Emergency Department/Urgent Care Centre

IACT CONSULTATION

June 2017

IACT Background

The IACT was developed in a project with East Grampians Health Service and the Victorian Managed Insurance Authority (VMIA).

IACT Content

This audit is for use in: an emergency department (ED) or urgent care centre (UCC)

Four sections:

1. Quality Systems Evaluation – review of the main quality systems for service delivery in the ED/UCC.
2. Clinical Process Evaluation- review of the documents that support the clinical processes in the ED/UCC.
3. Clinical Data Review – review of the related ED/UCC data for quality improvement purposes
4. Patient Record Review – review of patient records for general clinical processes (all patients) and specific clinical processes for selected ‘at risk’ sub populations.
5. Altered conscious state
6. Acute coronary syndrome
7. Abdominal pain
8. Suicidal/Self harm
9. Option to add other ‘at risk’ populations with criterion for inclusion in the internal audit.

Using the IACT

The IACT is used by the internal auditor in with an independent clinical expert in emergency care.

The complete tool can be used for a comprehensive review or select criteria to focus in on areas of significant risk, for example: triage and assessment, or, discharge and outcomes. The scope of the audit, the number of criteria and the patient groups is agreed by the team before starting.

The IACT columns are as follows

* Criteria: Definition of what is being measured
* Desired processes to address criteria: Lists the processes that are examined to provide evidence of meeting the criterion
* Evidence to support processes: Lists the possible sources of evidence used to determine if the process for each criterion are present. Additional evidence may be sought by the audit team
* Method of data collection: Lists possible methods of collecting evidence related to each process
* Phase: Suggestions as to whether the evidence could be reviewed onsite or offsite. This assists in planning the requirements for pre audit offsite documentation and documentation required onsite
* IA+/-ED expert: Who is involved with each phase of evidence collection and review
* Rating*:* The column for recording the rating of the evidence

Recording the results

This tool is used to record the information from the audit. The ‘Evidence to Support Process’ column is populated with the evidence for each criterion.

Part 4: The patient file data for Part 4 is documented on the separate data collection sheets and the cumulative score is recorded in the evidence columns.

The cumulative score for each criterion enables re-audit after recommendations have been implemented.

Retention of audit documentation is required for evidence that:

* represents data that is not easily referenced or accessed post audit
* demonstrates adverse findings
* documents the content of interviews or meetings

Criteria rating

Each organisation will have their own system of rating of controls and the priority of recommendations. In part 4 of the tool the clinical expert rates the aggregate findings in terms of severity (as described below). This allocation of rating, by the clinical experts allows the internal auditor to incorporate clinical findings and recommendations from Part 4 into the final audit report.

Scoping the Audit

The scope of the audit is finalised by discussion by the internal auditor with the organisation.

\*Note: the numbering of criterion is consistent across the tool and data collection templates so any amendment of the tool to reflect the new scope should not alter the numbering.

