive bias*
  ☐ ____
  ☐ ____
  ☐ ____
☐ previous reprimand re behaviour___________________

Team Factors

☐ Communication: verbal
  ☐ handover issue between _________&________
  ☐ other between_________&________
☐ Communication: written/EMR
  ☐ inadequate to provide clear picture issues/plan
  ☐ illegible
☐ Team structure
  ☐ Inadequate leadership ☐ supervision
  ☐ Inadequate team training ☐ interdisciplinary
  ☐ Inappropriate skill mix ☐ Inadequate role clarity

Work Environment Factors

☐ Inadequate induction/orientation
☐ Staffing levels
  ☐ After hours staffing inadequate
  ☐ Staff shortages - sick leave
  ☐ Use of temporary/locum staff
☐ Workload and shift patterns
  ☐ Inappropriate staffing levels
  ☐ High patient numbers in ED?(Cerner)
  ☐ High acuity in department? (Cerner)
  ☐ Access Block (no. of admited patients in ED >4/24 / Non-SSW admitted patients NEAT compliance < 90%?)
  ____
  ☐ Interruptions/ competeting taks/ distractions?
  ____
☐ Workspace not fit for process/purpose
____
____
☐ Desired service not available in timely manner_________________________________
☐ Other?________________________________

Technology factors

☐ Downtime (☐ scheduled/ ☐ unscheduled)
☐ Poor integration of incompatible programmes ('hybrid')
☐ Non-ituitive user interface/ poor data display
☐ information hard to find in timely manner (results/SMR)
☐ Lack of integrated decision support (guidelines, alerts)
☐ Actionable requests not actioned (eg: OPD appointments)
☐ Information routing error (eg: results to wrong person)
☐ User error
  ☐ Order entry slip (wrong pt, wrong dose)
  ☐ Inadequate training
  ☐ Cut & paste wrong information error
  ☐ Alert fatigue (___% ignored)
  ☐ Order entry workaround
☐ Other? ____________________________________

Equipment/test results

☐ test results unavailable or delay or inaccurate
☐ appropriate (medical/patient) equipment not available
☐ appropriate (medical/patient) equipment not functioning
  ☐ inadequate maintenace/upgrades/checklist compliance
☐ displays and controls not understandable
☐ several different models of equipment
☐ Other?_______________________________________

Organisational and Management factors

☐ guideline/policy/standards issue
  ☐ does not exist
  ☐ out of date/ not evidence based/ lacks clarity
  ☐ compliance issue
    ☐ poor policy awareness ☐ difficult to find
    ☐ tolerance of non-adherence ☐ violation
  ☐ guideline audit either not done or would not pick up this error
☐ Safety culture and priorities
  ☐ Similar incident in past
    ☐ previous investigations (level____________)
    ☐ recommendations not acted on
    ☐ recommendations acted on
      i)___________________________________
        ☐ fail.
        Reason______________________
      ii)__________________________________
        ☐ fail.
        Reason______________________
    ☐ was it possible to anticipate this fault?
  ☐ Inappropriate safety/efficiency balance
  ☐ system NOT designed to be fault tolerant

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Why did it happen? ('5 whys' of root cause analysis)

- No negative comments
- **Each human error and policy/procedure violation *MUST* have a preceding non-individual level cause**

Care delivery problem (CDP)	***Why?****(contributory factors)*	***Why?***	***Why?***	***Why?***	***Why?***
☐*Medication given to wrong patient*	*Nurse working for 14 hours which increases fatigue which increases risk of (slip/lapse) error*	*Asked by ANUM to work 'double' shift as staff had called in sick (allowed by management)*	*High levels of sick leave of senior nursing staff*	*Decreased senior: junior nursing staff ratios resulting in increased senior workload & increased senior sick leave*	*Budgetary decision*
☐					
☐					
☐					

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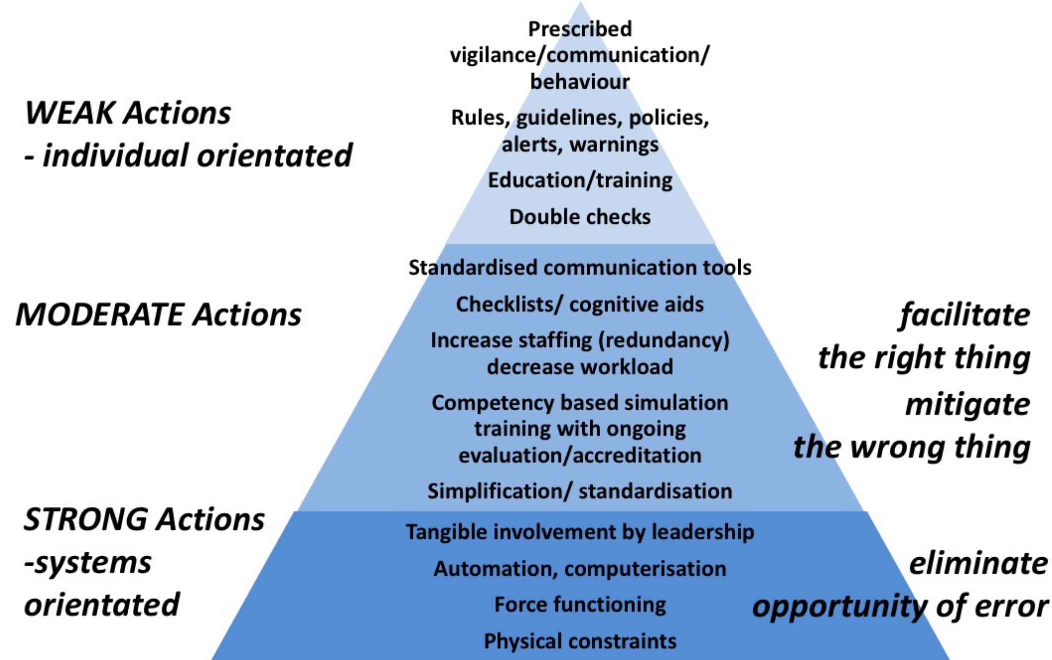
Recommendations Hierarchy (Human Factors Ergonomics)



What actions can *THE HOSPITAL* take to prevent this from happening again?

How will *THE HOSPITAL* know the action taken made a difference?

Recommended solutions	Strength	Treatment type	Whom	Due date	done	Outcome measure	Whom	Due date	done	Ongoing monitorin
	☐weak ☐mod ☐strong	☐accept ☐reduce ☐eliminate								☐yes ☐no
	☐weak ☐mod ☐strong	☐accept ☐reduce ☐eliminate								☐yes ☐no
	☐weak ☐mod ☐strong	☐accept ☐reduce ☐eliminate								☐yes ☐no

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