## RECOMMENDATION 1

<table>
<thead>
<tr>
<th>Contributing factors:</th>
<th>Policies/Procedures/Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation title:</td>
<td>Develop and implement policy for triage practice including detailed descriptors for the triage, assessment and care for the management of patient's presenting to the ED.</td>
</tr>
</tbody>
</table>
| Causation statement summary: | a. The lack of a triage process policy, which includes minimum practice standards for the triage, assessment and care for the management of patient's presenting to the ED, resulted in an incomplete triage which contributed in a failure to recognise the clinical condition of this patient.  
   b. The lack of a comprehensive triage, including a limited primary assessment of the patient, resulted in a triage score of 4 which led the patient to be allocated a wait time of 1 hour to be seen by medical staff which contributed in a delay in medical intervention. |
| Recommendation detail: | Develop and implement policy for triage practice including detailed descriptors for the triage, assessment and care for the management of patient's presenting to the ED.  
Develop, implement and resource the role of "Triage support nurse": works alongside Triage nurse - taking observations to enable a more thorough assessment and enable early commencement of management. |
| Recommendation type: | New procedure/memorandum/policy |
| How will this be measured: | Evidence of the published Triage policy. |
| Implementation evidence | Evidence of the published Triage policy. |
| Assigned to (Lead): | EDNS Priority | High |
| Implementation start date: | 19/05/2021 |
| Implementation due date: | 19/11/2021 |

## RECOMMENDATION 2

<table>
<thead>
<tr>
<th>Contributing factors:</th>
<th>Safety Mechanisms</th>
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<tr>
<td>Recommendation title:</td>
<td>Develop and implement a model for clinical supervision to support all staff in their clinical decision making.</td>
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</table>
| Causation statement summary: | a. A lack of clinical supervision resulted in further missed opportunities to recognise a sick patient which contributed to a delay in clinical intervention.  
   b. The demands of senior nurses to fulfil an increasing service role rather than supervisory role has impacted on the ability to facilitate planned education and supervision of junior nurses that may have decreased their knowledge and skill set when assessing a sick patient. |
| Recommendation detail: | Develop, implement and resource a model for clinical supervision to support all staff in their clinical decision making. |
### RECOMMENDATION 3

**Contributing factors:** Knowledge/Skills/Competence

**Recommendation title:** Review and align nursing clinical roles and responsibilities in ED and align to a capability framework.

**Causation statement summary:**

a. A failure to identify an abnormal temperature against clearly defined prompt on the PARROT chart to consider sepsis resulted in non-escalation which may have contributed to the patient outcome.

b. The lack of knowledge of the parental concern score on the PARROT chart is to be actioned for the ED and not only for inpatients resulted in a lower escalation score and contributed to the non-escalation of the patient’s treatment.

c. The lack of knowledge/skills and competence to recognise an unwell patient resulted in the non-escalation of the clinical care which may have contributed to the patient’s outcome.

d. Incomplete clinical handover between staff resulted in non-urgent escalation and contributed to delay in treatment.

**Recommendation detail:** A capability framework is created outlining nursing clinical roles and responsibilities in ED and resource provided to achieve implementation.

### RECOMMENDATION 4

**Contributing factors:** Safety Mechanisms

**Recommendation title:** Develop and implement a model for a parental escalation process in ED aligning with the inpatient ‘Call and Respond Early’ (CARE) Call in consultation with consumer representatives.

**Causation statement summary:**

a. A lack of recognition of persistent and significant parental concerns as a significant clinical concern to be escalated resulted in a delay in treatment which may have contributed to the patient’s outcome.

b. A lack of a formalised escalation process for families resulted in no clear pathway for seeking more senior assistance which...
RECOMMENDATION 5
Contributing factors: Knowledge/Skills/Competence
Recommendation title: Ensure contemporaneous education and use of the PARROT (V3) chart is conducted, evaluated and reported.
Causation statement summary: The lack of an established sepsis recognition tool in ED resulted in non-recognition of the patient's condition resulted in a delay in escalation which may have contributed to the outcome.
Recommendation detail: Ensure contemporaneous education and use of the PARROT (V3) chart is conducted, evaluated (including compliance with the process and measure of its effectiveness) and reported.
Recommendation type: Standardized communication tools
How will this be measured: Evidence of the education package, staff training numbers and implementation audits.
Implementation evidence Evidence of the education package, staff training numbers and implementation audits.
Assigned to (Lead): EDNS Priority | High
Implementation start date: 19/05/2021 Implementation due date: 19/11/2021