This first section of the IACT is used to evaluate the implementation and effectiveness of all (or selected parts depending on the scope of the audit) of the organisation wide quality structures and systems that support quality care and control risk in the ED or UCC.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CRITERIA | DESIRED PROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA+/-ED EXPERT |
| **POLICIES AND GUIDELINES** | | | | | |
| 1. ED/UCC level policies and procedures guide appropriate delivery of care through the client pathway | * 1. Periodic monitoring of compliance with ED/UCC level policies and procedures, protocols? | *Audits and Clinical audit schedules and reports*  *e.g. Documentation schedules and individual audit reports* | *Staff Interview,*  *Document Review* | *Offsite/Onsite* | IA |
| * 1. Policies, procedures and protocols are regularly reviewed/updated | *Clear process documented for regular review of policies, procedures and protocols*  *Sample of policies and procedures have last review date and next review date documented* | *Document review* | *Offsite* | IA |
| * 1. A clear process by which ED/UCC policies and procedures are distributed to, and understood by employees. | *Clear process documented for distribution and staff acknowledgement e.g. employee acknowledgment of* *their receipt of the information, confirmation that they have read it and understand it,*  *UCC – how are contracted GP’s informed of new/changed policies /procedures* | *Staff interview*  *Document review* | *Onsite* | IA |
| WORKFORCE | | | | | |
| 1. New staff receive appropriate orientation to the ED/UCC | * 1. The ED/UCC has orientation guidelines, procedures, checklists and logs to ensure comprehensive orientation for the clinical workforce in key areas identified through a risk based approach | ED/UCC *orientation procedures, guidelines, checklists*  *Sample of staff have orientation to* ED/UCC *recorded in appropriate documentation/log* | *Staff interview*  *Document review* | Offsite/Onsite | IA |
| 1. New staff have appropriate skills and knowledge of ED/UCC | * 1. New medical and ED/UCC staff undergo initial credentialling [[1]](#footnote-1)reviewed to ensure skills and knowledge are current and approriate to the individual scope of practice | *Credentialling policy/procedure*  *Audit of new staff personnel files for initial credentialling including:*   * professional credentials in emergency medicine regsitration and any restrictions of scope * review of practice * review of current organisation mandatory training requirement |  |  |  |
| 1. Existing staff are competant to undertake their defined scope of practice | 5.1 Periodic re credentialling[[2]](#footnote-2) of staff occurs to ensure skills and experience are appropriate to deliver defined scope of practice | *Evidence of system to periodically review currency of training, qualifications, registration, experience and currency of skills required to deliver defined scope of practice*  *Emergency Department requirements include:*   * *FACEM for Director of Emergency Department* * *Emergency department senior clinicians* - emergency medicine specialists or career medical officers with extensive experience and/or other post graduate qualifications.   *Urgent Care Centres*   * *Registered medical practitioner (with credentials in critical care, intensive care or emergency)* * *Registered nurse with relevant clinical knowledge*   Appropriate review of certification to provide:   * *ultrasound* * *procedural sedation* * *Basic life support* * *Advanced life support* * *Equipment Use ( defibillator, ventillator)* * *Suturing* * *Plastering* | Document review | Onsite | IA+ED |
| 5. Staff undertake professional development relevant to the ED/UCC and their individual scope of practice | 5.1 The ED/UCC has an education plan based on competency based requirements for ED/UCC and needs analysis of staff and consideration of presentation risks | *ED/UCC Education Plan which includes at a minimum:*   * *Basic Life Support,* * *Advanced Life Support* * *Triage* * *Pressure injury prevention* | Document review, staff interview | Onsite | IA and ED |
|  | 5.2 Attendance at staff education/training sessions is recorded | *Sample of staff have attendance at education recorded in appropriate documentation/log* | Document review | Onsite | IA |
|  | 5.3 The education program is periodically evaluated | *Education evaluation, analysis and recommendations*  *Frequency of evaluation* | Document review | Offsite | IA |
|  | 5.4 Individual professional development for ED/UCC is planned and implemented | *Professional Development Plans in Personnel file*  *ED*  *% of sampled staff with further emergency qualifications(grad dip emergency nursing, Advanced Life Support,*  *Acute and Complex Medical Emergencies,*  *Paediatric Life Support, trauma*)  UCC  *% of staff forming bank of rostered nursing staff for UCC with Scheduled Medicines(Rural and Isolated Practice) Endorsement[[3]](#footnote-3)*  *% of staff forming bank of rostered nursing staff for UCC with Advanced Life Support certification* | Document review | Onsite | IA and ED |
|  | 5.5 A record is maintained of staff meeting mandatory competency/certification requirements for delivering scope in ED/UCC | *% of sampled Triage staff who have completed the annual online ETEK triage competency package* | Document review | Onsite | IA+ED |
| 1. The ED/UCC periodically reviews the scope of services provided | 6.1 The conditions under which specific diagnostic groups will be transferred or admitted from the ED/UCC have been clearly defined in documentation | *e.g. Organisation Acute Admission Policy e.g. Safe Practice Framework*  *or Emergency Department Admission Policy* | Document review | Offsite | IA+ED |
| 1. Individual scope of practice is defined and periodically reviewed | 7.1 The scope of practice of individual staff in ED/UCC is documented and there is evidence of regular review after recredentialling | *Log of scope of practice or*  *addendum to position description documenting approved scope of practice such as:*   * *ultrasound[[4]](#footnote-4)* * *procedural sedation[[5]](#footnote-5)* * *X-ray* * *Suturing* * *Plastering* | Document review | Onsite | IA + ED |
|  | 7.2 Orientation to and review of scope of practice occurs in relation to the implementation of new procedures or equipment | *Evidence of training for new equipment or amendment to scope of proactice* | Document review  Staff interview | Onsite | IA +ED |
| 1. Appropriate levels of staffing in the ED/UCC | 8.1 The rosters demonstrate appropriate staffing in ED/UCC with respect to medical, nursing, administrative and other personnel. | *ED – 24hr triage staff*  *24 hour medical officers*  *24 hour on call access to designated senior doctor (emergency physician)*  *UCC -24hr access to registered GP and Nurse* | Document review  Staff interview | Onsite | IA +ED |
| 1. Appropriate access to specialist consultation | 9.1 The rosters demonstrate there is appropriate access to more senior emergency services consultation and other specialist consultation | *ED only – 24-hour access to more senior emergency consultation, general surgery, orthopaedics, general medicine, anaesthesia, intensive care and paediatrics*  *Evidence of contact list for external specialists*  *Regional collaboration agreement re access to specialists/telemedicine* | Document review | Onsite | IA +ED |
| 1. Appropriate access to support services | 10.1 The rosters demonstrate there is appropriate access to support services | *ED only- 24 hour per day access to pathology, radiology and operating theatres* | Document review | Onsite | IA +ED |
| 1. Staff culture in the ED/UCC is at an acceptable level | 10.1 Workforce Culture at the ED/UCC level is assessed, analysed and responded to | *Workforce culture/Staff satisfaction evaluation and analysis for ED/UCC*  *sick leave rate analysis for ED/UCC*  *turnover rate analysis for ED/UCC* | Document review  Staff interview. | Offsite/Onsite | IA |
