

FExNet 2026

Collated SAQs: Administration, Professionalism & Leadership

ANSWER BOOKLET

Model answers for the 26 administration / professionalism / leadership SAQs. References cited at the foot of each question. Items marked [core] are required for full marks; others are accepted alternatives. Apply local jurisdiction-specific legislation (e.g. state Coroners Act, Mental Health Act) where relevant.

26 questions • 276 marks

ACEM-aligned format. Sub-questions labelled a) b) c). Mark allocations indicative; references cited in the Answer Booklet. Question and answer indexes are clickable.

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Question 1 | Access Block — Definitions (12 marks)

You are a recently appointed FACEM. Your Director has asked you to lead a review of access block and overcrowding in your tertiary ED. The hospital executive has noticed deteriorating NEAT performance over the last quarter.

a) State the ACEM definition of access block. (2 marks)

Access block = the proportion of patients who have been admitted to the hospital from the ED whose total ED length of stay is >8 hours (including ward, ICU, OT or transfer destinations), per the ACEM definition.

b) State 2 differences between access block and ED overcrowding. (2 marks)

- Access block is an OUTPUT measure (admitted patients waiting for inpatient beds); overcrowding is a STATE measure (demand in ED exceeds capacity at a point in time)
- Access block is hospital-level driven (inpatient flow); overcrowding has multiple drivers including input (presentations) and throughput (ED process)
- Overcrowding can occur without access block (high-acuity surge with no admissions); access block usually causes overcrowding but not always

c) List 4 patient-level harms attributable to access block. (4 marks)

- Increased mortality (linear relationship with hours of access block) **[core]**
- Delayed time-critical interventions (antibiotics, reperfusion)
- Increased nosocomial infection (Clostridium difficile, MRSA)
- Worsened pain / discomfort / dignity
- Increased medication errors and missed care

d) List 4 strategies to reduce access block at the whole-of-hospital level. (4 marks)

- Hospital-wide flow strategy with accountable executive sponsor (matching admission demand to discharge timing)
- Predictable inpatient discharge before midday; weekend discharge planning
- Surgical short-stay / 23-hour units; medical assessment units; geriatric early discharge pathways
- Streaming pathways from ED (fast-track, short-stay unit, direct-to-ward criteria)
- Capacity escalation plan with executive triggers
- Address community / aged-care / mental health step-down capacity (input-side)

References: ACEM clinical policies and statements • National Emergency Access Target (NEAT) policy documents • ACEM Statement on Access Block

Question 2 | Access Block — Departmental Strategies (10 marks)

Your ED has 25% access block. The CEO requests an action plan within 4 weeks. NEAT performance is 58%. Average daily presentations are 220, with a 24% admission rate. The department has 32 cubicles and a 6-bay short-stay unit.

a) List 6 ED-level interventions that may improve flow (at the input, throughput or output level). (6 marks)

Domain	Intervention
Input	ED-GP-in-ED model; redirection of low-acuity to GP / urgent care; community alternatives for residential aged-care presentations
Throughput	Streaming (fast-track, ambulatory care zone); rapid assessment by senior decision-maker; criteria-led direct-to-ward admission
Throughput	Standardised pathways (chest pain, sepsis, cellulitis); early imaging from triage; point-of-care testing
Output	Discharge lounge; senior-led ward rounds before midday; weekend / public holiday discharge protocols
Output	Short-stay unit (defined criteria, 24-h cap); HITH (Hospital in the Home) and ED-substitution programs
Workforce	Senior decision-maker overnight; nurse-initiated investigations; physiotherapist/OT in ED

b) List 4 metrics you would track to measure improvement. (4 marks)

- NEAT (% completing care within 4 hours) **[core]**
- Access block rate (% admitted with ED LOS >8 h)
- Time to senior decision-maker / time to inpatient referral
- Did Not Wait (DNW) rate
- Patient experience / satisfaction scores
- Mortality and morbidity adjusted for case-mix

References: *ACEM clinical policies and statements • National Emergency Access Target (NEAT) policy documents*

Question 3 | Workplace Bullying (12 marks)

A junior registrar reports to you that they have been subjected to repeated belittling by a senior consultant during teaching ward rounds. The trainee is now reluctant to attend ward rounds and is considering withdrawing from the training program.

a) State the definition of workplace bullying as used in Australian/New Zealand workplace law. (2 marks)

