Tools for MOH Healthcare Practices

Customer Complaints Management and Root Cause Anal

Sally Rodgers
Acme
2008-Feb-05 : 11:33:20

Table of Contents

Applet Details	
Applet Title	CCM and RCA
Description	Customer Complaints Management and Root Cause Anal
Objective	To manage Customer Complaints Management and Root Cause Analysis.
Abstract	An iCT method of managing customer coplaints and root cause analysis.
Team Leader	Sally Rodgers
Commencement Date	25-Apr-2007
Expected Completion Date	31-May-2007
Completion Date	
Status	Not Completed
Team Name	CCM and RCA
Team Members	***No Team Members are selected.***

−	**1**	**ObGyn**
	1	MH 1
	2	MH 2
	3	Wad 8
	4	Wad 9
	5	Delivery
−	**2**	**Gen Surgery**
	1	NW 3
	2	NW 11
	3	Operation Theatre
−	**3**	**Plastik Surgery**
	1	PS 5A
	2	PS Clinic
	3	Recovery
−	**4**	**Nephrology**
	1	Nephrology
−	**5**	**Urology**
	1	PHDU
	2	Urology Surgery
−	**6**	**Orthopaedic**
	1	Orthopaedic
−	**7**	**Dermatology**
	1	Dermatology
−	**8**	**Anaesthesiology**
	1	Anaesthesiology
−	**9**	**Psychiatry**
	1	Psyciatry

	10	Ortholarnygology
	1	Ortholarnygology

1	+	Access
2	+	Communication
3	+	Decision Making
4	+	Quality of Clinical Care
5	+	Costs
6	+	Rights, Respect & Dignity
7	+	Grievances
8	+	Corporate Services
9	+	Professional Conduct

1	+	Clinical Management
2	+	Documentation and Communication
3	+	Healthcare Associated Infection
4	+	Abscondence/Missing/Left Against Medical Advice
5	+	Agents
6	+	Patient Behaviour
7	+	Patient Abuse
8	−	Patient Accidents
	1 +	Slips/Trips/Fall
	2 +	Sharp Object
	3 +	Impact/Collision
	4 +	Inappropriate Patient Handling/Positioning
	5 +	Exposure
9	+	Infrastructure
10	+	Resources
11	+	Other event types

1	+	Patient factors
2	+	Task and technology factors
3	+	Staff factors
4	+	Team factors
5	+	Work and care environment
6	+	Management and organisational factors
7	+	External Factors

−	**1**	**Status**
	1	Resolved
	2	Not Resolved
	3	Pending
−	**2**	**Impact**
	1	Minimum
	2	Minor
	3	Moderate
	4	Major
	5	Serious
−	**3**	**Risk**
	1	Rare
	2	Unlikely
	3	Possible
	4	Likely
	5	Almost Certain
−	**4**	**Relationship**
	1	Patient
	2	Relative
	3	Visitor
	4	Other Health Prof.
	5	Others
	6	Spouse
−	**5**	**Incident Type**
	1	Patient Complaint
	2	Customer Complaint
	3	Internal Complaint

	4	Patient Incident
	5	Customer Incident
	6	Internal Incident
−	6	**Gender**
	1	Male
	2	Female
−	7	**Race**
	1	Malay
	2	Chinese
	3	Indian
	4	Pakistani

	Minimum	Minor	Moderate	Major	Serious
Rare	1	1	2	2	3
Unlikely	1	1	2	3	4
Possible	1	2	3	3	4
Likely	1	2	3	4	4
Almost Certain	2	2	3	4	4

1	None
2	Minimal
3	Mini RCA
4	Full RCA

Time frame for resolution	8 (Days)

No.	Process Stage	Objective	None	Minimal	Mini RCA	Full RCA
1	Event Registry	To record the event and determine action needed	Record in iCT-M Event Registry	Record in iCT-M Event Registry	Record in iCT-M Event Registry	Record in iCT-M Event Registry
2	RCA Team	Form Team to investigate event	Not necessary to form team	Investigation manager	Investigation to be conducted by small RCA team	Investigation to be conducted by full RCA team with leader
3	Critical Events	Collect data relevant to incident	Not necessary to investigation	Investigation by manager	Investigation by manager and some others	Full investigation by manager and all stakeholders
4	Identify Causal Factors	To understand what happened	Not necessary to investigation	Basic sequence of events	Detailed sequence of events	Thorough sequence of events
5	Identify Root Causes	Identify the factors contributing to event	Identify one important factor	Identify a few important factors	Identify all important factors	Identify all important factors thoroughly
6	Recommendations	Take necessary actions	5 Why not necessary	5 Why necessary	Detailed 5 Why necessary	Thorough 5 Why necessary
7	Lesson Learnt	What did we learn?	Risk reduction action is not necessary	Basic risk reduction by manager	Detailed risk reduction by manager and team	Thorough risk reduction by manager and team
8	W3 Programme	Develop an action plan	Action plan is not necessary	Basic action plan is necessary	Detailed action plan is necessary	Thorough action plan is necessary
9	Close RCA	Take appropriate action and close RCA	Implementation action is not mandatory	Basic action plan is necessary	Detailed action plan is necessary	Thorough action plan is necessary
10	Effectiveness	Did we achieve an effective system?	Evaluation of effectiveness is not mandatory	Basic observation of effectiveness	Detailed observation of effectiveness	Detailed observation of effectiveness

Complaint No	**2**	**Relationship**	Relative
Person Affected		**Person Complaining**	
Name	Rosita Ahmad	**Name**	Ahmad Ibrahim
Gender	Female	**Gender**	Male
NRIC No	42424353	**NRIC No**	7586979709
Date Of Birth	02-May-2007	**Date Of Birth**	01-Jun-2007
Race	Malay	**Race**	Malay
Incident Type	Internal Incident		
Describe the Incident	The patient fainted and fell to the floor after being given an IV drug.		
Immediate Corrective Action	The drug was changed immediately. The patient was assured of the correct medicine and put in intensive care.		
What the complainant wants to see happen	The nurse on duty used the drug for the patient in the next bed because both patients have similar problems but the drugs prescribed are of different concentrations.		
Department	Gen Surgery NW 11	**Complaint Type**	Communication Misinformation or failure in communication (but not ¿failure to consult¿) Give inaccurate/wrong information
Event Type	Agents Medication Preparation/Dispensing	**Causal Factors**	Task and technology factors Decision making aids Availability, use and reliability of specific types of tests, e.g. blood testing
Impact	Major	**Status**	Not Resolved
Risk	Almost Certain	**Completion date**	
Investigation Level	**4 Full RCA**		
Final Remarks	Not yet resolve the matter		

		30-Apr-2007	01-May-2007	02-May-2007	03-May-2007	04-May-2007	05-May-2007	06-May-2007	07-May-2007	08-May-2007	09-May-2007	10-May-2007	11-May-2007	12-May-2007	13-May-2007
Date of Incident	02-May-2007														
Date of Complaint	03-May-2007														
Date of Informing Department	05-May-2007														
Date of Acknowledgement to Complainant	08-May-2007														
Date of Letter to HOD for Actioning	11-May-2007														
Date of Response from HOD after Actioning															

Root Cause Analysis
for
Incident Number : 2
for
Patient : Rosita Ahmad
Date : 02-May-2007

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Person Affected		**Person Complaining**	
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Date of Response from HOD after Actioning															

To : Deborah

The Incident Management Committee authorises

1	Deborah
2	Elaine

To conduct an investigation into the following Incident.

Identification Number	**2**
Date Event Occurred	02-May-2007
Investigation Level	4

Description of Incident :
The patient fainted and fell to the floor after being given an IV drug.

Brief Description :
Please study this incident immediately. A report of this must be sent to the Safety Department.

This team shall

1	Observe the working environment.
2	Interview the victim.
3	Interview the hospital staff who provided the service.
4	Keep samples from the incident.

Description Of Incident

The patient fainted and fell to the floor after being given an IV drug.

1	**Medical Records**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	The patient has been given similar medicines before.	Patient	02-May-2007	02-May-2007	Patient was cooperative.
	2	The patient admits not noticing any difference at the time of the IV.	Patient	02-May-2007	02-May-2007	Patients family is worried.
2	**Documentation**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	Copy of incident report	X-Ray department	03-May-2007	09-May-2007	Very slow to receive records.
	2	Copy of protocol/guidelines for IVTT	Dr. Abc	03-May-2007	04-May-2007	The guidelines hardcopy was available in document control.
	3	Copy of patient record	SRN XX	04-May-2007	04-May-2007	The nurse provided the records immediately.
	4	Written statement	Patient	02-May-2007	03-May-2007	The written statement was provided by the patients father.
3	**Status of Immediate Situation**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	The nurse noted that the patient was shortness of breath.				
	2	Patient was sweating profusely and red in the face.				
4	**Interview Involved Persons**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	Patient said that the medicine appeared darker red than usual.				
	2	The nurse said that the patient was not on his usual bed and she could not remember the patients name.				
5	**Incident Scene**					

	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	The used bottle and syringe are kept in the lab.				
6	**Safeguard Pertinent Evidence**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	Syringe driver and attachments are kept in the test lab.				
7	**Other Relevant Information**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	The incident happened at the end of shift.				
8	**Photographs**					
	No.	Description Of Information	PIC	Date Request	Date Receive	Comments
	1	None available.				

No.	Event Date-Time	Event Location	Person(s) Involved	Event Description	Comments
1	02-May-2007 11:49 AM	Patient Ward	Nurse A	Nurse A prepared medicines on a tray for the patients	Usual procedure
2	02-May-2007 06:51 PM	Patient Ward	Nurse A	Nurse A on a phone call for 15 mins	The nurse has a new boyfriend
3	02-May-2007 06:52 PM	Patient Ward	Nurse A	Nurse A asked Nurse B to gave the medications to patients due for 8am dose	Nurse B and Nurse A are good friends
4	02-May-2007 06:53 PM	Patient Ward	Nurse B	Gave and administered prepared medications to patients	Nurse B gave the drug while Nurse A was on the phone
5	02-May-2007 06:53 PM	Patient Ward	Nurse B	Patient PDC injected with Amoxicillin known to have allergy to Penicillin	Nurse B did not know of patients allergy
6	02-May-2007 06:54 PM	Patient Ward	Nurse B	Nurse B finished giving medications to patients	Nurse B unaware of actions
7	02-May-2007 06:54 PM	Patient Ward	Nurse A	Patient PDC complaints of itchiness and difficulty of breathing	Nurse A surprised at patients reaction
8	02-May-2007 06:54 PM	Patient Ward	Nurse A	Nurse A called Patient Dr BK about the patient	Nurse A and B both scared
9	02-May-2007 06:55 PM	Patient Ward	Sister S	Patient was given Oxygen inhalation	Sister S was very helpful
10	02-May-2007 06:55 PM	Patient Ward	Patient	Patient suffered Severe Anaphylactic Shock	Patients father was very angry
11	02-May-2007 06:55 PM	Patient Ward	Dr. BK	Dr. BK came to realize that staff nurse administered wrong medication for patient	Dr. BK was visibly upset at Nurse A and B
12	02-May-2007 06:55 PM	Patient Ward	Patient	Patient was transferred to PICU (Pediatric Intensive Care Unit) ward	Patients father demanded an explanation

−	1	Patient Factors	Brief Conttributing Factor	RCA	
	1	Children who are in stable condition likely to transfer from one bed to another	Nurses lack knowledge on childs behavior	Yes	Patient factors Personal Cultural background
−	2	Task and Technology Factors	Brief Conttributing Factor	RCA	
	1	No proper medication tray for each patient	Hospital did not provide tray		Task and technology factors Record and test results Need to chase up information
	2	Medication are not labelled properly/similarity of appearance of medications	Nurse made an error	Yes	Task and technology factors Task design Design deficiency
−	3	Individual Staff Factors	Brief Conttributing Factor	RCA	
	1	Chief Nurse have poor supervision and dont have proper monitoring on their staffs work.	Nurses are not 100 % focus in their work	Yes	Team factors Written communication Missing signature
	2	Nurse prepared medications without proper labelling	Nurse made an error		
	3	Nurse A handed unfinished work to nurse B	Nurse failed to give priority in their work		
	4	Nurse did not check properly if medication given or administered to the right patient.	Nurse made an error		
−	4	Team Factors	Brief Conttributing Factor	RCA	
	1	No proper hand-over of task	No proper knowledge on the right handover of task		
	2	No proper designation of work	Lack of supervision form the chief/head nurse		
−	5	Work and Care Environment Factors	Brief Conttributing Factor	RCA	
	1	Nurse station is not organized in which things place anywhere.	Staff needs training on how to make working place clean & organize		
	2	Ward is crowded and not well oraganize	Ward needs to be re arrange		
−	6	Management and Organisational Factors	Brief Conttributing Factor	RCA	
	1	Management are not aware of the problems encountered by staff in the ward.	Staff never informed anything to the management what problems they are facing in the ward		

	2	Management did not monitor their staff & their working place.	No proper designation of person in charge to do the monitoring		
−	7	External Factors	Brief Conttributing Factor	RCA	
	1	No proper guidelines for nurses/staff when on duty	Management never implement visible guidelines for staff		
	2	No proper guidelines for patients and visitors in the hospital	Management never put visible guidelenes for patients when admitted		

1	**Nurses lack knowledge on childs behavior**			
	1	Why?	Why did the nurse lacks the knowledge on childs behavior?	Nurse have no proper training on childs care
	2	Why?	Why the nurse mistakenly given the medication on the wrong patient?	Because the nurse not aware patient moved to the other bed without informing the nurse
	3	Why?	Why did the nurse not aware patient move to other bed?	Because the nurse dont bother to check if the patient on the bed same patient listed
	4	Why?	Why did the nurse failed to check if patient still the same patient listed on teir record	Because the nurse is stress from work and in a hurry to go home after the long hour working shift
	5	Why?	Why was the nurse stressed and in a hurry to go home?	Because of shortage of nurses on duty and the nurse have another responsibility in her family after work

Root Cause

Shortage of nurses on duty and the nurse have another responsibility in her family after work

2	**Nurse made an error**			
	1	Why?	Why did the nurse made an error?	Because the nurse prepared the medications without proper labelling.
	2	Why?	Why did the nurse failed to make proper labelling on the medications?	Because the nurse is busy and preoccupied with other things (eg. like answering phone call)
	3	Why?	Why was the nurse is preoccupied with other task?	Because of shortage of staff, nurse was doing multiple tasks.
	4	Why?	Why were there shortage of staff?	Because the management overlooked the working capabilities of the staff.
	5	Why?	Why did the management fail to notice the problems encountered of having shortage of staff?	Because the management seldom or never do monitoring and proper supervision in their staff while on duty.

Root Cause
Management seldom or never do monitoring and proper supervision in their staff while on duty.

3	Nurses are not 100 % focus in their work		
1	Why?	Why did it happen?	Because the chief nurse had overconfidence on their staff and was not aware to the problems encountered in the ward.
2	Why?	Why did the chief nurse not aware of the problems in the workplace of their staff?	Because the chief nurse did not implement proper monitoring of staff.
3	Why?	Why did the chief nurse not able to implement proper monitoring of staff?	Maybe the chief nurse needs to attend training to improve the quality of staff performance.
4	Why?	Why should the chief nurse needs to attend quality training?	To improve the work performance of the staff, make work easier, better and faster.
5	Why?	Why is it important to have a quality work performance?	In order to deliver good quality care service and customers/patients satisfaction.