| RISK MANAGEMENT | | | | | |
| 1. Risk identification and assessment occurrs regularly | 12.1 The ED/UCC undertakes the identification and analysis of risks (including clinical) | *Risk profile or register for ED/UCC includes clinical risks* | Review risk register | Onsite | IA |
|  | 12.2 Data (e.g. incident data, clinical audits, waiting time data, literature) is used to inform the identification of risks and selection of appropriate controls. | *Risk documentation* | Staff interview. Document review | Onsite | IA+ED |
|  | 12.3 A risk based methodology is applied to the approval of new procedures and equipment, within the ED/ UCC | *Applications for use of new equipment/procedures with evidence that a risk assessment has been undertaken* | Staff interview. Document review | Onsite | IA+ED |
| 1. Monitoring of risk occurs regularly | 13.1 ED/UCC risks that have been identified as requiring action have assoIACTed action plans with strategies for risk reduction, timelines and responsibilities | *Risk register* | Document review | Onsite | IA |
|  | 13.2 Risk rating of identified ED/UCC risks changing over time (mitigating) | *Risk register shows progression of risk management* | Document review | Onsite | IA |
|  | 13.3 ED/UCC Risk escalation is consistent with the organisation’s risk management framework | *Evidence if risk escalation to appropriate position* | Document review | Onsite | IA |
| 1. Controls put in place to manage key risks are monitored for effectiveness | 14.1 Testing of contols identified in risk assesssment (procedures, clinical guidelines compliance) occurs periodically | *Audit occurs against known high risks* | Document review | Onsite | IA+ED |
| 1. Risk reporting and communication is effective | 15.1 The risk profile of the ED/UCC is reported to relevant risk committee | *Periodic risk profiling and reporting* | Document review | Offsite | IA |
|  | 15.2 Communication to staff occurs regarding key ED/UCC risks and emerging risks and management strategies | *Evidence in minutes, agendas, bulletin* | Staff interview, document review | Onsite | IA |
|  | 15.3 There is clear ownership of risk management through allocation of risk portfolios to ED/UCC staff | *Risk register demonstrates risk ownership* | Document review | Onsite | IA |
| 1. All incidents and near misses are reported, appropriately documentated and managed | 16.1 ED/UCC incidents, adverse events and near misses are recorded in the incident system | *Review of incident register*  *Review of audits from patient file review for coverage of all incidents* | Incident database review  Staff interview, | Onsite | ED |
| 16.2 Management are able to track the incident trends in the ED/UCC and there is evidence of action taken | *Incident reporting such as trends data over 3yr period* | Report review | Onsite | ED |
|  | 16.3 Root casue analysis of serious incidents or adverse events is undertaken in the ED/UCC | *Sample of highest category incidents have had root cause analysis undertaken* | Report review | Onsite | ED |
|  | 16.4 There is clear articluation of and familiarity with the open disclosure process | *Open Disclosure Policy/procedure*  *Evidence staff familiar with process* | Document review Staff interview | Onsite | IA+ED |
| QUALITY IMPROVEMENT | | | | | |
| 1. Responsibility for quality improvement is clearly assigned in the ED/UCC | 17.1 All relevant responsbilities for quality have been allocated in ED/UCC and individuals understand and enact their responsbilities in relation to quality | *e.g. Responsibilities for*   * *quality plan oversight and implementation* * *Audits and Clinical audits* * *Monitoring and reporting on quality* * *Development of clinical pathways* * *Sentinel event monitoring* * *Complaint investigation and resolution* | *PD’s of managers and staff,*  *Staff interview* | *Offsite/ onsite* | IA |
|  |
| 1. The accountability and reporting mechanisms for quality of care in the ED/UCC are documented and followed | 18.1 Relevant metrics/reports are provided in line with a reporting framework to the board, relevant committees and management in relation to the ED/UCC quality of care? | *Evidence of scheduled reports or reporting framework with specification of reporting frequency, accountability and responsibility. Data reported may include:*   * *Mandatory indicators - Victorian Emergency Minimum Dataset (VEMD) and SOP KPI’s* * *non mandatory indicators– ACHS Emergency Medicine Clinical Indicators* * *Clinical audit reports* | Document review | Onsite | IA+ED |
|  | 17.2 Data is used to improve processes in the ED/UCC | *Reports and minutes to committee show monitoring data over time and improvement in processes as a result of monitoring* | Document review  Staff interview | Onsite | IA and ED |
|  | 17.3 There is a process in place and regular meetings to feedback results of any monitoring or audits and any action arising to ED/UCC staff | *Reports and minutes , newsletter demonstrate communication to staff in relation to monitoring and related quality improvement actions* | Document review  Staff interview | Onsite | ED |
| 1. Quality improvement is a planned coordinated activity | 19.1 There is a quality improvement plan for the ED/UCC that has:   * clear links to whole of hospital strategic quality initiatives * timeframes, responsibilities * evaluation * resulted in improvement | *ED/UCC quality plan demonstrating requirements that has been evaluated* | Document review  Staff interview | Onsite | ED |
| PATIENT EXPERIENCE | | | | | |
| 1. Patient experience is periodically evaluated with appropriate tools in the ED/UCC according to organisation policy | 20.1 The analysis of patient experience/satisfaction in ED/UCC is undertaken and analysed periodically to improve quality of care | *Recommendations from patient experience assessment implemented and evaluated e.g.*   * *Understanding of discharge self-management* * *Understanding of medication management* * *Understanding of follow up appointment* | Document review | Onsite | IA and ED |
| 1. Patient complaints in the ED/UCC are resolved within organisational timelines | 21.1 There is analysis and action in relation to ED/UCC complaints   * Timely response to complaints * Majority of complaints resolved | *Complaints policy and procedure*  *Analysis of complaints process effectiveness (timeliness and resolution)* | Document review  Staff Interview | Onsite | IA |
| INFRASTRUCTURE | | | | | |
| 1. IT systems support recording and reporting on key data | 22.1 A functional electronic patient information management system that enables data reporting in ED/UCC | *A safe effective data system that allows:*   * *Timely reporting of ED data* * *Data presented in a format that enables analysis e.g. trends* * *Secure system with password protection and timeout* | Staff Interview | Onsite | IA and ED |
| 1. The financial resources of the ED/UCC are managed appropriately | 23.1 A departmental budget is linked to the ED/UCC operational plan (which aligns with the organisation’s strategic plan) | *ED/UCC budget with links to unit operational plan and organisational strategy*  *UCC*  *Human Resources strategy to UCC staffing roster has a risk based approach that considers potential risks such as impact on inpatient nurse/patient ratio* | Document review | Offsite | IA |
| 1. The infrastructure resources of the ED/UCC are managed appropriately | 24.1 There is an equipment maintenance register that is current | *Equipment such as:*   * *resuscitation* * *monitoring(ECG, BP, )* | Document review | Onsite | IA+ED |
| 24.2 Equipment appropriate to the service is available when needed |  | Staff interview | Onsite | ED |
|  | 24.3 There is an effective system for restocking essential items |  | Document review  Staff interview | Onsite | IA |

