# ED RCA Report Taxonomy and Checklist (v 3.2)

**Guidance**

This checklist is used to classify incidents in Emergency Departments (EDs) through reviewing Root Cause Analysis (RCA) reports. It can be used to classify:

- factual information regarding the patient and incident as clearly described by the RCA
- findings identified in RCA reports by the team
- additional information. These may be `reading between the lines' issues that are not an RCA finding, but which you consider relevant or a contributory factor based on your professional expertise.

Please avoid rushing and ensure sufficient time to complete the checklist. It draws on your professional knowledge and skills. Please pay particular attention to the following areas.

1. Completing the checklist may require **re-reading** the RCA to capture all relevant information:
   - **Patient factors** - some may be revealed later in the RCA and not only in the presentation description
   - The`**patient disposition from ED**' classification may have more than one answer for re-presentations
   - **Specific services** and **staff grades** involved in the incident - ensure all relevant services and grades are included. If the specific staff grade in the RCA is not listed in the checklist, please either discuss with the ECI data and information manager or see further guidance on page 7 of this document.
2. The checklist seeks to classify most themes in RCA reports - but not necessarily all. If something important is not included, please set this out in the Further Comments section or relevant `other' box.

## RCA identification details

**Name of IAC reviewer***:*

**Summary** *(inc age and gender)*

**DOH RIB:**

**Incident date:**

*This should be the date as reported by the RCA cover sheet (i.e. no interpretation needed)*

**Incident time:**

*This should be the approximate time that any failings occurred (24hour clock). If not known, use time of presentation to ED (if a representation, use the presentation in which most care quality issues arose).*

**Is this RCA an emergency department incident?** ◯ Yes ◯ No (you do not need to complete the checklist)

## 1. Patient Factors

### Description of patient

*Demographics*

- ☐ Child / infant
- ☐ Greater than 75 years old
- ☐ Aboriginal or Torres Strait Islander

*Other patient factors*

- ☐ Developmentally delayed / disability
- ☐ Bariatric / Obese
- ☐ Currently aggressive
- ☐ Substance misuse (not including alcohol)
- ☐ Alcohol related
- ☐ Mental illness
- ☐ NESB
- ☐ Frequent ED user

☐ **Re-presentation (directly related to the incident)**

On presentation to ED, when was the onset of reported symptoms (estimated nearest number of days) Days

### Previous residency / location

- ☐ From residential aged care
- ☐ From other hospital
- ☐ From home
- ☐ From GP clinic
- ☐ Other - please specify

### Source of referral

- ☐ Self
- ☐ Relative
- ☐ Carer
- ☐ GP
- ☐ Other - please specify

Presenting problem/ diagnosis

## 2. General incident information

**Did the patient die?** ◯ Yes ◯ No or unknown

**Was the patient's death referred to the coroner?** ◯ Yes ◯ No or unknown

**Complaint made?** ◯ Yes ◯ No or unknown

**Consequence of the incident for the patient?**

◯ Death (SAC1)

◯ Major harm (SAC2)

◯ Minor harm (SAC3)

◯ No harm (SAC4)

**Was this incident a near miss?*** ◯ Yes ◯ No or unknown

**If the patient died, was this avoidable?*** ◯ Yes ◯ No or unknown

*These questions draw on your professional knowledge and skills, rather than feeling or sense. If answering 'yes' please consider the strength of evidence you have to support your view and be prepared to justify in the general comments section at the end of the document.

**Complications on presentation**

- ☐ Comorbidities
- ☐ Delirium / confusion / mentally disordered
- ☐ Non compliant (e.g. diabetic not taking medication)
- ☐ No advocate/support
- ☐ Out of hours presentation
- ☐ Other - please specify

**Summarise patient disposition(s) from ED**. In case of death, disposition relates solely to death in ED. If multiple presentations you may select more than one (e.g. if a discharged home patient returns DOA, select both).

