Australasian College
for Emergency Medicine

Respectful Communication

Stephen Priestley

Patient Safety Workshop March 2019

Australasian College
for Emergency Medicine

Disrespectful Communication

Stephen Priestley

Patient Safety Workshop March 2019

Australasian College
for Emergency Medicine

Disrespectful Communication
or
Can a Rude Physician Hurt More than a Patient's Feelings?

Stephen Priestley

Patient Safety Workshop March 2019

Incompatible Blood Transfusion

Trauma Doctor

Previous complaint received from a staff member

"*Dr X arrived in OT 45 mins after the case was scheduled to start. He immediately reprimanded the residents, OT staff, and the Anaesthetist because the patient was still awake and the abdomen not yet opened.*"

Previous complaint received from a patient

" I asked the doctor why he was seeing me so much later than my appointment time, which was 9am. It was now 11.30 am. He started yelling at me : people cant get in to see me. You're lucky you got an appointment. I don't need this"

Unprofessional Behaviours
Disruptive Behaviours

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Disruptive Behaviours

Any conduct by a team member that interferes with, or has the potential to interfere, with the teams ability to achieve intended outcomes.

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Disruptive Behaviours

Any conduct by a team member that interferes with, or has the potential to interfere, with the teams ability to achieve intended outcomes.

→ *"Behaviours that undermine a culture of safety"*

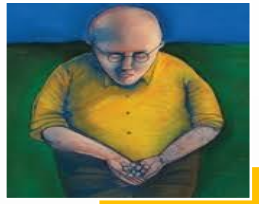
Spectrum of undermining behaviours

Aggressive

- Inappropriate anger
- Yelling,publicly degrading team members
- Intimidation
- Pushing, throwing objects
- Swearing
- Physical abuse
- Outbursts of verbal abuse/anger

Passive Aggressive

- Derogatory comments about hospital, services
- Inappropriate joking
- Sexual harassment
- Complaining
- Blaming
- Hostile notes, emails



Passive

- Chronically late
- Disregard of policy, procedure
- Not available
- Ill prepared
- Non participation
- Avoiding meetings, individuals
- Inappropriate, inadequate chart notes
- Failure to participate in handovers

Rudeness & Team Performance

NICU Teams exposed to ill-mannered behaviour demonstrated poorer diagnostic and procedural performance than those not exposed to rudeness.

These effects were mediated by a reduction in information-sharing and help- seeking behaviours exhibited by teams.

These are valuable team collaborative processes that allow teams to function optimally and are essential for patient care and safety.

Riskin et al 2015

Rudeness

UK study reported a high prevalence of rude, dismissive and aggressive (RDA) communication affecting 31% of doctors on a daily or weekly basis

RDA behaviour had a marked adverse effect on those subject to it, with 40% of respondents saying that this behaviour moderately or severely affected their working day.

-Personal misery

-Professional demotivation

-Impaired cognitive skills

-harms cooperation and the willingness to help others

Sticks and stones: investigating rude, dismissive and aggressive communication between doctors

Bradley et al Clinical Medicine 2015 Vol 15, No 6: 541–5

Patient complaints and ‘lawsuit – prone physicians”

Patient complaints and ‘lawsuit – prone physicians”

The doctor made me wait well past my appointment time.

The surgeon never visited with my family after my surgery

The doctor was rushed, so she didn’t listen to us, skimped on her exam, failed to order appropriate tests, and made an error on my prescription

Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications

Cooper et al JAMA Surg 2017;152(6) 522-529

OBJECTIVE

To examine whether patients of surgeons with a history of higher numbers of unsolicited patient observations are at greater risk for postoperative complications than patients whose surgeons generate fewer such unsolicited patient observations.

Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications

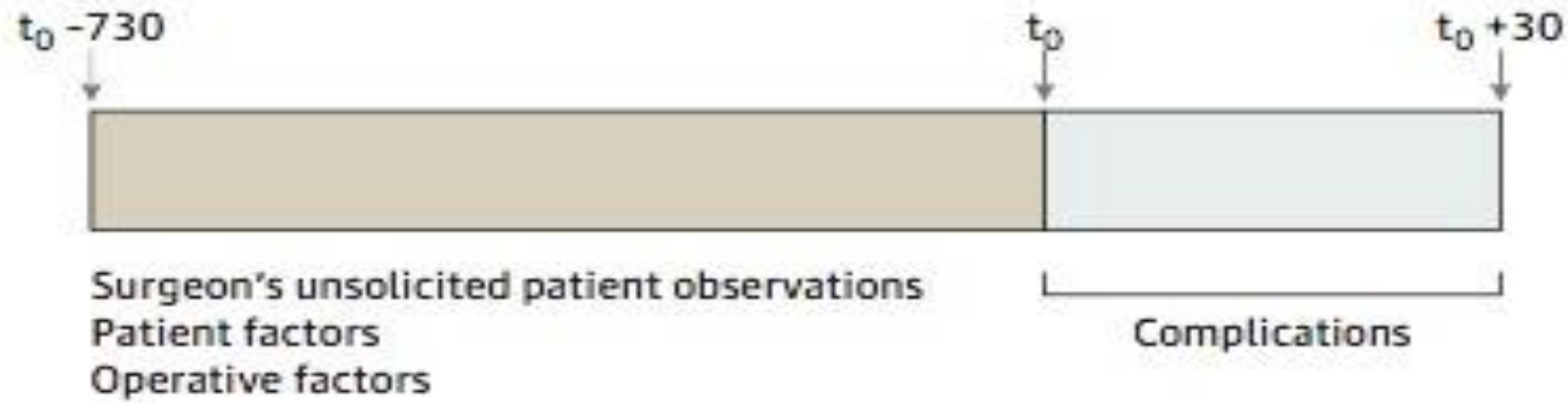
Cooper et al JAMA Surg 2017;152(6) 522-529

32,125 operations by 817 surgeons across 7 centres in US

Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications

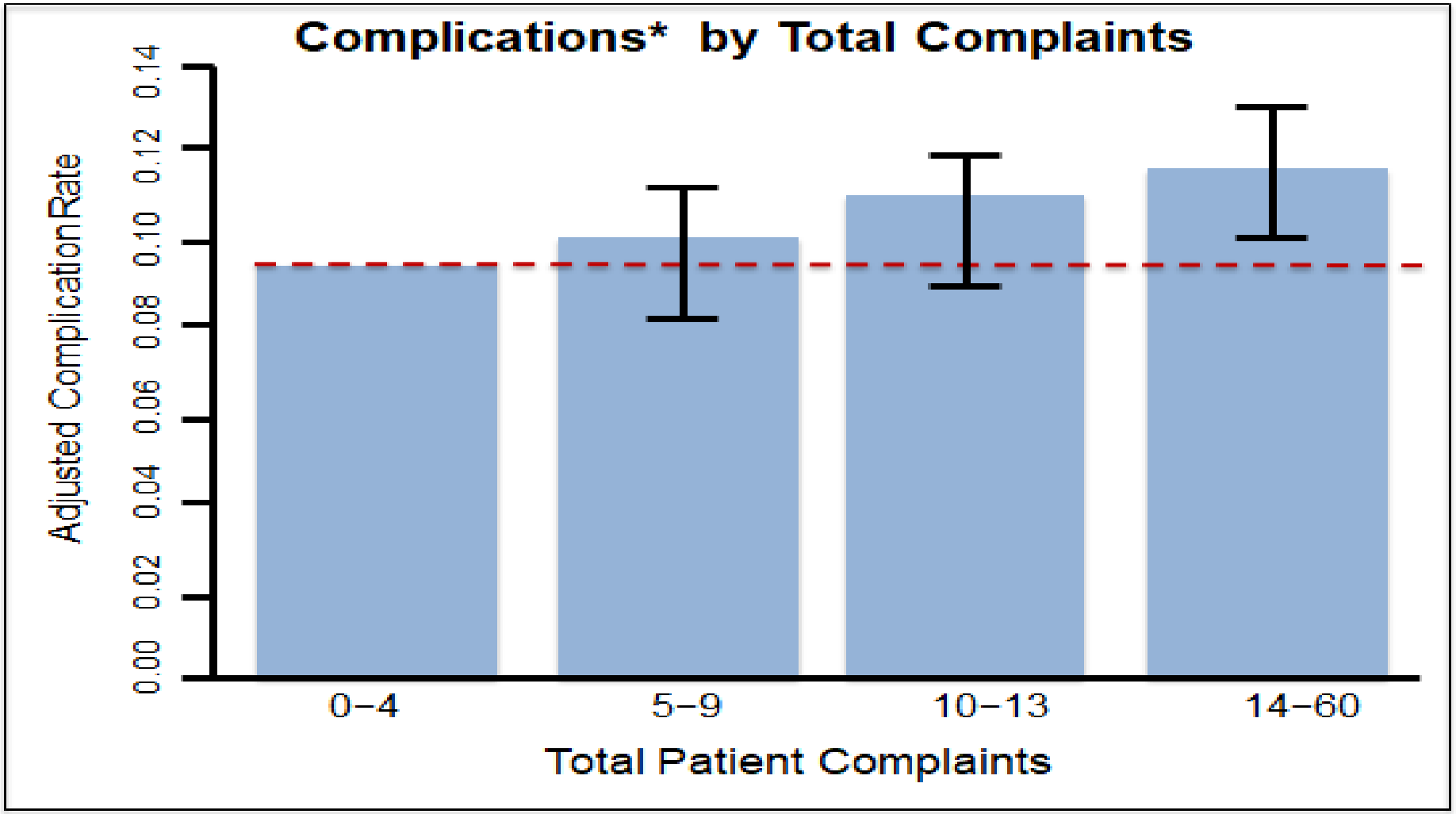
Cooper et al JAMA Surg 2017;152(6) 522-529

Figure 1. Study Design



Association between a surgeon's prior unsolicited patient observations and complications following operations for patients in the National Surgical Quality Improvement Program. t_0 Indicates the date of the operation.

Surgical Complications and Patient Complaints



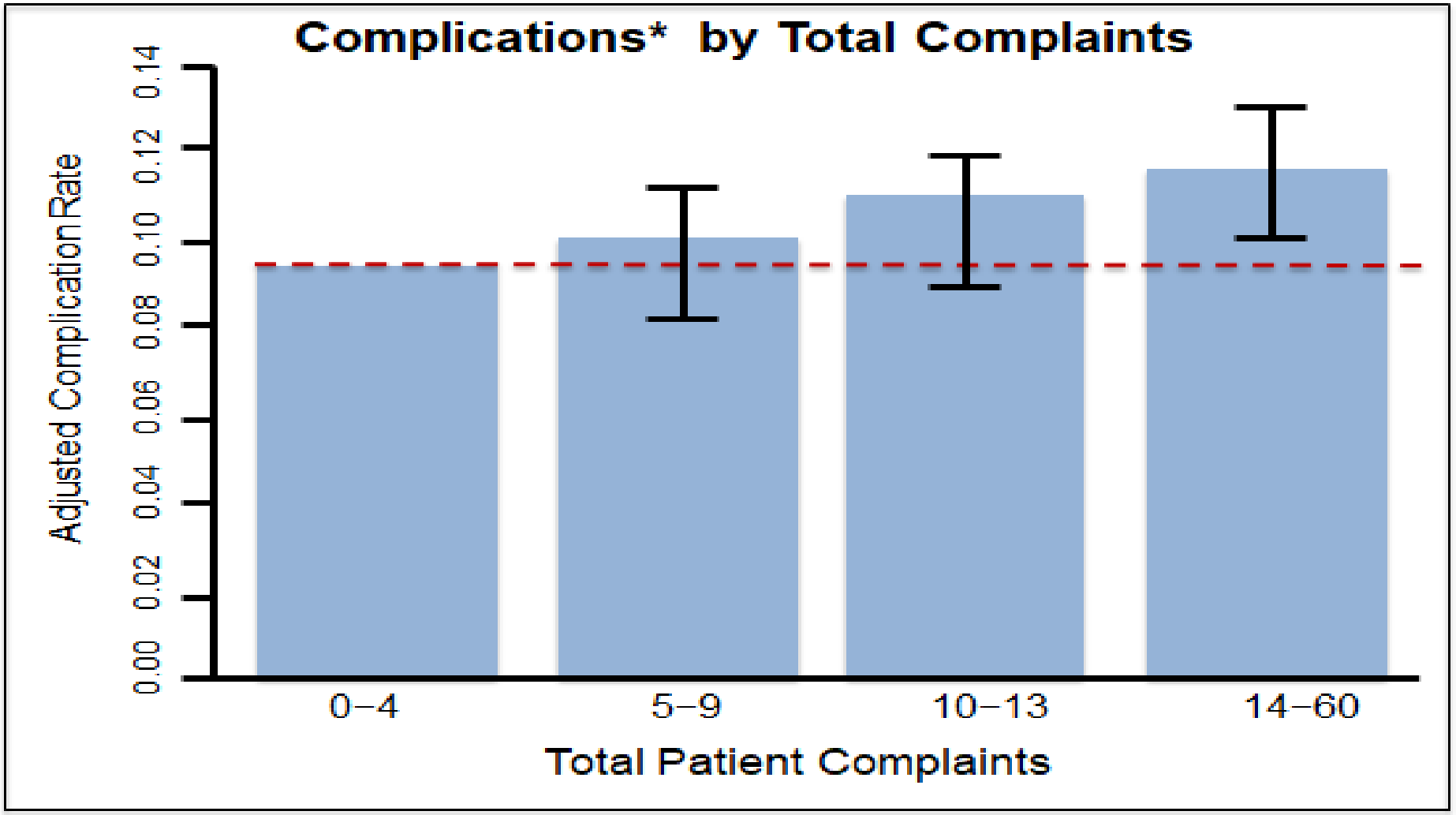
426

Additional Complications

*Includes surgical site infections, wound disruptions, and medical complications (e.g. pneumonia, embolism, stroke, MI, UTI)

Cooper W, et al. 2017

Surgical Complications and Patient Complaints

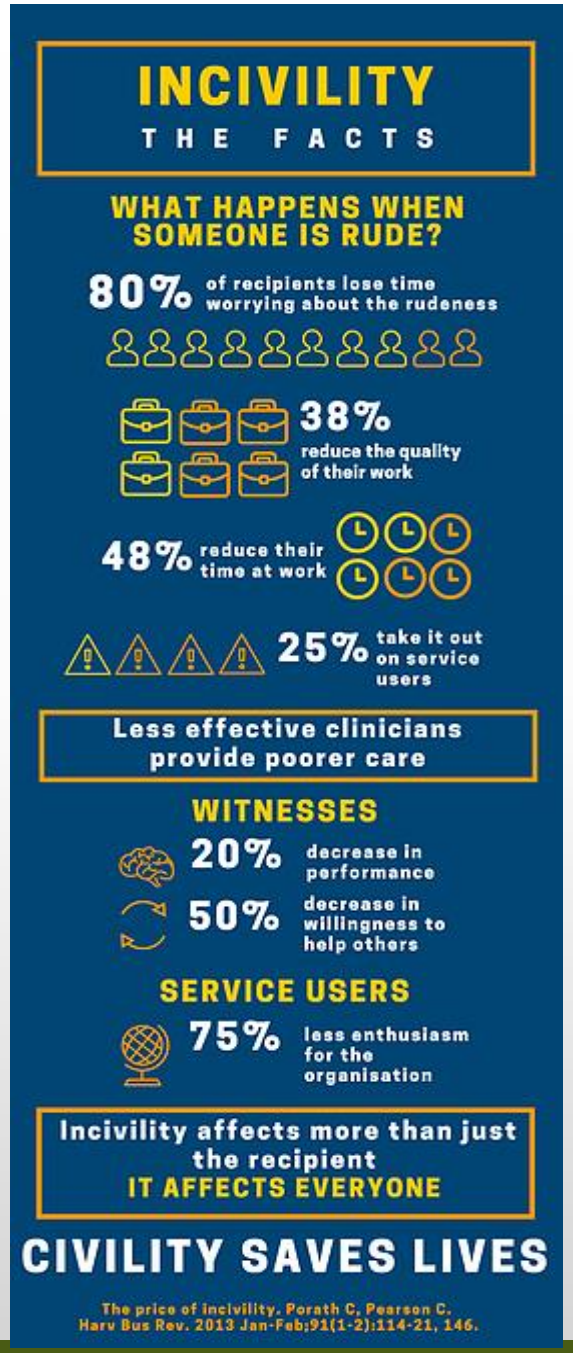


426
Additional Complications

In the US:
356,000
Additional Complications Per Year

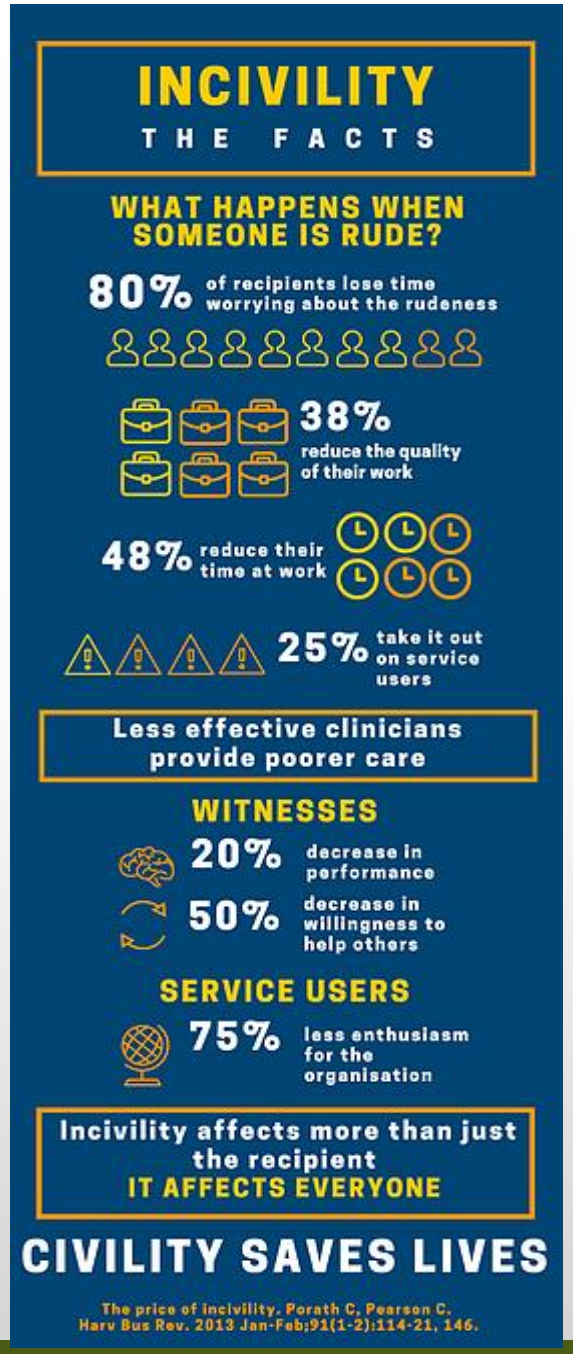
*Includes surgical site infections, wound disruptions, and medical complications (e.g. pneumonia, embolism, stroke, MI, UTI)