This second section of the clinical internal audit tool is used to evaluate the appropriateness of documents (policies, procedures and guidelines) that support all (or selected parts) of the clinical related processes that control risk in the emergency department/urgent care centre.

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| CRITERIA | DESIRED PROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA+/-ED EXPERT |
| **ACCESS** | | | | | |
| 1. Access to emergency Care is available | 25.1The ED/UCC offers 24-hour care or has in place local arrangements which clearly communicate times of limited access and direct patients to another emergency facility of the same or higher level when they are closed | *Document which articulates arrangements* | Document Review  Staff interview | Offsite | ED |
| 1. Document/s support the prioritisation of patients in a timely manner | 26.1 There is a current policy/procedure for patient triage which addresses the requirements for:   * A uniform approach to undertaking the assessment of triage category * How to document triage category * Triage compentency requriements for staff * Orientation to triage for all new staff | *Document contains all elements* | Document Review  Staff interview | Offsite | ED |
| **ASSESSMENT** | | | | | |
| 1. Document/s support the initial assessment[[6]](#footnote-6) of patient clinical status | 27.1 There is a current procedure/protocol/template for patient initial assessment that outlines:   * key clinical observations to be recorded * Timeframes for initial assessment to be undertaken | *Document contains all elements* | Document Review  Staff interview | Offsite | ED |
| 1. Document/s support the provision of a comprehensive assessment | 28.1 There is a current procedure/protocol for patient comprehensive assessment with a minimum standard defined for comprehensive assessment including:   * Structured history * Objective examination * Timeframes for comprehensive assessment to be undertaken | *Document contains all elements* | Document Review  Staff interview | Offsite | ED |
| 1. Patient informed consent for intervention has been obtained | 29.1 There is a current policy/procedure for patient informed consent in ED/UCC that has been implemented | Policy/procedure for informed consent available and accessible  Identification of procedures requiring consent is understood by staff | Document Review  Staff interview | Offsite/Onsite | ED |
| 1. Document/s support the periodic monitoring of patient clinical status | 30.1 There is a current procedure/protocol for patient monitoring and documentation of clinical status in ED/UCC with:   * Physiological monitoring required * Clear clinical deterioration escalation triggers * Clear requirements for use of emergency codes | *UCC – documented process includes mechanisms for additional assistance with clinical deterioration* | Document Review  Staff interview | Offsite | ED |
| 1. Document/s support timely medical/ specialist review | 31.1 There is a current procedure/protocol outlining:   * communication of deterioration and handover protocols * timeframe for medical/speciality consultant reviews to be carried out to faciliatate treatment and discharge/disposition | *ED – Documented process for communIACTion and handover for specialist review*  *UCC – Documented process for communication and handover to GP, recording drug order by phone* | Document Review  Staff interview | Offsite | ED |
| 1. Document/s support the referral of patients to support services in a timely manner | 32.1 There is a current procedure/protocol for referral to support services including*:*   * Pathology, Imaging, Pharmacy,Surgery, NETS/PETS/ARV   Acceptable turnaround times | *UCC - procedure includes criteria for activation of*  NETS/PETS/ARV[[7]](#footnote-7) | Document Review  Staff interview | Offsite | ED |
| **INTERVENTION** | | | | | |
| 1. ED/UCC procedures and protocols are evidence based and reviewed periodically | 33.1 ED/UCC clinical procedures and protocols reference current clinical standards and guidelines. This is supported by a system to make readily available clinical standards and guideline | *Sample of clinical procedures and protocols have clear references to clinical guidelines upon which they are based and evidence that they have been reviewed periodically e.g.*   * *Nurse initiated medication protocols* * *Airways management procedure/protocol* * *Patient transfer procedure/protocol* * *Pneumothorax procedure/protocol* * *Asthma management protocol* * *Acute Coronary Syndrome protocol* * *Stroke Protocol*   *(record evidence in worksheet)*  *Readily available standards and guidelines include: emergency medicine textbooks, journals, Clinical management guidelines and protocols are available on site. There should also be access to electronic sources of medical information[[8]](#footnote-8)* | Document Review  Staff interview | Offsite | ED |
| **DISCHARGE** | | | | | |
| 1. Document/s support the provision of a comprehensive timely discharge plan to all of: the person, their family and other providers involved in their care. | 34.1 There is a current procedure/protocol for discharge from ED/UCC that address the requirements for:   * Safe discharge * Transfer policy with use of NETS/PETS/ARV * After hours discharge * Admission to hospital * Discharge communication * Follow up appointments | *Safe admission policy/protocol*  *Transfer policy* | Document Review  Staff interview | Offsite | ED |

