APPENDIX E

Assessing the impact of actions to address incidents' root causes

Figure E1 shows a selection of measures out of a sample of 16 serious incident action plans we reviewed across the four audited health services compared to better-practice examples. The selection captures a spread of incident and measure types from the sampled action plans. There were two incidents where health services used relevant measures to assess the impact of implemented actions. We denote these measures with a '^'.

FIGURE E1: **Reported and proposed outcome measures for selected serious incidents**

Incident type	Outcome measure/s reported in action plan	Better-practice outcome measure/s
Failure to respond to clinical deterioration of a patient resulting in a Code Blue alert (for patient resuscitation)	• Adopt a tiered approach to escalation of patient deterioration	• 100% completion of colour-coded patient observation charts in the specified clinical area—for all consecutive admissions for one month, and then a random sample of charts each quarter for the next 12 months (via file audit) • Number of medical emergency team calls greater than Code Blue calls in the specified clinical area and other relevant areas of the health service—monthly calculation (KPI monitoring)
Fetal growth restriction leading to higher risk birth	• Improved quality of communication between staff • Complete documentation of patient escalations and other incidental clinical communications in electronic medical record	• 100% staff understanding new protocols in specified clinical areas—quarterly for 12 months (brief staff survey using case vignettes) • 100% compliance with new protocols in all relevant clinical areas—for consecutive cases of suspected/actual fetal growth restriction for the next 12 months, and a random sample of cases quarterly for the next 12 months (via file audit) • Performance within statewide target for severe fetal growth restriction as specified in SOP across the health service—quarterly calculation (KPI monitoring)
Medication mismanagement of older patient experiencing delirium	• Staff education about delirium management	• 100% staff understanding of delirium management protocols in specified clinical area/s—quarterly for 12 months, annually thereafter (brief staff survey using case vignettes)

Incident type	Outcome measure/s reported in action plan	Better-practice outcome measure/s
	• No serious medication incidents related to high-risk medications • Ensure staff awareness of best-practice care	• 100% compliance with delirium risk screening in designated clinical area and other relevant units—for all relevant consecutive admissions for one month and then a random sample of charts each quarter for the next 12 months (via file audit) • 100% staff compliance with delirium management policy and guidelines in designated and other relevant clinical units—for all relevant consecutive admissions for one month and then a random sample of charts each quarter for the next 12 months (via file audit)
Incorrect application of stroke patient clinical pathway	• Audit staff knowledge of stroke pathway pre and post re-education • 100 per cent compliance with stroke pathway^	• 100% staff understanding of stroke management pathway in specified clinical area—quarterly for 12 months and annually thereafter (brief staff survey using case vignettes) • 100% compliance with stroke management pathway in specified clinical area—for all relevant consecutive admissions for one month and then a random sample of charts each quarter for the next 12 months (via file audit)
Retained products post surgical procedure	• Staff re-educated about revised procedures • 0 per cent future incidents of retained surgical products^	• 100% compliance with revised surgical count policy at completion of designated and other relevant, procedures—monitored quarterly via random selection of cases (via tally of count sheet reconciliations)
Failure to manage venous thromboembolism (VTE) prophylaxis (to prevent blood clots)	• Nil	• 100% of patients admitted on VTE prophylaxis with effective ongoing management post discharge for all relevant admissions—for one month and then a random sample of charts each quarter for the next 12 months (via file audit) • 100% VTE prophylaxis at admission is maintained at discharge for all relevant admissions unless clinically contraindicated—monthly (new KPIs for monitoring)

Note: ^Denotes measures that assess the impact of implemented actions.
Source: VAGO.