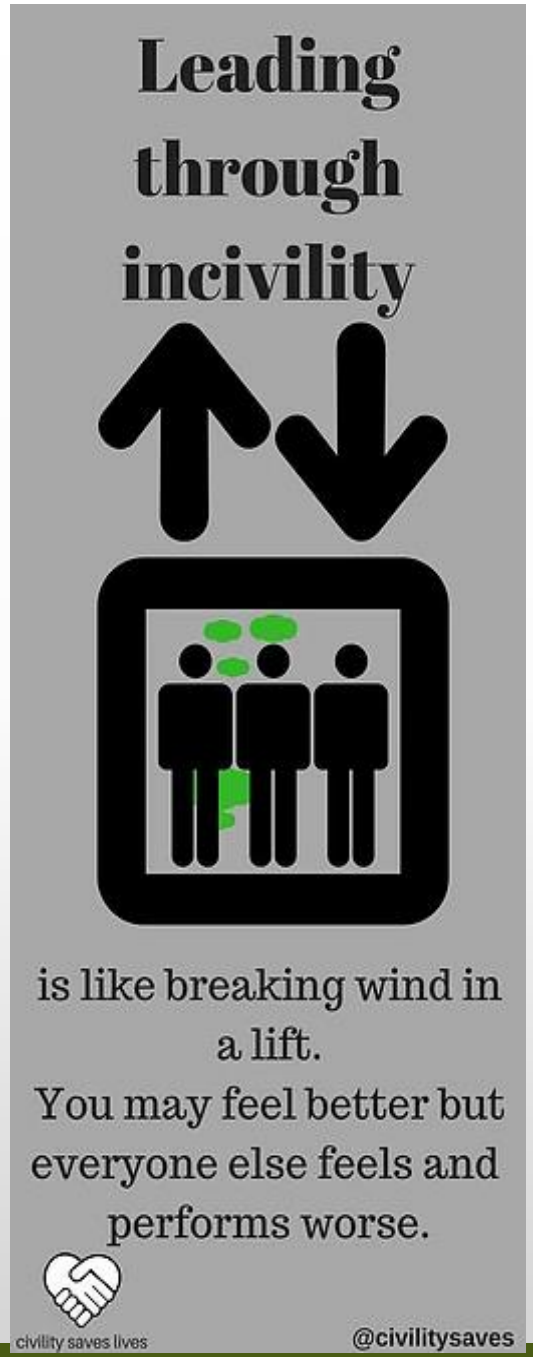
Cooper W, et al. 2017



civilitysaveslives.com

civilitysaveslives.com





Australasian College
for Emergency Medicine

Building a safety culture

Translational wellness - individual and team wellness as a precondition for safe and quality patient care

Dr Shahina Braganza

Senior Emergency Physician, Gold Coast Health, Queensland

Australasian College
for Emergency Medicine

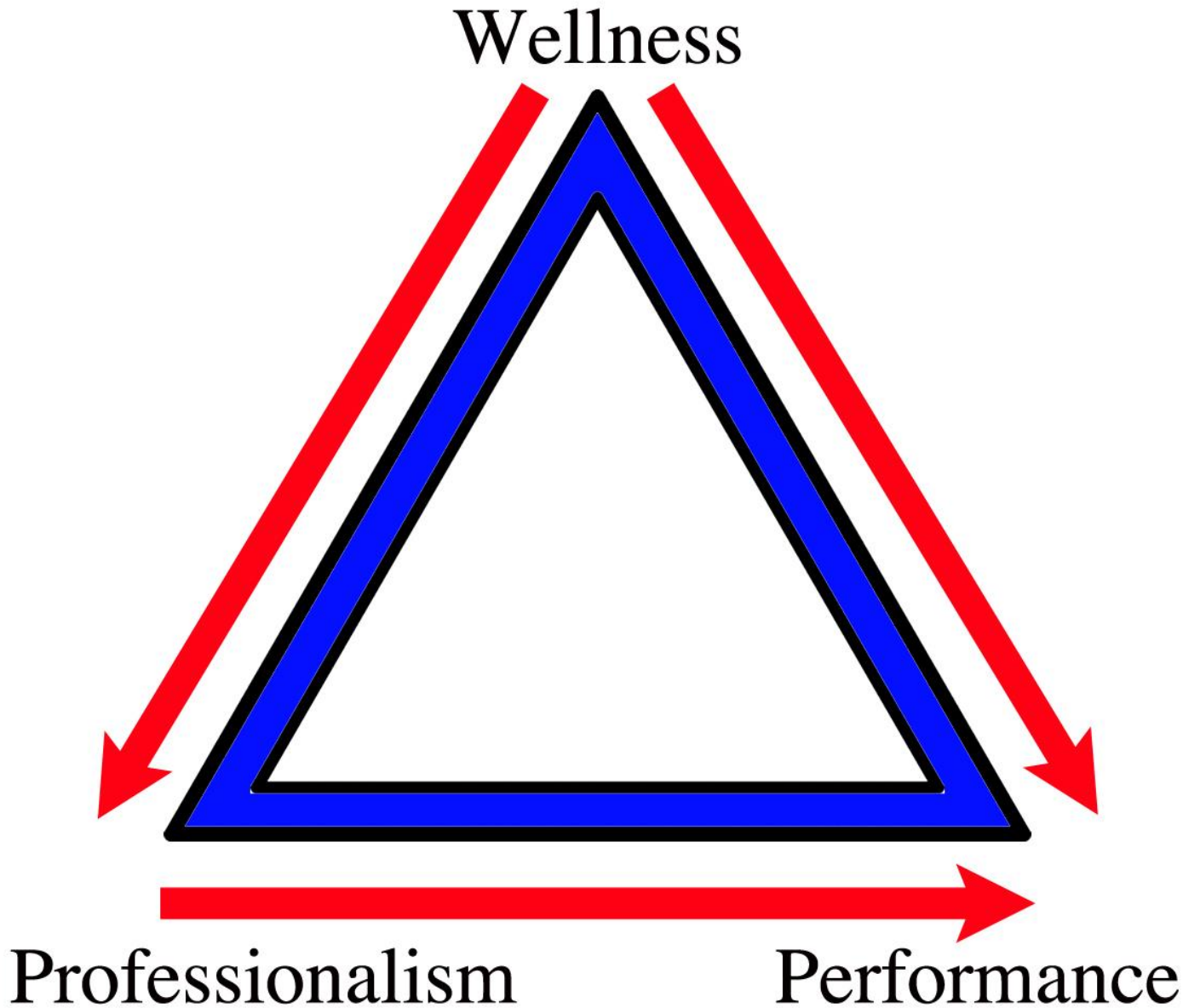
Translational Wellness

Individual and team wellness

as a precondition for safe and quality patient care

The psychological and physical safety (and wellbeing) of the workforce is integral to the provision of high quality and safe patient care.


Wellness
Professionalism
Performance


Wellness
Professionalism
Performance


Wellness
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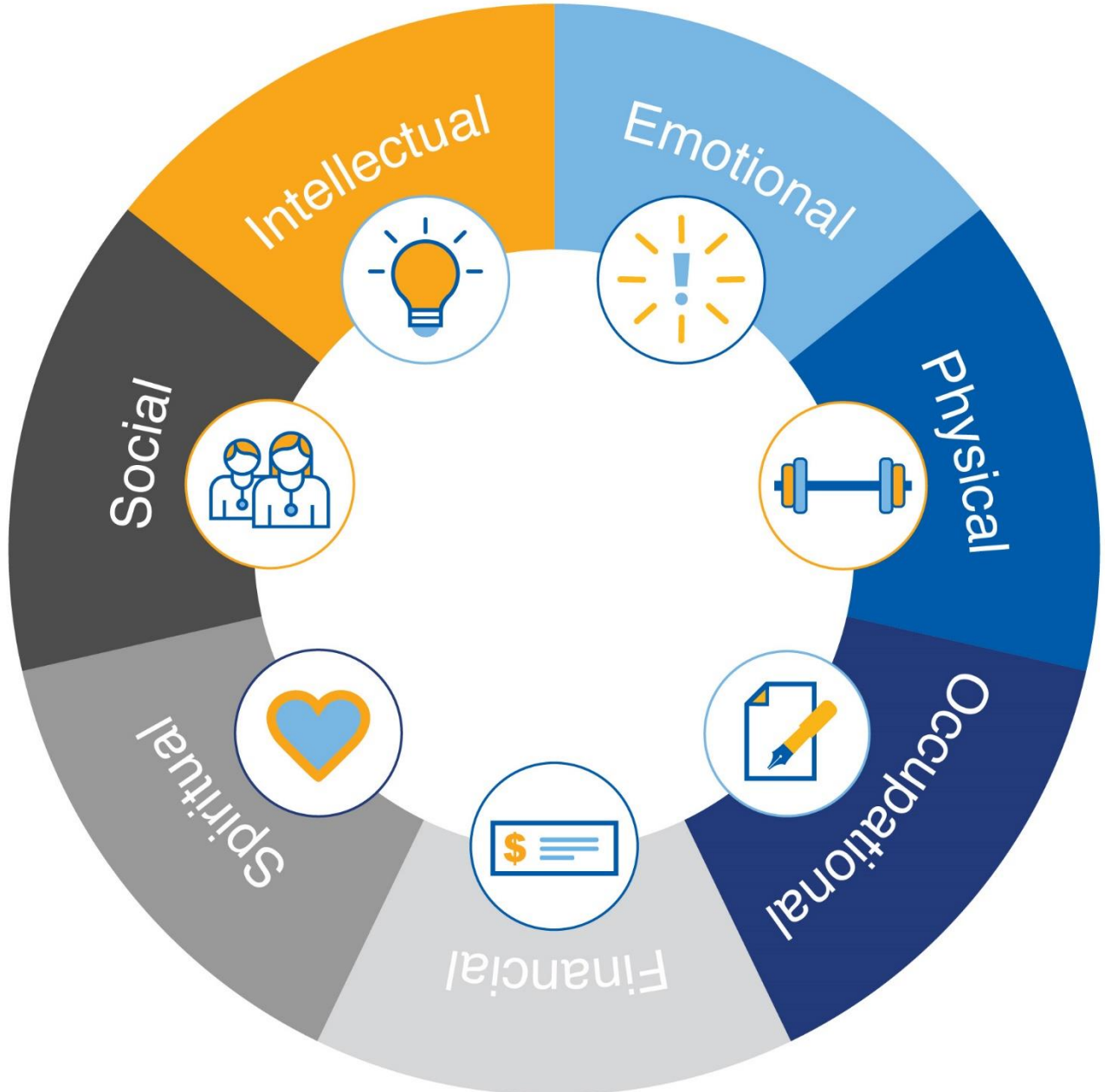

Intellectual
Emotional
Physical
Occupational
Financial
Spiritual
Social

Those who were depressed made more than six times as many medication errors as their non-depressed peers.

Fahrenkopf, A.M., et al., *Rates of medication errors among depressed and burnt out residents: prospective cohort study.* BMJ, 2008. **336**(7642): p. 488-491.


Wellness
Culture
Patient safety
Performance

EMA Emergency Medicine Australasia

Original Research | Full Access

oneED: Embedding a mindfulness-based wellness programme into an emergency department

Shahina Braganza, Jessica Young, Amy Sweeny, Victoria Brazil

OneTeam Practice

thinking ahead in resuscitation

MEET YOUR TEAM
then...

01

What do we Know?

eg 87 male driver, single vehicle collision on the drivers side with ALOC

02

What do we Expect? ”Plan A”

Anticipated issues/injuries and how to prepare

03

What will we Change? ”Plan B”

Secondary approach if the predicted initial impression is inaccurate
or our resuscitation efforts are failing

04

Roles

Having identified early needs and priorities assign specific personnel
to each task in alightment with plan A

The psychological and physical safety (and wellbeing) of the workforce is integral to the provision of high quality and safe patient care.

Australasian College
for Emergency Medicine

Building a safety culture

Preparing students for errors

Dr Julia Harrison

Senior Lecturer, Monash University, Victoria

Preparing students to cope with their inevitable contribution to adverse events.

ACEM Patient Safety Symposium 2019

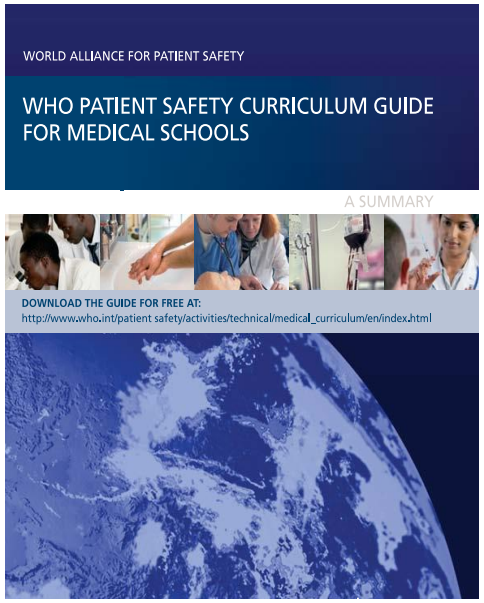
Dr. Julia Harrison MBBS(Hons), GCHPE, FACEM