Repeated unreasonable behaviour directed towards a worker (or group) that creates a risk to health and safety. 'Repeated' = persistent or recurring; 'unreasonable' = what a reasonable person would consider unreasonable in the circumstances. **Reasonable management action** conducted in a reasonable way is NOT bullying (e.g. constructive feedback, performance management).

b) List 4 immediate priorities in your response. (4 marks)

- Listen empathically; ensure trainee safety and wellbeing first; offer EAP / peer support **[core]**
- Document the conversation contemporaneously
- Clarify whether the trainee wants formal investigation, informal resolution, or just to be heard
- Identify any immediate safety / workload risk; consider shift / supervision adjustments
- Seek senior guidance (DEMT, EM Director, HR) without breaching confidentiality

c) List 6 systemic actions to reduce bullying culture in the department. (6 marks)

- Visible Code of Conduct / Charter of Behaviour endorsed by the consultant group and HOD
- Bystander training and explicit upstander expectations
- Anonymous staff survey with feedback loop
- Robust complaints process with multiple entry points (DEMT, EM Director, HR, EAP, AHPRA)
- Trauma-informed debrief after critical incidents
- Zero-tolerance approach to retaliation against complainants
- Leadership development for senior staff including feedback / supervision training
- Regular review of training-program experience and consultant-to-trainee feedback

References: ACEM clinical policies and statements • Good Medical Practice — A Code of Conduct for Doctors in Australia • Safe Work Australia Guide to Preventing Workplace Bullying (current)

Question 4 | Patient Complaint (12 marks)

You receive a written complaint from a patient who attended your ED 6 weeks ago with chest pain. They allege that they were sent home and subsequently had a STEMI 24 hours later. Their letter requests a meeting with the consultant who saw them and a written explanation.

a) List 4 immediate steps in your handling of this complaint. (4 marks)

- Acknowledge receipt within 5 working days; thank the patient for raising the concern **[core]**
- Notify the EM Director, hospital patient liaison / complaints unit, and the treating clinician
- Secure the medical record; review investigation results, documented decision-making, and discharge advice
- Initial root-cause review — was this a system, process, or individual issue?
- Consider whether disclosure obligations apply (Open Disclosure Framework)

b) List 4 components of an open-disclosure conversation with the patient. (4 marks)

- Sincere apology / expression of regret using the word 'sorry' (not an admission of liability) **[core]**
- Factual explanation of what happened (avoiding speculation)
- What is being done to prevent recurrence (system response)
- Opportunity for the patient / family to relate their experience and ask questions
- Ongoing support (counselling, EAP, financial assistance for follow-up care)

c) List 4 sources of support for the treating clinician. (4 marks)

- Employee Assistance Program (EAP) / hospital wellbeing service
- Medical Defence Organisation (e.g. MDA, Avant, MIPS) — early notification
- Peer / mentor support; consultant colleagues
- Doctors4Doctors confidential helpline
- ACEM Wellbeing resources; Medical Board of Australia (only if AHPRA notification triggered)

References: Australian Open Disclosure Framework — Australian Commission on Safety and Quality in Health Care 2013 • ACEM clinical policies and statements • Good Medical Practice — A Code of Conduct for Doctors in Australia • Australian Commission on Safety and Quality in Health Care national standards (current edition)

Question 5 | Coroner's Reportable Death (10 marks)

A 65-year-old woman dies in your resuscitation cubicle 30 minutes after arrival. She had presented with chest pain and was thought to have ACS. CPR was unsuccessful. She has a partner present.

a) List 5 categories of death that are reportable to the Coroner under Australian state legislation. (5 marks)

- Unexpected, unnatural, or violent death (including suicide and homicide) **[core]**
- Death within 24 hours of admission to hospital or within 24 hours of an anaesthetic/operation/procedure
- Death of a person in custody or care (police, prison, involuntary mental health, residential care)
- Death where the cause cannot reasonably be explained on natural causes by the treating doctor
- Death from suspected medical misadventure / healthcare-associated harm
- Identity of deceased not established

b) List 3 key considerations when speaking with the patient's partner immediately after death. (3 marks)

- Quiet, private space; dedicated staff member; no time pressure
- Clear, unambiguous language ('your wife has died') — avoid euphemisms; check understanding
- Cultural and religious considerations; opportunity to view the body; involvement of family liaison / pastoral care
- Explanation of the coronial process and likely autopsy implications without being prescriptive

c) List 2 mandatory documentation steps required for a coronial case. (2 marks)

