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

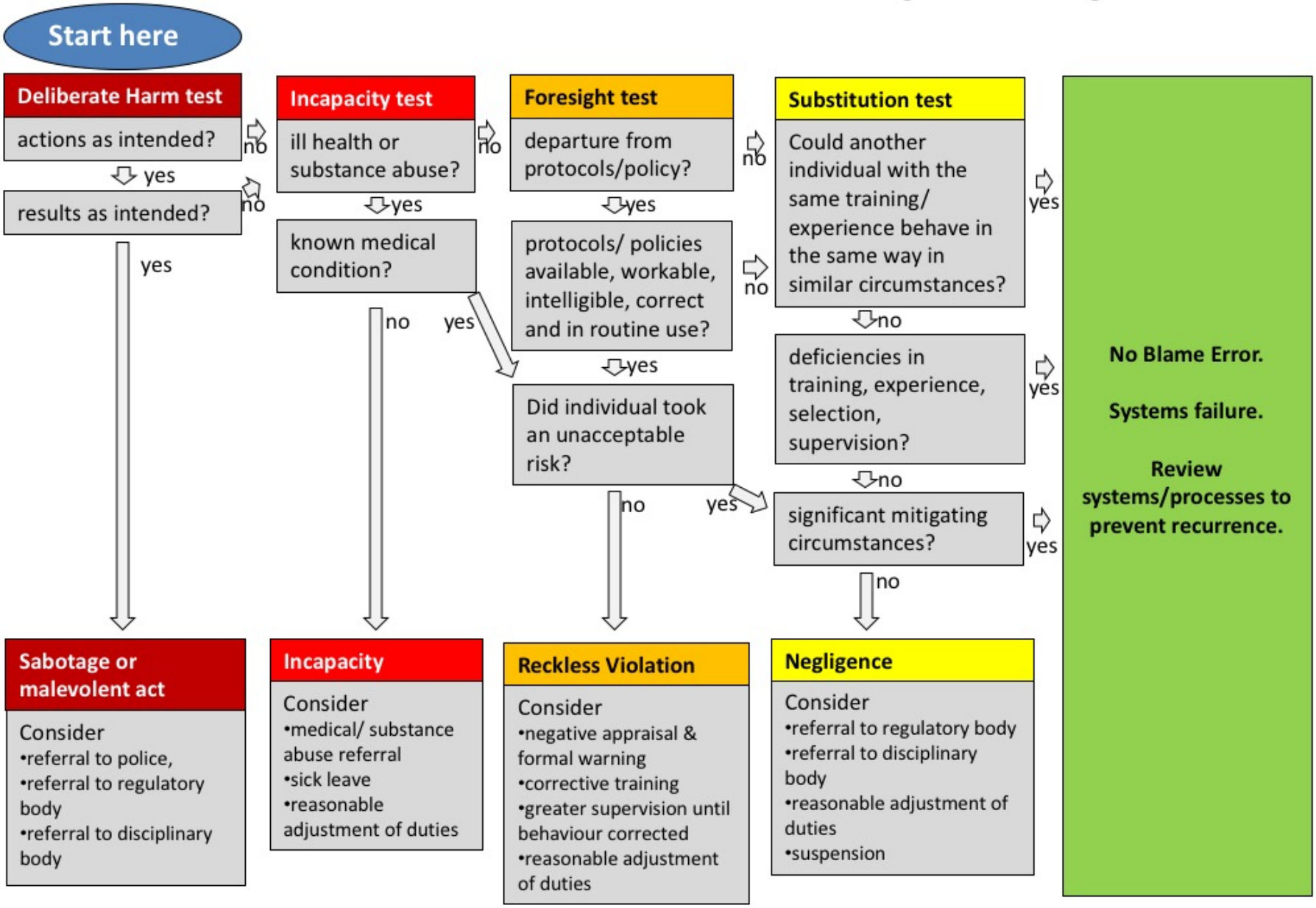
- ☐ ***ISR 1: Unexpected death/permanent injury harm***
- ☐ ***ISR 2: Temporary harm or reduction in functioning***
- ☐ ***ISR 3: Mild harm***
- ☐ ***ISR 4: Near miss event that resulted in no harm***

- *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



(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.

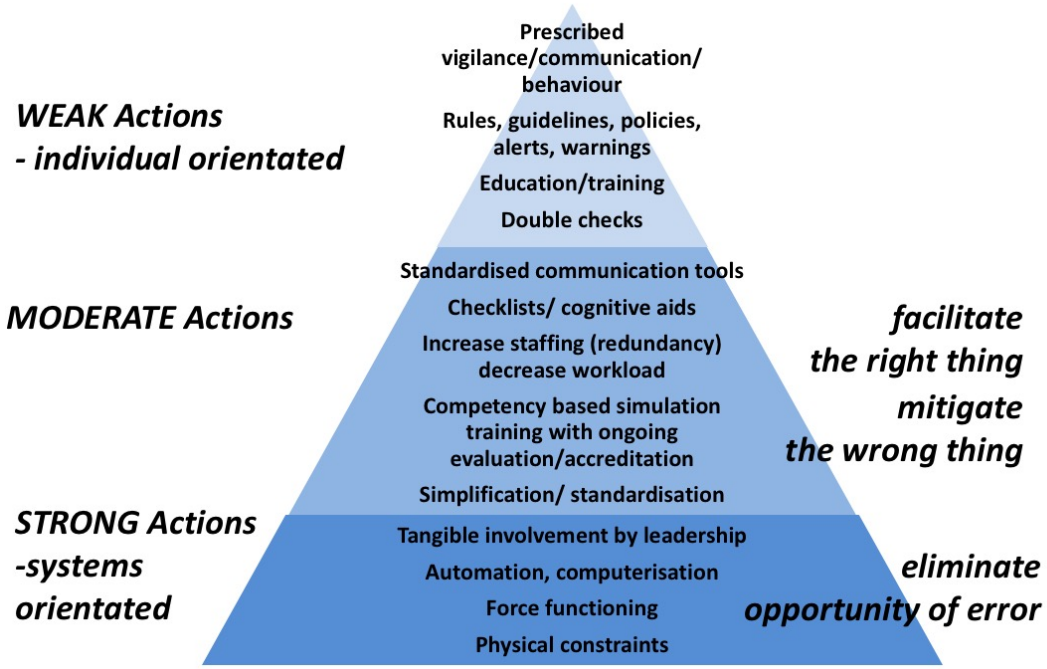
      Reason_____
    - ☐ was it possible to anticipate this fault?
  - ☐ Inappropriate safety/efficiency balance
  - ☐ system NOT designed to be fault tolerant

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*
☐					
☐					
☐					

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