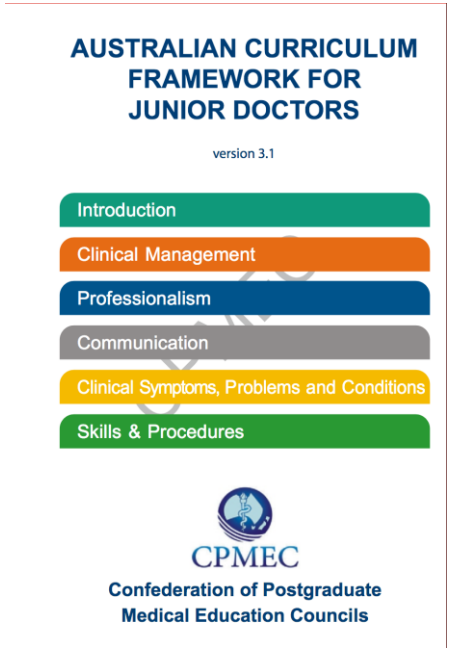
Julia.Harrison@monash.edu

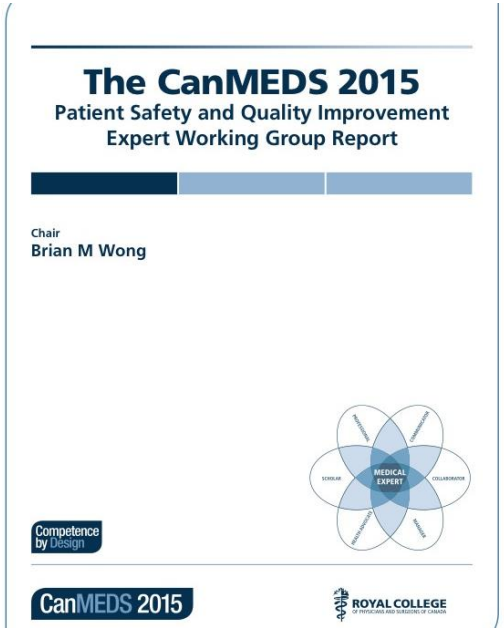
1995

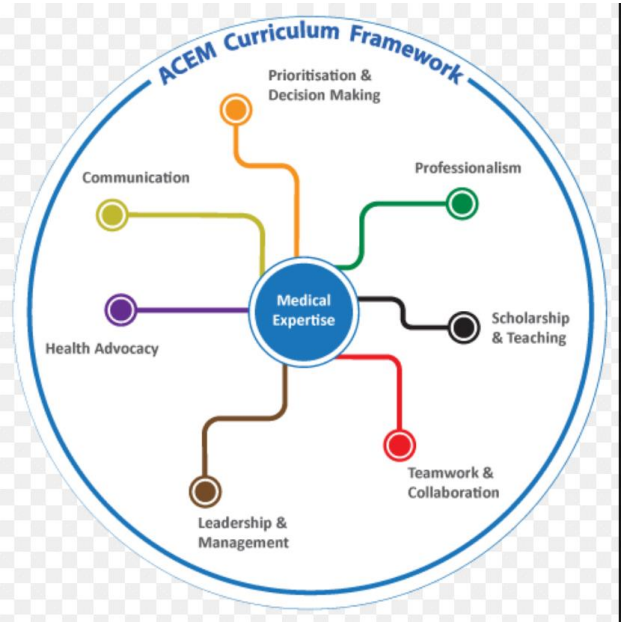
2019

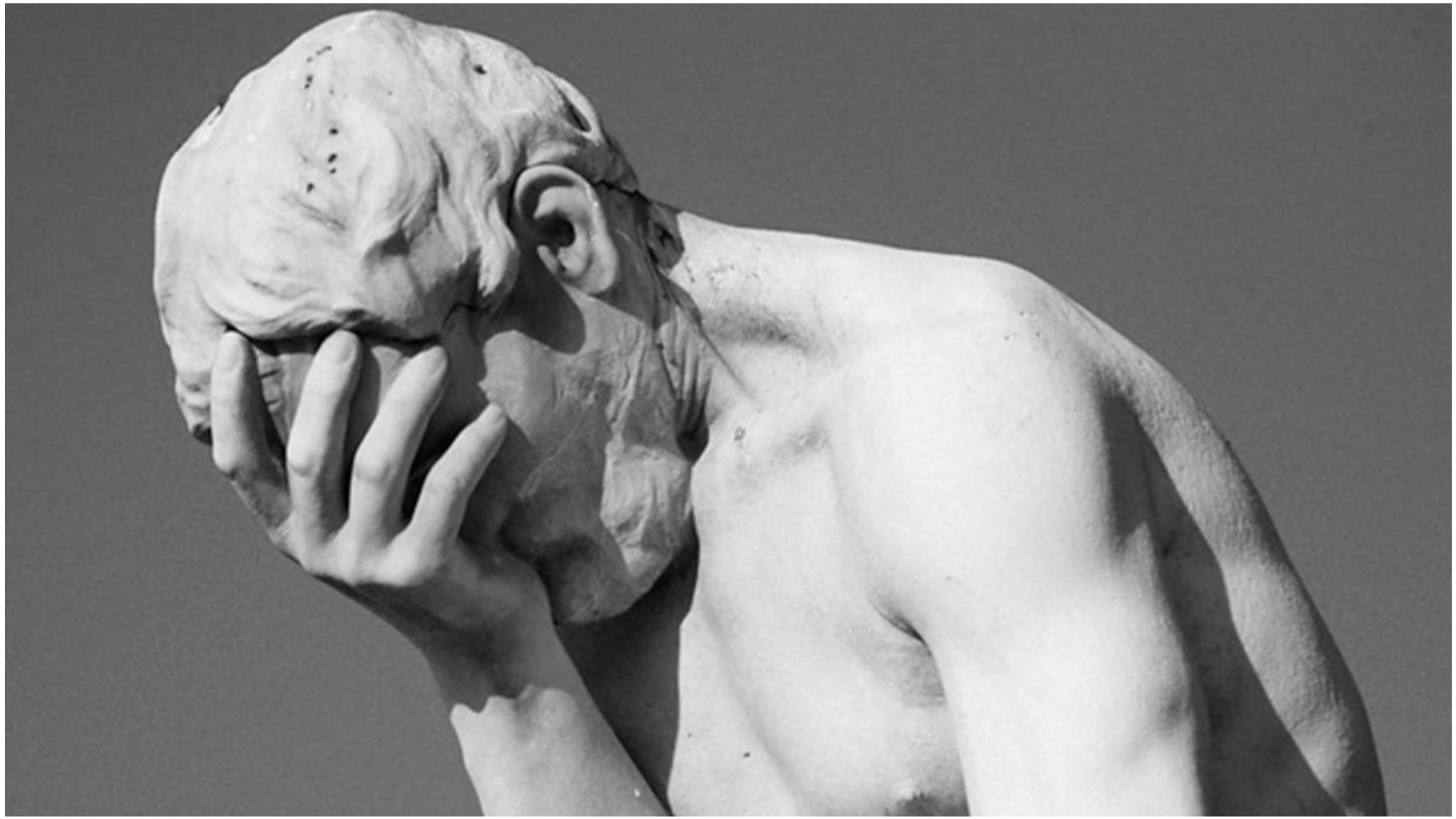

Australian Open Disclosure Framework
Better communication, a better way to care
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
NSQHS STANDARDS
Australian College of Nursing
shpa


WORLD ALLIANCE FOR PATIENT SAFETY
WHO PATIENT SAFETY CURRICULUM GUIDE FOR MEDICAL SCHOOLS
A SUMMARY
DOWNLOAD THE GUIDE FOR FREE AT:
http://www.who.int/patient safety/activities/technical/medical_curriculum/en/index.html


AUSTRALIAN CURRICULUM FRAMEWORK FOR JUNIOR DOCTORS
version 3.1
Introduction
Clinical Management
Professionalism
Communication
Clinical Symptoms, Problems and Conditions
Skills & Procedures
CPMEC
Confederation of Postgraduate Medical Education Councils


The CanMEDS 2015
Patient Safety and Quality Improvement Expert Working Group Report
Chair
Brian M Wong
Competence by Design
CanMEDS 2015
ROYAL COLLEGE


ACEM Curriculum Framework
Prioritisation & Decision Making
Communication
Professionalism
Medical Expertise
Health Advocacy
Scholarship & Teaching
Teamwork & Collaboration
Leadership & Management



Reactions…

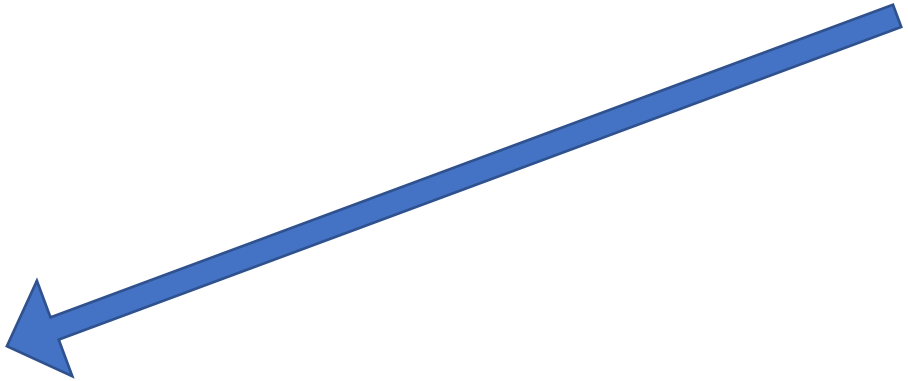
internalise

Reactions…

internalise

externalise

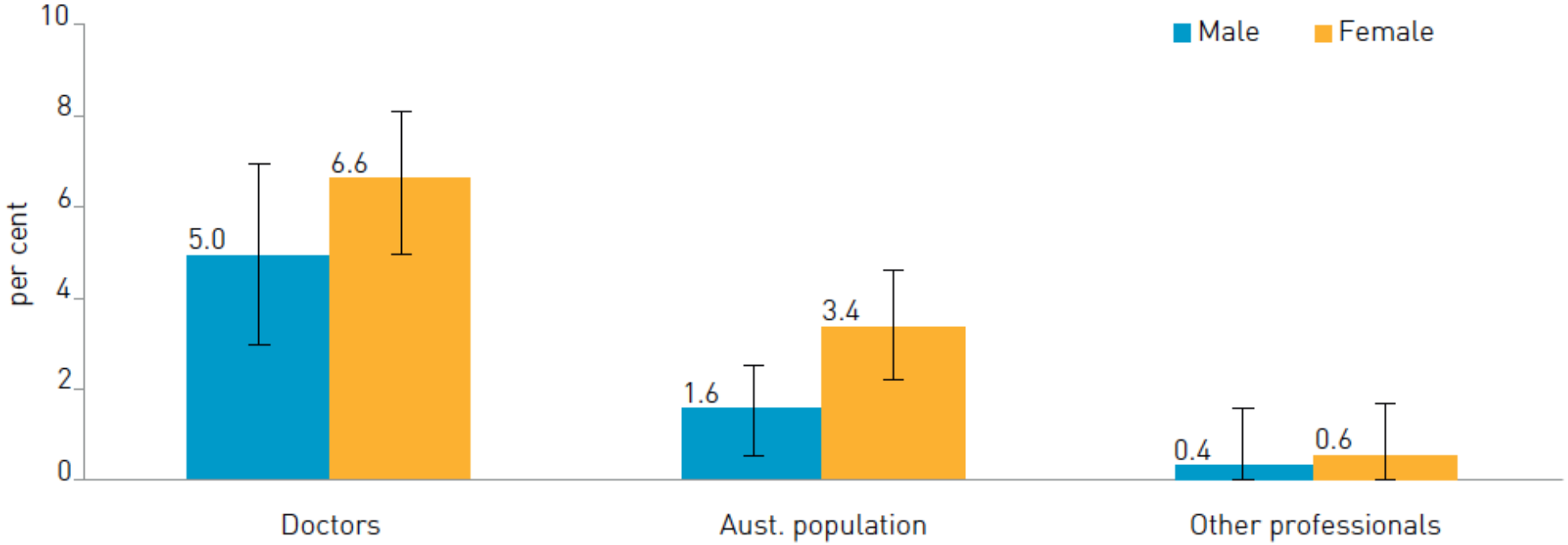
Reactions…



National mental health survey of doctors and medical students (Beyond Blue, 2013)

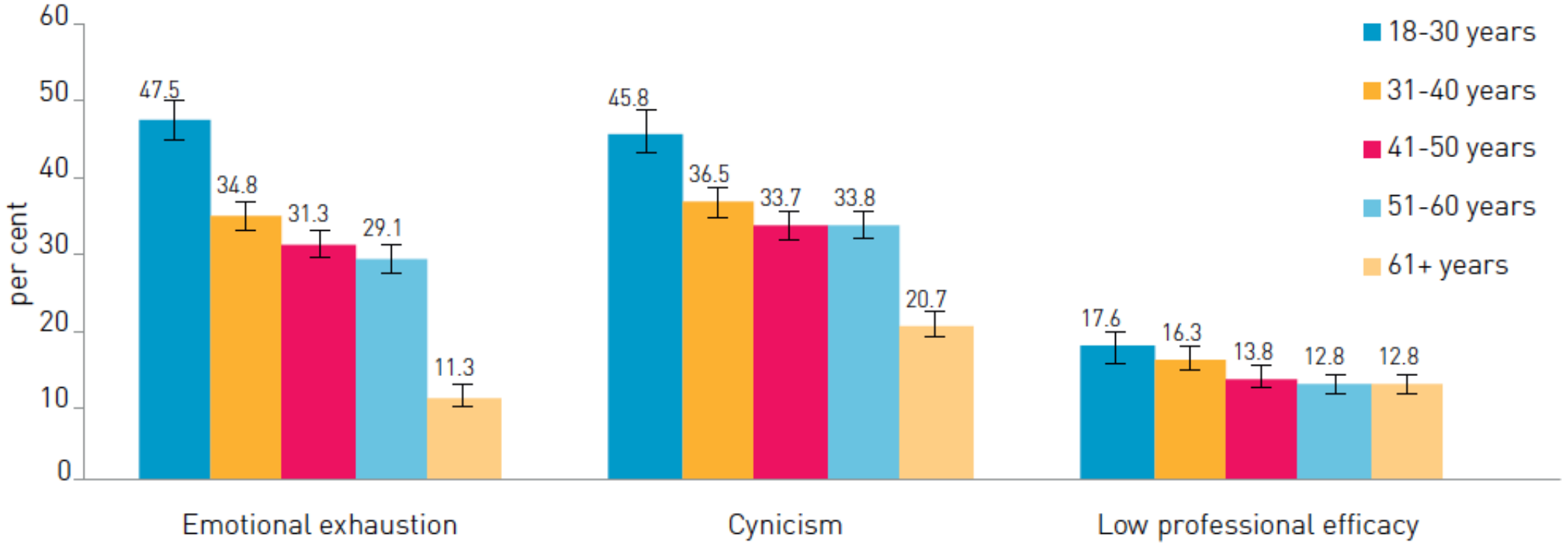
(based on the responses of over 12,000 doctors, 28% response rate)

Figure 1: Levels of very high psychological distress by gender in doctors, the Australian population and other Australian professionals aged 30 years and below



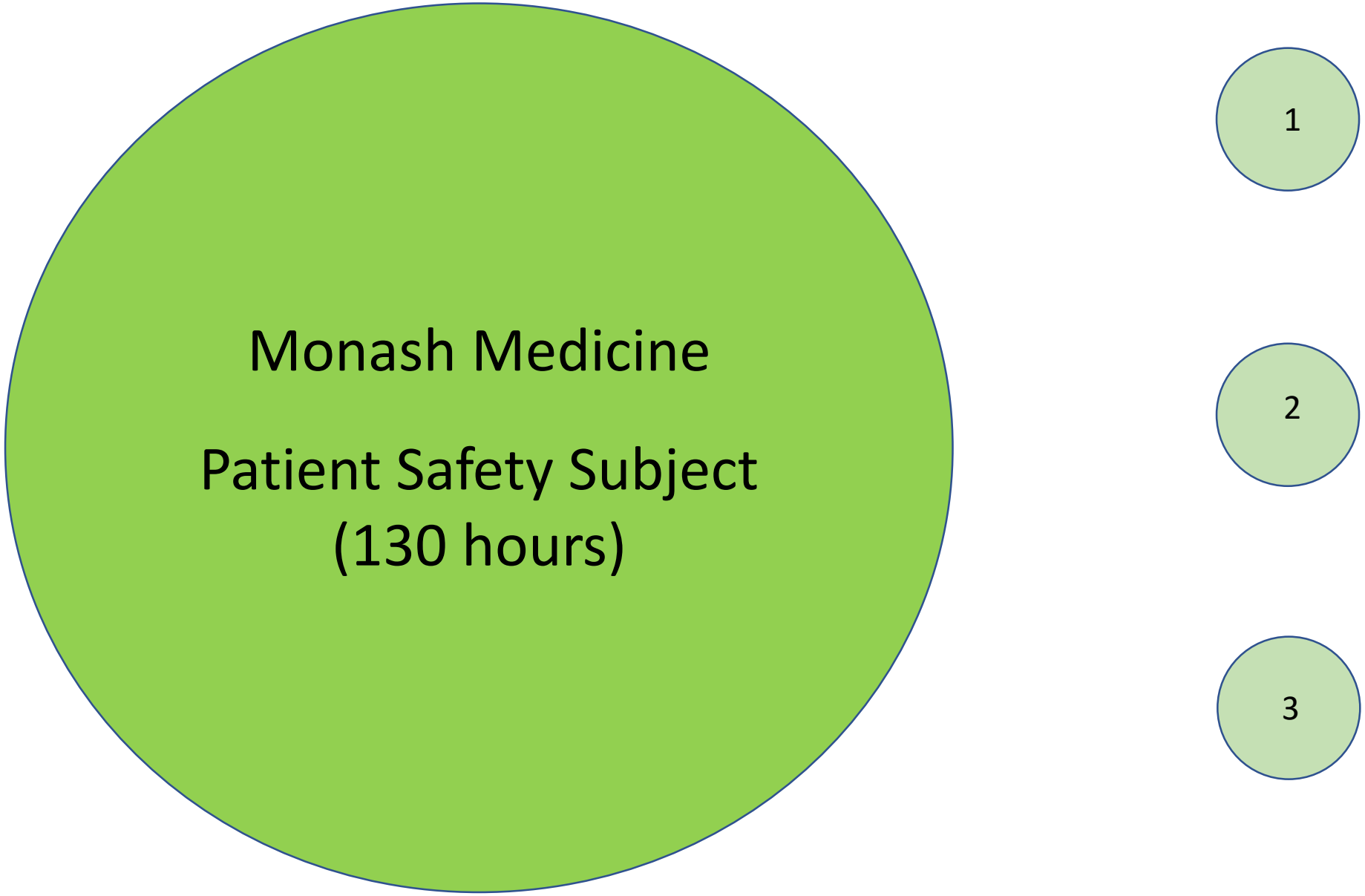
Burnout

Figure 4: Burnout in the domains of emotional exhaustion, cynicism and professional efficacy, by age group