- Detailed contemporaneous medical record entry — events, decision-making, witnesses, family communications
- Police notification and completion of relevant coronial form (varies by jurisdiction; e.g. NSW Form B); preservation of all lines, tubes, and clinical material
- Notification to medical administration and EM Director; MDO notification

References: *State/territory Coroners Act (current — relevant jurisdiction)* • *ACEM clinical policies and statements* • *Australian Open Disclosure Framework*

Question 6 | Cultural Safety — Aboriginal and Torres Strait Islander Patient (12 marks)

A 42-year-old Aboriginal man presents with chest pain. He appears anxious. He becomes increasingly withdrawn during the assessment. He tells the nurse he wants to leave. There is no Aboriginal Liaison Officer on shift.

a) List 4 components of culturally safe care for this patient. (4 marks)

- Identify Aboriginal/Torres Strait Islander status respectfully (asked of all patients at registration) **[core]**
- Engage an Aboriginal Liaison Officer (or family / community support) as soon as possible — including by phone if not on-site
- Address shame, fear of hospitals, prior negative experiences and racism — invite the patient to share concerns
- Ensure shared decision-making; explain investigations and rationale; check understanding; offer family presence
- Avoid jargon; allow time; recognise communication style differences; acknowledge silence as part of communication

b) List 4 system-level actions to improve cultural safety in the department. (4 marks)

- 24-hour Aboriginal Liaison Officer / cultural support service
- Mandatory cultural-safety training for all clinical staff, co-designed with local Aboriginal community
- Routine flagging of Aboriginal/Torres Strait Islander status and DAMA risk on triage
- Acknowledgement of Country in department; visible Aboriginal art and signage; welcome statement
- Aboriginal employment strategy (clinical and non-clinical roles)
- Co-designed care pathways for high-prevalence conditions (rheumatic heart disease, diabetes, renal disease)

c) List 4 reasons Aboriginal and Torres Strait Islander patients leave EDs without completing care. (4 marks)

- Prior negative experience with the health system; intergenerational trauma
- Direct or indirect experience of racism / discrimination
- Long waiting times without explanation; loss of autonomy
- Communication barriers — jargon, talking 'down' to patient, lack of cultural broker
- Family / community obligations; need to return to country
- Financial / transport / accommodation barriers

References: AIDA Cultural Safety Training Standards (current) • ACEM Reconciliation Action Plan • Closing the Gap National Agreement • Cultural Safety Frameworks — AIDA / RACMA / RACGP

Question 7 | Discharge Against Medical Advice (10 marks)

A 35-year-old man with type 1 diabetes presents in DKA (pH 7.10, glucose 28 mmol/L, ketones 5 mmol/L). He is alert, GCS 15, and demands to leave to attend his children. Insulin infusion has been running for 30 minutes.

a) List 4 elements of capacity assessment for this patient. (4 marks)

- **Understands** the relevant information about the decision (diagnosis, risks of leaving, alternatives) **[core]**
- **Retains** the information long enough to make a decision **[core]**
- **Weighs** the information as part of decision-making (not affected by acute illness, intoxication, mental health)
- **Communicates** the decision (any means)
- Decision-specific (capacity is not global) and time-specific

b) List 3 actions you would take if the patient leaves with capacity despite the high-risk DKA. (3 marks)

- Document the capacity assessment in detail; have patient sign AMA form (note: signature is not required for legal validity but is good practice)
- Provide written and verbal safety advice (return immediately for vomiting, confusion, breathlessness); offer follow-up
- Offer compromise — IV fluids and short-acting insulin in ED, rapid endocrine review, alternative arrangements for child care via social work
- Provide GP / endocrinology follow-up letter; consider Hospital-in-the-Home if available

c) List 3 actions if the patient does NOT have capacity. (3 marks)

- Treat under common-law doctrine of necessity (life-saving treatment in incapacitated patient)
- Engage nominated substitute decision-maker / Person Responsible per state Guardianship legislation
- If acutely psychotic / delirious / intoxicated: Mental Health Order if criteria met; minimum-restrictive measures
- Document capacity finding in detail; consult MDO; involve Guardianship Tribunal if prolonged

References: *ACEM clinical policies and statements* • *Good Medical Practice — A Code of Conduct for Doctors in Australia* • *State/territory Guardianship and Mental Health Acts*

Question 8 | Did Not Wait — Risk Management (10 marks)

Your department's DNW rate has risen from 4% to 9% over the past 6 months. Audit shows 1 in 4 of those who DNW are ATS category 3.