Root Cause
Deliver good quality care service and customers/patients satisfaction.

1	**Shortage of nurses on duty and the nurse have another responsibility in her family after work**

1	Increase staffing to decrease workload and responsibilities.
2	Nurses should have checklist to prevent errors in their work.
3	5 S Housekeeping must be implemented in their workplace.
4	The following should be implemented: Creative scheduling options, Let nurse choose their overtime, and offer referral bonuses to employees.

2	**Management seldom or never do monitoring and proper supervision in their staff while on duty.**

1	Chief Nurse should monitor their staff and make a monthly report to the management.
2	ICT should be implemented within the hospital so that management can gain access in all departments activities without wasting time giving notice to all and wait till everybody involve is free to attend the meeting.
3	If possible must implement a paperless work for all to prevent data being misplace or lost especially when it is badly needed.

3	**Deliver good quality care service and customers/patients satisfaction.**

1	Management should implement a systematic method of assessment, monitoring and evaluation for all staff.
2	Clinical Performance Development and Management System (CPDMS) should be implemented for all hospital staff to improve clinical quality care.
3	Use appropriate ICT tools within the hospital to make work easier, faster and better.
4	Provide Quality training to all hospital staff. Staff should apply what they learned in their working place to deliver a good quality clinical care to customers/patients.

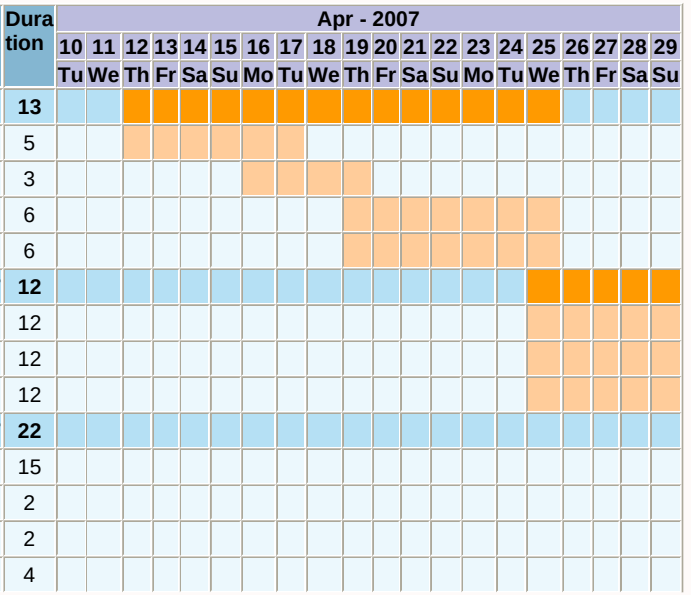
1	**Patient factors: patients themselves can contribute to an incident by virtue of their clinical condition, personal characteristics or circumstances, and inter-personal relationships.**
1	Patients and families nowadays are becoming more aware and knowledgeable of the health care system. Hospital management and medical service providers should be aware of the role of patients and families in improving health care quality and improvement.
2	Management should implement an awareness program to all medical service providers and patients to improve health care quality.

2	**Task and technology factors: the care tasks (e.g. as defined in care pathways or protocols) and technology involved, including medicines, can contribute to an incident.**
1	Should emphasize the importance of checklist in all departments for better and quality service. Checklist will help medical service providers to take care of things so they can work easier, faster, faster and error free.
2	Shortening waiting time for patients satisfaction, reducing medical errors and for quality improvement as well as better service delivery in the health care system.
3	The importance of Quality in management and in clinical care will reflects the Quality improvement in health care system in general. Hospitals should designed strategies on how to prevent medical errors. Hospital management and staff should adapt ICT mean

3	**Individual staff factors: staff can contribute to an incident.**
1	Hiring more knowledgeable and well experienced medical staff to reduce medical errors. Management should encourage hospital staff to attend seminars and conferences to keep them updated and improved.
2	Employees (eg. nurses & other staff) satisfaction is the key for patients satisfaction.
3	Management should implement a creative scheduling options to avoid job and work related stress. It is recorded that most medical errors frequently occurs during shift changes and patients tranfers between units. Others not focused on their work because

From Date : 10-Apr-2007 **To Date** : 27-May-2007

No.	Root Cause	Recommendations	Resources	PIC	From Date	To Date	Duration
22	**Shortage of nur**				**12-Apr-2007**	**25-Apr-2007**	**13**
1	Increase staffi	Assign mor	Hire more	Allan	12-Apr-2007	17-Apr-2007	5
2	Nurses should h	Nurses sho	Provide ap	Brian	16-Apr-2007	19-Apr-2007	3
3	5 S Housekeepin	Apply 5S H	Provide nu	Collin	19-Apr-2007	25-Apr-2007	6
4	The following s	Design and	Give nurse	Doreen	19-Apr-2007	25-Apr-2007	6
22	**Management seld**				**25-Apr-2007**	**07-May-2007**	**12**
1	Chief Nurse sho	Design and	Chief nurs	Elaine	25-Apr-2007	07-May-2007	12
2	ICT should be i	Make appoi	Encourage	Frenie	25-Apr-2007	07-May-2007	12
3	If possible mus	Encourage	Provide nu	Geraldine	25-Apr-2007	07-May-2007	12
22	**Deliver good qu**				**07-May-2007**	**29-May-2007**	**22**
1	Management shou	Designate	Give train	Helen	07-May-2007	22-May-2007	15
2	Clinical Perfor	Plan a tra	Provide CP	Irene	22-May-2007	24-May-2007	2
3	Use appropriate	Select app	Submit bud	Janete	22-May-2007	24-May-2007	2
4	Provide Quality	Send hospi	Call a Qua	Karen	25-May-2007	29-May-2007	4



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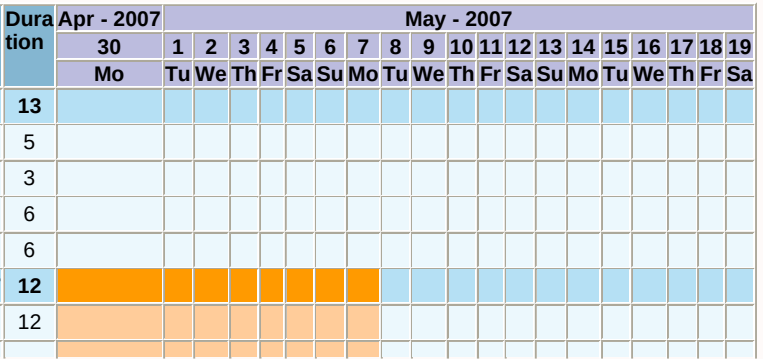

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No.	Root Cause	Recommendations	Resources	PIC	From Date	To Date	Duration	May - 2007							
								20	21	22	23	24	25	26	27
								Su	Mo	Tu	We	Th	Fr	Sa	Su
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No.	Root Cause	Recommendations	Resistance Faced	How to Overcome Resistance	Progress	PIC
1	**Shortage of nurses on duty and the nurse have another responsibility in her family after work**					
1	Increase staffing to decrease workload and responsibilities.	Assign more nurses that are knowledgeable and well-experienced to prone-medical error workplace.	Lack of knowledgeable and well-trained nurses.	Give incentives to staff who can refer a qualified nurses for the position.	More qulified nurses applied for the position posted.	Allan
2	Nurses should have checklist to prevent errors in their work.	Nurses should use checklist in all types of work.	Nurses prefer to do work on their routine way.	Provide Awareness training to all nurses.	More nurses adapt to use checklist in their daily work.	Brian
3	5 S Housekeeping must be implemented in their workplace.	Apply 5S Housekeeping in the workplace.	Nurses not interested to do 5S in the workplace.	Send nurses for a Workshop on 5S Housekeeping.	Nurse station is well-organized and arranged. Nurses able to locate things easily. Nurses done their work with ease and on time in a better way.	Collin
4	The following should be implemented: Creative scheduling options, Let nurse choose their overtime, and offer referral bonuses to employees.	Design and develop a creative scheduling options for nurses and provide them with better incentives and benefits.	Shortage of nurses.	Hire more knowledgeable and experienced nurses. Give nurses good salary, better incentives and benefits. Offer referral bonuses to employees.	More qulified nurses being added. Nurses are more focus on their work. They are happy with their working schedule.	Doreen
2	**Management seldom or never do monitoring and proper supervision in their staff while on duty.**					
1	Chief Nurse should monitor their staff and make a monthly report to the management.	Design and develop strategic plan to monitor the staff.	Chief nurse so busy. No available reports on problems encounter in the ward.	Chief nurse must do on the spot checking in the ward on a daily basis. Chief nurse must do frequent meetings with staff to know their progress in work and problems encounter in the ward.	Management provide additional nurses in the ward. Nurses are more focus in their work.	Elaine
2	ICT should be implemented within the hospital so that management can gain access in all departments activities without wasting time giving notice to all and wait till everybody involve is free to attend the meeting.	Make appointment with the management regarding implementation of ICT.	Management show less interest.	Prepare a presentation showing the statistics of medical errors in the hospitals and complaints received. Convince the management how ICT be helpful to undertake all the problems	Management asks to do another presentation and ask for a quotation regarding budget needed to implement ICT in the workingplace.	Frenie

					arise.		
	3	If possible must implement a paperless work for all to prevent data being misplace or lost especially when it is badly needed.	Encourage paperless workplace to all nurses and other hospital staff.	Nurses dont feel at ease and comfortable with concept of a paperless workplace. They still want to do their work consuming more papers.	Provide nurses a workshop on a Papaerless Workplace, make it a real situation workshop so they will realize the difference.	Nurses accept the idea of a paperless workplace. Now papers consumed during duties were reduced.	Geraldine
3	**Deliver good quality care service and customers/patients satisfaction.**						
	1	Management should implement a systematic method of assessment, monitoring and evaluation for all staff.	Designate a person who will be responsible to do proper monitoring and assessment of staff.	Staff performance report not sent to the management on time.	Send designated person for training on strategic method of saasessment, monitoring and evaluation of all staff.	Staff performance report is sent to the management on time.	Helen
	2	Clinical Performance Development and Management System (CPDMS) should be implemented for all hospital staff to improve clinical quality care.	Plan a training for hospital staff to improve quality clinical care.	Hospital staff not bothered what type of services they delivered.	Send hospital staff for training to improve their clinical performance and management.	Hospital services improved.	Irene
	3	Use appropriate ICT tools within the hospital to make work easier, faster and better.	Select appropriate ICT tools appropriate for the hospital application.	Hospital staff not bothered what type of services they delivered.	Send hospital staff for training to improve their clinical performance and management.	Hospital services improved.	Janete
	4	Provide Quality training to all hospital staff. Staff should apply what they learned in their working place to deliver a good quality clinical care to customers/patients.	Send hospital staff for Quality training.	Hospital staff not bothered what type of services they delivered.	Send hospital staff for training to improve their clinical performance and management.	Hospital services improved.	Karen

No.	Root Cause	Recommendations	Key Indicators	Monitoring & Review	Communication Strategies
1	**Shortage of nurses on duty and the nurse have another responsibility in her family after work**				
1	Increase staffing to decrease workload and responsibilities.	Assign more nurses that are knowledgeable and well-experienced to prone-medical error workplace.	More qualified nurses added.	Nurses able to do work easily and finish their work faster without a mistake.	
2	Nurses should have checklist to prevent errors in their work.	Nurses should use checklist in all types of work.	All nurses use checklist in all their tasks.	Usage of checklist is being implemented after 1 month.	
3	5 S Housekeeping must be implemented in their workplace.	Apply 5S Housekeeping in the workplace.	Nurse station and the ward is well arranged and organized.	5S is being applied in the workplace immediately after the workshop.	
4	The following should be implemented: Creative scheduling options, Let nurse choose their overtime, and offer referral bonuses to employees.	Design and develop a creative scheduling options for nurses and provide them with better incentives and benefits.	Decrease number of complaints recieved. No medical errors reported.	Nurses are more more focus on their work. They are happy with their working schedule.	
2	**Management seldom or never do monitoring and proper supervision in their staff while on duty.**				
1	Chief Nurse should monitor their staff and make a monthly report to the management.	Design and develop strategic plan to monitor the staff.	Chief nurse able to send reports of the working performance of staff to the management on time.	Management able to review and assess the staff easily.	
2	ICT should be implemented within the hospital so that management can gain access in all departments activities without wasting time giving notice to all and wait till everybody involve is free to attend the meeting.	Make appointment with the management regarding implementation of ICT.	Management able to monitor their staff using ICT. Less time spent for frequent meetings with incomplete attendance.	Managements able to act and do solution without delay on problems encounter in every department.	
3	If possible must implement a paperless work for all to prevent data being misplace or lost especially when it is badly needed.	Encourage paperless workplace to all nurses and other hospital staff.	Less papers seen on nursing station and other department areas.	Nurses and other hospital accepted and applied the concept of a paperless working place rigt after the workshop.	
3	**Deliver good quality care service and customers/patients satisfaction.**				
1	Management should implement a systematic method	Designate a person who will be	Staff Performance Report is	Management able to assess and	