Sources of work related stress for doctors

	n (est.)	Per cent	95%CI	
			Lower	Upper
Conflict between study/career and family/personal responsibilities	18,791	26.8	25.9	27.6
Too much to do at work	17,534	25.0	24.1	25.8
Responsibility at work	14,624	20.8	20.0	21.6
Long work hours	13,706	19.5	18.7	20.3
Fear of making mistakes	13,125	18.7	17.9	19.5
Making the right decision	12,100	17.2	16.5	18.0
Speaking in front of an audience	11,520	16.4	15.7	17.1
Demands of study and examinations	10,892	15.5	14.8	16.2
Sleep deprivation	9,665	13.8	13.1	14.5
Finances and debt	9,642	13.7	13.0	14.4
Dealing with difficult patients	9,621	13.7	13.0	14.4
Making mistakes	9,501	13.5	12.9	14.2
Keeping up to date with knowledge	9,459	13.5	12.8	14.1
Unpaid work hours	9,236	13.2	12.5	13.8
Limitations of resources	7,614	10.8	10.2	11.5
Litigation fears	7,020	10.0	9.4	10.6
Difficult relations with senior colleagues	6,639	9.5	8.9	10.0
Talking to distressed patients and/or relatives	5,068	7.2	6.7	7.7
Disclosing mistakes to colleagues, patients and/or their relatives	4,777	6.8	6.3	7.3
Dealing with death	3,425	4.9	4.5	5.3
Being bullied	3,151	4.5	4.1	4.9
Threat of violence at work	1,290	1.8	1.6	2.1
Racism	1,173	1.7	1.4	1.9



1

2

3

1. Everybody makes mistakes lecture

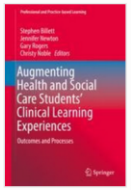
This session

- You will make mistakes
- It's normal
- We all make mistakes
- What to do when a mistake occurs
- Ideas on how to cope
- Open disclosure
- Staying safe

Key messages

- For small mistakes…
  - Learn and move on
- For big mistakes…
  - Be kind to yourself
  - Seek some support (emotional and cognitive)
  - Time
  - Learn
  - Time
  - Teach others
- Do the best with what you've got and learn as you go.

2. C-PEGs: Clinician Peer Exchange Groups



Augmenting Health and Social Care Students' Clinical Learning Experiences pp 95-120 | Cite as

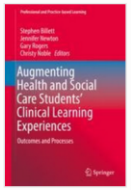
Clinician Peer Exchange Groups (C-PEGs): Augmenting Medical Students' Learning on Clinical Placement

Authors Authors and affiliations

Julia Harrison ✉, Elizabeth Molloy, Margaret Bearman, Chee Yan Ting, Michelle Leech

- A case
- Something you were taught
- A mistake you (or someone else) made and what you would do next time if you had the chance
- Your observations about the work your unit does
- Something that surprised, pleased or disappointed you
- Provide a brief summary of a common clinical problem on your unit
- A description of doing something for the first time, what was it, how did it go, what did you learn?
- A challenging situation

2. C-PEGs: Clinician Peer Exchange Groups



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- A challenging situation

C-PEGs How to Guide 1/2

Tips for facilitators

- Give participants advance warning of the activity so they can be on the lookout for learning moments in the workplace. Consider sending participants a reminder to think of a contribution several days before the session.
- Consider sharing some contributions of your own as examples when introducing C-PEGs to participants. The sessions will work best if participants don't feel a strong need to impress their peers with their knowledge and skills. A little humility or vulnerability on show from the facilitator can set the scene for participants to feel comfortable enough to be open and honest with their peers.
- Have the contribution triggers on view during the session, in case learners need reminding. e.g. white-board, laminated sheet.
- Remind participants that their peers' contributions are confidential and not to be discussed beyond the session.
- Thirty minutes is a good length of time for the activity.
- If there are several groups, some people may be interested to know what was discussed in other groups. At the end of the small group conversation, the groups can be invited to share a contribution with the whole group. This is also a mechanism to further amplify the learning.
- Sometimes participants may want input from a more senior clinician. The absence of a more senior facilitator in the small groups may facilitate greater peer connection. A senior facilitator may inhibit junior colleagues from talking freely with each other. So consider how you can provide input if requested by students without imposing too much on the small groups.
- The very open-ended discussion triggers give the participants the opportunity to talk about whatever recent experience is on their mind – this is part of the design. It is possible to provide more focus to the discussion by changing the contribution triggers. Be mindful that if you do so, students lose the chance to choose items that matter most to them.
- Some people do not like being asked to reflect on demand, and some people are more private than others. With C-PEGs, contributions of a factual impersonal nature are valued just as much as more personal reflections.

Document prepared by Julia Harrison (Medicine, Monash University), Fiona Kent (Physiotherapy, Monash University), Kristin Lo (Physiotherapy, Monash University), and Debra Palesy (Nursing, University of Technology Sydney), 2018. This activity design is an output of the OLT funded project: Augmenting students' learning for employability through post-practicum educational processes, led by Professor Stephen Billett.

Reference:
Harrison, J., Molloy, E., Bearman, M., Ting, C. Y., & Leech, M. (2018). Clinician Peer Exchange Groups (C-PEGs): Augmenting medical students' learning on clinical placement. In S. Billett, J. Newton, G. D. Rogers, & C. Noble (Eds.), *Augmenting health and social care students' clinical learning experiences: Outcomes and processes*. Dordrecht: Springer. 'in press'.

CRICOS Provider: Monash University 00008C. TRSU

MONASH University

C-PEGs

Information for facilitators and participants

What is C-PEGs?

C-PEGs stands for Clinician Peer Exchange Groups.

It is an educational activity in which peers share learning and experiences from the clinical environment.

What is the aim of C-PEGs?

The clinical environment is a rich source of learning. Many useful things learnt in the workplace cannot be found in textbooks or from a lecture. C-PEGs are an efficient and enjoyable way to share this learning. The clinical environment is also a challenging place to work. It can be helpful to discuss challenging situations with peers and share ideas for how to handle them in the future.

Exchange of recent learning, challenging cases and clinical situations is a popular method of ongoing professional development for senior clinicians. It can also be a good source of moral support. C-PEGs have been designed to provide a structured setting for more junior clinicians and students to benefit from learning-focused conversations with peers.

What are the key elements of C-PEGs?

1. One or more groups of approximately five participants
2. All participants are encouraged to contribute
3. Contributions may be of an impersonal factual nature, a story, a reflection on an experience, or a combination of these
4. Some contributions may generate discussion amongst the group
5. Presence of a more senior facilitator in the background to set up the activity and provide support if required
6. Participants do not share stories of others' experiences beyond the session

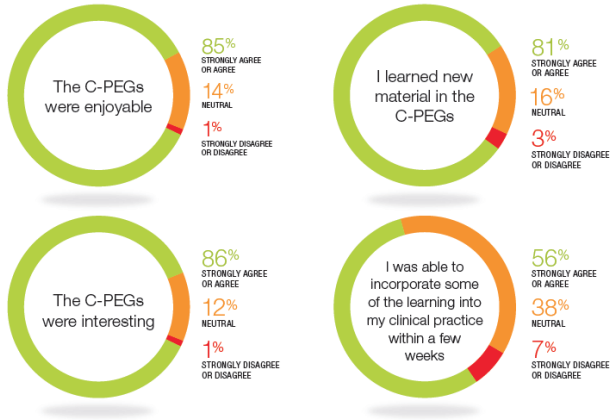
For which type of learner cohorts is C-PEGs most suitable?

- Junior clinicians or senior students on placement who have some workplace responsibilities and will soon be entering the workforce in their field of study
- Participants with workplace experiences to share
- Participants with experience of peer learning
- Learner groups with sufficient foundation knowledge to make sense of workplace experiences (more junior students would likely need more direct input from a facilitator)

C-PEGs How to Guide 2/2

How do people rate C-PEGs?

74/74 final year medical students rate aspects of C-PEGs after 2 or 3 thirty minute sessions



What do people like about C-PEGs?

The learning…

"Sharing our mistakes is useful to learn and remember when we are in the same situation."

"Often relevant and interesting things to learn."

The connection with peers…

"Talking to new people that I otherwise would not have interacted with."

"Engage with other students."

The peer support…

"Judgement free zone to talk."

"Learning from peers makes things so much less intimidating."

"Normalizes the student experience."

"Discussion and support from peers."

"Getting to debrief about the week is good."

C-PEGs contribution triggers

Below is a list of C-PEGs contribution triggers from which participants may select:

- A case
- Something you learned or were taught
- A mistake you (or someone else) made and what you would do next time if you had the chance
- Your observations about the work your unit/ward/clinic does
- Something that surprised, pleased or disappointed you
- A brief summary of a common clinical problem on your unit/ward/clinic
- A description of doing something for the first time, what was it, how did it go, what did you learn?
- A challenging situation

Tips for participants

- Aim to come prepared with something to talk about.
- Introduce yourselves to each other at the start of the session. Make sure everybody knows each other's name and current placement.
- Consider appointing someone in the group to chair. The role of the chair is to ensure everybody has the chance to make a contribution within the allocated time and to keep the group on task.
- Remember that other participants' contributions are not to be shared beyond the session.
- Be careful not to share misinformation. Check your facts beforehand if unsure.
- Try to keep the conversation constructive. Teach each other, share tips, share experience, problem solve.
- Your clinical experiences are unique and hence you will have learning of value to share.
- If the thing you learned is new to you, perhaps it will be new to others too. If not, it can serve as revision for others, or as an example of how knowledge might play out in practice. Nothing is too basic to share.
- If you find a situation challenging, it is likely that some of your peers may feel the same way. Other participants may not have encountered the issue before, and if you raise it, they will be more prepared if and when they find themselves in a similar situation.
- The facilitator is available to join your discussion if you would like a more senior person's input.

- **If you have had a troubling experience that you would like to discuss one-on-one with someone, please make this known to the facilitator.**

3. ORARDA: Online Readings and Reflective Discussion Activities

Topics	Text/media artifact	Student Activity	Moderator Activity
• **Correct Patient Identification** • **Learning Curves** • **Handover** • **When Things go Wrong** • **Patient Safety Culture** • **Equipment and Human Factors** • **Diagnostic Error**	Readings and/or video including • case studies • expert commentary • scientific papers • autobiographical text • workplace documentation	• Read or view prescribed material with particular questions in mind. • Post a summary of thoughts / answers or an angle that hasn't yet been covered. • Read and comment on a fellow student's post	• Have some presence, although no need to respond to every students' post • Allow students to respond to controversy or fill in gaps before responding • Ask questions • Add emphasis • Correct misinformation • Explain relevance • Summarise

ORARDA: Online Readings and Reflective Discussion Activities

Topics	Text/media artifact	Student Activity	Moderator Activity
• **Correct Patient Identification** • **Learning Curves** • **Handover** • **When Things go Wrong** • **Patient Safety Culture** • **Equipment and Human Factors** • **Diagnostic Error** • **Humility in medicine**	Readings and/or video including • case studies • expert commentary • scientific papers • autobiographical text • workplace documentation	• Read or view prescribed material with particular questions in mind. • Post a summary of thoughts / answers or an angle that hasn't yet been covered. • Read and comment on a fellow student's post	• Have some presence, although no need to respond to every students' post • Allow students to respond to controversy or fill in gaps before responding • Ask questions • Add emphasis • Correct misinformation • Explain relevance • Summarise

Humility in medicine - readings

"How to Counter the Circus of Pseudoscience"

- **By Lisa Pryor**
- **New York Times**

The New York Times

My Human Doctor

Medical school teaches us to examine, to research, to treat. We don't learn to err and recover.

Getty Images

By Sara Manning Peskin, M.D.

Oct. 4, 2018

71

Humility in Medicine - readings

WHY MINDSET MATTERS FOR JUNIOR DOCTORS

Medical students and junior doctors have to cope with high stakes on a daily basis; now a new program is helping them build resilience

By Professor Jill Klein, University of Melbourne

I am bookended by survivors.

My father is a Holocaust survivor; he was in Auschwitz in 1944 when he was 16 years old. My daughter is a tsunami survivor; she was 4 years old in 2004 when the tsunami hit her village in Thailand, leaving her an orphan.

The Culture of Perfection: A Barrier to Medical Student Wellness and Development

To the Editor: Medical schools are changing their curricula and cultures as the evidence of student burnout

Humility in medicine - readings

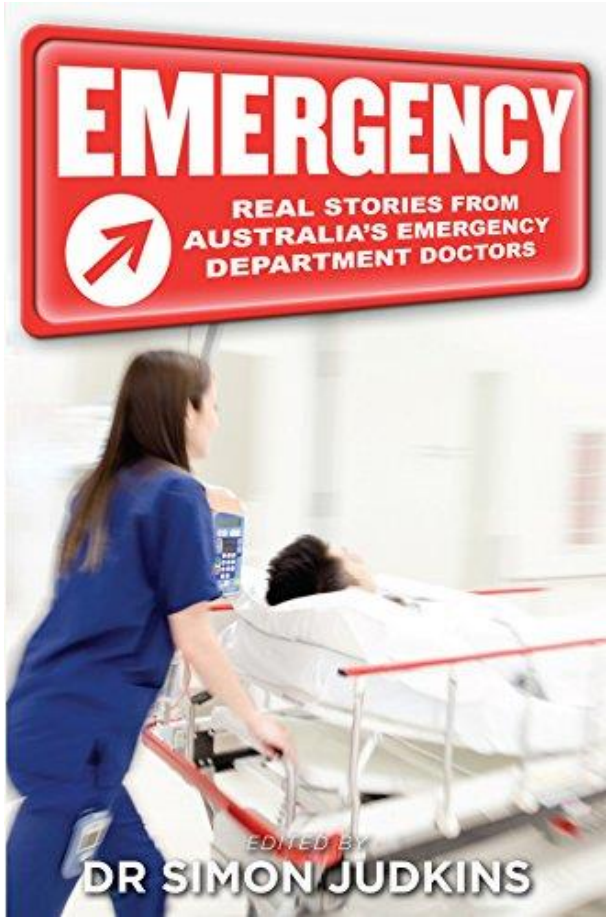
medical education
www.mededuc.com

Emotion Matters

How can tomorrow's doctors be more caring? A phenomenological investigation

Hannah Gillespie, Martina Kelly, Gerard Gormley, Nigel King, Drew Gilliland, Tim Dornan

First published: 25 September 2018 | https://doi.org/10.1111/medu.13684



How can we help prime our juniors to cope when they contribute to medical error?

- Teach the limits of human performance, why and how errors occur
- Acknowledge our fallibility (but still strive for excellence)
- Help juniors understand and accept the high risk nature of our work
- Role-model humility (openness to learning, not defensiveness)
- Encourage peer conversations (for learning and support)
- Provide them with the tools to survive and thrive

Australasian College
for Emergency Medicine

Building a safety culture

Our journey together to achieve: Outstanding healthcare for all Victorians. Always.