- ☐ Home
- ☐ Residential care
- ☐ Self discharged against advice / absconded
- ☐ Admitted
- ☐ Inter-hospital transfer
- ☐ Died (specifically in the ED only)
- ☐ Returned dead on arrival

**Specific services and consultations involved in the identified issues in the RCA - select only relevant services** (e.g. if arrival by ambulance was uneventful, you may not need to select it)

- ☐ Aged care / Rehab / Palliative
- ☐ Ambulance
- ☐ Anaesthetics / Theatre
- ☐ Cancer care
- ☐ Cardiology
- ☐ Respiratory
- ☐ Dental
- ☐ Emergency
- ☐ Gastroenterology
- ☐ Renal
- ☐ ICU / HDU
- ☐ Radiology
- ☐ Justice health
- ☐ Maternal / Perinatal
- ☐ Medicine
- ☐ Paediatrics
- ☐ Pathology
- ☐ Surgical (please specify below)
- ☐ Orthopaedic
- ☐ Trauma
- ☐ Diabetes services
- ☐ Transplant
- ☐ Retrieval service
- ☐ Mental health / D&A
- ☐ Neurology
- ☐ MAU/EMU/CDU*
- ☐ Police
- ☐ Other - please specify

*MAU - Medical Assessment Unit, EMU - Emergency Medical Unit
CDU - Clinical Decision Unit

## 2. General incident information - continued

**Does the incident relate to recognised care pathways?**

- ☐ Mental health restraint/scheduled
- ☐ SEPSIS
- ☐ Cardiac
- ☐ Stroke
- ☐ Pressure ulcers
- ☐ Other - please specify

**Does the RCA identify any of the following clinical risk groups?**

- ☐ Deteriorating patient
- ☐ Medication related
- ☐ Falls
- ☐ Mental health

## 3. What happened, clinical management

**Which Clinical Management classification is most appropriate for this incident (tick all that apply)?** This section focuses on what physically / practically happened. The next section deals with explanatory / system issues

**Triage**

- ☐ Delayed patient triage
- ☐ Incorrect allocation of triage category
- ☐ Failure to recognise a sick patient

**Investigations / pathology / tests**

- ☐ Inappropriate / inadequate
- ☐ Delayed
- ☐ Results not reviewed
- ☐ Results not actioned
- ☐ Delayed disposition decision
- ☐ Patient ID issues

**Medical imaging (radiology)**

- ☐ Patient ID matter
- ☐ Non-compliance with ID process
- ☐ Incorrect site / patient
- ☐ Delayed imaging
- ☐ Delayed reporting of results
- ☐ Results not reviewed
- ☐ Results not actioned
- ☐ Misinterpretation of results

**Major errors**

- ☐ Wrong patient
- ☐ Wrong procedure
- ☐ Wrong site

**Diagnosis**

- ☐ Missed / inadequate differential diagnosis
- ☐ Delayed
- ☐ Wrong

**Monitoring / observations**

- ☐ Not performed
- ☐ Inadequate
- ☐ Not reviewed
- ☐ Significance not recognised
- ☐ Delay / failure to respond
- ☐ Inappropriate response to escalation

**Patient supervision**

- ☐ Lack of supervision
- ☐ Inappropriate care level
- ☐ Inappropriate restraint
- ☐ Falls (e.g. toilet)

**Treatment and medication**

- ☐ Delayed
- ☐ Inadequate
- ☐ Failed to administer
- ☐ Inappropriate

## 4. Contributory factors - why did it happen?

**Access block**

- ☐ To service: bed - delayed / not available
- ☐ To diagnostics
- ☐ Outlier (inappropriate ward)

**Care planning**

- ☐ Inadequate care plan documented in the patient records
- ☐ High risk presentation not considered
- ☐ Lack of consensus by clinicians regarding appropriate patient care
- ☐ Perceived as palliative
- ☐ Patient / carer not involved in care planning
- ☐ Informed consent not obtained

**Communication**

- ☐ GP / specialist / VMO
- ☐ ED consultant / ED physician
- ☐ Within ED team
- ☐ Admitting consultant
- ☐ Inadequate handover in ED
- ☐ Between ED and ward
- ☐ Administration
- ☐ Persons responsible not available
- ☐ Inappropriate referral
- ☐ Patient / carer
- ☐ IT failure / IT incapacity