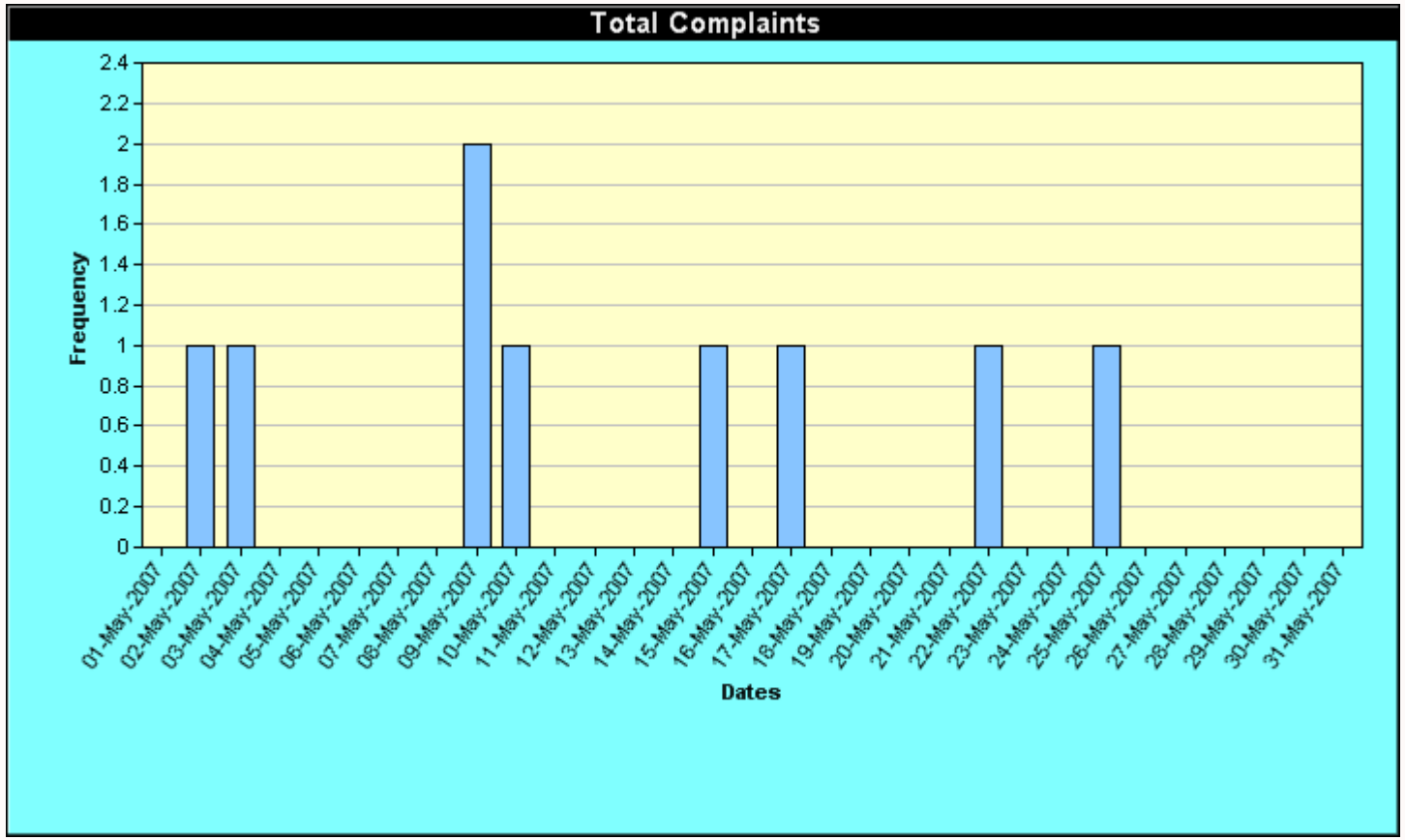
		of assessment, monitoring and evaluation for all staff.	responsible to do proper monitoring and assessment of staff.	sent to the management immediately.	act on the performance of the staff.	
	2	Clinical Performance Development and Management System (CPDMS) should be implemented for all hospital staff to improve clinical quality care.	Plan a training for hospital staff to improve quality clinical care.	Hospital staff delivered quality care services to patients.	Patients and relatives are happy and satisfied.	
	3	Use appropriate ICT tools within the hospital to make work easier, faster and better.	Select appropriate ICT tools appropriate for the hospital application.	Management ask for a presentation for an appropriate ICT tools needed for the hospital.	Nurses and other hospital staff found the ICT tools very helpful in their work. Management ask for an actual situation demo.	
	4	Provide Quality training to all hospital staff. Staff should apply what they learned in their working place to deliver a good quality clinical care to customers/patients.	Send hospital staff for Quality training.	Patient and relatives are satisfied for the treatment and services they received.	Increase numbers of patients observed after a few months.	

Incident Type : Patient Complaint **Outcome** : All **Investigation Level** : All

Resolved within policy time frame Resolved out of policy time frame Not resolved and out of policy time frame

Complaint Id.	Incident Type	Outcome	Invest Level	Complaint Date	Complaint	Days
9	Patient Complaint	Not Resolved	None	17-May-2007	The patient did not like the food given in the wards.	264

From Date : 01-May-2007 **To Date** : 31-May-2007 **Display By** : Daily

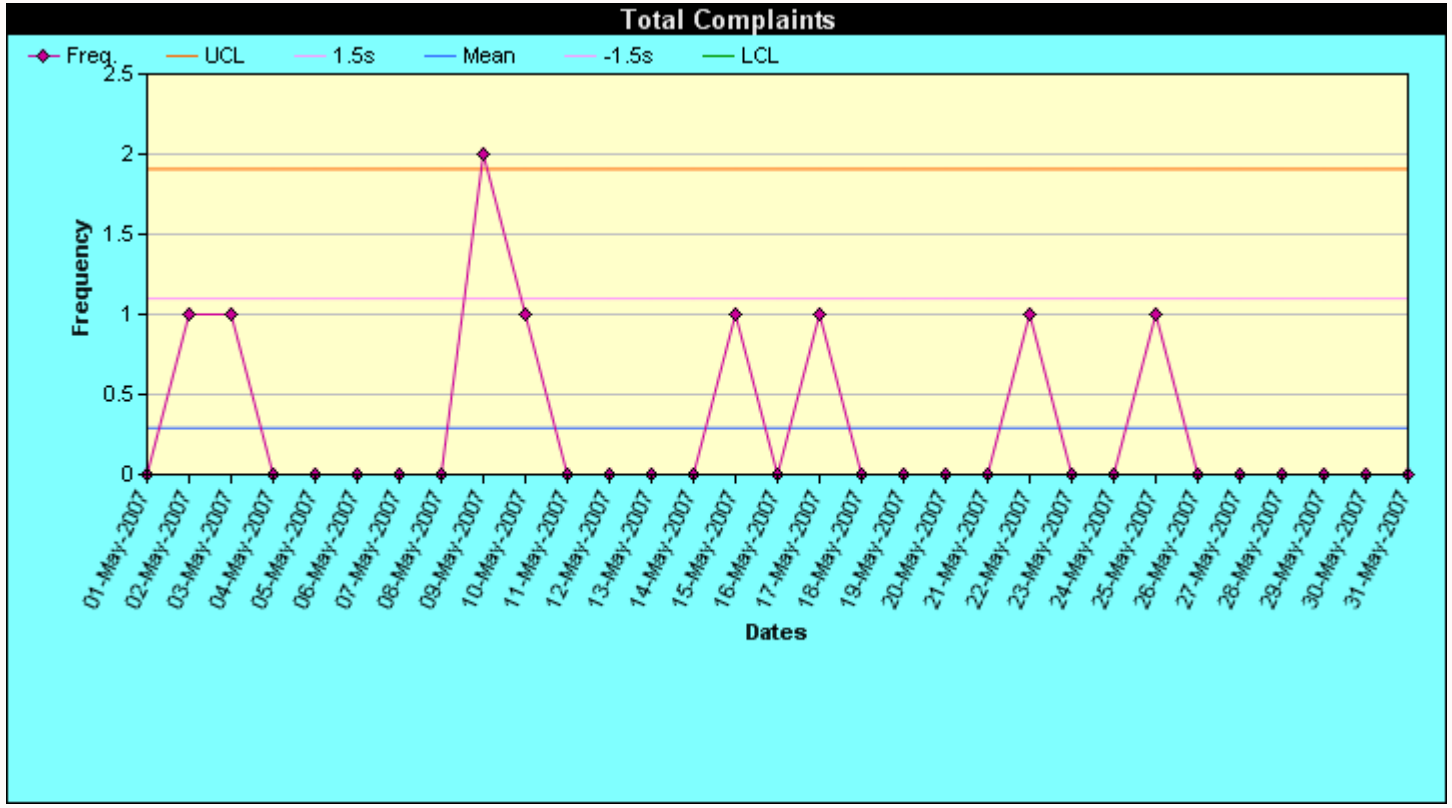


No.	From Date	To Date	No. Of Complaints
1	01-May-2007	01-May-2007	0
2	02-May-2007	02-May-2007	1
3	03-May-2007	03-May-2007	1

4	04-May-2007	04-May-2007	0
5	05-May-2007	05-May-2007	0
6	06-May-2007	06-May-2007	0
7	07-May-2007	07-May-2007	0
8	08-May-2007	08-May-2007	0
9	09-May-2007	09-May-2007	2
10	10-May-2007	10-May-2007	1
11	11-May-2007	11-May-2007	0
12	12-May-2007	12-May-2007	0
13	13-May-2007	13-May-2007	0
14	14-May-2007	14-May-2007	0
15	15-May-2007	15-May-2007	1
16	16-May-2007	16-May-2007	0
17	17-May-2007	17-May-2007	1
18	18-May-2007	18-May-2007	0
19	19-May-2007	19-May-2007	0
20	20-May-2007	20-May-2007	0
21	21-May-2007	21-May-2007	0
22	22-May-2007	22-May-2007	1
23	23-May-2007	23-May-2007	0
24	24-May-2007	24-May-2007	0
25	25-May-2007	25-May-2007	1
26	26-May-2007	26-May-2007	0
27	27-May-2007	27-May-2007	0
28	28-May-2007	28-May-2007	0
29	29-May-2007	29-May-2007	0
30	30-May-2007	30-May-2007	0
31	31-May-2007	31-May-2007	0

From Date : 01-May-2007 **To Date** : 31-May-2007 **Display By** : Daily

LCL	0	-1.5s	0	Mean	0.29	1.5s	1.099	UCL	1.907

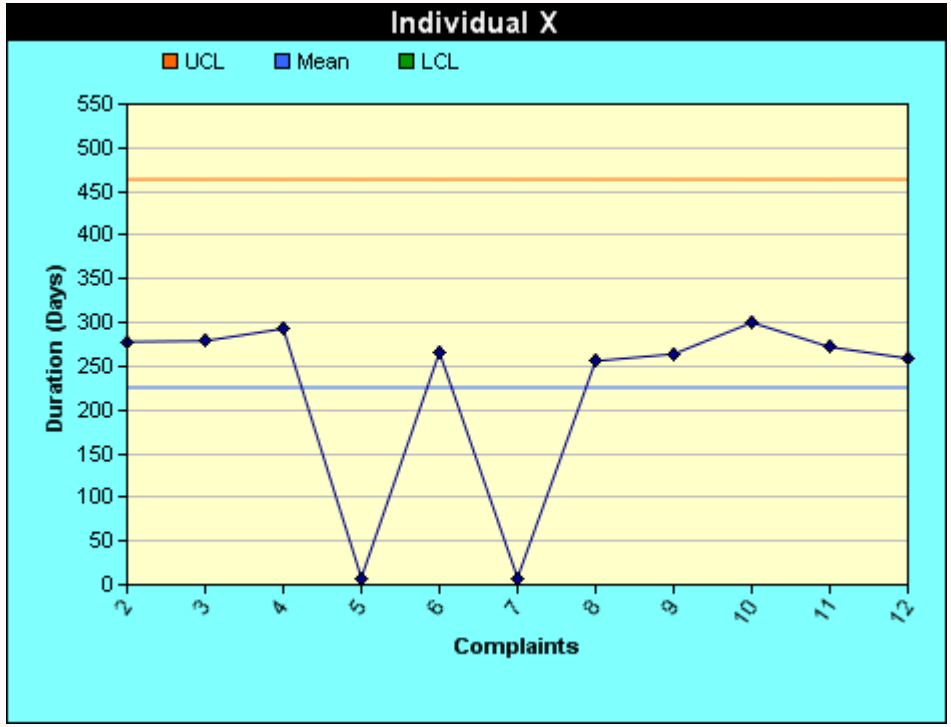


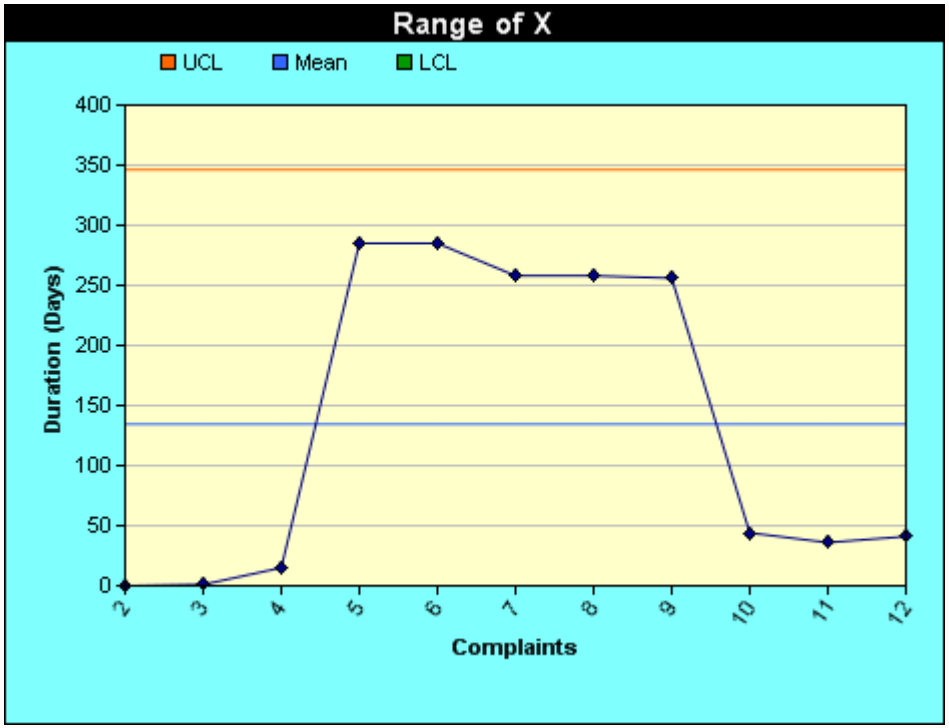
No.	From Date	To Date	Frequency
1	01-May-2007	01-May-2007	0
2	02-May-2007	02-May-2007	1
3	03-May-2007	03-May-2007	1

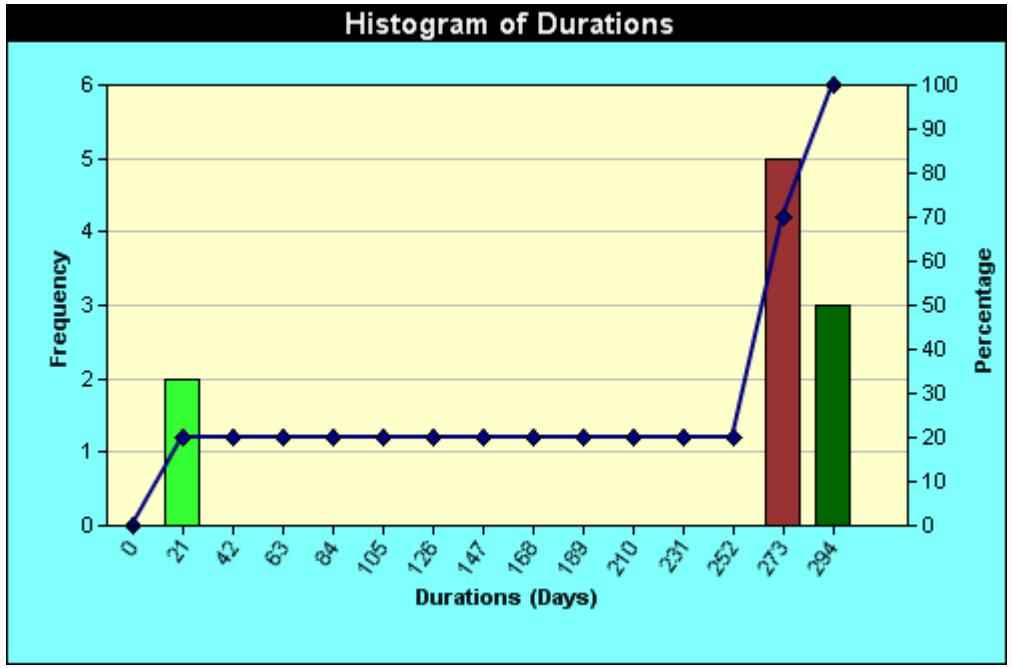
4	04-May-2007	04-May-2007	0
5	05-May-2007	05-May-2007	0
6	06-May-2007	06-May-2007	0
7	07-May-2007	07-May-2007	0
8	08-May-2007	08-May-2007	0
9	09-May-2007	09-May-2007	2
10	10-May-2007	10-May-2007	1
11	11-May-2007	11-May-2007	0
12	12-May-2007	12-May-2007	0
13	13-May-2007	13-May-2007	0
14	14-May-2007	14-May-2007	0
15	15-May-2007	15-May-2007	1
16	16-May-2007	16-May-2007	0
17	17-May-2007	17-May-2007	1
18	18-May-2007	18-May-2007	0
19	19-May-2007	19-May-2007	0
20	20-May-2007	20-May-2007	0
21	21-May-2007	21-May-2007	0
22	22-May-2007	22-May-2007	1
23	23-May-2007	23-May-2007	0
24	24-May-2007	24-May-2007	0
25	25-May-2007	25-May-2007	1
26	26-May-2007	26-May-2007	0
27	27-May-2007	27-May-2007	0
28	28-May-2007	28-May-2007	0
29	29-May-2007	29-May-2007	0
30	30-May-2007	30-May-2007	0
31	31-May-2007	31-May-2007	0

