Incident Reporting and Root Cause Analysis (RCAs)

James talks to Dr Andrew Baker, Director of Prevocational Education and Training and Medical Administrator, about incident reporting and root cause analysis (RCAs) and their importance in providing safe clinical care for patients.

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About Dr Andrew Baker

Dr Andrew Baker completed his residency years at St George Hospital and has spent most of his medical career in Hospital Management. He has worked in Medical Administration at Westmead Hospital, Royal North Shore, Bankstown and Western Sydney Area Health Service, as well as Clinical Governance at Western Sydney.

Andrew has been the Director of Prevocational Education and Training at Westmead Hospital for the last 4 years. As well as completing an MBBS, Andrew has a Masters in Health Planning and is a Fellow of the Royal Australasian College of Medical Administrators.

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With Dr Andrew Baker, Director of Prevocational Education and Training at Westmead Hospital, New South Wales, Australia

Introduction

Incident reporting is something that many junior doctors are not familiar with and do not routinely participate in. It is, however, a responsibility of everyone working in the hospital system and leads to positive outcomes for patients, hospitals, and even for those involved in the reporting process.

Case

You are asked to review a 50-year-old female inpatient for fever. You notice the area surrounding her cannula site is cellulitic. You take blood cultures and commence the necessary treatment and then consider whether you ought to make an incident report.

1. Why is Incident Reporting important?
• Short term benefit: allows for the issue reported to be investigated and resolved in the short term
• Long term benefit: aims to identify what is happening within the system, what is leading to this, and how the system can be improved
• A form of communication that allows for a message to be heard more broadly
  • Reporting only to your team will not identify issues that may affect the entire hospital, health district, or state

2. Whose responsibility is it?

• All hospital employees
  • Although generally embraced more by nursing staff, all doctors should be aware of the system and capable of putting something into the system

3. What is worth reporting?

• Any instance where you feel something has happened that should not have:
  • no socomial infections
  • falls
  • medication errors
  • aggression
  • OHS
  • accidents
  • equipment failure
  • errors of clinical decision making
  • near misses: things can go wrong but not cause harm to patients, these are still worth looking into
• NOT for playing politics or complaining about colleagues

4. What is the process of reporting?

• IIMS: incident information management system – is the system used for incident reporting throughout NSW (similar systems are in use in other states)
• IIMS can be accessed from any hospital computer via the intranet
• Link will direct to an electronic form requiring:
- patient details
- where it happened
- what happened
- suggestions of what could be done better
- indication of severity - SAC (severity assessment code)
  - SAC-1 (most severe) – usually death or significant disability
  - SAC-2 – patient requires increased level of care (e.g. moved to HDU)
  - SAC-3
  - SAC-4 (least severe)
  - Note: the severity score you give is only an indication – the final severity score may differ

You are NOT required to identify yourself

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5. Is reporting ever detrimental to the individuals involved?

- Junior doctors are often concerned that if an incident involving themselves is reported that they may be identified and that this may affect their reputation or assessment
  - Keep in mind:
    - In most instances senior staff will already be aware of issues even without an IIMS
    - The intent of the system is not to attribute blame but to fix system-related problems
    - Reports ought to be de-identified however this is not necessarily always the case
    - Senior staff may in fact respond positively
      - Contributing to IIMS shows that you are able to reflect on the work you do and are concerned about the quality of care that you / your team / your organisation provides – this is a skill often admired by senior staff
      - This is an opportunity to show how you respond to error and demonstrate self-improvement – this is an impressive skill that often comes up in job interviews

6. How is a SAC-1 Investigated?

- All SAC-1 are required by policy and law to be investigated with RCA – Root Cause Analysis
- An investigation organised by the hospital Clinical Governance Unit to identify the ultimate cause and generate recommendations to address this

- Junior doctors may be asked to attend a RCA to provide information but are very rarely the target of the investigation – if you are asked to attend, review the notes and stick to the facts

- RCA team
  - Small group of senior clinicians
  - ~3 meetings over 10 weeks
  - JMOs may be asked to serve on a RCA team where relevant

- Important to relay to the patient and their family that it is a lengthy process as quick answers and solutions are often expected

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7. Types of recommendations which may come from investigation

- Changes in staff training/orientation
- Check lists
- Equipment changes
- Systemic – e.g. ‘between the flags’

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Take home messages

- Reflect on the quality of your care
- Get involved in clinical governance

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Tags: #accidents,#clinical governance,#equipment failure,#errors in clinical decision making,#Falls,#IIMS,#incident information management system,#incident reporting,#medication errors,#OHS,#patient care,#patient safety,#RCAs,#Root Cause Analysis,#SAC,#safe clinical care,#severity assessment code
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