This third section of the clinical internal tool is used to evaluate the type of patient related data that is collected and analysed in the ED/UCC for quality improvement purposes. The data is separated in to process and outcome data. The audit does not collect and verify the raw data but looks at the units own collection and analysis of this data.

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| CRITERIA | DESIRED DATA TO ADDRESS CRITERIA | EVIDENCE  (record evidence sighted) | METHOD |
| **Demand Data** | | | |
| 1. Presentations/demand data is collected and analysed in the ED/UCC | Total presentations  Presentation by date of week and hour of day  Presentation by ambulance or self | Evidence of collection and analysis of demand and peak demand times | All data reviewed onsite by ED expert |
| **Process Data** | | | |
| 1. Complaints data is collected and analysed in the ED/UCC | Number and type of complaints /10,000 ED /1000UCC presentations and trend over time | Evidence of collection and analysis |  |
| 1. Incident data is collected and analysed in the ED/UCC | Number and type of incidents /10,000 ED/1000UCC presentations and trend over time | Evidence of collection and analysis |  |
| 1. National Emergency Access target (NEAT) data is collected and analysed in the ED | 2013 (VIC) 75%[[9]](#footnote-9) of all ED patients leave within 4 hours  2014 (VIC) 84% of all ED patients leave within 4 hours  2015 (AUS) 90% of all ED patients leave within 4 hours | Evidence of collection and analysis (ED only) |  |
| 1. Access block data is collected and analysed data is collected and analysed in the ED | Percentage of patients with a length of stay longer than 8 hours | Evidence of collection and analysis |  |
| 1. Length of stay data is collected and analysed | Percentage of patients with a length of stay longer than 24 hours | Evidence of collection and analysis |  |
| 1. Time to thrombolysis is analysed for AMI patients is collected and analysed | Percentage of patients to receive thrombolytic therapy within 30 minutes[[10]](#footnote-10)  (For ED’s with cardiac catheterisation facilities examine door to balloon time of less than 30 minutes) | Evidence of collection and analysis |  |
| 1. Unplanned re-attendances are monitored and analysed | Percentage of ED patients who have unplanned re attendances within 48 hours[[11]](#footnote-11) | Evidence of collection and analysis |  |
| 1. % of ATS category patients seen within clinically recommended times   Immediate for Cat 1  10 minutes for Cat 2  30 minutes for Cat 3  60 minutes for Cat 4  120 minutes for Cat 5 | % patients receiving assessment and treatment in target time for triage category[[12]](#footnote-12) | Evidence of collection and analysis |  |
| 1. Presentation type is analysed | Presentation analysis may include:  Percentage of presentation of ATS 1-5  Reason for presentation via ICD-10 diagnosis (ED only)  Percentage of patients over 65 years of age | Evidence of collection and analysis |  |
| 1. Collection and analysis of patient who did not wait | Percentage of presentations to the emergency department where the patient did not wait for treatment[[13]](#footnote-13) | Evidence of collection and analysis | Document review |
| 1. Mortality data is collected and analysed in the Emergency Department/UCC | Evidence of analysis and benchmarking of mortality data  Evidence of mortality data analysis used to inform action  E.g.Percentage in hospital mortality for admissions from ED/UCC | Evidence of collection and analysis | Document review |
| 1. Unplanned representation rates (within 48 hours) for ED/UCC are collected and analysed | Evidence of analysis and benchmarking of data  Evidence of data analysis used to inform action | Evidence of collection and analysis | Document review |
| 1. Time to radiology services | Average time to CT  Average time to MRI  Average time to Plain X ray | Evidence of collection and analysis | Document review |
| 1. Time to Pathology Results | Average time to ABG results  Average time to Cardiac enzymes results  Average time to FBE&UE results  Average time to Blood GROUP/cross match) results | Evidence of collection and analysis | Document review |
| 1. Total ED time for inpatient admitted and non-inpatient admitted patients | Average total ED time for admitted patients  Average total ED time for non- admitted patients | Evidence of collection and analysis | Document review |

This fourth section of the IACT is used to evaluate the individual medical records for evidence of appropriate clinical processes that control risk in the emergency department/urgent care centre. This section is divided into those general clinical processes that would be expected to be found in any medical record in ED/UCC and a section which for the elements that would be expected in a specific sub population of patients and includes

1. Altered conscious state
2. Acute coronary syndrome
3. Abdominal pain
4. Suicidal/Self harm

This part of the IACT is designed to be undertaken with the support of a member of staff member to navigate the file.