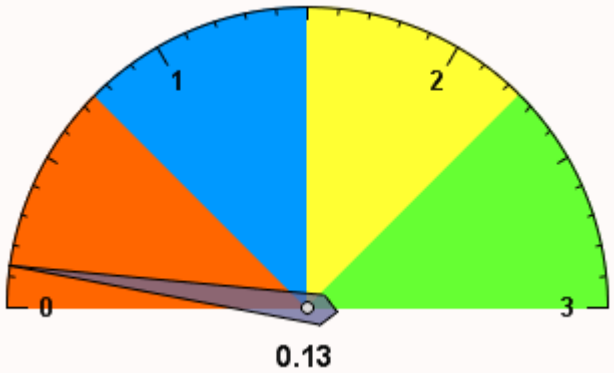
From Date : 01-Jan-2007 To Date : 31-May-2007

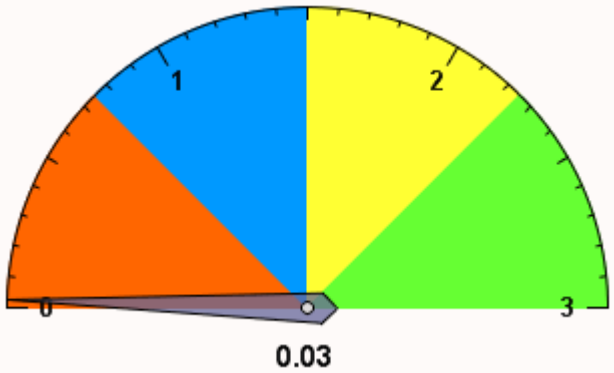
USL	250.000	LSL	0.000	Group Size	3




Range of X
UCL
Mean
LCL
400
350
300
250
200
150
100
50
0
Duration (Days)
2
3
4
5
6
7
8
9
10
11
12
Complaints


Histogram of Durations
Frequency
Percentage
Durations (Days)
0
21
42
63
84
105
126
147
168
189
210
231
252
273
294

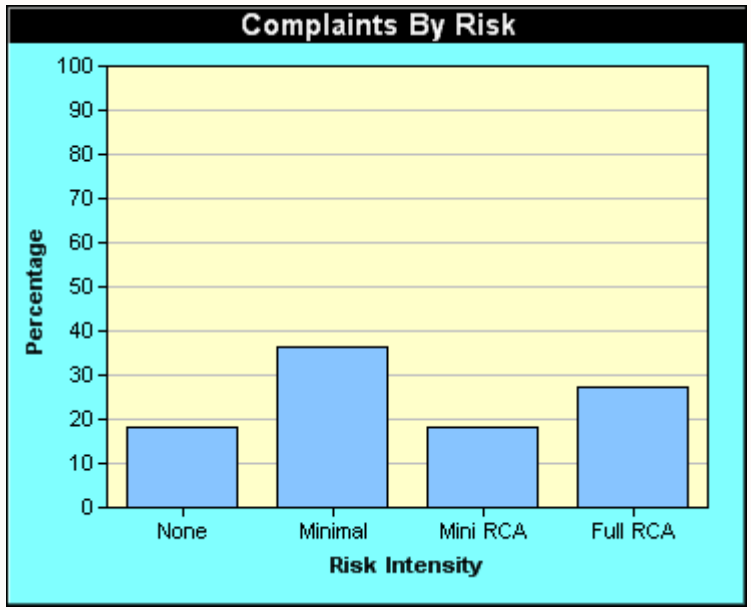

0
1
2
3
0.13

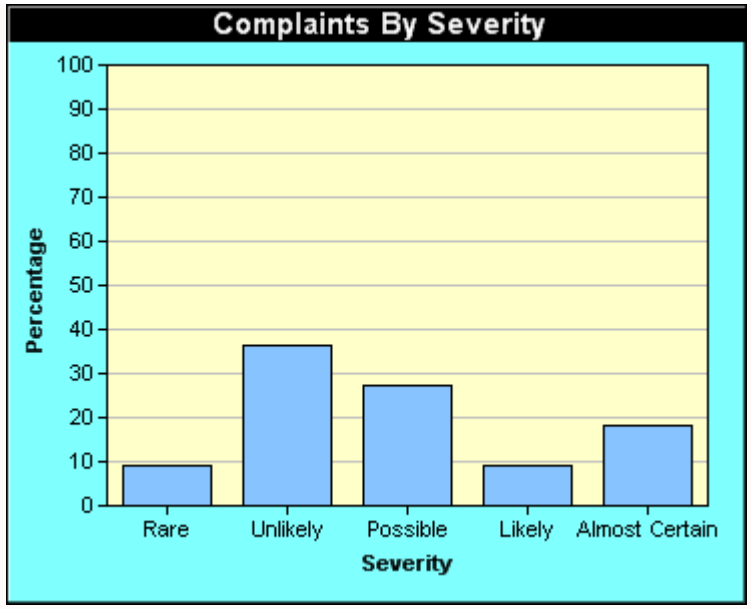

0
1
2
3
0.03

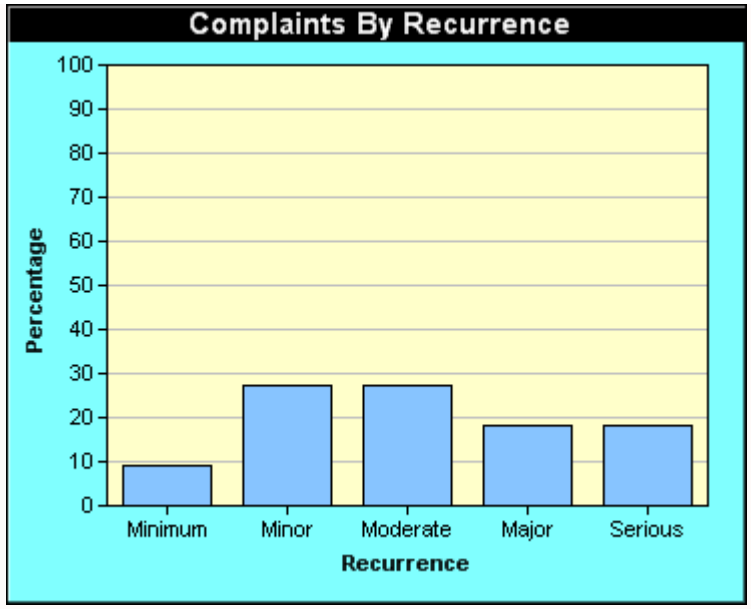
Display Graph By : Percentage

	Minimum	Minor	Moderate	Major	Serious	Total
Rare	0	0	1	0	0	**1**
Unlikely	1	1	1	1	0	**4**
Possible	0	2	0	0	1	**3**
Likely	0	0	0	0	1	**1**
Almost Certain	0	0	1	1	0	**2**
Total	**1**	**3**	**3**	**2**	**2**	**11**

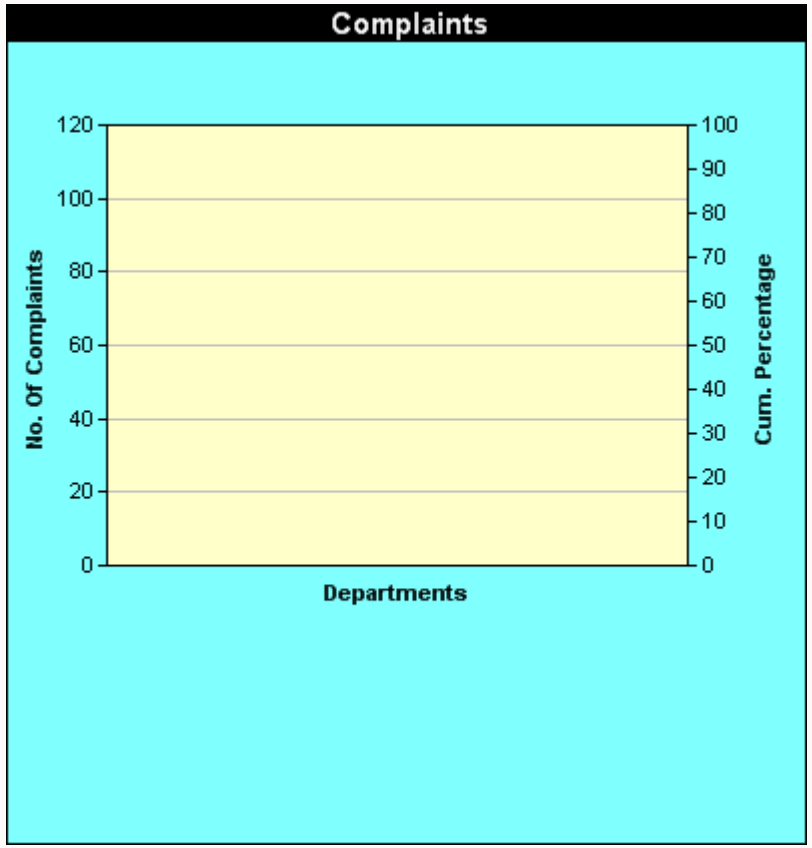
1	**None**	**2**	**18.18%**
2	**Minimal**	**4**	**36.36%**
3	**Mini RCA**	**2**	**18.18%**
4	**Full RCA**	**3**	**27.27%**

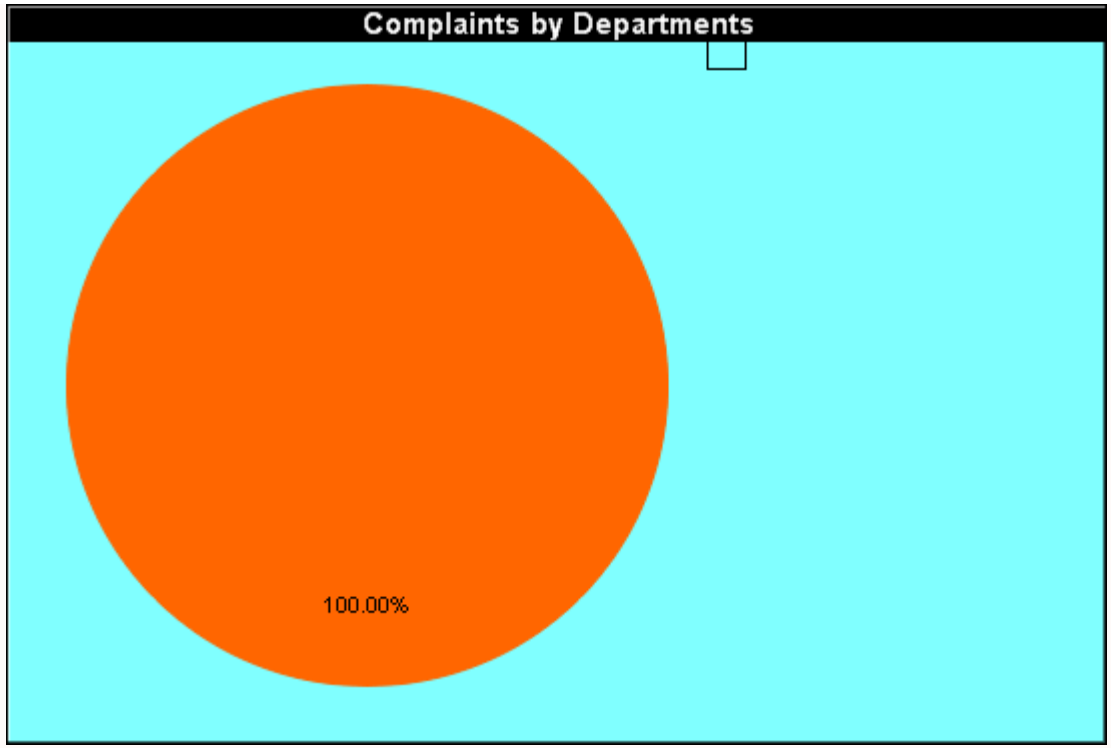



Complaints By Severity
Percentage
100
90
80
70
60
50
40
30
20
10
0
Rare
Unlikely
Possible
Likely
Almost Certain
Severity


Complaints By Recurrence
100
90
80
70
60
50
40
30
20
10
0
Percentage
Minimum
Minor
Moderate
Major
Serious
Recurrence

From Date : 02-Jan-2007 **To Date** : 31-May-2008 **Department** : Nephrology
Display By : Complained Departments