RECOMMENDATION 6
Contributing factors: Other
Recommendation title: The organisation conducts an independent external review of the emergency department: staffing, patient flow model, clinical supervision and education programme and ensures the monitoring of serious clinical incidents via regular Morbidity & Mortality Meetings, and the findings from this report are considered to inform the terms of reference of this review.
Causation statement summary: a. Having the waiting room nurse as a member of the resuscitation team resulting in the waiting room being effectively
RECOMMENDATIONS

unattended during resuscitations, led to fragmented care, a delay in reassessment, and may have contributed to the outcome.

b. Lack of clinical supervision and education on a deteriorating child may have contributed to delayed escalation.

c. Since Oct 2020, senior clinicians had escalated substantial concerns around patient safety to senior management. The panel found that these risks had not been effectively mitigated until recently.

d. A culture has developed which saw escalation as futile and ineffective with subsequent failure to call for assistance at times of increased acuity & activity (more obvious among nursing staff), even when there was availability of senior CNS from outside ED.

e. There is limited privacy in the waiting room to do an extensive physical assessment.

f. Since COVID-19, individual rooms in pods keep their equipment outside the room due to infection control. This allows for misplacement of equipment-RN2 spent several minutes trying finding appropriately sized BP cuff which may have delayed assessment.

g. The removal of the waiting room nurse resulted in a delay in comprehensive assessment and may have contributed to the patient outcome.


Recommendation type: Tangible involvement by leadership

How will this be measured: The published Terms of reference of the review.

Implementation evidence: The published Terms of reference of the review.

Assigned to (Lead): EDSQ&I Priority High

Implementation start date: 19/05/2021 Implementation due date: 19/11/2021

RECOMMENDATION 7

Contributing factors: Communication

Recommendation title: The organisation implements an awareness program focusing on CALD populations to ensure patient safety in the ED.

Causation statement summary: The perceived lack of cultural awareness by staff for CALD families and patients may have resulted in non-recognition of the family’s significant concerns whilst attempting to escalate care which may contributed to the delay in clinical intervention.

Recommendation detail: The organisation implements a review of its ability to respond to cultural and linguistic diversity in the delivery of healthcare across its services including the ED. The outcome of the review should result in improved awareness and practices of clinical staff through education and training in treating patients of different ethnic and cultural backgrounds.

Recommendation type: Standardized communication tools
### RECOMMENDATION 8

**Contributing factors:** Equipment/Information Systems/Applications  
**Recommendation title:** Purchase a second blood gas machine for the ED.  
**Causation statement summary:** The lack of a second or a consistently working blood gas machine in the ED resulted in a delayed first blood gas reading during the resuscitation which may have contributed to delayed intervention or an inaccurate reading.  
**Recommendation detail:** Purchase a second blood gas machine for the ED.  
**Recommendation type:** New devices with usability testing  
**How will this be measured:** The blood gas machine is operational in the ED.  
**Implementation evidence:** The blood gas machine is operational in the ED.  
**Assigned to (Lead):** EDS&Q  
**Implementation start date:** 19/05/2021  
**Implementation due date:** 19/11/2021

### RECOMMENDATION 9

**Contributing factors:** Safety Mechanisms  
**Recommendation title:** Review and adapt the physical layout of the triage area in ED to facilitate improvements to triage and assessment processes.  
**Causation statement summary:**  
- a. The workplace design of the triage area resulted in limited accessibility to physically reach the patients which contributed to an incomplete assessment.  
- b. The practice of not taking a manual pulse or feeling the skin may have contributed to a limited assessment of how sick this patient was.  
**Recommendation detail:** The physical layout of the triage area is reviewed to facilitate improvements to triage and assessment processes.  
**Recommendation type:** Architectural/physical plant changes  
**How will this be measured:** Viewing the changes made to the triage area.  
**Implementation evidence:** Viewing the changes made to the triage area.
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**SAC 1 Clinical Incident Investigation Report**

**RECOMMENDATIONS**

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<thead>
<tr>
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<th>EDMS</th>
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**RECOMMENDATION 10**

**Contributing factors:** Work Environment / Scheduling

**Recommendation title:** Develop and implement a robust system of medical unexpected leave (including sick leave) cover in ED.