Adj. A/Prof Ann Maree Keenan

Deputy CEO and Chief Nurse and Midwifery Officer

Safer Care Victoria

Safer Care Victoria

7 March 2019

Australian College of Emergency Medicine

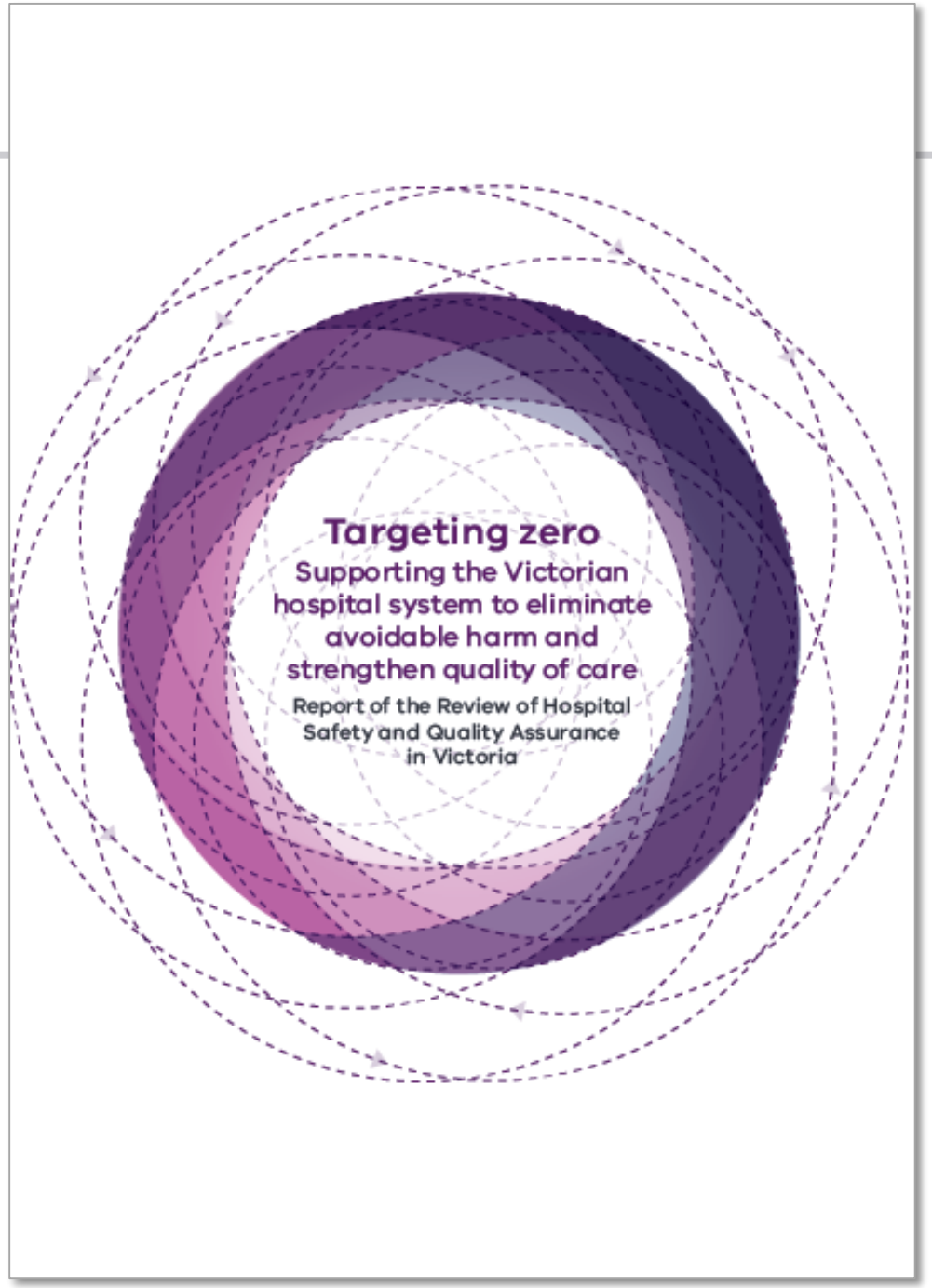
Our journey together to achieve:

Outstanding healthcare for all Victorians.

Always.

Ann Maree Keenan, Deputy CEO, CNMO

VICTORIA State Government


Targeting zero
Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care
Report of the Review of Hospital Safety and Quality Assurance in Victoria

About Safer Care Victoria

- We are the state's healthcare quality and safety improvement agency
- Established January 2017 as part of *Targeting Zero* health reforms
- Creating a deliberate separation of quality and safety from other functions of the department to elevate importance
- We bring a new, independent-minded approach to driving improvement and innovation
- Our mission: Outstanding healthcare for all Victorians, always.

How do we achieve our Mission?

Sentinel event reports

Performance monitoring

Clinical guidance

Patient feedback

Improvement projects

Capability building

System safety reviews

Safety alerts and advisories

Advice and support

Consumer and clinician participation

Innovation partnerships

Leadership and governance

We bring a new approach to improving quality and safety

We are independent-minded and challenge the norm

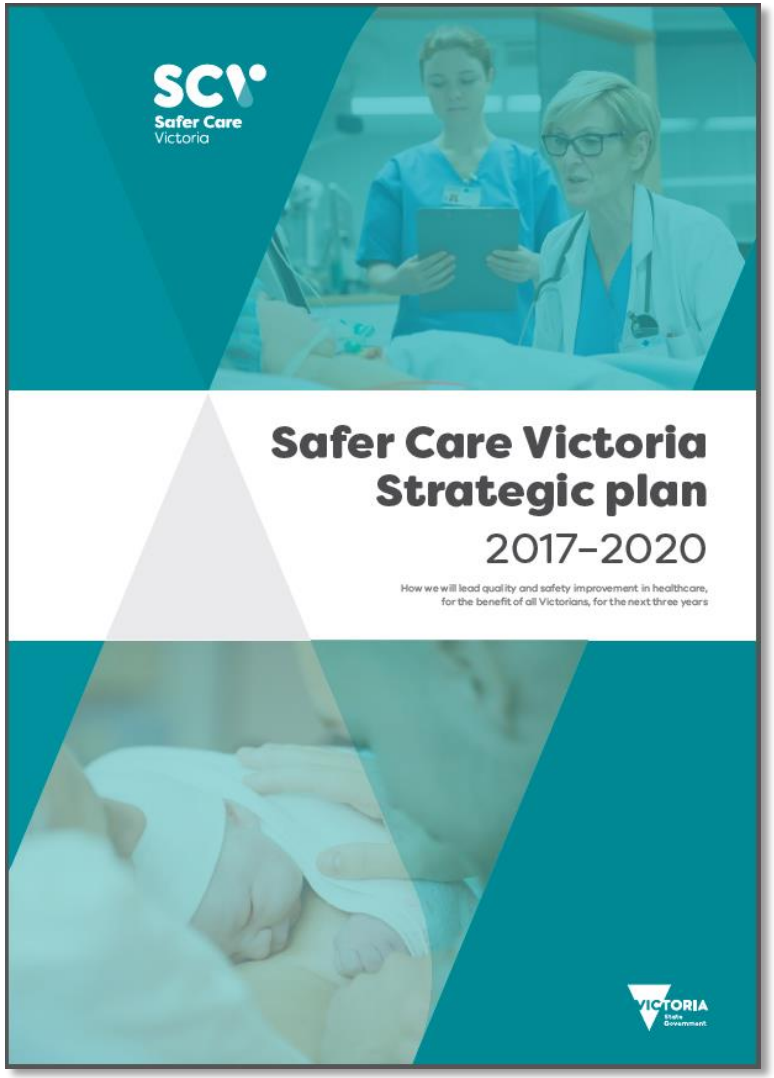
We place patients and families at the centre of everything we do

We work closely with health services and clinicians to help identify areas for improvement and create sustainable change

We underpin our work with evidence-based best practice

Safer Care Victoria

- Partnering with consumers
- Partnering with clinicians
- Stewardship and support
- System improvement, innovation and leadership
- Office of the Chiefs



Key areas of focus

- Changing how we engage and work with clinicians
- Strengthening Victoria’s sentinel events program
- Supporting innovation and improved capability
- Focusing on patient experience and participation
- Providing best practice guidance and advice

Governance is about ……

- having a clear, specific and measurable vision for the future
- having consumer partnerships at the centre of care
- strong, visible clinical leadership
- a just organisational culture
- providing continual staff learning and improvement
- well supported staff, working effectively in teams
- systematic and embedded quality improvement, informed by data

Partnering with consumers

Increasing Consumer participation in Health Services

Improving Communication with patients and families

Placing patients at the centre of what we do

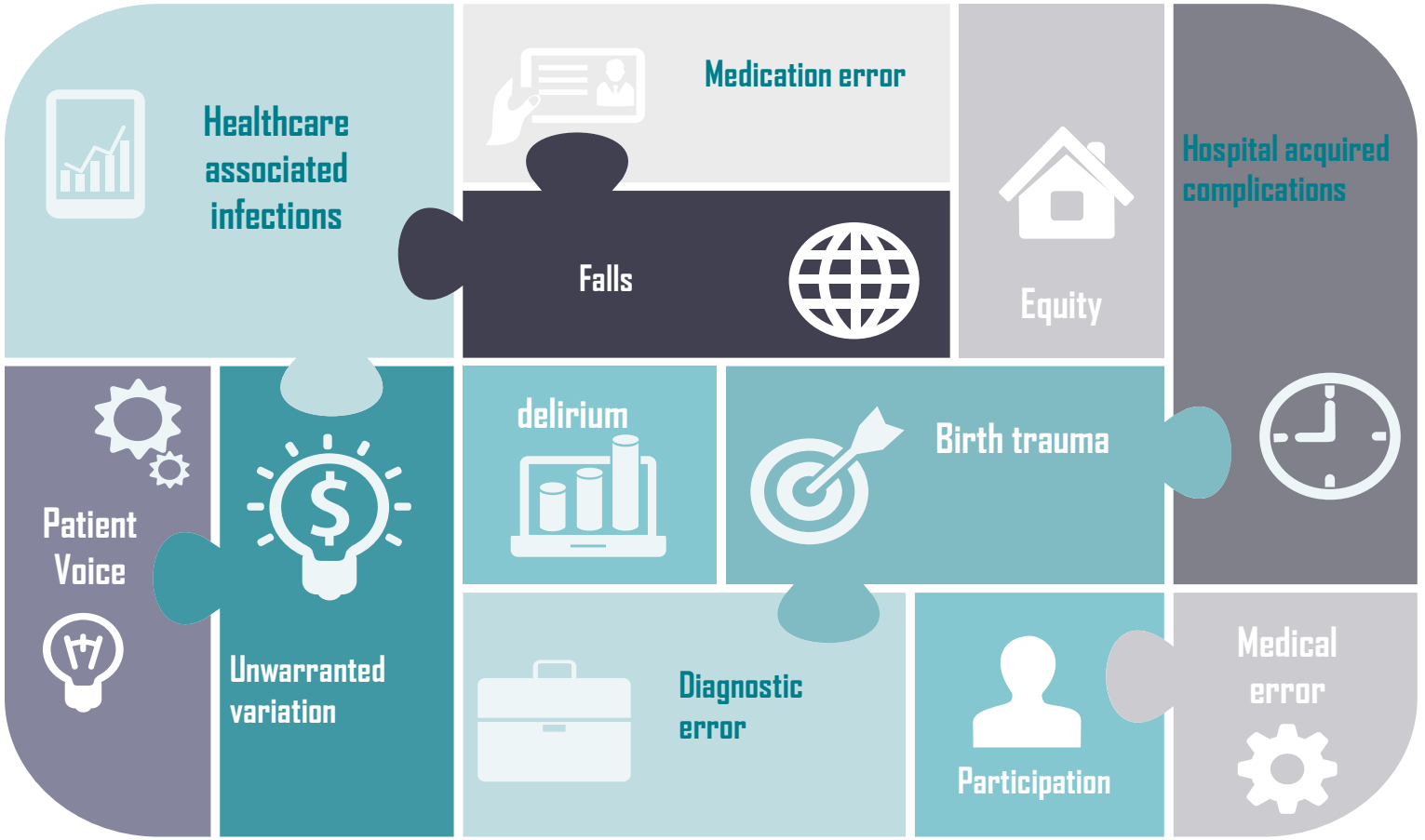
Patient safety is a system experience

Patient harm is a patient experience

If you want to know about harm,
you've got to ask the patient.

Clinical Networks

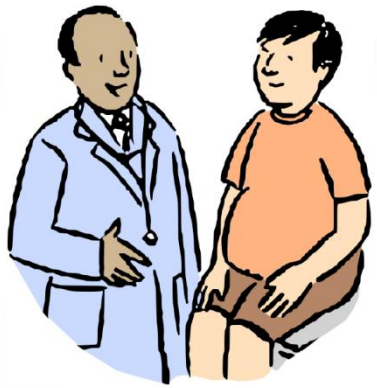
Review and response: data and stewardship



quality is all about the patient-clinician interaction.
everything should be designed to support that.

compliance

(external measurement)



culture

(intrinsic motivation)

Connect with us


www.bettersafercare.vic.gov.au


info@safercare.vic.gov.au


@safercarevic


Safer Care Victoria

Subscribe to our e-news at www.bettersafercare.vic.gov.au

Australasian College
for Emergency Medicine

Building a safety culture

Using EMER in safety reporting and learning

Dr Carmel Crock

Director, Emergency Department

Royal Victorian Eye and Ear Hospital, Victoria

Dr Kim Hansen

Director of St Andrew's Hospital Emergency and Senior Staff Specialist

The Prince Charles Hospital Emergency Department, Queensland

Australasian College
for Emergency Medicine

Errors and Near misses in Emergency Medicine - Using a Voluntary, Online Reporting System to Identify Errors in Australasian Emergency Departments

emer.org.au

Dr Kim Hansen MBBS(Honsl) MBA FACEM

Director of Emergency Services, St Andrew's War Memorial Hospital

Senior Emergency Consultant, The Prince Charles Hospital

QLD Faculty Chair

ACEM Council Advocacy. Policy & Partnerships member

IFEM Quality and Safety Special Interest Group Chair

@hansendisease

Dr Carmel Crock MBBS BLitt FACEM

Director Emergency Department Royal Victorian Eye and Ear Hospital

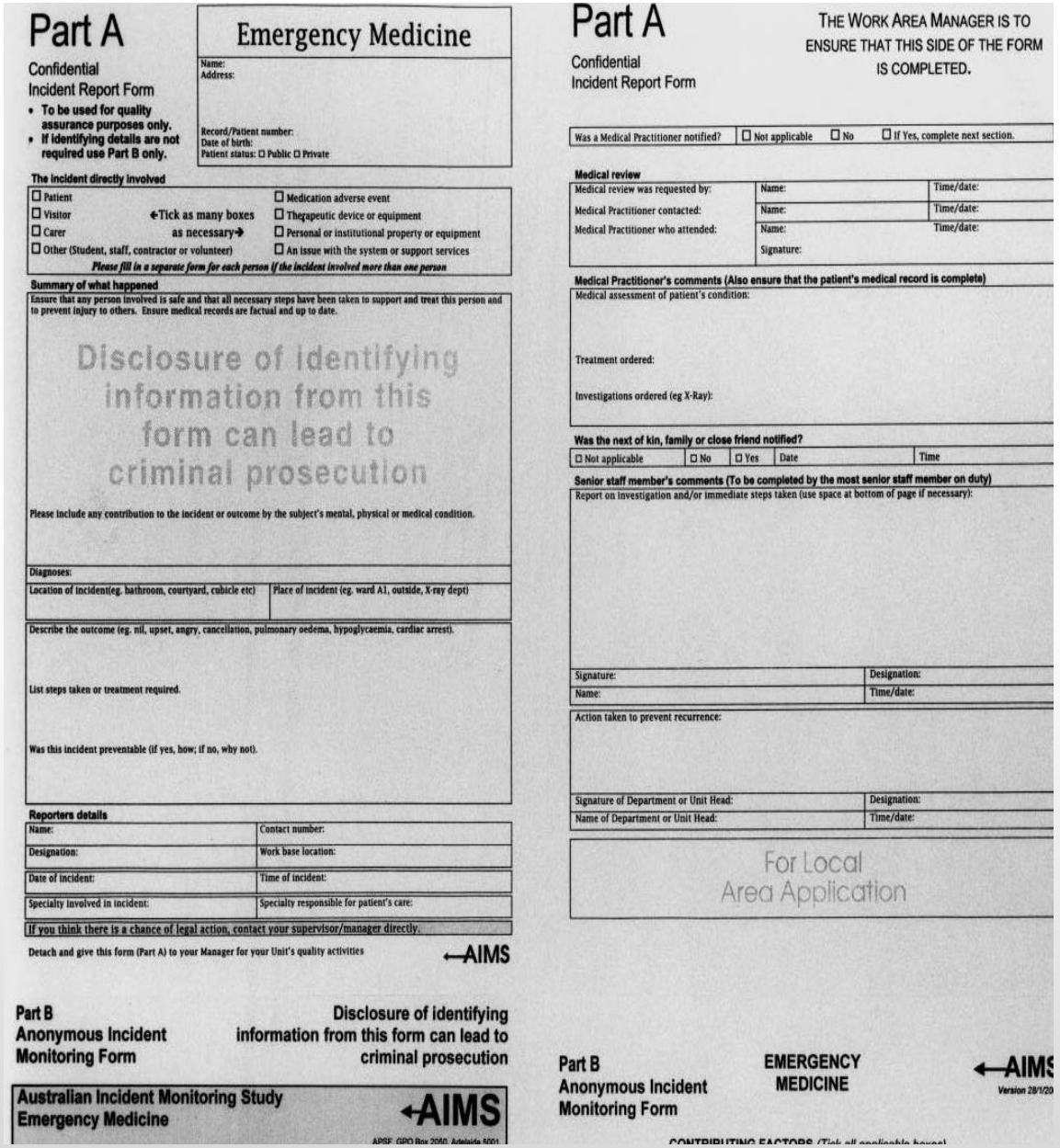
Director Royal Victorian Eye and Ear Hospital ED

Senior lecturer Melbourne University

With thanks to the EMER Steering Group and Site Champions

twitter

emer.org.au



Part A

Confidential
Incident Report Form

- To be used for quality assurance purposes only.
- If identifying details are not required use Part B only.