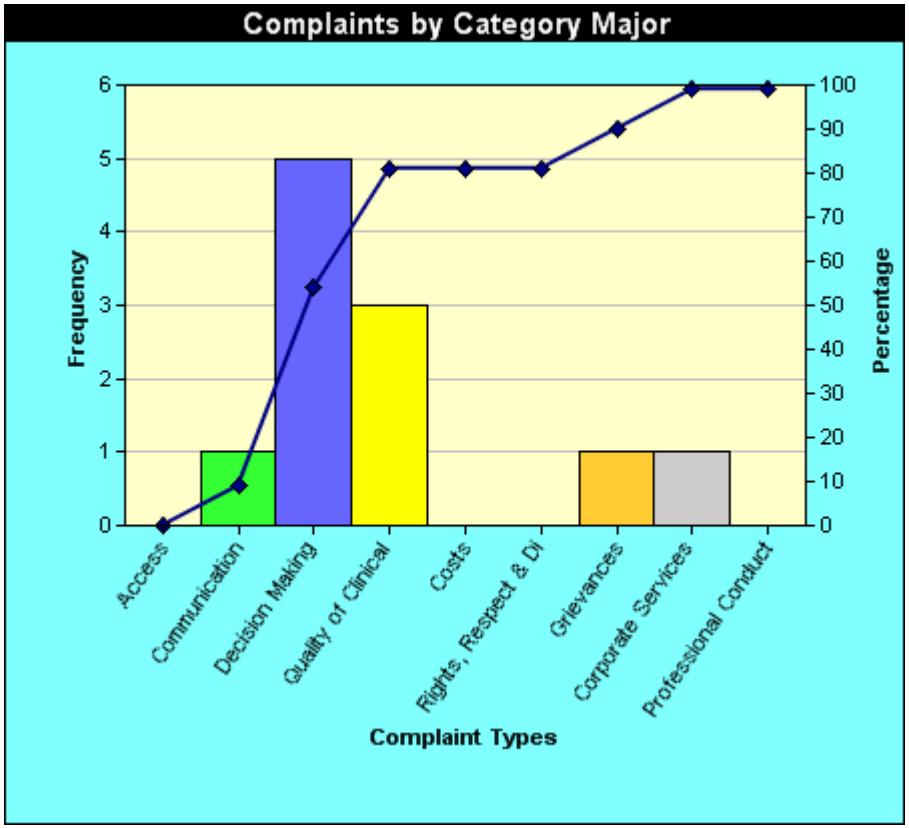


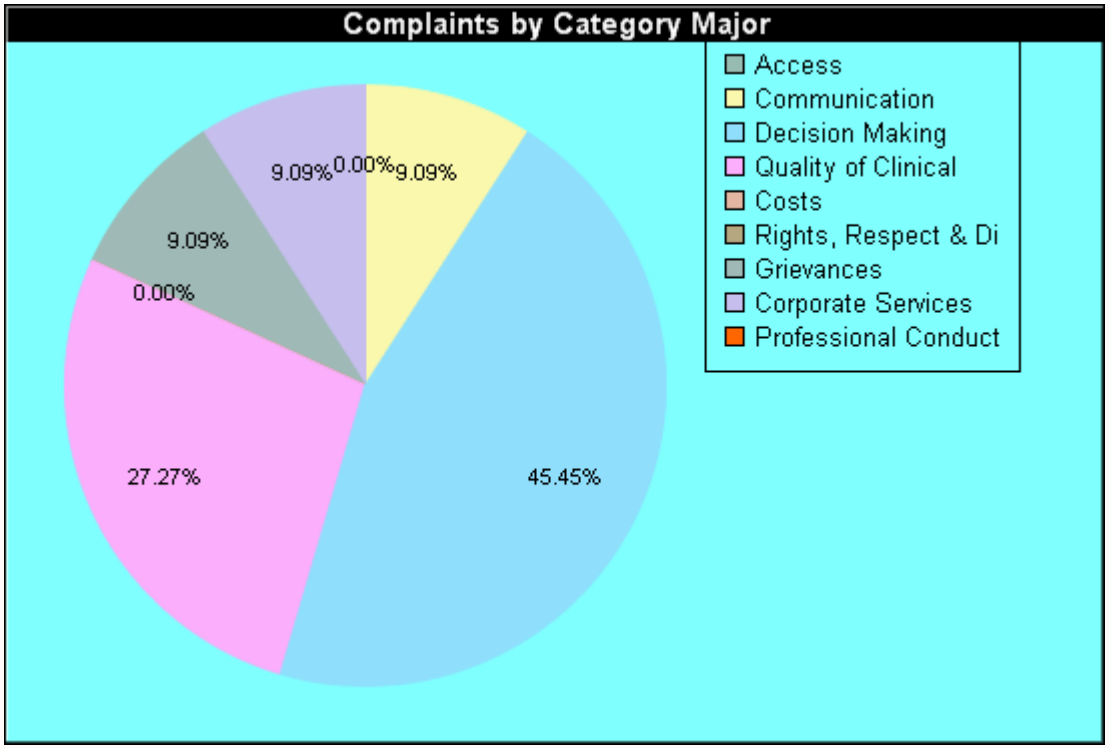


No.	Department	No. Of Complaints	Cum. Percentage
1		0	NaN

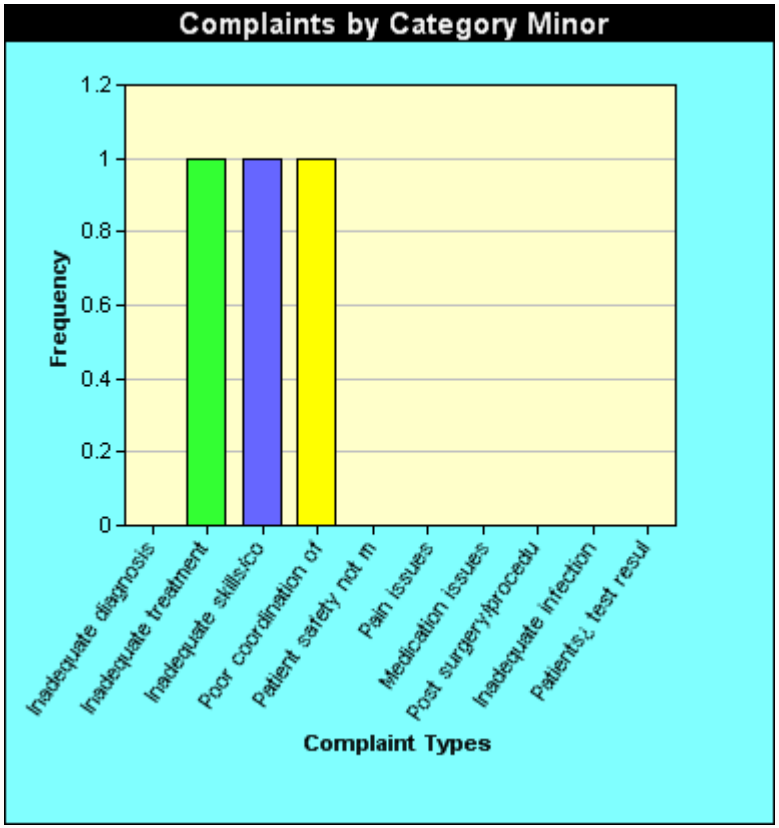
From Date : 01-Apr-2007 **To Date :** 31-May-2007

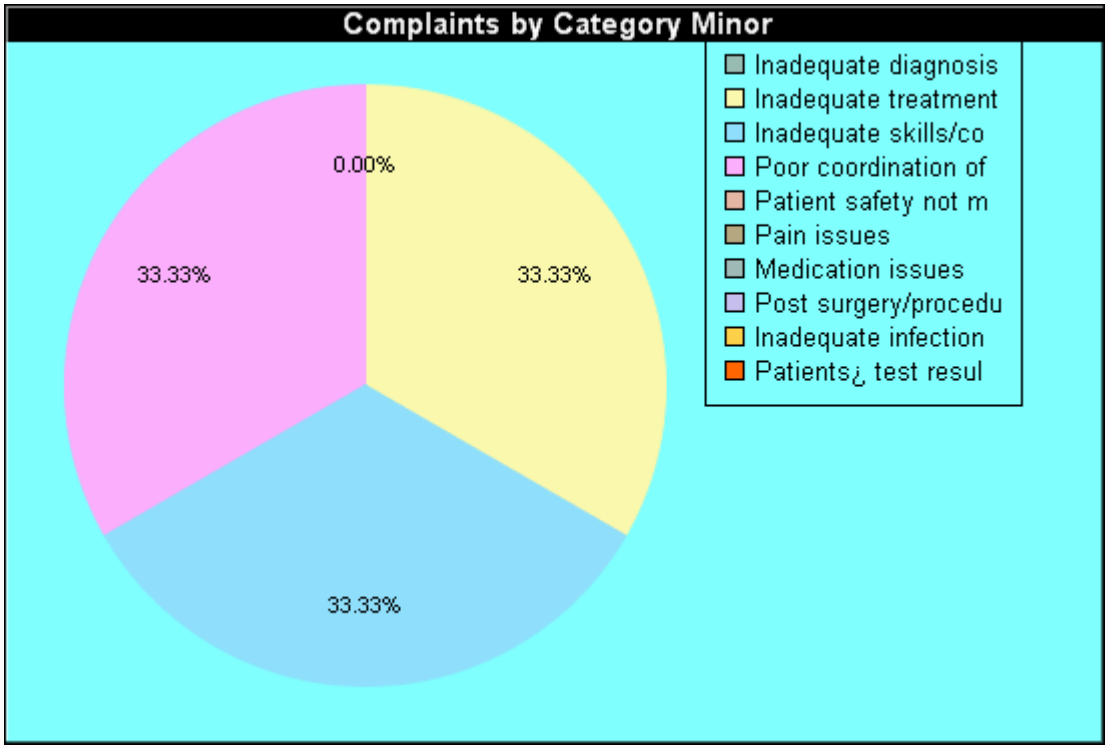
		1	2	3	4	5	6	7	8	9	10	Total	Percentage
1	Access	0	0	0	0	0	0	0	0	0	0	0	0.00
2	Communication	0	0	1	0	0	0					1	9.09
3	Decision Making	2	0	0	3							5	45.45
4	Quality of Clinical Care	0	1	1	1	0	0	0	0	0	0	3	27.27
5	Costs	0	0	0	0	0	0					0	0.00
6	Rights, Respect & Dignity	0	0	0	0	0	0	0	0			0	0.00
7	Grievances	1	0									1	9.09
8	Corporate Services	0	0	1	0	0	0					1	9.09
9	Professional Conduct	0	0	0	0	0	0	0				0	0.00


Complaints by Category Major
Frequency
Percentage
0
1
2
3
4
5
6
0
10
20
30
40
50
60
70
80
90
100
Access
Communication
Decision Making
Quality of Clinical
Costs
Rights, Respect & Di
Grievances
Corporate Services
Professional Conduct
Complaint Types

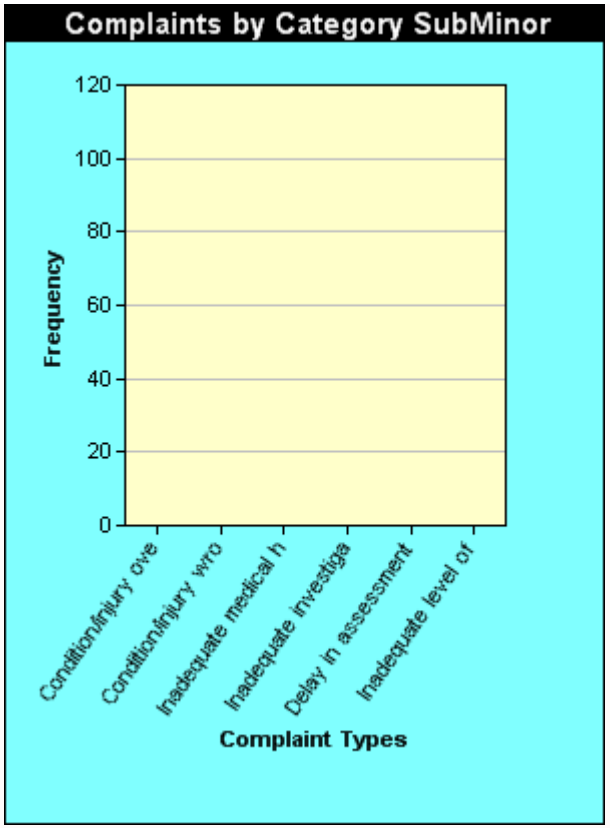


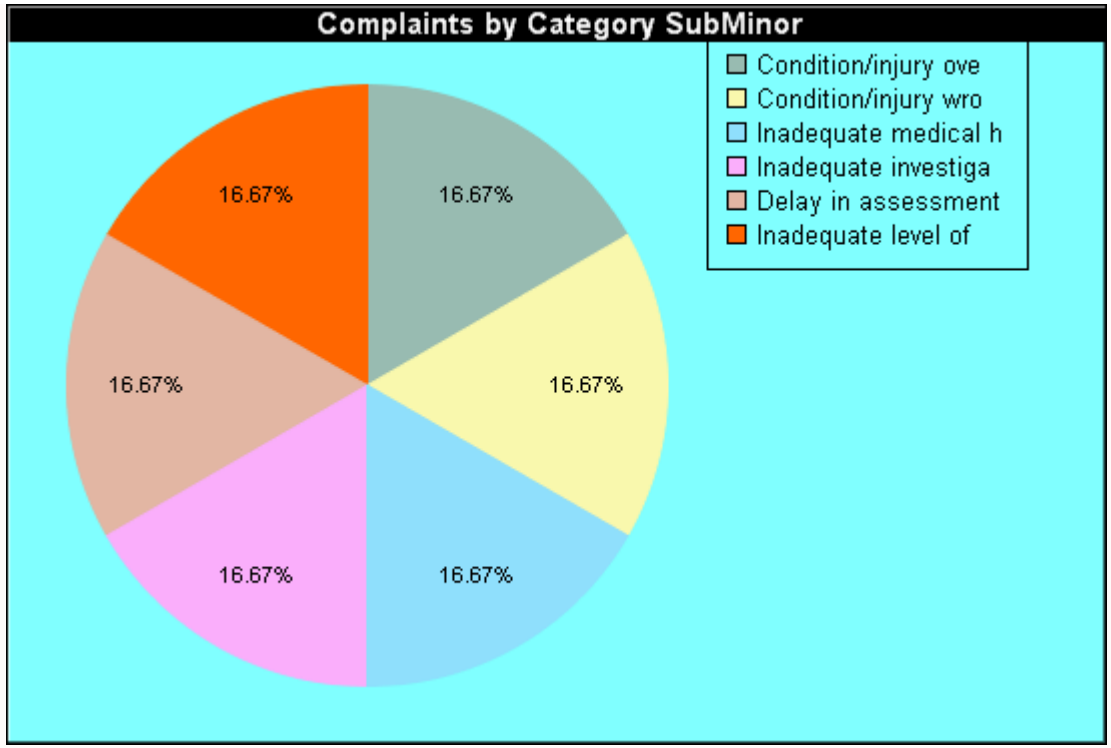
Complaint Type : Quality of Clinical Care


Complaints by Category Minor
1.2
1
0.8
0.6
0.4
0.2
0
Frequency
Inadequate diagnosis
Inadequate treatment
Inadequate skills/co
Poor coordination of
Patient safety not m
Pain issues
Medication issues
Post surgery/procedu
Inadequate infection
Patient's test resul
Complaint Types



Complaint Type : Inadequate diagnosis/observations


Complaints by Category SubMinor
120
100
80
60
40
20
0
Frequency
Condition/injury ove
Condition/injury wro
Inadequate medical h
Inadequate investiga
Delay in assessment
Inadequate level of
Complaint Types