**Leadership, management and supervision**

- ☐ Inadequate clinical leadership / teamwork
- ☐ Supervision / staff support inadequate
- ☐ No identified lead clinician
- ☐ Senior management notified? (select if yes)

***Issues arising:***

- ☐ Not notified
- ☐ Delayed response
- ☐ Inadequate response

**Inappropriate / unsafe environment**

- ☐ Inadequate security
- ☐ Unable to adequately visualise or monitor patient
- ☐ Overcrowding/no bed available in ED
- ☐ Overwhelming acuity of patients

**Equipment, mobility aids & patient facilities**

- ☐ Not maintained
- ☐ Not available
- ☐ Not meeting needs (e.g. no bariatric chairs)
- ☐ Home device issues
- ☐ Inadequate knowledge / skills for using equipment
- ☐ Inadequate compliance with equipment checklist

**Policy / guidelines / pathways**

- ☐ Not known
- ☐ Not accessible
- ☐ Inadequate / not clear

**Risk management**

- ☐ Review / monitoring system inadequate
- ☐ Falls risk management
- ☐ Safety security check not completed
- ☐ Leaving patient with known high risk of violence in ED for long periods

***Inadequate management for:***

- ☐ Suicide risk
- ☐ Biohazards infection control
- ☐ Other - please specify

- ☐ Discharge decision wrong*

*Consider also the discharge section overleaf.

**End of life decision-making / advance care directive**

- ☐ None
- ☐ Inadequate
- ☐ Not available
- ☐ Not adhered to by family
- ☐ Not adhered to by staff

## 4. Contributory factors - why did it happen? (continued)

### Accountability and responsibility

- [ ] Consultation requested? (select if yes)

***Result:***

- [ ] No consultation
- [ ] Delayed
- [ ] Refused
- [ ] Inappropriate
- [ ] Other - please specify

- [ ] Failure to understand clinical responsibility or level of skill required

***ED escalation plan:***

- [ ] No plan
- [ ] Not enacted
- [ ] Not responded to
- [ ] Not complied with
- [ ] Plan inadequate

### Documentation

- [ ] Clerical error
- [ ] Inadequate documentation in patient records
- [ ] Inadequate patient transfer documentation
- [ ] Inadequate access to medical records (e.g. with hybrid medical records)
- [ ] Inadequate forms or clinical pathways for patient records (paper or electronic)
- [ ] EMR related documentation problems - please specify

### Discharge**

- [ ] Inadequate considerations / knowledge of patient's residential situation and condition
- [ ] Inadequate discharge reporting (e.g. to GP / Specialist)
- [ ] Inappropriate discharge
- [ ] Inappropriate diagnosis at discharge
- [ ] Liaison with relatives / carers
- [ ] Transport arrangements
- [ ] Self discharged against medical advice
- [ ] Absconded / DNW
- [ ] Inadequate discharge advice to patient / carer

### Workforce / demand

- [ ] Skill mix inappropriate
- [ ] Orientation / induction inadequate
- [ ] Training / skills / education inadequate
- [ ] Issues with credentialising / scope of practice
- [ ] Senior staff unavailable
- [ ] Inadequate staff numbers
- [ ] Inappropriate rostering
- [ ] Casual JMO / locum or agency staff new to ED
- [ ] Base Hospital receiving frequent calls from multiple facilities without medical officer
- [ ] No Medical Officer available on call (COSOPS - clinical operations standing operating procedure)

### Transfer of care / retrieval (inter or intra hospital)*

- [ ] Handover - inadequate (from ED to or from another service)
- [ ] Inadequate initiation of patient transfer / retrieval
- [ ] Delay in speciality accepting patient
- [ ] Unable to access bed
- [ ] Inappropriate transfer / retrieval
- [ ] Patient unstable / unsuitable for transfer (time /service)
- [ ] Inadequate patient preparation / stabilisation
- [ ] Inadequate monitoring / care during transfer
- [ ] Delay in ambulance acceptance of transfer
- [ ] Inadequate community -based care
- [ ] Transport delayed - please specify

*To avoid overlap in taxonomy categories, consider using options under 'Access Block' and *Inadequate handover in ED* under 'Communication'

