

MONASH SAQ 2023.1 - ADMIN

A 65 year old man presented late on Sunday evening with acute, atraumatic hip pain. He was assessed as category 3 and after waiting for four hours, collapsed in the waiting room. Resuscitation efforts were unsuccessful and he died.

You are the ED consultant involved in the root cause analysis.

Question 1:

(2 marks)

Define root cause analysis. State two points in your answer.

Root Cause Analysis (RCA) is a method or methodology used to investigate an incident in order to assist in the identification of health system failures that may not be immediately apparent at initial review.

The purpose of an RCA is to identify system issues that contributed to or resulted in the incident occurring and to provide recommendations on actions to be taken to prevent or minimise a recurrence of a similar incident. It is interdisciplinary in nature and uses a structured process which endeavours to answer three questions:

- What happened?
- Why did it happen?
- How can it be prevented from occurring again?

An RCA is not used to apportion blame to staff; it is designed for learning and improving the quality of the health system

Question 2:

(6 marks)

List three systems issues that could lead to an adverse event in the ED and how each would contribute.

Systems Issue	How this contributes
ED overcrowding due to access block (boarding of admitted patients)	<ul style="list-style-type: none">• Patient unable to get into a nursed area to have obs/initial investigations/medical review• Potentially unwell/unstable patients become "lost" in the long list of patients waiting to be seen and are not recognised as being unwell• Admitted patients are de-prioritised by ED staff due to the need to see new patients, therefore deterioration in this group can go unchecked.
Inadequate staffing	<ul style="list-style-type: none">• Not enough people to efficiently see patients when they arrive• No one physically available to carry out initial investigations/brief assessment

Inexperienced staff	<ul style="list-style-type: none"> Lack of availability of senior staff or combination of junior staff leads to lack of expertise/prioritisation/decision making therefore having the potential for important signs to be missed and treatment to be delayed
Teamwork and communication issues	<ul style="list-style-type: none"> Conflict between staff can lead to lack of communication about relevant issues or can lead to no communication due to fear or reprisal. Therefore can miss information that is required for adequate treatment
Lack of equipment or equipment failures	<ul style="list-style-type: none"> Can impact directly on ability to provide treatment or pick up diagnosis eg CT scan broken down, Lack of available pumps to administer fluids/drugs
Reliability of consultation services or inadequate consultation services	<ul style="list-style-type: none"> Lack of regular inpatient service provision, lack of oncall service can mean specialist advice is not available when needed urgently
Lack of education/training	<ul style="list-style-type: none"> Lack of recognition of potentially life threatening conditions Lack of knowledge around correct management and urgency of management Lack of insight around when to escalate to senior members of staff
Lack of complete medical records	<ul style="list-style-type: none"> Staff reliant on verbal handovers which can lead to missed important information Lack of documentation of important information such as allergies can lead to drug errors
Difficulty using electronic health record or order entry system	<ul style="list-style-type: none"> Can mean documentation is limited and therefore important information is missed

Insufficient processes for surge/high demand	<ul style="list-style-type: none">• Unable to identify potentially unwell patients and re-prioritise their care as the triage system cannot adequately identify the priorities in the lesser acuity patients• Inability to access treatment spaces for new patients
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Question 3:

(4 marks)

State four aspects the open disclosure process must include.

At a minimum, an open disclosure process must include:

- an apology or expression of regret
- a factual explanation of what occurred, including actual consequences
- an opportunity for the affected patient to relate their experience
- the steps taken to manage the event and prevent its recurrence

If you have any questions about the question or answers or anything you'd like to discuss about training/exam issues, please don't hesitate to get in touch.

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