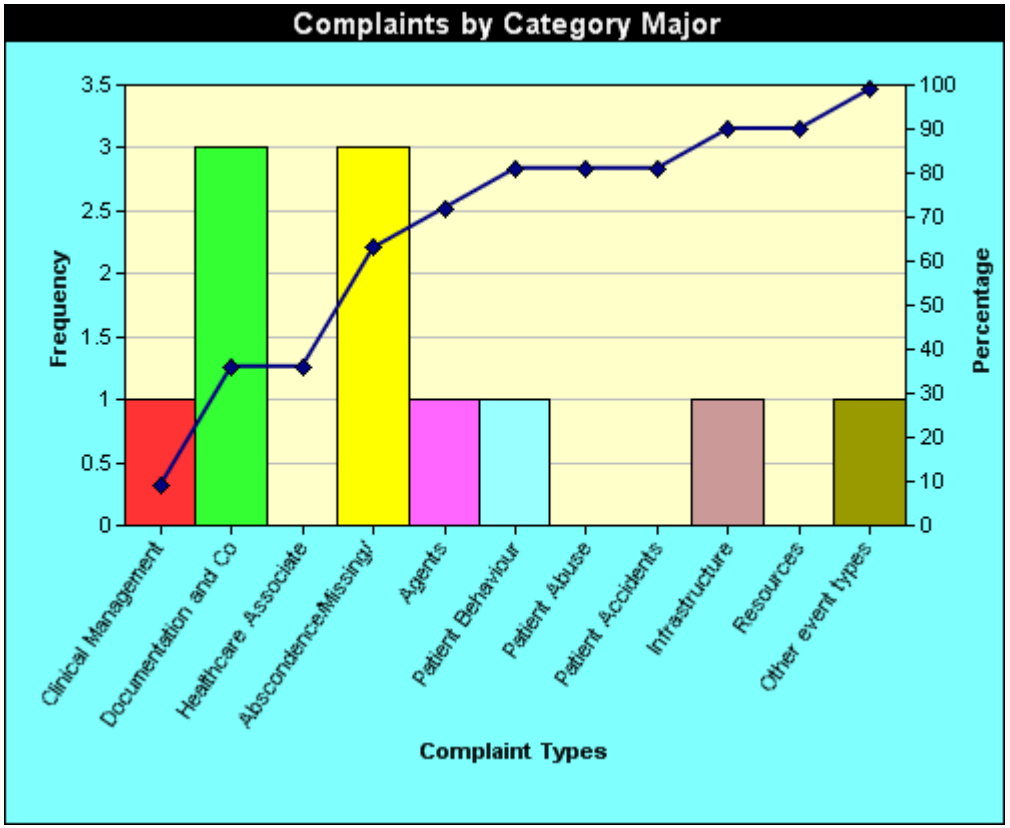
No.	Complaint Types	Total Complaints
1	**Inadequate diagnosis/observations**	**0**
1	Condition/injury overlooked	0
2	Condition/injury wrongly identified	0
3	Inadequate medical history taken	0
4	Inadequate investigation of symptoms	0
5	Delay in assessment of new symptoms	0
6	Inadequate level of observations	0
2	**Inadequate treatment/therapy**	**1**
1	Delay in treatment	0

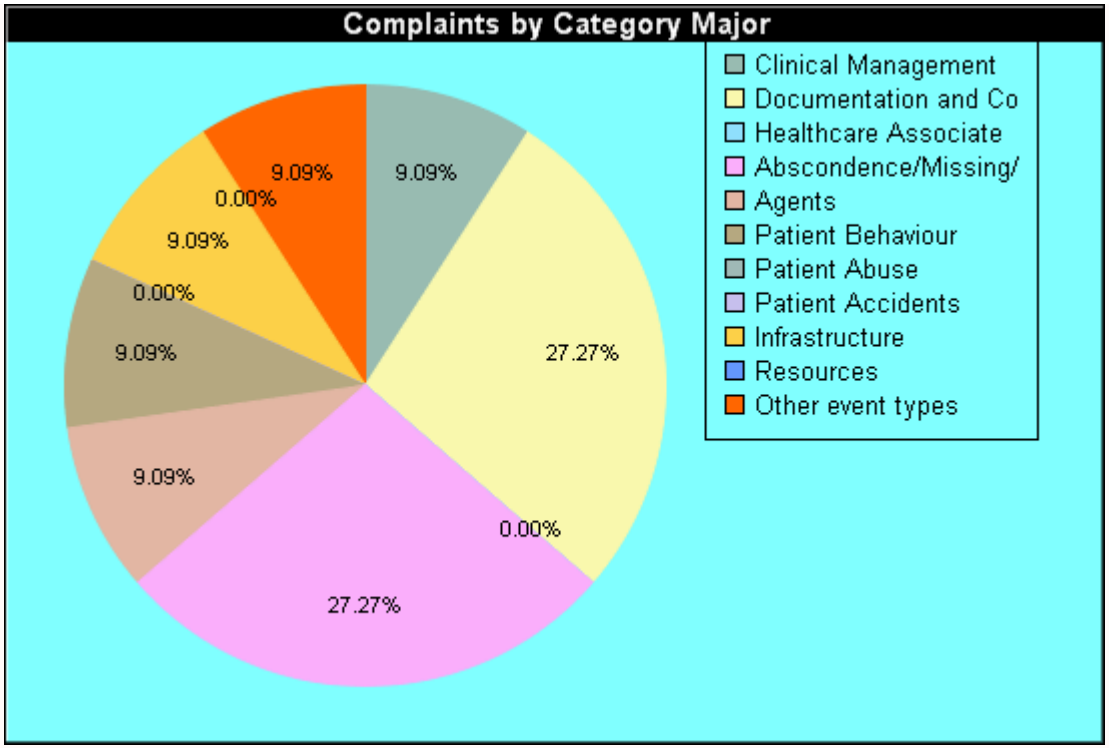
2	Rough treatment	0
3	Inadequate or no assistance with activities of daily living	0
4	Incompetent treatment	0
5	Equipment/supplies not available	0
6	Alleged failure in duty of care	1
7	Alleged negligent treatment ¿ explicit allegation of legal liability (as distinguished from "alleged incompetent treatment")	0
8	Wrong treatment	0
9	Incorrect choice of treatment has been made/offered	0
10	Inadequate amount of therapy	0
3	**Inadequate skills/competence for the task**	**1**
1	Too inexperienced for complexity of the procedure	1
2	Clumsy/unskilled performance of a treatment/procedure	0
4	**Poor coordination of treatment**	**1**
1	Conflicting decisions by different treating specialities	0
2	Poor communication between the different treating teams	1
3	Too many changes of beds/wards	0
4	Moved/cared for outside of case speciality area	0
5	**Patient safety not maintained**	**0**
1	Complaints of slips, trips and falls	0
2	Restraints including bed rails not fitted	0
3	Bed rails present but not put up, restraints not used	0
4	Assistance with ambulation not offered when required	0
5	Inadequate pressure area care leading to pressure sore/s	0
6	Delays in answering call bells	0
7	Aids not offered/provided	0
8	Not given adequate training on sue of aids (eg crutches, using stairs with crutches etc)	0
6	**Pain issues**	**0**
1	Inadequate pain control	0
2	Delay in receiving analgesia	0
3	Inadequate analgesia given either before or after a procedure	0

4	Unnecessary pain inflicted during treatment	0
7	**Medication issues**	**0**
1	Medication error (g wrong dose, site, time, route, drug not given or given twice)	0
2	Prescribed medication despite documented allergy	0
3	Loss of patient¿s own medication	0
4	Patient¿s identity not checked before giving medication	0
8	**Post surgery/procedure complications**	**0**
1	Perforation occurred	0
2	Unintended burns	0
3	Nerve damage	0
4	Infection occurred	0
9	**Inadequate infection control**	**0**
1	Poor hygiene practices including lack of hand washing by staff	0
2	Equipment not cleaned/sterilised adequately	0
10	**Patients¿ test result not followed up**	**0**
1	Failure to review the test results	0
2	Failure to act on the test results	0
3	Failure to refer abnormal test results to doctors following up patients after discharge	0

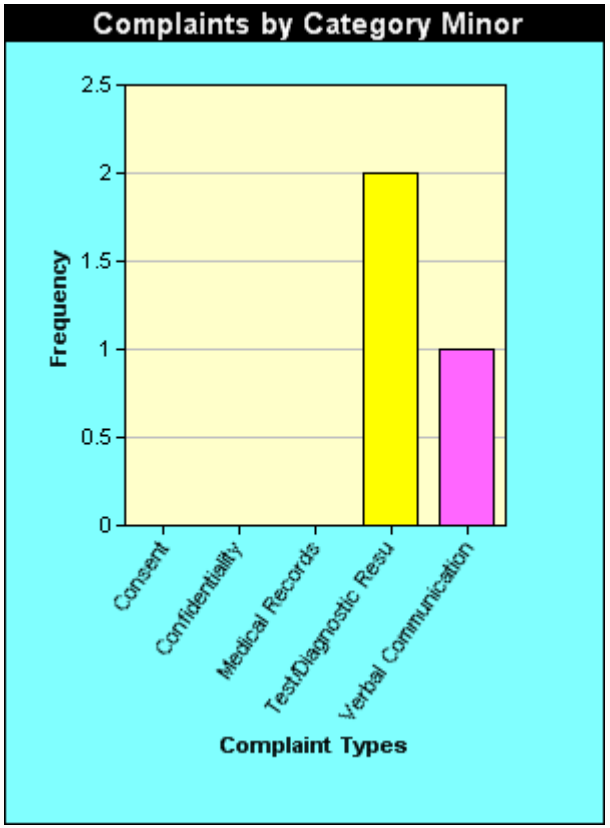
From Date : 28-Mar-2005 **To Date :** 01-Jun-2007

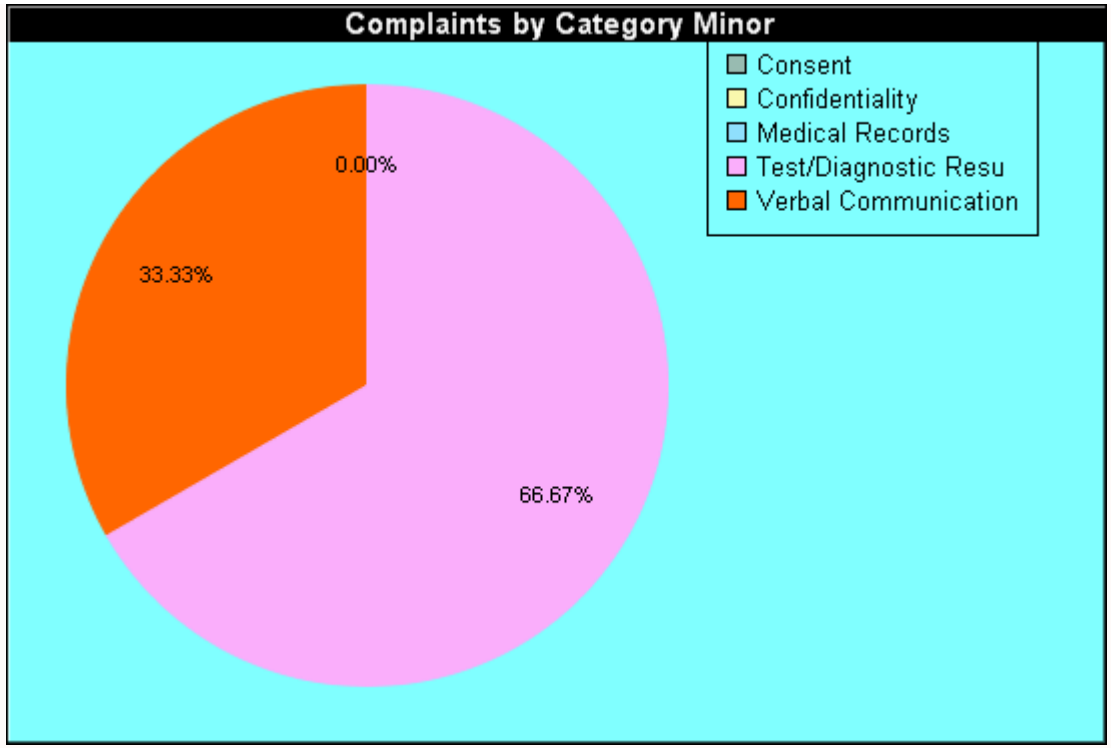
		1	2	3	4	5	6	7	Total	Percentage
1	Clinical Management	0	1	0	0	0	0	0	1	9.09
2	Documentation and Communication	0	0	0	2	1			3	27.27
3	Healthcare Associated Infection								0	0.00
4	Abscondence/Missing/Left Against Medical Advice	3							3	27.27
5	Agents	1	0	0	0	0	0	0	1	9.09
6	Patient Behaviour	1	0						1	9.09
7	Patient Abuse	0	0	0	0				0	0.00
8	Patient Accidents	0	0	0	0	0			0	0.00
9	Infrastructure	0	1	0					1	9.09
10	Resources	0	0	0	0				0	0.00
11	Other event types	1							1	9.09


Complaints by Category Major
Frequency
Percentage
3.5
3
2.5
2
1.5
1
0.5
0
100
90
80
70
60
50
40
30
20
10
0
Clinical Management
Documentation and Co
Healthcare Associate
Abscondence/Missing/
Agents
Patient Behaviour
Patient Abuse
Patient Accidents
Infrastructure
Resources
Other event types
Complaint Types

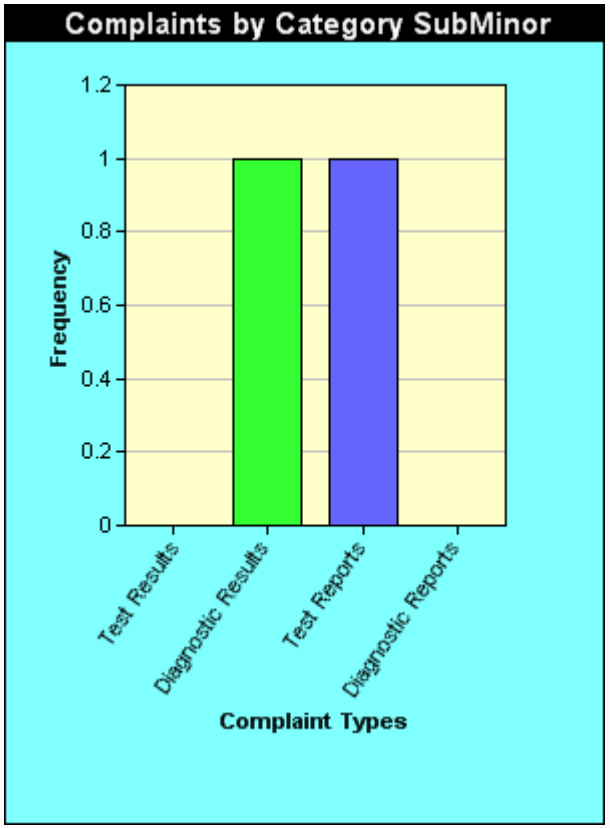


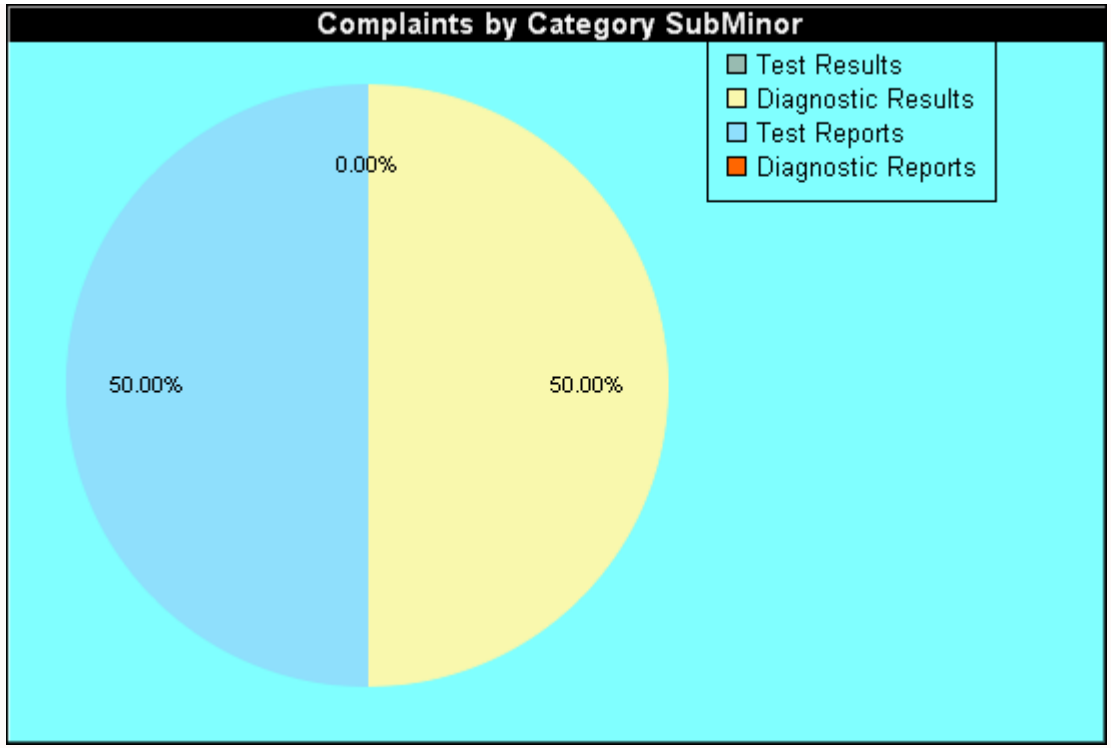
Complaint Type : Documentation and Communication