**Classification for *discharge decision wrong* is under 'Risk management'

## 5. Human Factors

**Cognitive errors -** failure to understand / synthesize / act appropriately on available information / seek assistance

**Thought-based errors**

- ☐ Pattern matching (an 'overly' automated approach to interpreting information and identifying underlying patterns)
- ☐ False hypothesis (e.g. wrong diagnosis, relying on a hypothesis with insufficient evidence)
- ☐ Mindset / narrow thinking or confined to rule-based thinking

**Risky behaviours**

- ☐ Exceeding scope of practice
- ☐ Acting outside widely-accepted standards
- ☐ Inappropriate use of equipment / medications

**Personal conditions**

- ☐ Physically fatigued or unwell
- ☐ Mentally fatigued, distracted or unwell
- ☐ Rushed clinical decision making
- ☐ Unsatisfactory attitude / behaviour

**Skill-based errors** - these are practically-orientated mistakes (i.e. slips and lapses) rather than lack of skills, training etc, which is covered under the 'Workforce' section.

- ☐ Errors of omission or commission during diagnosis, planning or treatment
- ☐ Attention - slips / lapse
- ☐ Memory - slip / lapse

**Further Guidance - medical staff grades**

Some RCAs use different phrases to name medical staff grades. The following provides further guidance for classifying medical staff grades if they are not listed (on the right).

-Senior MO or Senior Medical Officer - not specific to a staff grade - classify as "MO (title unknown)"

-Senior EDMO - classify as "MO (title unknown)"

-Senior Clinician - classify as "MO (title unknown)" if you think this refers to a doctor, otherwise as "Nurse or Medical Officer (unknown)"

Any further issues with classifying medical grades, please contact Matthew.Murray@aci.health.nsw.gov.au

**Staff skill level** (related to the incident) - skill level relates only to the staff directly involved in the incident. The objective is to look at staff mixes, teams and skill levels. If grades in the RCA are not listed here, see further guidance (below left).

**Staff skill level involved in the incident**

- ☐ Intern
- ☐ Technical / physician's assistant
- ☐ Resident
- ☐ Registrar
- ☐ Fellow
- ☐ Non-ED Staff Specialist / Consultant
- ☐ CMO / non-specialist ED Medical Officer
- ☐ Emergency physician / ED consultant / ED Staff Specialist
- ☐ Locum MO
- ☐ JMO (Junior Medical Officer)
- ☐ GP
- ☐ GP/VMO (Visiting Medical Officer)
- ☐ MO / Medical Officer (title unknown)
- ☐ AIN
- ☐ EN
- ☐ RN
- ☐ CNS
- ☐ CNE
- ☐ CNC
- ☐ NP
- ☐ Triage
- ☐ Nurse (title unknown)
- ☐ Nurse or Medical Officer (unknown)
- ☐ Senior ED managers
- ☐ Executive hospital managers
- ☐ Administrators
- ☐ Telephone operators
- ☐ Security / wards person
- ☐ Ambulance staff
- ☐ Other - please specify

## 6. RCA review

**Number of recommendations made?**

**Appropriate time frame?** ◯ Yes ◯ No

**Are there recommendations for each causal statement?** ◯ Yes ◯ No

If no, what causal statements do not have recommendations?

**Does the RCA report identify and analyse the key contributing factors for the incident?**

If No, what appears to have been missed and what action(s) does the committee recommend?

◯ Yes - all factors
◯ No - some of the factors but not all
◯ No - does not identify / analyse key factors

**Overall judgement on the quality of the RCA report?**

Specify any further comments for RCA education (e.g. Use this RCA as a good/bad teaching example)

◯ Excellent
◯ Good
◯ Room for improvement
◯ Below standard

**RCA follow up required?*** ◯ Yes ◯ No

**Outcomes and findings***

- ☐ Escalate to the Clinical Risk Action Group
- ☐ Respond to specific CEC requests
- ☐ Develop feedback loop to report findings to State-wide Emergency Departments
- ☐ Develop education package re: RCA documentation / process

*At this stage these actions may not be undertaken - these lists are illustrative of what might happen as the IAC develops its reporting role.

**Any further comments**

**When complete, please email the completed form to matthew.murray@aci.health.nsw.gov.au**