Emergency Medicine

Name:
Address:

Record/Patient number:
Date of birth:
Patient status: ☐ Public ☐ Private

The incident directly involved

☐ Patient
☐ Visitor
☐ Carer
☐ Other (Student, staff, contractor or volunteer)

←Tick as many boxes as necessary→

☐ Medication adverse event
☐ Therapeutic device or equipment
☐ Personal or institutional property or equipment
☐ An issue with the system or support services

Please fill in a separate form for each person if the incident involved more than one person

Summary of what happened

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

Disclosure of identifying information from this form can lead to criminal prosecution

Please include any contribution to the incident or outcome by the subject's mental, physical or medical condition.

Diagnoses:

Location of incident(eg. bathroom, courtyard, cubicle etc)	Place of incident (eg. ward A1, outside, X-ray dept)

Describe the outcome (eg. nil, upset, angry, cancellation, pulmonary oedema, hypoglycaemia, cardiac arrest).

List steps taken or treatment required.

Was this incident preventable (if yes, how; if no, why not).

Reporters details

Name:	Contact number:
Designation:	Work base location:
Date of incident:	Time of incident:
Specialty involved in incident:	Specialty responsible for patient's care:

If you think there is a chance of legal action, contact your supervisor/manager directly.

Detach and give this form (Part A) to your Manager for your Unit's quality activities ←AIMS

Part B

Anonymous Incident Monitoring Form

Disclosure of identifying information from this form can lead to criminal prosecution

Australian Incident Monitoring Study
Emergency Medicine ←AIMS

APSF, GPO Box 2050, Adelaide 5001

Part A

Confidential
Incident Report Form

THE WORK AREA MANAGER IS TO ENSURE THAT THIS SIDE OF THE FORM IS COMPLETED.

Was a Medical Practitioner notified?	☐ Not applicable	☐ No	☐ If Yes, complete next section.

Medical review

Medical review was requested by:	Name:	Time/date:
Medical Practitioner contacted:	Name:	Time/date:
Medical Practitioner who attended:	Name:	Time/date:
	Signature:	

Medical Practitioner's comments (Also ensure that the patient's medical record is complete)

Medical assessment of patient's condition:

Treatment ordered:

Investigations ordered (eg X-Ray):

Was the next of kin, family or close friend notified?

☐ Not applicable	☐ No	☐ Yes	Date	Time

Senior staff member's comments (To be completed by the most senior staff member on duty)

Report on investigation and/or immediate steps taken (use space at bottom of page if necessary):

Signature:	Designation:
Name:	Time/date:

Action taken to prevent recurrence:

Signature of Department or Unit Head:	Designation:
Name of Department or Unit Head:	Time/date:

For Local Area Application

Part B

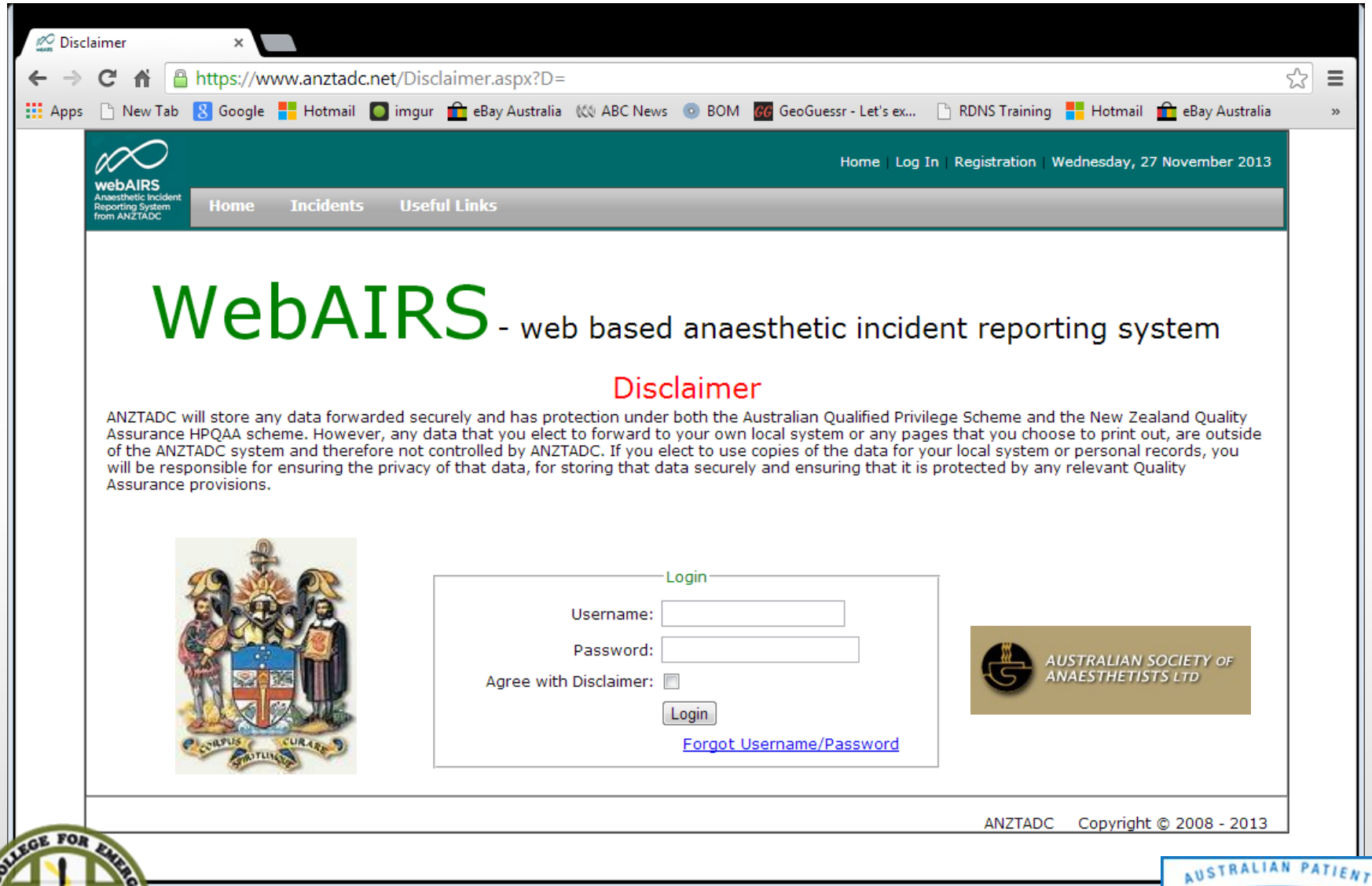
Anonymous Incident Monitoring Form

EMERGENCY MEDICINE

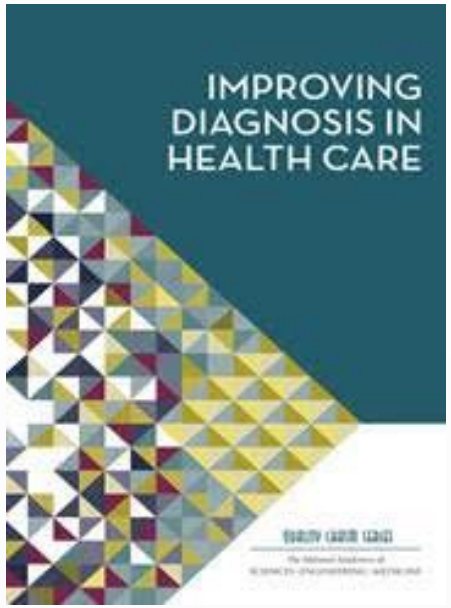
←AIMS
Version 28/1/20

CONTRIBUTING FACTORS (Tick all applicable boxes)

Follow us @EmergMedER



Follow us @EmergMedER



"Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice"

"Develop a reporting environment and medical liability system that facilitates improved diagnosis through learning from diagnostic errors and near misses."

?

Government of South Australia
SA Health

Northern Territory Government
Department of Health and Community Services

SA Health

Queensland Government
Queensland Health

NSW GOVERNMENT

VicHealth

MINISTRY OF HEALTH
MANATŪ HAUORA

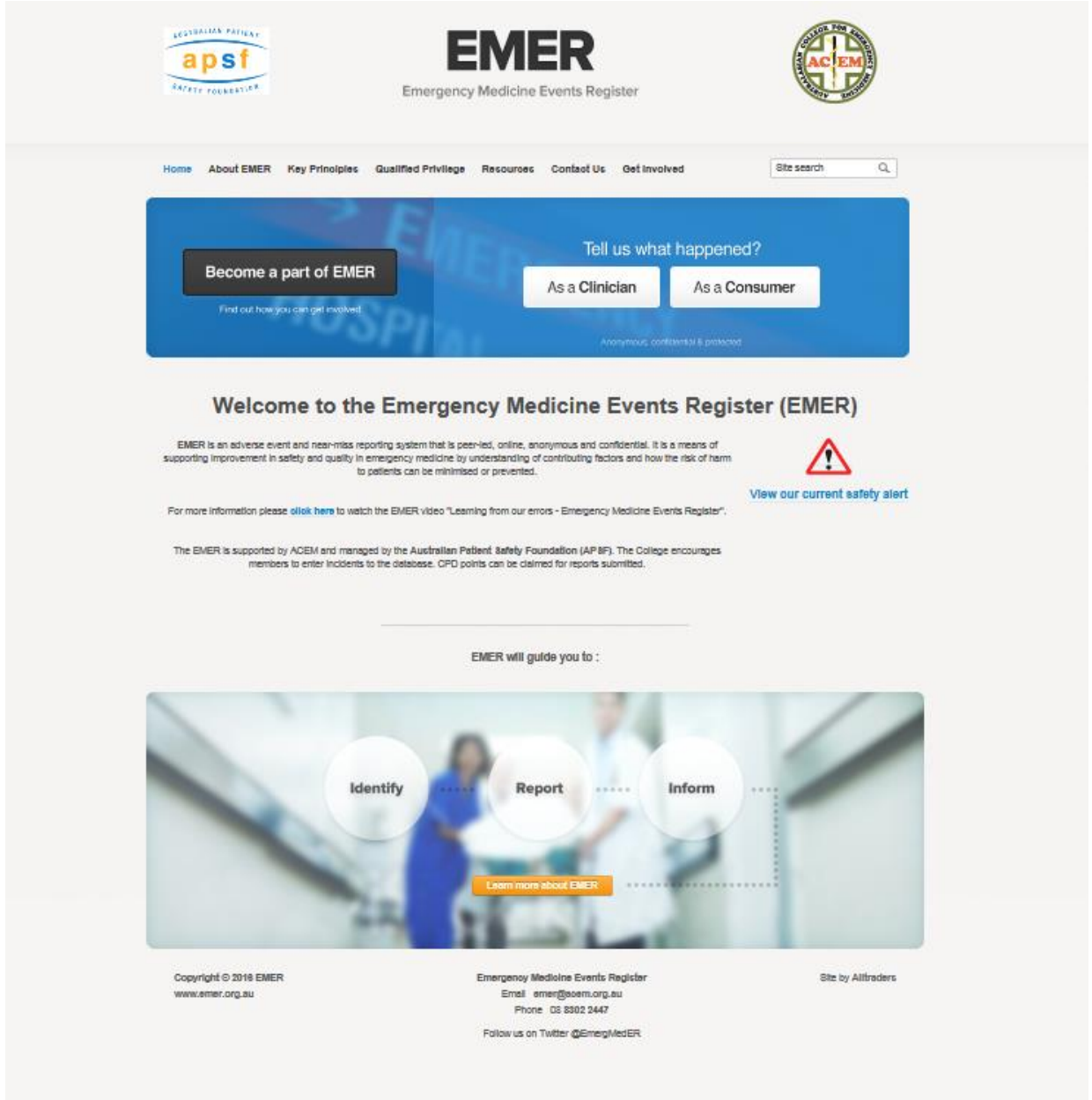
Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

Tasmanian Government

ACT Government
Health

AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE
ACEM

emer@acem.org.au


EMER
Emergency Medicine Events Register
Home
About EMER
Key Principles
Qualified Privilege
Resources
Contact Us
Get involved
Site search
Become a part of EMER
Find out how you can get involved
Tell us what happened?
As a Clinician
As a Consumer
Anonymous, confidential & protected
Welcome to the Emergency Medicine Events Register (EMER)
EMER is an adverse event and near-miss reporting system that is peer-led, online, anonymous and confidential. It is a means of supporting improvement in safety and quality in emergency medicine by understanding of contributing factors and how the risk of harm to patients can be minimised or prevented.
For more information please click here to watch the EMER video "Learning from our errors - Emergency Medicine Events Register".
The EMER is supported by ACEM and managed by the Australian Patient Safety Foundation (APSF). The College encourages members to enter incidents to the database. CPD points can be claimed for reports submitted.
View our current safety alert
EMER will guide you to :
Identify
Report
Inform
Learn more about EMER
Copyright © 2018 EMER
www.emer.org.au
Emergency Medicine Events Register
Email emer@acem.org.au
Phone 03 8302 2447
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Site by Alltraders

emer.org.au

emer.org.au

EMER

Emergency Medicine Events Register

Home | About EMER | Key Principles | Qualified Privilege | Resources | Contact Us | Get Involved

Site search

Incident Report

Page 1 of 4

Please enter incident details below - mandatory fields are marked with an asterisk (*).

Country *

Australia

How is the organisation funded? *

On what date did the incident occur? (Please use date picker on right hand side.) *

Date is

Exact date ☐ Weekend ☐ Public Holiday

Timeband

00:00 to 00:59

About the project

- Executive Summary 2015
- ED-specific incident reporting
- How does EMER work?
- What does EMER collect?
- The pilot study

emer.org.au

Incident Report

*Page **2** of 4*

What was the patient's triage score on presentation? *

Which medical specialty(ies) was involved in the incident?

- Ambulance Service
- Anaesthetics
- Burns
- Cardiology
- Cardiothoracic Surgery
- Colorectal
- Dermatology
- Drug & Alcohol
- Emergency Medicine
- ENT
- Endocrinology
- Facio-Maxillary Surgery
- Gastroenterology
- General Medicine
- General Surgery
- Geriatrics
- Haematology
- Immunology
- Infectious Diseases
- Intensive Care
- Neurology
- Neurosurgery
- Obstetrics & Gynaecology
- Oncology
- Ophthalmology
- Orthopaedics
- Other
- Paediatric Medicine
- Paediatric Surgery
- Palliative Care
- Plastic Surgery
- Psychiatry
- Radiology/Imaging
- Rehabilitation Medicine
- Renal Medicine
- Respiratory
- Rheumatology
- Urology
- Vascular Surgery

What was the patient's age at the time of the incident?

Gender

Clinical presentation

Incident Report

*Page **3** of 4*

What happened? *

What were the contributing factors?

What were the factors that reduced the impact of the incident?

What were the consequences or outcomes of the incident?