a) List 4 factors that increase a patient's likelihood of leaving without being seen. (4 marks)

- Long wait time in waiting room (most powerful predictor)
- Lower triage acuity (ATS 4–5 most likely)
- Younger age
- Mental health / substance misuse presentations
- Aboriginal and Torres Strait Islander identity (system factors)
- Lack of regular GP / health-system distrust
- Financial pressure (work, child care)

b) List 4 strategies to reduce DNW rate while maintaining patient safety. (4 marks)

- Improve flow / reduce wait time (root cause)
- Senior clinician at triage / streaming (rapid assessment and disposition)
- Visible communication of expected wait times; regular updates to waiting patients
- Pre-emptive analgesia, fluids, and basic investigations from triage
- Welcoming environment (especially for mental health, homeless, ATSI patients) — comfort, food, dignity
- Targeted follow-up for high-risk DNW cohorts (e.g. mental health, paed <2 yrs, ATSI)

c) List 2 governance steps if a patient who left dies or comes to harm. (2 marks)

- Mandatory critical-incident review / Severity Assessment Code (SAC1/2) reporting per state policy
- Open disclosure with the family; Coroner notification if criteria met; MDO involvement
- Root-cause analysis; system-level recommendations and implementation; tracked through ED morbidity meeting

References: *ACEM Australasian Triage Scale Implementation Guidelines* • *ACEM clinical policies and statements* • *National Safety and Quality Health Service Standards (2nd ed, NSQHS)*

Question 9 | Paediatric Did Not Wait (8 marks)

A 2-year-old child triaged ATS-3 leaves the waiting room with a parent without being seen, after a 90-minute wait. The child was triaged with fever and lethargy.

a) List 4 immediate actions on discovery the child has left. (4 marks)

- Attempt phone contact with parents/carers using registration details **[core]**
- Document time of departure, attempts to contact, and any information available about the child's clinical state
- Notify treating senior / NUM and triage nurse
- Consider Child Protection / vulnerable child notification if concerns about safety, neglect, or repeated DNW patterns
- Notify GP if known (with consent considered)

b) List 4 system safeguards specific to paediatric DNW. (4 marks)

- Lower threshold for streaming children to fast-track / paediatric area regardless of triage category
- Identification at triage of high-risk infants (<3 months, incomplete immunisations, medical complexity)
- Regular re-triage / re-observation of waiting children
- Standard operating procedure for follow-up phone call to all paediatric DNW within 24 h
- Mandatory child-protection review for repeat DNW or DAMA

References: *ACEM Australasian Triage Scale Implementation Guidelines • RCH Melbourne paediatric ED clinical governance documents • ACEM clinical policies and statements*

Question 10 | Frequent Attender (12 marks)

A 45-year-old man has presented to your ED 18 times in 6 months with chronic abdominal pain, anxiety, and requests for opioid analgesia. He has multiple inpatient admissions and 4 endoscopies, all normal. He has unstable housing.

a) List 4 common contributors to frequent ED attendance. (4 marks)

- Chronic pain syndromes / opioid use disorder
- Mental illness — anxiety, depression, personality disorder, psychosis
- Substance use / alcohol use disorder
- Social isolation / homelessness / poverty / domestic violence
- Poorly managed chronic disease (CHF, COPD, diabetes) — primary care access deficits
- Cognitive impairment / acquired brain injury / dementia

b) List 6 components of an MDT case-management plan. (6 marks)

- Single, accessible care plan in the ED record agreed with the patient and updated regularly **[core]**
- Identified GP / community service as primary care home
- Mental health and addiction team co-management
- Social work / housing support
- Pain medicine consultation; opioid stewardship plan
- Pharmacy review; reconciliation of polypharmacy
- Aboriginal Liaison / cultural support if relevant
- Monthly MDT review with feedback to patient and treating clinicians

c) List 2 ED-specific principles when this patient represents. (2 marks)

- Approach with respect and consistency; do not assume presentation is non-genuine — evaluate each visit on its merits
- Follow the documented care plan (analgesia, investigation thresholds); avoid step-changes between clinicians
- Rapid de-escalation strategies; safety planning if self-harm risk; engagement of mental health / addiction team early

References: ACEM clinical policies and statements • eTG (Therapeutic Guidelines, current) • ACEM Frequent Presenter position statement

Question 11 | Clinical Guideline Development (10 marks)

Your department wishes to develop a local guideline for management of mild–moderate community-acquired pneumonia in adults. You have been asked to lead this work.