**Causation statement summary:** Uncovered sick leave of medical staff resulted in a reduction in available medical staff during the evening, delays in medical assessments/prolonged waiting times and impeded the capacity for medical staff to provide a more comprehensive response to parental escalation. These factors may have contributed to a delay in recognition of the severity of illness and initiation of treatment.

**Recommendation detail:** Develop and implement a robust system of medical unexpected leave (including sick leave) cover in ED.

**Recommendation type:** New devices with usability testing

**How will this be measured:** The medical roster indicating the process and availability of medical staff replacement.

**Implementation evidence:** The medical roster indicating the process and availability of medical staff replacement.

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**RECOMMENDATION 11**

**Contributing factors:** Safety Mechanisms

**Recommendation title:** Develop and implement enhanced functionality to Emergency Department Information System (EDIS) or an Electronic Medical Record (EMR) to enable safe handover of clinical information.

**Causation statement summary:** The lack of an available contemporaneous, identifiable, non-editable and visible electronic system for recording handover of clinical information resulted in a fragmented response to escalation attempts by the family which led to a delayed escalation of care and may have contributed to the outcome.

**Recommendation detail:** Evidence of the enhanced functionality to Emergency Department Information System (EDIS) or an Electronic Medical Record (EMR).

**Recommendation type:** Enhanced documentation, communication

**How will this be measured:** Evidence of the enhanced functionality to Emergency Department Information System (EDIS) or an Electronic Medical Record (EMR).

**Implementation evidence:** Evidence of the enhanced functionality to Emergency Department Information System (EDIS) or an Electronic Medical Record (EMR).
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SAC 1 Clinical Incident Investigation Report
RECOMMENDATIONS

Assigned to (Lead): EDMS
Priority: High
Implementation start date: 19/05/2021
Implementation due date: 19/11/2021

Please note: the evaluation due date is always 6 months from the date the report is signed off by the Executive Director.

Do the RCA Panel request a declassification of this clinical incident? ☐ Yes ☒ No
Quality Activities are incidental findings or recommendations not contributory to the incident but their implementation will improve practice.

**QUALITY IMPROVEMENT ACTIVITY 1**

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<tr>
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<tr>
<td><strong>Quality improvement activity title:</strong></td>
<td>The ED annually audit the assigned at primary assessment against the documented clinical picture of the presentation. This is utilised as a tool to educate triage nurses and clinical staff.</td>
</tr>
<tr>
<td><strong>Causation statement summary:</strong></td>
<td>The lack of a comprehensive triage, including a primary assessment of the patient, resulted in a triage score of 4 which led the patient to be allocated a wait time of 1 hour to be seen by medical staff which contributed in a delay in medical intervention.</td>
</tr>
<tr>
<td><strong>Quality improvement activity detail:</strong></td>
<td>Every 12 months ED conducts an audit of 20 medical records to review the assigned at primary assessment against the documented clinical picture of the presentation.</td>
</tr>
<tr>
<td><strong>Quality improvement activity type:</strong></td>
<td>Checklist/cognitive aids</td>
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<tr>
<td><strong>How will this be measured:</strong></td>
<td>GEKO number and audit results forwarded to the Co-Directors Medical Services and tabled at the governance committee.</td>
</tr>
<tr>
<td><strong>Implementation evidence:</strong></td>
<td>GEKO number and audit results and evidence of tabling at the governance committee.</td>
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**QUALITY IMPROVEMENT ACTIVITY 2**

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<tr>
<td><strong>Quality improvement activity title:</strong></td>
<td>The hospital reviews the process for supporting families and their caregivers after a death has occurred.</td>
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<tr>
<td><strong>Causation statement summary:</strong></td>
<td>No cause was identified.</td>
</tr>
<tr>
<td><strong>Quality improvement activity detail:</strong></td>
<td>The hospital reviews and evaluates existing processes of bereavement and family support (which are actioned when a patient passes away) to seek improvements and assurance of the effectiveness of the process.</td>
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<td><strong>Quality improvement activity type:</strong></td>
<td>New procedure/memorandum/policy</td>
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Quality Activities

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