Complaints by Category Minor
2.5
2
1.5
1
0.5
0
Frequency
Consent
Confidentiality
Medical Records
Test/Diagnostic Resu
Verbal Communication
Complaint Types



Complaint Type : Test/Diagnostic Results/Reports


Complaints by Category SubMinor
1.2
1
0.8
0.6
0.4
0.2
0
Frequency
Test Results
Diagnostic Results
Test Reports
Diagnostic Reports
Complaint Types

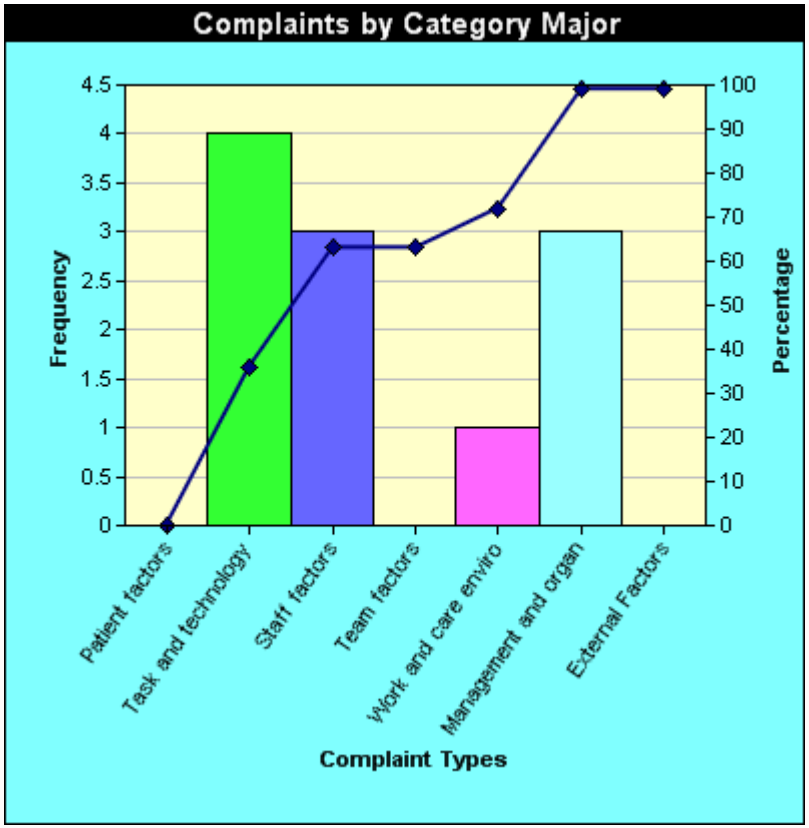


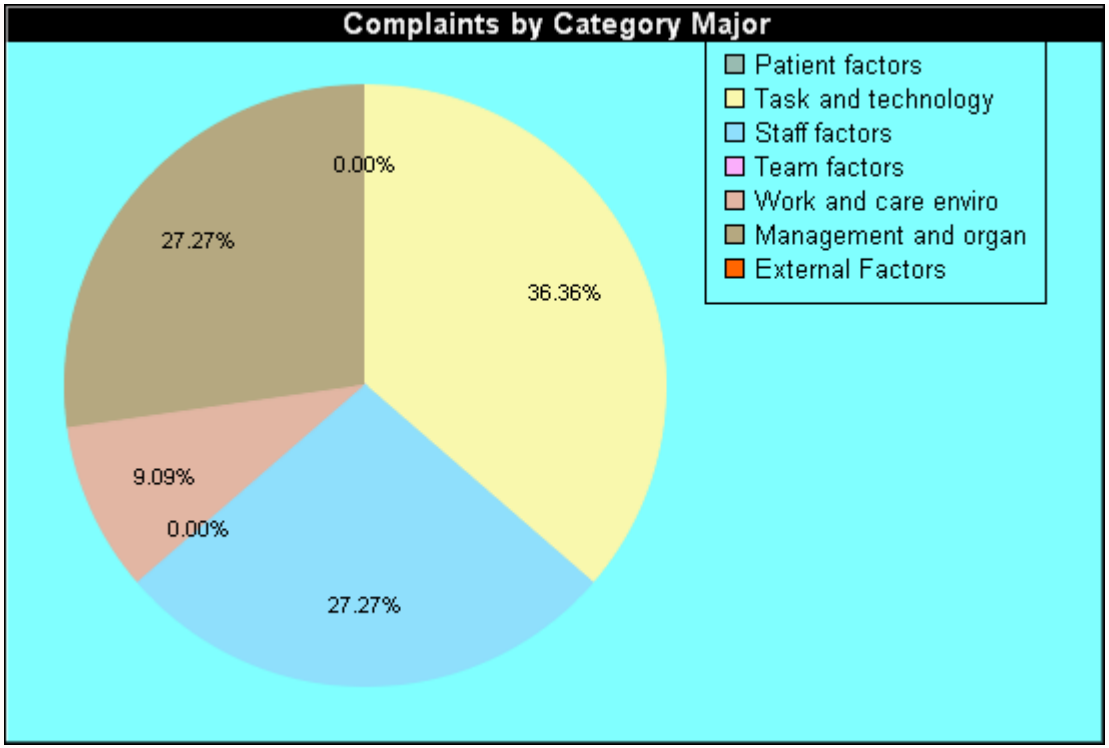
No.	Event Types	Total Complaints
1	**Consent**	**0**
1	Consent	0
2	**Confidentiality**	**0**
1	Confidentiality	0
3	**Medical Records**	**0**
1	Medical Records	0
4	**Test/Diagnostic Results/Reports**	**2**
1	Test Results	0
2	Diagnostic Results	1

3	Test Reports	1
4	Diagnostic Reports	0
5	**Verbal Communication**	**1**
1	Verbal Communication	1

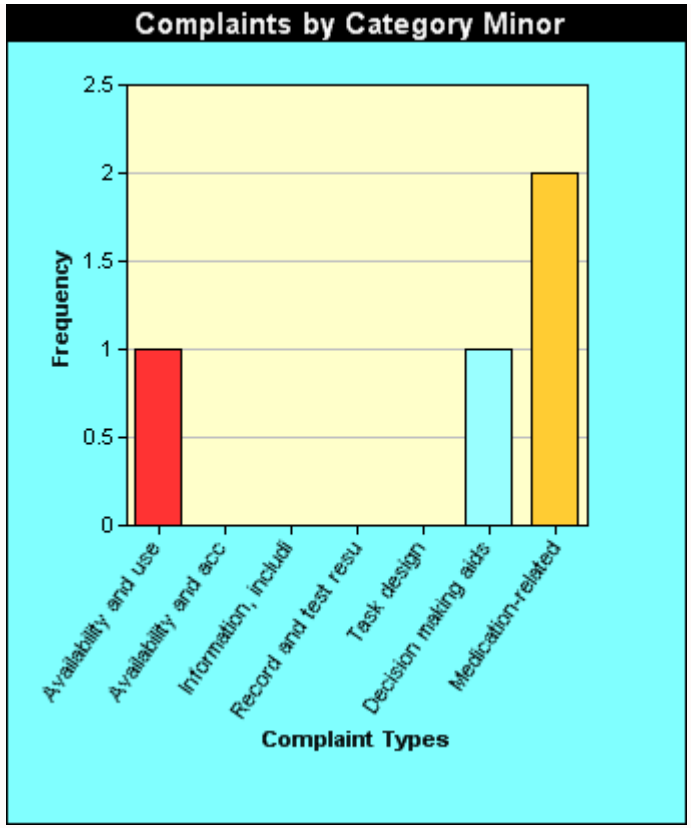
From Date : 26-Mar-2007 **To Date :** 01-Jun-2007

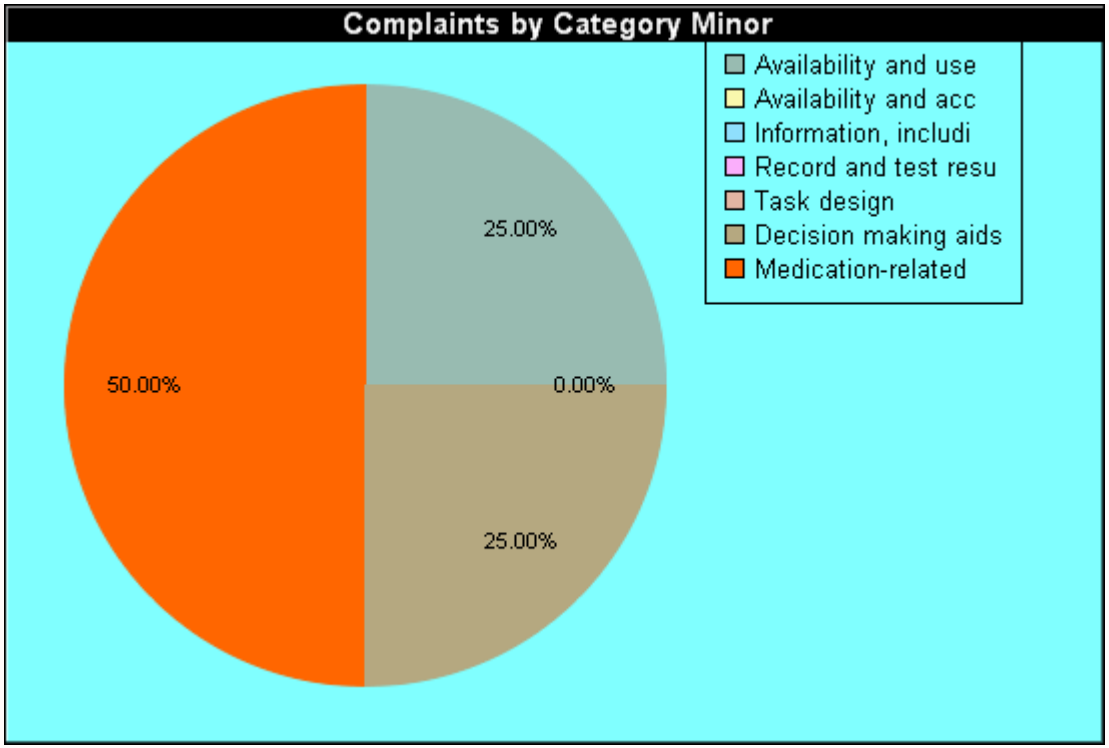
		1	2	3	4	5	6	7	8	Total	Percentage
1	**Patient factors**	0	0	0						**0**	**0.00**
2	**Task and technology factors**	1	0	0	0	0	1	2		**4**	**36.36**
3	**Staff factors**	0	1	1	1					**3**	**27.27**
4	**Team factors**	0	0	0	0	0	0			**0**	**0.00**
5	**Work and care environment**	0	1	0	0	0	0	0	0	**1**	**9.09**
6	**Management and organisational factors**	0	0	1	1	1				**3**	**27.27**
7	**External Factors**	0	0	0	0	0				**0**	**0.00**


Complaints by Category Major
Frequency
Percentage
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
100
90
80
70
60
50
40
30
20
10
0
Patient factors
Task and technology
Staff factors
Team factors
Work and care enviro
Management and organ
External Factors
Complaint Types

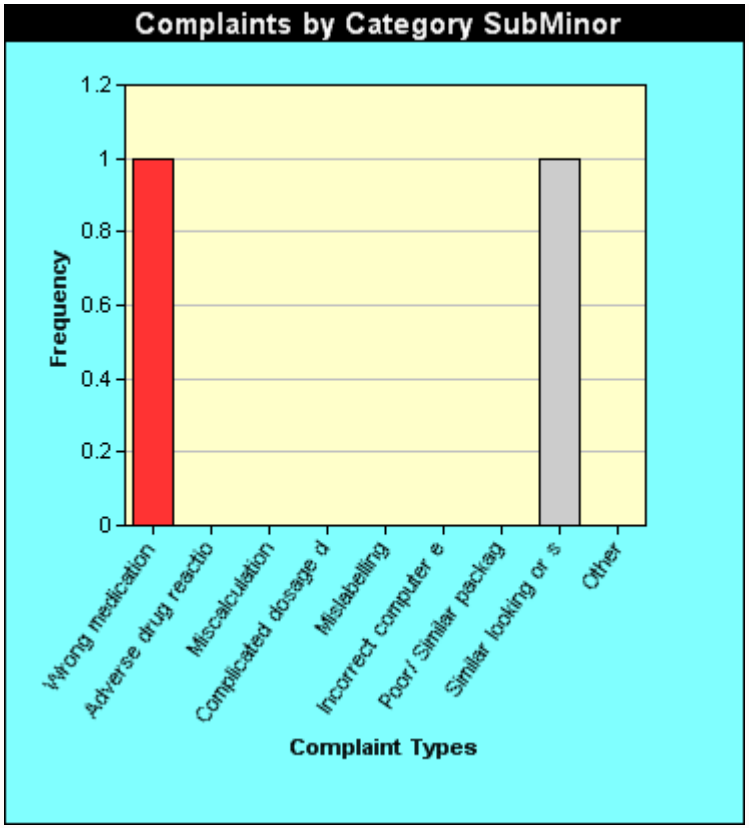


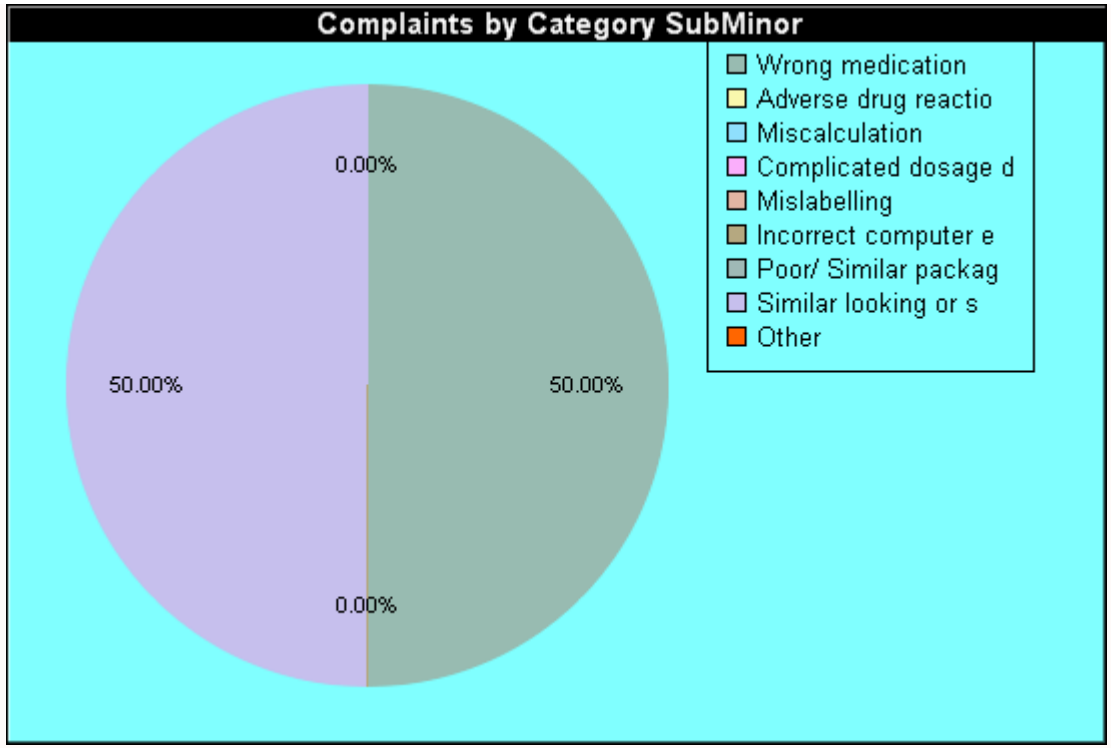
Complaint Type : Task and technology factors