Sampling

The sample for review is chosen by the audit team with the general criteria and relevant population specific criteria applied.

For ED the audit sample size is a minimum of 10 randomly selected files( for each subpopulation group selected in the scope of the IACT) with presentations in the last 12 months. All general criteria is examined on an agreed random sample of these files, and the population specific criteria would be examined in all the relevant medical files of patients in the specified subpopulation.. An additional consideration in the selection of files is ensuring files cover different shifts in the clinical area, for example some files randomly selected from the evening/night shift.

For UCC it may not be possible to get a large numbers of cases in the specific subpopulation in the last 12 months. A minimum of 5 randomly selected files for each subpopulation group selected in the scope of the audit with presentations in the last 12 months. All general criteria is examined on an agreed random sample of these files (minimum of 10) and the population specific criteria is examined in all the relevant medical files of patients falling in the specified subpopulation.

Patient files need to be checked for suitability prior to the internal audit and there needs also to be provision made for additional files if needed at the onsite visit.

How to document data

The patient file data from individual patient files for Part 4 are documented on the separate data collection sheets for the general and sub population specific criteria. The aggregate data from all the patient records is recorded in the evidence columns in this document. In most cases the aggregate data required to be entered in this document is an indication of the total number of files that demonstrate the criterion (the numerator) over the total number of files examined (the denominator).

For some criterion the calculation of an average and or median time for an activity to occur is required. The average or *mean* is the arithmetic average of a set of numbers. The mean is used for values that fall in a normal distribution. The median relates to a value lying at the midpoint of a distribution of observed values. The median is generally used for skewed distributions. The mean is not a robust metric since it is largely influenced by outliers. The median is better suited for skewed distributions to derive at central tendency as it is more robust. In scoping the internal audit a decision will need to be made regarding the use of the mean or the median for criterion listed in Part 4. Generally the median is a more representative measure of the time for an activity to occur.

Assessment of Severity Rating

For each of the aggregate criterion results demonstrating a significant omission of care, the clinical expert (with the assistance the internal auditor if required) needs to make a severity rating of therisk, omissions in care or documentation, and represent to the organisation the urgency of addressing these.

The rating scale used needs to be confirmed by the internal auditor but would generally follow the form of *high, medium* and *low* ratings based on consideration of the following criteria:

* likelihood of the error to potentially cause signiﬁcant harm
* the likelihood to expose the health service to successful litigation
* urgency with which it needs to be addressed by the organisation

Recommendations

For each of the criterion with a severity rating the clinician should provide a brief recommendation to improve practice

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| General Criterion | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high , medium and low) and Recommendations |
| **ACCESS** | | | | | |
| 1. Date and time of triage is documented |  |  |  |  |  |
| 1. Presenting problem, relevant limited history and relevant assessment is documented |  |  |  |  |  |
| 1. Initial Triage category is recorded |  |  |  |  |  |
| **INITIAL ASSESSMENT/INITIAL CLINICAL OBSERVATION[[14]](#footnote-14)** | | | | | |
| 1. Time of initial assessment/ clinical observations commenced is documented |  |  |  |  |  |
| 1. Respiratory rate is documented |  |  |  |  |  |
| 1. Oxygen saturation is documented |  |  |  |  |  |
| 1. Heart Rate is documented |  |  |  |  |  |
| 1. Blood pressure is documented |  |  |  |  |  |
| 1. Temperature is documented |  |  |  |  |  |
| 1. Conscious state is documented |  |  |  |  |  |
| **COMPREHENSIVE ASSESSMENT** | | | | | |
| 1. Documentation of date and time of comprehensive assessment |  |  |  |  |  |
| 1. Patient seen within timelines for triage category?[[15]](#footnote-15) |  |  |  |  |  |
| 1. Average and/or median time between initial assessment /clinical observation and comprehensive assessment |  |  |  |  |  |
| 1. Tailored patient assessment was undertaken and documented |  |  |  |  |  |
| 1. Tailored examinations undertaken |  |  |  |  |  |
| * Neurological |  |  |  |  |  |
| * Respiratory |  |  |  |  |  |
| * Cardiovascular |  |  |  |  |  |
| * Other relevant exams |  |  |  |  |  |
| 1. Falls risk assessment has been undertaken and documented |  |  |  |  |  |
| **DIAGNOSIS AND MANAGEMENT PLAN** | | | | | |
| 1. Differential diagnoses were documented |  |  |  |  |  |
| 1. Management plan documented |  |  |  |  |  |
| **INTERVENTIONS** | | | | | |
| 1. An appropriate clinical response and communication to recognised escalation triggers or deterioriation is documented |  |  |  |  |  |
| **MONITORING** | | | | | |
| 1. Appropriate types of monitoring of clinical condition were undertaken and documented (e.g. respiratory rate, oxygen saturation, heart rate, BP, Temp, conscious state) |  |  |  |  |  |
| 1. Frequency of monitoring occurred at reasonable time intervals (as appropriate to patient condition or as specified in ED/UCC protocol)? |  |  |  |  |  |
| 1. Documentation was made of escalation communication/use of emergency code (if applicable) |  |  |  |  |  |
| **DISCHARGE PLANNING** | | | | | |
| 1. Copy of discharge plan in records |  |  |  |  |  |
| 1. Date and time of ready for discharge documented |  |  |  |  |  |
| 1. Inpatient bed request time documented |  |  |  |  |  |
| 1. If transfer indicated , appropriate transfer documentation is recorded |  |  |  |  |  |
| 1. Date and time of discharge documented |  |  |  |  |  |
| 1. Date and time of discharge plan documented |  |  |  |  |  |
| 1. Record of follow up appointment date and time in discharge plan |  |  |  |  |  |
| 1. Record of Medication prescribed and reconciliation in discharge plan |  |  |  |  |  |
| 1. Interventions provided in ED/UCC recorded in discharge plan |  |  |  |  |  |
| 1. Key contacts recorded in discharge plan |  |  |  |  |  |
| 1. Self management strategy recorded in discharge plan |  |  |  |  |  |