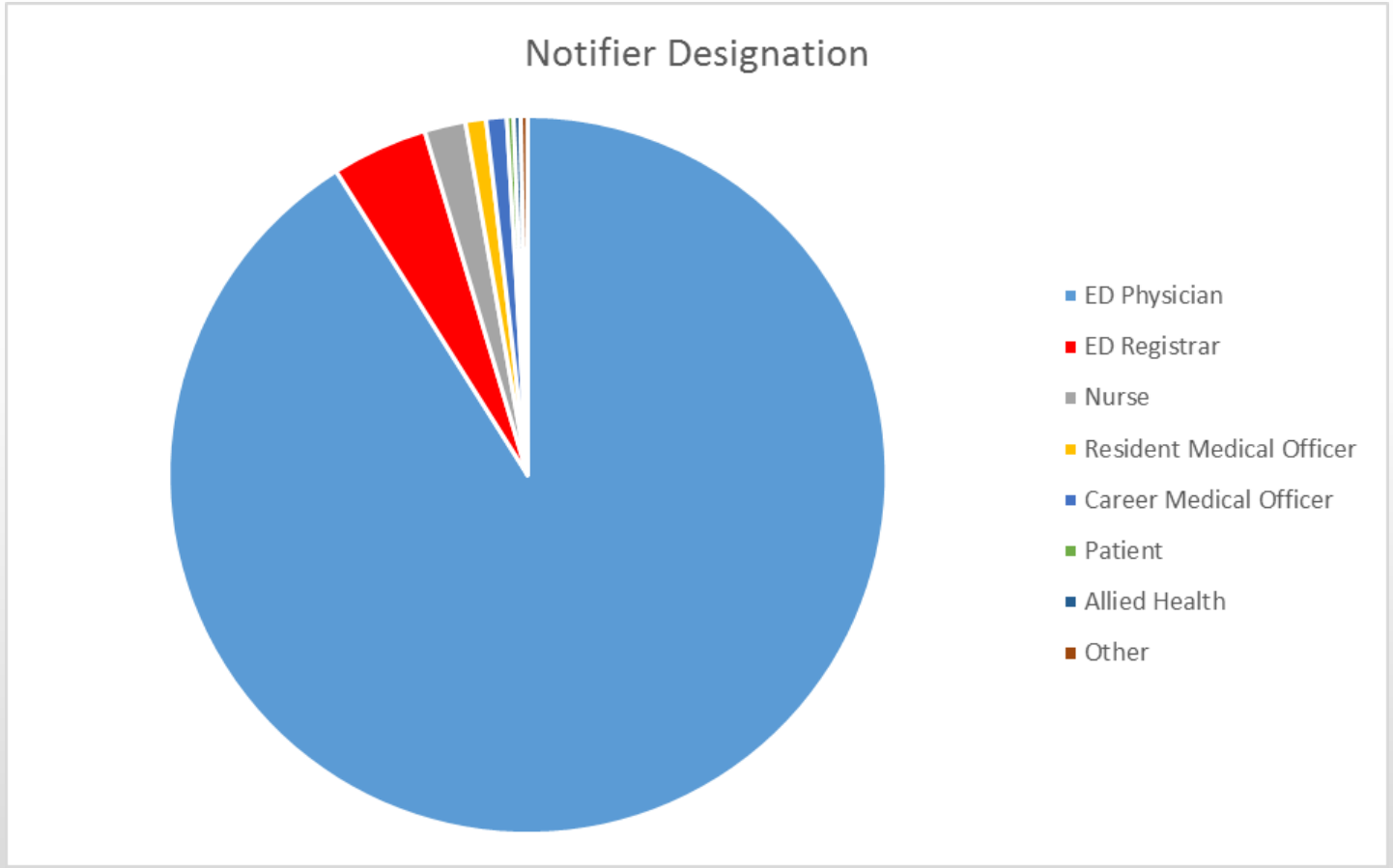
How could the incident have been prevented?

View our current safety alert

About the project

- Executive Summary 2015
- ED-specific incident reporting
- How does EMER work?
- What does EMER collect?
- The pilot study

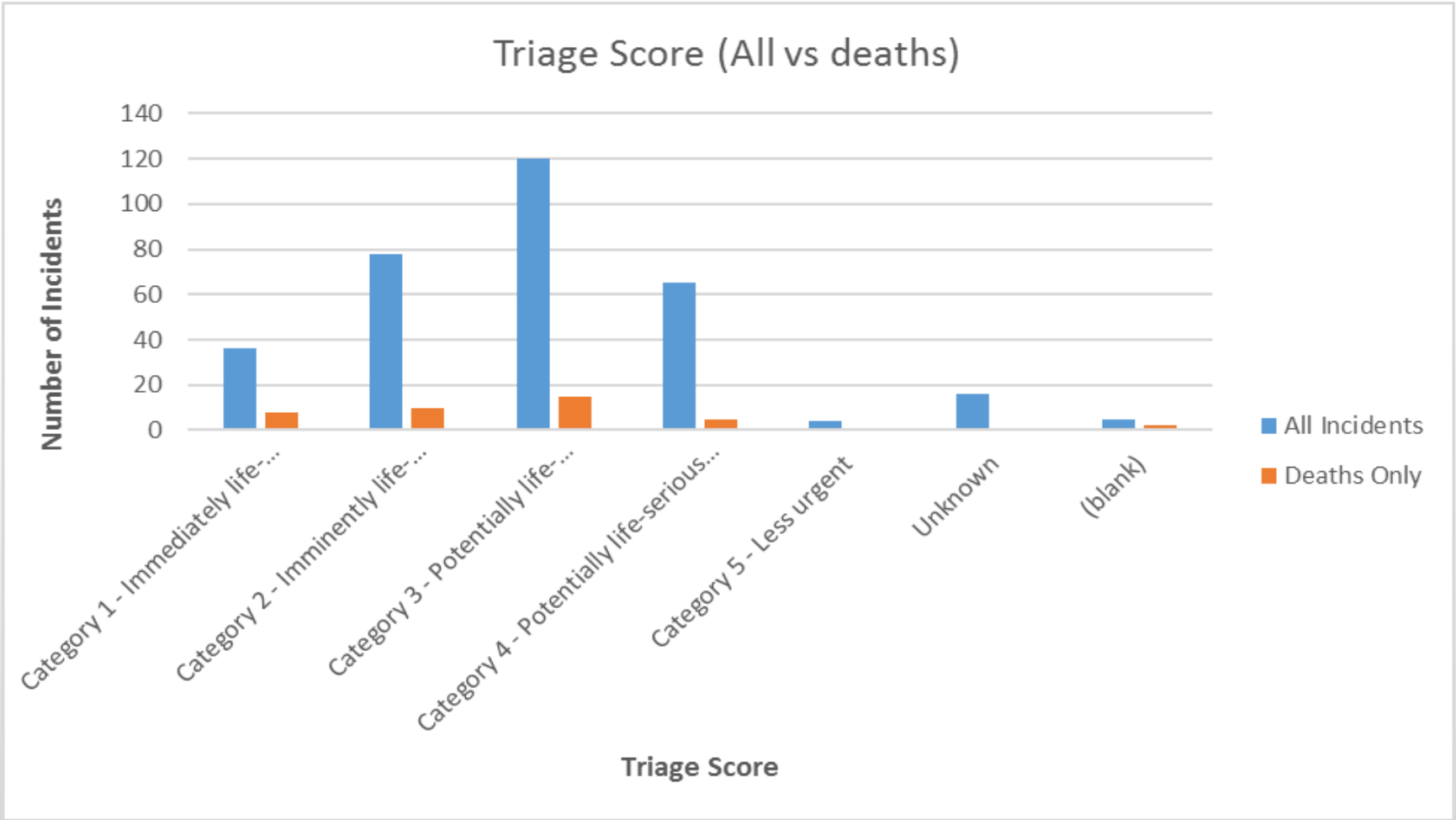
Reporter


Notifier Designation
ED Physician
ED Registrar
Nurse
Resident Medical Officer
Career Medical Officer
Patient
Allied Health
Other

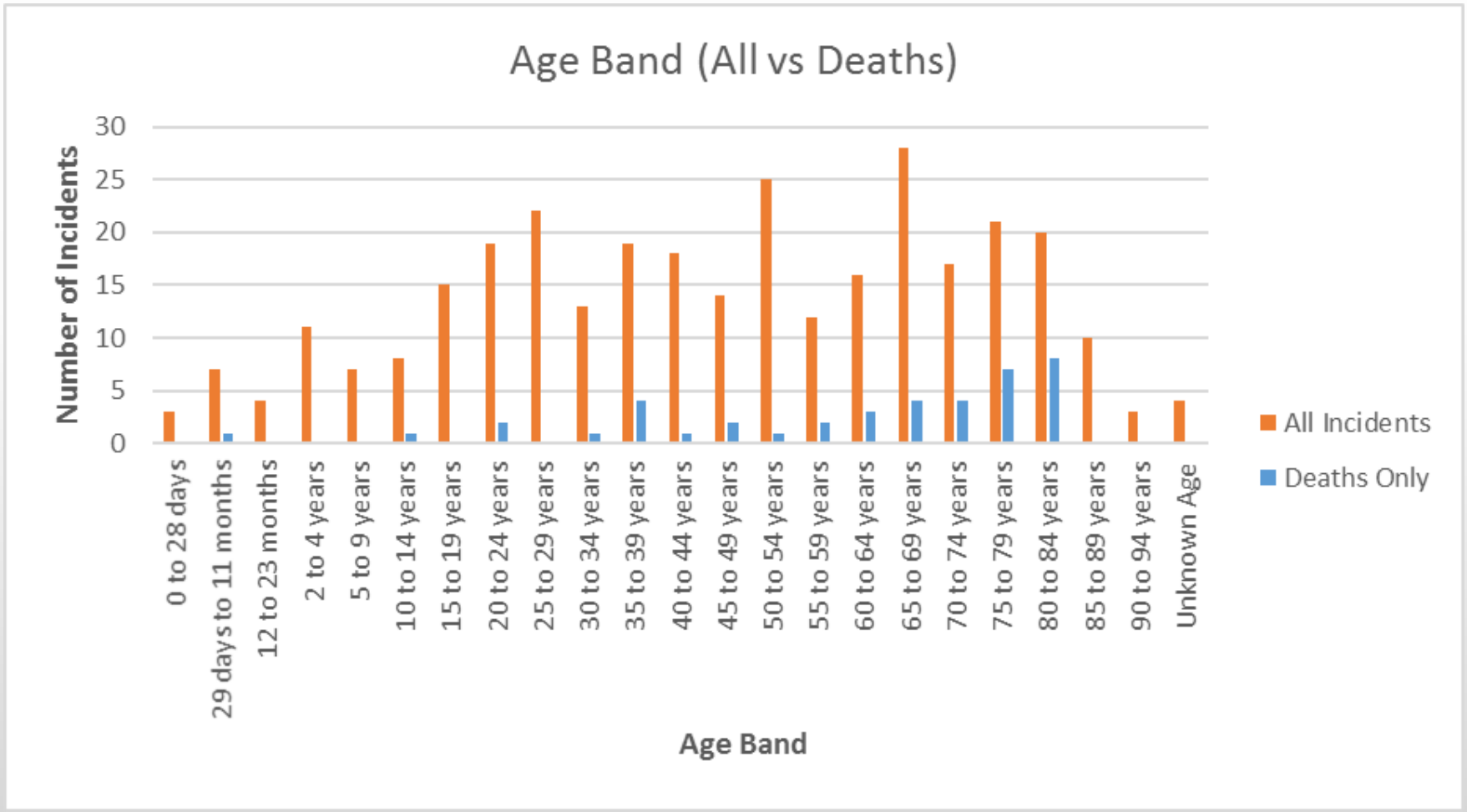
Device

Device Category	Acquisition
	Sessions ↓
	7,424 % of Total: 100.00% (7,424)
1. desktop	**6,079** (81.88%)
2. mobile	**975** (13.13%)
3. tablet	**370** (4.98%)