Complaints by Category Minor
Frequency
2.5
2
1.5
1
0.5
0
Availability and use
Availability and acc
Information, includi
Record and test resu
Task design
Decision making aids
Medication-related
Complaint Types



Complaint Type : Medication-related


Complaints by Category SubMinor
1.2
1
0.8
0.6
0.4
0.2
0
Frequency
Wrong medication
Adverse drug reactio
Miscalculation
Complicated dosage d
Mislabelling
Incorrect computer e
Poor/ Similar packag
Similar looking or s
Other
Complaint Types

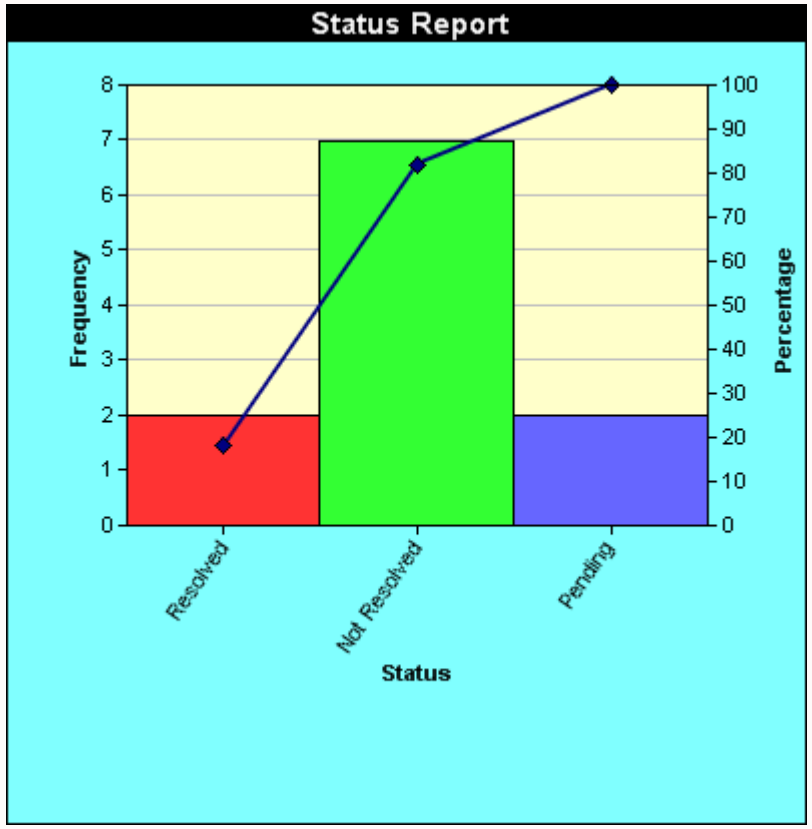


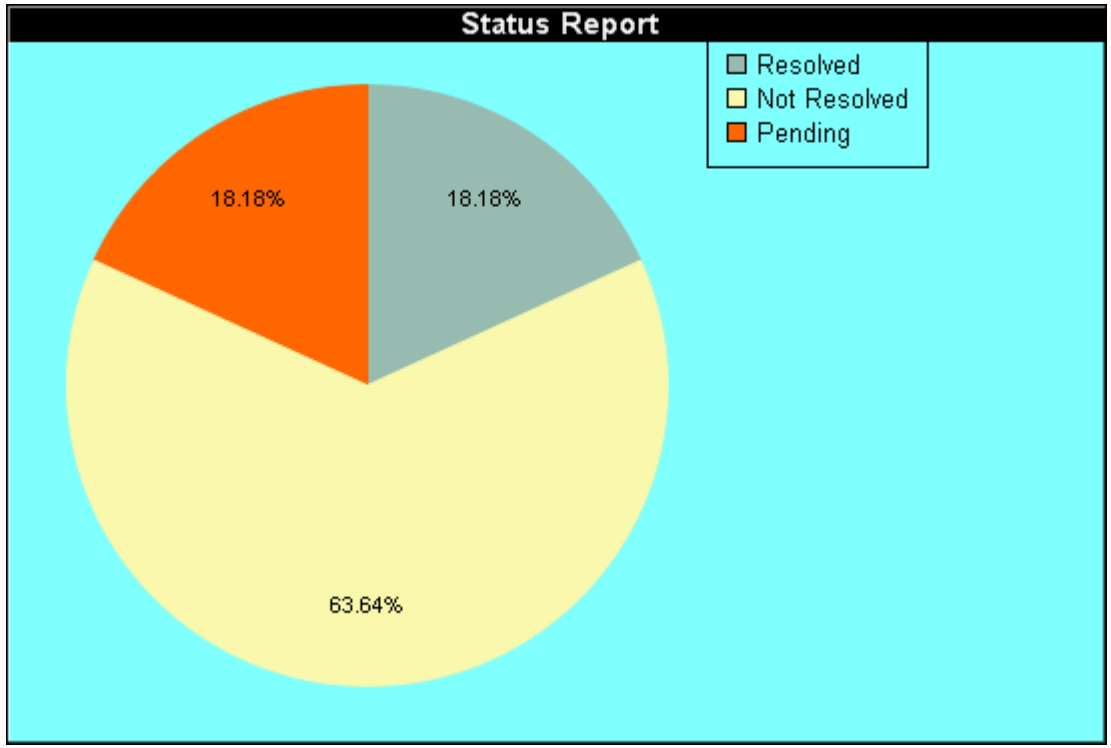
No.	Contributory Factors	Total Complaints
1	**Availability and use of protocols (including guidelines)**	**1**
1	Availability of protocols to staff	0
2	Use of protocols	0
3	Poor quality of information included in the protocol ??Procedures for reviewing and updating protocols	0
4	Procedures for reviewing and updating protocols	1
5	Inappropriate use of protocol	0
6	Other	0
2	**Availability and accuracy of health**	**0**
1	Availability of information	0

2	Reliability of information	0
3	**Information, including medical**	**0**
1	Information inaccessible to staff	0
2	Misinterpretation by staff	0
4	**Record and test results**	**0**
1	Disagreements regarding the interpretation of information	0
2	Inadequately flagged information/alert	0
3	Need to chase up information	0
4	Other	0
5	**Task design**	**0**
1	Relevance	0
2	Ease of task execution	0
3	Design deficiency	0
4	Other	0
6	**Decision making aids**	**1**
1	Availability, use and reliability of specific types of equipment e.g. CTG	0
2	Availability, use and reliability of specific types of tests, e.g. blood testing	1
3	Availability and use of a senior clinician	0
4	Other	0
7	**Medication-related**	**2**
1	Wrong medication	1
2	Adverse drug reaction	0
3	Miscalculation	0
4	Complicated dosage design	0
5	Mislabelling	0
6	Incorrect computer entry	0
7	Poor/ Similar packaging and labelling	0
8	Similar looking or sounding names	1
9	Other	0

From Date : 09-Apr-2007 **To Date** : 03-Jun-2007

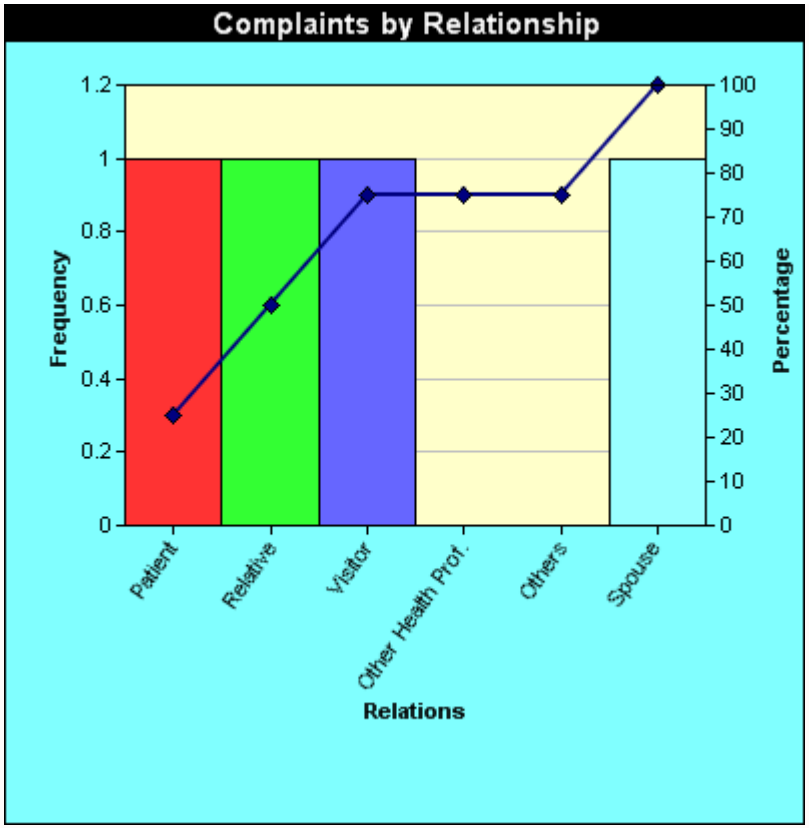
No.	Status	Total Complaints	Percentage
1	Resolved	2	18.18
2	Not Resolved	7	63.64
3	Pending	2	18.18

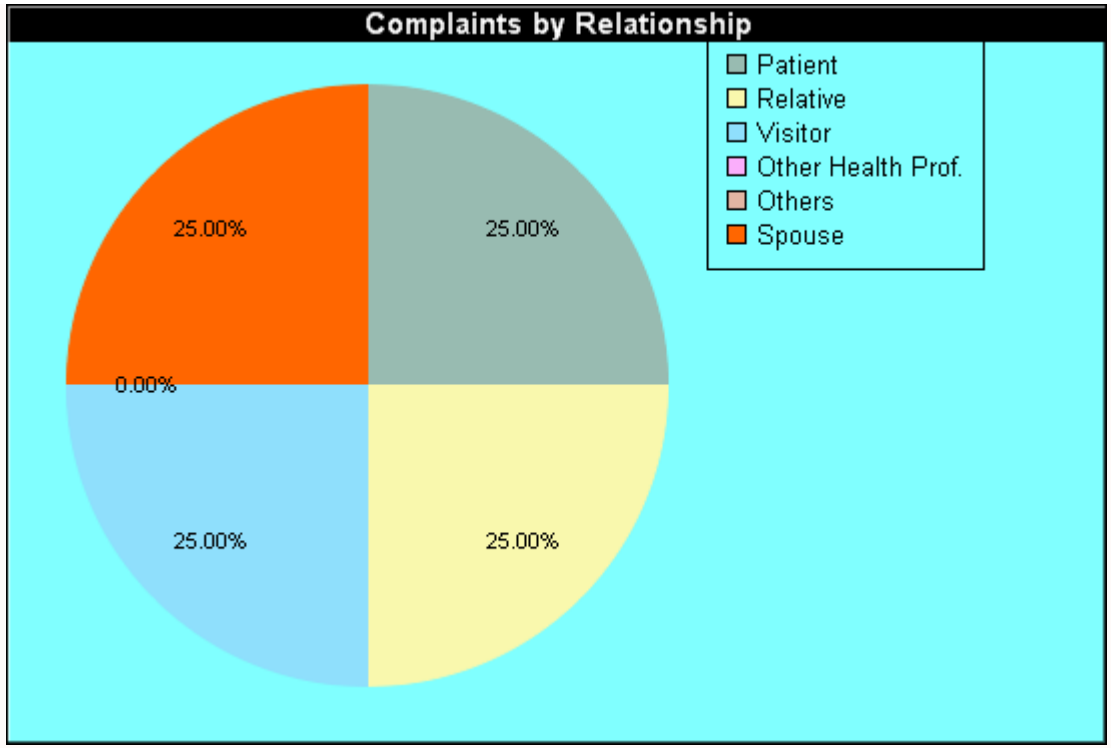



Status Report
Resolved
Not Resolved
Pending
18.18%
18.18%
63.64%

From Date : 01-May-2007 **To Date :** 31-May-2007

No.	Status	Total Complaints	Percentage
1	Patient	1	25.00
2	Relative	1	25.00
3	Visitor	1	25.00
4	Other Health Prof.	0	0.00
5	Others	0	0.00
6	Spouse	1	25.00


Complaints by Relationship
Frequency
Percentage
1.2
1
0.8
0.6
0.4
0.2
0
100
90
80
70
60
50
40
30
20
10
0
Patient
Relative
Visitor
Other Health Prof.
Others
Spouse
Relations


Complaints by Relationship
Patient
Relative
Visitor
Other Health Prof.
Others
Spouse
25.00%
25.00%
0.00%
25.00%
25.00%

Comments

Incident management is an easy process with iCT-M.

Observations

No special skill is necessary to use iCT-M.

Lesson Learnt

We have so far not been able to conduct a proper Incident Management because of the lack of software.

With iCT-M, we are now able to maintain and monitor an advance system of Incident Management.

Summary

Incident Management using iCT-M is a very simple procedure that be managed very easily.

Next Action

Management must look at the advantagous of using an ICT approach to Incident Management.