This next section of the patient record review examines criteria in specific sub populations. The subpopulation included in the audit and the sample size would be confirmed in the planning process and scoping of the internal audit.

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| Population: Altered Conscious State  (note this applies to altered conscious  state from any cause and not restricted  to neurological causes) | Number of patients who meet criteria (Numerator) | Total number  of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| 1. Glasgow coma scale undertaken and documented |  |  |  |  |  |
| 1. Pupillary size and reaction to light documented |  |  |  |  |  |
| 1. Orientation to person, place and time documented |  |  |  |  |  |
| 1. Behaviour documented |  |  |  |  |  |
| 1. Post traumatic amnesia ( tested via A-WPTAS) documented |  |  |  |  |  |
| 1. Blood Sugar level documented |  |  |  |  |  |
| 1. CT/MRI ordered where indicated |  |  |  |  |  |
| 1. Average and/or median time from patient presentation to CT/MRI (ASAP but less than 24hr) |  |  |  |  |  |

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| Population:  Acute Coronary Syndrome | Number of patients who meet criteria (Numerator) | Total number of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| 1. Chest pain assessment pathway completed and documented[[16]](#footnote-16) |  |  |  |  |  |
| 1. ECG undertaken and analysed |  |  |  |  |  |
| 1. Average and/or median time to ECG 10 minutes or less[[17]](#footnote-17) (Time of ECG –time of presentation) |  |  |  |  |  |
| 1. Fibrinolysis undertaken (STEMI)undertaken |  |  |  |  |  |
| Or percutaneous coronary intervention undertaken (STEMI)undertaken |  |  |  |  |  |
| 1. Average and/or median time to Fibrinolysis less than 30 minutes[[18]](#footnote-18) (thrombolysis time- presentation time) |  |  |  |  |  |
| Or Average and/or median time to percutaneous coronary intervention less than 90 minutes[[19]](#footnote-19) (thrombolysis time- presentation time) |  |  |  |  |  |
| 1. Troponins undertaken |  |  |  |  |  |
| 1. Average and/or median time to cardio-specific troponins result 60 minutes or less[[20]](#footnote-20) (troponins time- presentation time) |  |  |  |  |  |
| 1. Chest X ray undertaken |  |  |  |  |  |
| 1. Average and/or median time to Chest X ray (Chest X ray time- presentation time) |  |  |  |  |  |

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| Population:  Abdominal Pain | Number of patients who meet criteria (Numerator) | Total number of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| 1. Initial pain assessment score documented |  |  |  |  |  |
| 1. Documented reassessment pain score |  |  |  |  |  |
| 1. Analgesia given where indicated |  |  |  |  |  |
| 1. Time to analgesia 30 minutes or less ( time of analgesia- presentation time) |  |  |  |  |  |
| 1. CT undertaken |  |  |  |  |  |
| 1. Average and/or median time to CT abdomen ( Time of CT abdomen – presentation time) |  |  |  |  |  |
| 1. Average and/or median time to surgical review |  |  |  |  |  |
| 1. Pathology results undertaken |  |  |  |  |  |
| 1. Average and/or median time from patient presentation to pathology results for: |  |  |  |  |  |
| * LFT results |  |  |  |  |  |
| * Amylase results |  |  |  |  |  |
| * Lipase results |  |  |  |  |  |
| * Lactate results |  |  |  |  |  |
| * FBE&UE results |  |  |  |  |  |
| * Blood group/cross match results |  |  |  |  |  |

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| Population:  Suicidal/Self harm | Number of patients who meet criteria (Numerator) | Total number of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| 1. Victorian Emergency Department Mental Health Triage Tool has been administered (or similar) and category recorded |  |  |  |  |  |
| 1. Average or Median time from triage to assessment by trained mental health clinician in ED/UCC |  |  |  |  |  |
| 1. Average or Median time from referral to assessment by trained mental health clinician in ED/UCC[[21]](#footnote-21) |  |  |  |  |  |

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| Population:  Additional specific population agreed  with organisation | Number of patients who meet criteria (Numerator) | Total number of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| Agreed criteria for population  (e.g. % patients over 65 years, paediatric, obstetric, infectious patients) |  |  |  |  |  |

1. Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments. [↑](#footnote-ref-1)
2. Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments. [↑](#footnote-ref-2)
3. An endorsement granted by the Nursing and Midwifery Board of Australia that authorises registered nurses to use or supply medicines for nursing practice in a rural and isolated practice area. [↑](#footnote-ref-3)
4. An emergency medicine sonologist is an emergency medicine practitioner who has successfully completed this credentialing process or has successfully completed the Certificate in Clinician Performed Ultrasound (CCPU) or who possesses DDU (Diploma of Diagnostic Radiology), FRANZCR (Fellow of the Royal Australian and New Zealand College of Radiology) or equivalent, or qualifications such as the Graduate Certificate in Health Science (Medical Sonography). [↑](#footnote-ref-4)
5. For UCC JCCA accreditation of rural GP anaesthetists or Fellowship of ACRRM. For ED agreed organisation certification or [↑](#footnote-ref-5)
6. Initial assessment refers to the time at which an ED/UCC observation chart is created [↑](#footnote-ref-6)
7. Newborn Emergency Transport Services, Perinatal Emergency Referral Services and Adult Retrieval Victoria [↑](#footnote-ref-7)
8. Royal Children’s Hospital Clinical Practice Guidelines <http://www.rch.org.au/clinicalguide/>, NHMRC Clinical Practice Guidelines Portal <http://www.clinicalguidelines.gov.au/> [↑](#footnote-ref-8)
9. From Statement of Priorities [↑](#footnote-ref-9)
10. ACHS clinical indicator [↑](#footnote-ref-10)
11. DH Redesign Hospital Care program, National Partnership Agreement Key Performance indicator C43 [↑](#footnote-ref-11)
12. ACEM Guidelines on the implementation of the Australasian triage scale (G24) state that time of medical assessment and treatment is usually the time of first contact between the patient and the doctor recorded as time seen by doctor. Where a patient has exclusive contact with nurse under clinical supervision of a doctor it is the time of first contact with nurse and is recorded as time seen by nurse. [↑](#footnote-ref-12)
13. DH PRISM indicator [↑](#footnote-ref-13)
14. Initial assessment refers to the time at which an ED/UCC observation chart is created [↑](#footnote-ref-14)
15. Maximum waiting times specified in the Australasian Triage Scale are calculated from the time between arrival and commencement of medical assessment and treatment (ACEM P06 Policy on the Australasian Triage Scale). Time of medical assessment and treatment is usually the first contact between the patient and the doctor initially responsible for their care (time seen by doctor). When a patient has contact exclusively with nursing staff acting under the clinical supervision of a doctor it is the time of first nursing contact (time seen by nurse) (ACEM G24 Guidelines on the implementation of the Australasian tirage scale in emergency departments) [↑](#footnote-ref-15)
16. Indicator 1a, Australian Commission on Safety and Quality in Health Care. Indicator Specification: Acute Coronary Syndromes Clinical Care Standard. Sydney: ACSQHC, 2014. [↑](#footnote-ref-16)
17. Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of ST-segment elevation myocardial infarction (STEMI) have a 12-lead electrocardiogram (ECG) performed within a target of 10 minutes of emergency department (ED) arrival. (Centers for Medicare & Medicaid Services (CMS). Specifications manual for hospital outpatient department quality measures (v 5.1a). Baltimore (MD): 2011 Dec) [↑](#footnote-ref-17)
18. ACHG Clinical Indicator 2.1 [↑](#footnote-ref-18)
19. Indicator 3c, Australian Commission on Safety and Quality in Health Care. Indicator Specification: Acute Coronary Syndromes Clinical Care Standard. Sydney: ACSQHC, 2014 [↑](#footnote-ref-19)
20. ‘ There is a consensus that a turnaround time of 1 h or less should be achieved for cardiac marker assays’ from [Ervasti M](http://www.ncbi.nlm.nih.gov/pubmed?term=Ervasti%20M%5BAuthor%5D&cauthor=true&cauthor_uid=18605943), [Penttilä K](http://www.ncbi.nlm.nih.gov/pubmed?term=Penttil%C3%A4%20K%5BAuthor%5D&cauthor=true&cauthor_uid=18605943), [Siltari S](http://www.ncbi.nlm.nih.gov/pubmed?term=Siltari%20S%5BAuthor%5D&cauthor=true&cauthor_uid=18605943), [Delezuch W](http://www.ncbi.nlm.nih.gov/pubmed?term=Delezuch%20W%5BAuthor%5D&cauthor=true&cauthor_uid=18605943), [Punnonen K](http://www.ncbi.nlm.nih.gov/pubmed?term=Punnonen%20K%5BAuthor%5D&cauthor=true&cauthor_uid=18605943)Diagnostic, Clinical and laboratory turnaround times in troponin T testing. [Clin Chem Lab Med.](http://www.ncbi.nlm.nih.gov/pubmed/18605943) 2008;46(7):1030-2. [↑](#footnote-ref-20)
21. **ACHS clinical indicators** Mental health assessment turnaround time CI 4.1: Mean time from referral to assessment by a mental health worker (L) [↑](#footnote-ref-21)