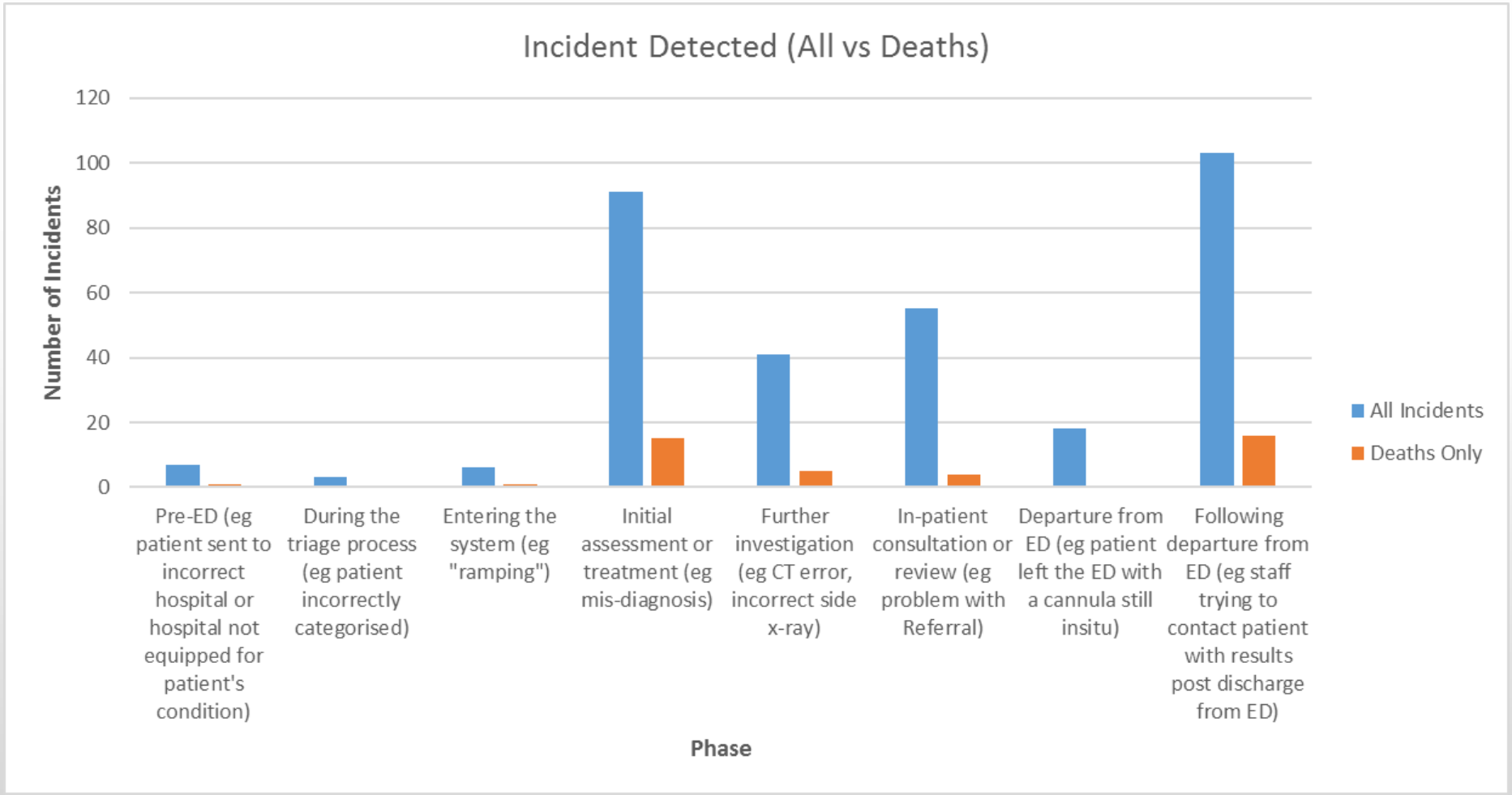
Triage Category

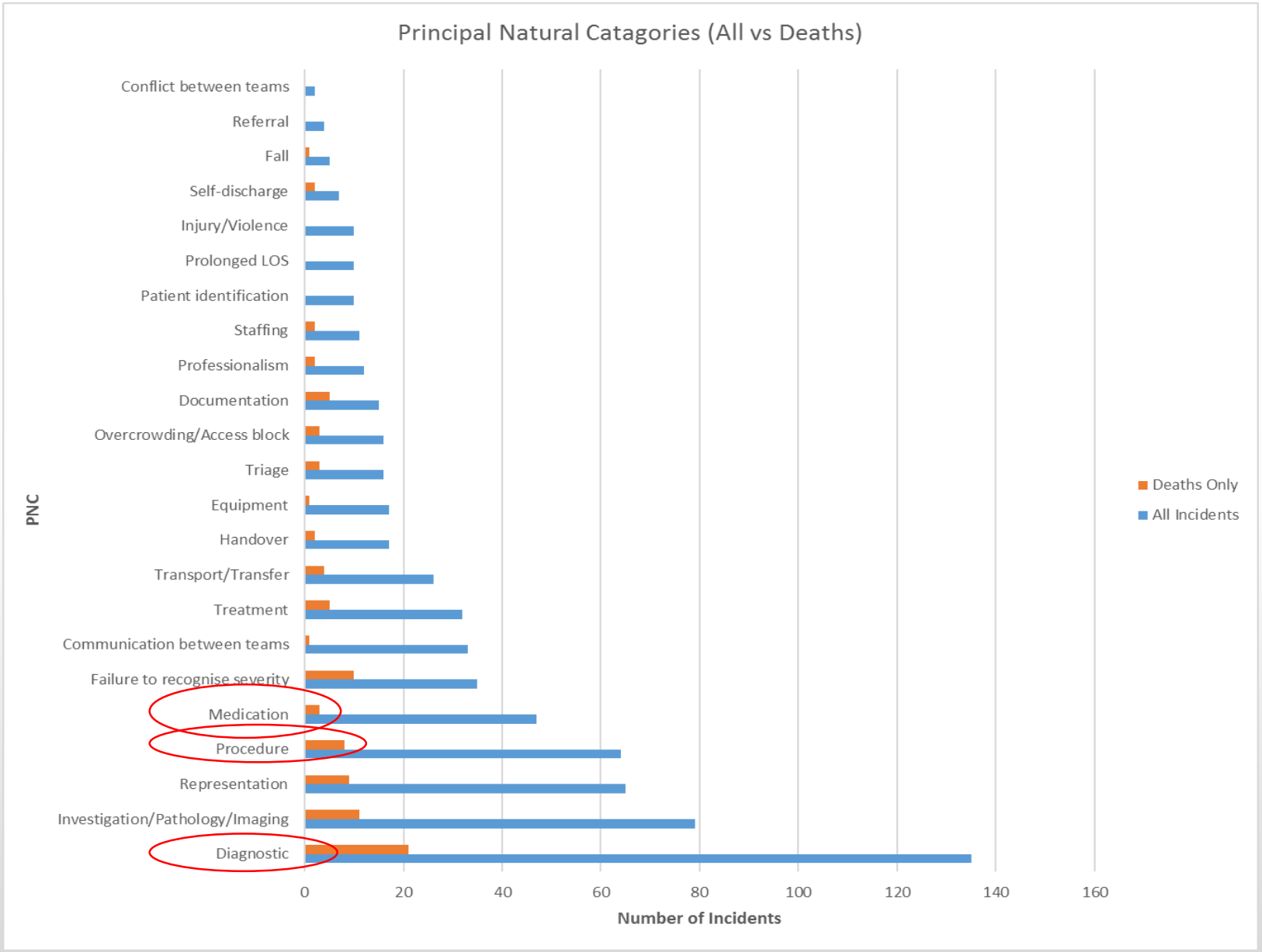


Age

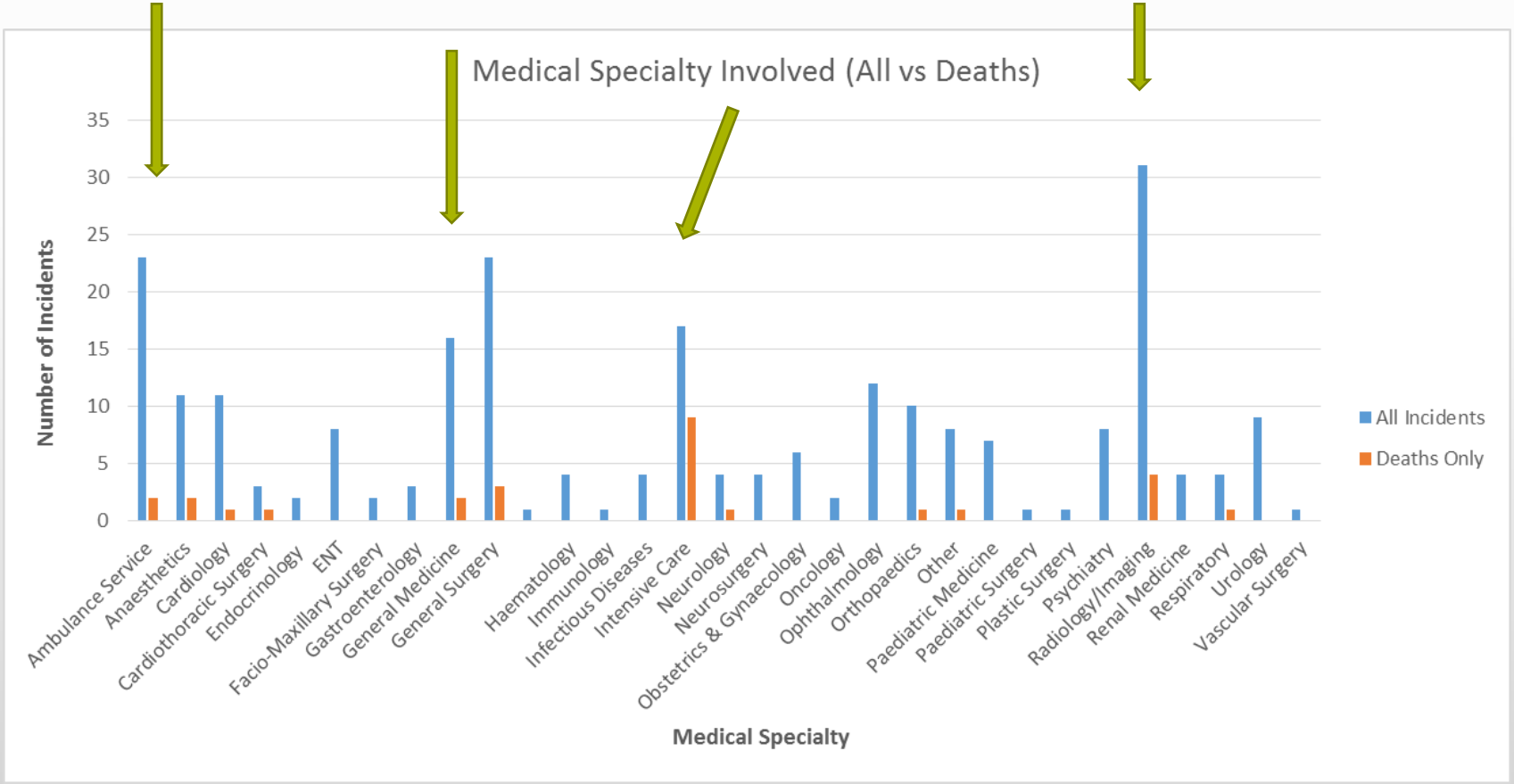

Age Band (All vs Deaths)
Number of Incidents
30
25
20
15
10
5
0
0 to 28 days
29 days to 11 months
12 to 23 months
2 to 4 years
5 to 9 years
10 to 14 years
15 to 19 years
20 to 24 years
25 to 29 years
30 to 34 years
35 to 39 years
40 to 44 years
45 to 49 years
50 to 54 years
55 to 59 years
60 to 64 years
65 to 69 years
70 to 74 years
75 to 79 years
80 to 84 years
85 to 89 years
90 to 94 years
Unknown Age
Age Band
All Incidents
Deaths Only

“At what stage of the patient’s journey was the event detected?




Principal Natural Catagories (All vs Deaths)
Conflict between teams
Referral
Fall
Self-discharge
Injury/Violence
Prolonged LOS
Patient identification
Staffing
Professionalism
Documentation
Overcrowding/Access block
Triage
Equipment
Handover
Transport/Transfer
Treatment
Communication between teams
Failure to recognise severity
Medication
Procedure
Representation
Investigation/Pathology/Imaging
Diagnostic
PNC
0
20
40
60
80
100
120
140
160
Number of Incidents
Deaths Only
All Incidents

Ambulance General Surgery Intensive Care Imaging



There are lessons to be learnt from medical errors.

EMER provides the opportunity to collect incidents, which, after analysis and reporting, can be used to improve patient safety in your ED.

How to we share EMER's information?

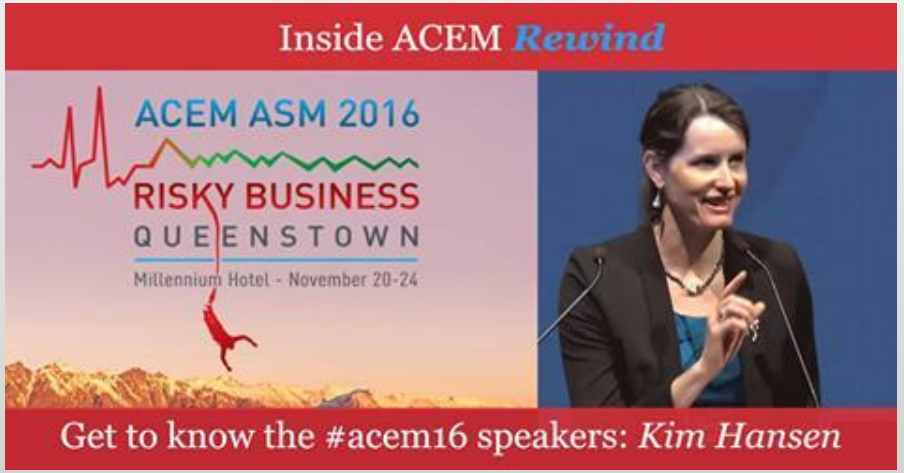
Publications : EMA, BMJ

Conferences – BMJ Quality and Safety, ASM, ICEM, SMACC, Diagnostic error conference

Twitter - *Follow us @EmergMedER*

Hospital education sessions

Patient Safety Alerts



Diagnostic error: Missed fractures in emergency medicine

EMA Emergency Medicine Australasia

The following incident was submitted to the Emergency Medicine Events Register (EMER – http://www.emer.org.au). EMER is an anonymous, confidential and protected incident-reporting system that is supported by ACEM. Anyone working in emergency medicine can enter a near miss or AE by following the link from the website. It should only take 5 min and will help to inform practice and improve patient safety in emergency medicine.

The case presented in Box 1 demonstrates the failure of an ED registrar to correctly identify a triquetral fracture on X-ray. A diagnostic error is broadly defined as any mistake or failure in the diagnostic process leading to a misdiagnosis, a missed diagnosis or a delayed diagnosis. Failure to diagnose a fracture accounts for up to 80% of ED diagnostic errors,[1] occurs in 1% of all ED visits in a Norwegian hospital[2] (when 3% of fractures were missed) and is a leading cause of litigation.[1] The rate of missed fractures in emergency radiology is highest in the extremities (foot, 7.6%; hand, 5.4%; wrist, 4.1%; ankle, 2.8%), the knee (6.3%), elbow (6.0%) and hip (3.9%).[3]

This missed fracture highlights a system issue (lack of timely X-ray reporting) that could potentially result in significant patient harm. According to Reason (p. 768), a systems approach to error 'concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects'.[4] Such an approach is characteristic of high-reliability organisations, which

BOX 1. *Data reported into EMER from an adverse event*

Clinical presentation – Injured wrist
Incident description – ED registrar interpreted XR as normal – missed the triquetral fracture
Contributing factors – Small fracture, inexperience, no ED consultant review of XR, delayed reporting of XR
Action taken – Patient phoned to come in, did represent for plaster and referral to fracture clinic
Factors that reduced the impact – XR reported 24 h later by radiology, results phoned through to ED consultant, patient presented for plaster
Prevention – Further education of ED registrars, supervision by ED consultant
Consequence or Outcome – 1-day pain
Time of Incident – 00.00–00.59 hours
Reporter – ED Physician

EMA Emergency Medicine Australiasia

Original Research

The Emergency Medicine Events Register: An analysis of the first 150 incidents entered into a novel, online incident reporting registry

Kim Hansen, Timothy Schultz, Carmel Crock, Anita Deakin, William Runciman, Andrew Gosbell

First published: 31 July 2016 | https://doi.org/10.1111/1742-6723.12620 | Cited by: 4

Kim Hansen, MBBS (HonsI), FACEM, Emergency Consultant; Timothy Schultz, BSc (HonsI), PhD, Research Fellow; Carmel Crock, MBBS, FACEM, ED Director; Anita Deakin, BAppSci (Nurs), Research Fellow; William Runciman, BSc (Med), MBBCh, FANZCA, FJFICM, FHKCA, FRCA, PhD, President; Andrew Gosbell, PhD, Director of Policy and Research, Deputy CEO.

EMA Emergency Medicine Australiasia

Original Research

Lessons learnt from incidents involving the airway and breathing reported from Australasian emergency departments

Carmel Crock, Kim Hansen, Toby Fogg, Angela Cahill, Anita Deakin, William B Runciman

First published: 16 August 2017 | https://doi.org/10.1111/1742-6723.12836

Carmel Crock, MBBS, FACEM, Director; Kim Hansen, MBBS (HonsII), FACEM, Director, Senior Lecturer; Toby Fogg, BM, MRCS Ed, FACEM, FRCEM, Senior Staff Specialist, Medical Director; Angela Cahill, RN, BSc, AdvDipBusMan, Project Coordinator; Anita Deakin, BAppSci (Nurs), Research Fellow; William B Runciman, MBBCh, FANZCA, FFICM, FRCA, FHKCA, PhD, Professor.

Research

Impact of scribes on emergency medicine doctors' productivity and patient throughput: multicentre randomised trial

BMJ 2019 ; 364 doi: https://doi.org/10.1136/bmj.l121 (Published 30 January 2019)
Cite this as: *BMJ* 2019;364:l121

Opinion
It's time to think hard about how clinicians work in a digital age

Katherine Walker, director of emergency medicine research, adjunct clinical associate professor [1 2], Michael Ben-Meir, director of emergency medicine, adjunct senior lecturer [1 2], William Dunlop, head scribe, medical student [1 3], Rachel Rosler, director of clayton emergency medicine [4], Adam West, director of paediatric emergency medicine [4], Gabrielle O'Connor, emergency physician [5], Thomas Chan, director of emergency medicine, adjunct associate professor [5 6], Diana Badcock, director of emergency medicine [7], Mark Putland, adjunct senior lecturer, clinical director of emergency medicine, director of emergency medicine [4 7 8], Kim Hansen, emergency physician, director of emergency medicine [9 10], Carmel Crock, director of emergency medicine [11], Danny Liew, chair of clinical outcomes research [12], David Taylor, professor, director of emergency medicine research [6 13], Margaret Staples, adjunct senior research fellow, biostatistician [2 14]

Author affiliations

Correspondence to: K Walker katie_walker01@yahoo.com.au

EMER

Emergency Medicine Events Register

Patient Safety Alert

Subject: Testicular Torsion

Testicular torsion in young males is over-represented in the EMER database. Currently, 3% of incidents (7/235) involved a probable testicular torsion. All incidents in the EMER database are coded into categories by an expert panel. The most common incident categories in reports involving torsion is **delay to treatment**, **conflict between teams** and **diagnostic error**.

The management of testicular torsion is rapid surgical exploration to maximise the chance of a positive outcome. The patient should be given analgesia and kept fasted. Ultrasound scanning should not delay surgical exploration.[1] Referral and treatment pathways should be established by the ED Leadership team in advance.

Patient Safety Alert No. 1 /09/11/2015. Follow us on Twitter at @EmergMedER Information obtained from Emergency Medicine Events Registry – an online, anonymous incident reporting system for Emergency Department doctors in Australia and New Zealand. Contact: emer@acem.org.au. Reference: 1. Deakin, A. and Shepherd, M. (2015), 'Knickers in a twist'. Emergency Medicine Australasia. doi: 10.1111/1742-6723.12473

EMER

Emergency Medicine Events Register

Patient Safety Alert

Subject: Aortic Dissection

Aortic Dissection is over-represented in the EMER database. Currently, 2% of incidents (5/272) involve an aortic dissection. The incident categories in reports involving aortic dissections are **diagnostic error** and **delay to treatment**.

The diagnosis of aortic dissection can be difficult because the patients present with atypical chest, abdominal or back pain, with or without limb symptoms. In some patients, the pain resolves. All five EMER patients were put on an "ACS rule-out" pathway with ECGs and troponin. One patient had a normal VQ after a positive d-dimer. Equal bilateral BPs and the absence of mediastinal widening on CXR are not sufficiently accurate to rule out an aortic dissection.[1] A delayed diagnosis can be fatal – two EMER patients were found deceased in the days after discharge from ED.

Patient Safety Alert No. 2. 25/05/2016. **Follow us on Twitter at @EmergMedER** Information obtained from Emergency Medicine Events Registry – an online, anonymous incident reporting system for Emergency Department doctors in Australia and New Zealand. Contact: emer@acem.org.au.

1.http://lifeinthefastlane.com/ccc/acute-aortic-dissection/

EMER

Emergency Medicine Events Register

Patient Safety Alert

Subject: Airway Management

Adverse events in airway management are over-represented in the EMER database. Currently, 11% of EMER reports(30/270) involved an incident relating to intubation. All incidents in the EMER database are coded into categories. The most common types of airway incidents are **CICO** ('can't intubate, can't oxygenate), **medication errors** and **delay to decision to intubate**. Outcomes included unrecognised oesophageal intubation, surgical airway, crico-thyroidotomy and 5 deaths (16.7% of airway incidents).

Advanced airway management remains a high risk procedure in Emergency Departments. To reduce errors a number of strategies can be utilised including equipment standardisation, simulation, selection of experienced practitioners, and use of a pre-intubation checklist and difficult airway algorithm. [1]

Patient Safety Alert No. 3. 06/09/2016. **Follow us on Twitter at @EmergMedER** Information obtained from Emergency Medicine Events Registry – an online, anonymous incident reporting system for Emergency Department doctors in Australia and New Zealand. Contact: emer@acem.org.au.

Reference: 1. Fogg et al, The Royal North Shore Hospital Emergency Department airway registry: closing the audit loop. Emergency Medicine Australasia (2016) 28, 27–33

Benefits …

Opportunity using incidents to work with other Specialty Colleges and State Hospital systems.

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What's next (for incident monitoring) ? a few thoughts…

System 1 vs System 2

Reporting good saves?

Trainees?

FACEMs - CPD ?

Expertise in Patient safety

Physician wellbeing/ Debriefs

Research – diagnostic, procedural, medication error

Consumer reporting?

Interdisciplinary learnings –radiology (double reporting), anaesthetics (human factors, crew resource management) surgery (mortality databases), Ambulance Research Centre (Frankston) into wellbeing

International interest in sharing learnings!

SAVE THE DATE

2ND AUSTRALASIAN DIAGNOSTIC ERROR IN MEDICINE CONFERENCE

Communicating for safer diagnosis

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