a) List 4 essential components of a robust clinical guideline. (4 marks)

- Clearly stated scope, target audience, and clinical question
- Evidence base — systematic review or appraisal of national/international guidelines (eTG, IDSA, BTS, ANZICS)
- Multidisciplinary authorship and stakeholder consultation (ED, ID, respiratory, pharmacy, nursing, consumer)
- Clear flowcharts and decision criteria; prescribing detail (drug, dose, duration, route, allergies)
- Versioning, review date, and audit/feedback mechanism
- Local adaptation — antibiotic resistance patterns, formulary, available investigations

b) List 3 differences between a guideline and a protocol. (3 marks)

Guideline	Protocol
Recommendations to inform clinician judgment	Step-by-step rules with mandatory compliance
Permits variation based on patient factors	Variation requires documented justification
Typical for complex / heterogeneous conditions	Typical for high-risk / time-critical interventions (massive transfusion, anaphylaxis)

c) List 3 strategies to improve guideline uptake. (3 marks)

- Embed in electronic medical record / order sets / clinical decision support
- Departmental education, simulation, and visible aids (laminated cards, posters)
- Audit and feedback to clinicians with peer comparison
- Champions / opinion leaders; multidisciplinary endorsement
- Regular review and update with version control

References: *Australian Commission on Safety and Quality in Health Care national standards (current edition)* • *eTG (Therapeutic Guidelines, current)* • *National Safety and Quality Health Service Standards (2nd ed, NSQHS)*

Question 12 | Evaluating a New Intervention (10 marks)

A pharmaceutical representative presents data supporting the use of a new IV antiemetic in your ED. They claim it reduces nausea by 'three times as much as ondansetron'. You are asked to evaluate the evidence and decide whether to add it to formulary.

a) List 4 critical-appraisal questions to ask of the evidence presented. (4 marks)

- What was the study design (RCT, observational), blinding, randomisation, sample size, and comparator? **[core]**
- Were the outcomes patient-important, and were absolute rather than relative measures reported?
- Was the population studied representative of your ED patients (ED setting, severity, comorbidities)?
- Conflicts of interest / industry sponsorship — was the trial registered, with pre-specified analysis plan?
- Was the result statistically and clinically significant (NNT, confidence intervals)?

b) List 3 governance steps before adding to formulary. (3 marks)

- Drug & Therapeutics Committee submission with cost-effectiveness analysis
- Local clinician consensus and pharmacy review (interactions, stability, storage)
- Implementation plan: ordering, education, monitoring of adverse events, audit of use

c) List 3 cognitive biases that may affect your decision. (3 marks)

- Anchoring to the headline relative-risk figure
- Confirmation bias (looking for evidence supporting the new drug)
- Authority bias (industry sponsor, prominent author)
- Availability bias (recent dramatic anecdote)
- Reciprocity bias from gifts / hospitality

References: *Australian Commission on Safety and Quality in Health Care national standards (current edition)* • *eTG (Therapeutic Guidelines, current)* • *Good Medical Practice — A Code of Conduct for Doctors in Australia* • *Pharmaceutical Society of Australia Code of Ethics*

Question 13 | Departmental KPIs (10 marks)

Your hospital executive has asked you to choose 5 key performance indicators for your ED. The CEO is focused on NEAT but you wish to ensure quality is also captured.

a) List 6 KPIs spanning timeliness, safety, effectiveness, patient-centredness and equity. (6 marks)

Domain	KPI
Timeliness	NEAT (% completing care within 4 hours); access block rate (%)
Timeliness	Time to senior decision-maker; time to antibiotic in sepsis; door-to-balloon time STEMI
Safety	Unplanned 72-hour re-presentation rate; in-ED death rate (case-mix adjusted); SAC1/2 incident reporting rate
Effectiveness	Compliance with sepsis bundle; troponin pathway completion; appropriate analgesia for hip fracture
Patient-centredness	Patient experience score; complaints rate; Did Not Wait rate
Equity	ATSI presentation rate, DNW rate, and admission rate vs non-Indigenous; care provided to homeless / non-English-speaking patients

b) List 4 risks of focusing solely on NEAT. (4 marks)

- Premature inpatient transfer / 'streamed' patient with incomplete workup
- Inappropriate short-stay admission to meet 4-hour target
- Gaming (re-clocking the timer; reassigning category)
- Reduced focus on quality measures (sepsis bundle, anticoagulation in AF)
- Loss of patient-centred conversations under time pressure

References: National Emergency Access Target (NEAT) policy documents • ACEM clinical policies and statements • Australian Commission on Safety and Quality in Health Care national standards (current edition)

Question 14 | Morbidity & Mortality Meeting (12 marks)

You are asked to chair the monthly M&M; meeting. A case is presented in which a patient with subarachnoid haemorrhage was misdiagnosed as migraine and discharged. They returned obtunded 24 hours later.

a) List 4 principles to guide a constructive M&M; meeting. (4 marks)

- Just-culture approach — separate human error, at-risk behaviour, and reckless behaviour **[core]**
- Focus on systems, not individuals (avoid blame; psychological safety)
- Pre-discussion case review by senior — anonymise details where possible
- Multidisciplinary attendance; shared learning; closed-loop feedback to the original treating team
- Clear action items with named owner and review date

b) List 4 systems-level contributors to this misdiagnosis. (4 marks)

- Lack of standardised pathway for thunderclap headache (Ottawa SAH rule, CT timing)
- Cognitive load / overcrowding leading to anchoring on first diagnostic impression
- Handover failures between shifts; absence of structured tool (ISBAR / ISOBAR)
- Workforce factors — junior decision-maker without senior review of high-risk presentations
- EMR design — alerts not triggered; no decision support
- Discharge process — no documented advice / safety net instructions

c) List 4 actions arising from this case. (4 marks)

- Adopt a standardised headache pathway (Ottawa SAH rule, CT <6 h, LP if >6 h or atypical)
- Mandatory consultant review of all atypical / red-flag headaches before discharge
- Discharge advice template with explicit return-precautions
- ED education session and simulation case
- Open disclosure with patient/family
- Audit of headache discharges over preceding 6 months

References: *ACEM clinical policies and statements* • *Australian Commission on Safety and Quality in Health Care national standards (current edition)* • *WHO Reporting and Learning Systems*

Question 15 | Mass Casualty Incident (14 marks)

A bus crash on a nearby highway has resulted in 35 casualties. Pre-hospital triage estimates 8 critical, 12 serious, 15 minor injuries. ETA first ambulance is 10 minutes. You are the in-charge EM consultant.

a) List 4 immediate priorities in the first 5 minutes. (4 marks)

- Activate hospital MCI plan (Code Brown / External Emergency); senior nurse and operations manager [core]
- Establish command structure (AIIMS): Incident Controller, Medical Coordinator, Triage, Treatment, Transport
- Clear ED of non-essential patients (early discharge, ward transfer); cancel elective surgery; recall staff
- Set up triage area at ambulance entry; prepare resus bays; stage non-critical patients in surge area
- Brief all staff with situation update; document timings

b) List 4 components of triage at the ED entrance. (4 marks)

- Use a standardised triage system — START / triage sieve (walking, breathing, capillary refill / radial pulse) <30 sec per patient
- Categorise: Red (immediate), Yellow (urgent), Green (delayed), Black (deceased / expectant)
- Re-triage on arrival in treatment area (triage sort)
- Tag patients with unique identifier; document triage time, category, and trajectory

c) List 3 communication priorities during the response. (3 marks)

- Single point of communication with pre-hospital command (MICA / NSW Ambulance) and other receiving hospitals
- Regular staff briefings (every 15–30 minutes)
- Family liaison area separate from clinical area; structured family enquiry process
- Media liaison via hospital PR — single spokesperson; staff directed not to comment
- Documentation: incident log with named scribe

d) List 3 priorities in the post-incident phase. (3 marks)

- Staff debrief — operational (hot debrief within hours), structured (within days)
- Psychological first aid; identify staff at risk of psychological harm; offer EAP
- Formal incident review with named recommendations and implementation timeline
- Patient family follow-up; coronial obligations for any deaths

References: Australasian Inter-service Incident Management System (AIIMS) and MIMMS (Major Incident Medical Management and Support) • ACEM clinical policies and statements • Australian Health Disaster Management Plan • MIMMS Major Incident Medical Management

Question 16 | Mass Casualty Triage Categories (8 marks)

You are nominated as Triage Officer at the ambulance entrance during the MCI.

a) List the 4 mass-casualty triage categories with the criteria for each. (4 marks)

Category	Criteria
RED — Immediate (P1)	Life-threatening but potentially survivable with prompt treatment (e.g. tension pneumothorax, haemorrhagic shock, airway compromise)
YELLOW — Urgent (P2)	Serious but stable; can wait several hours (e.g. fractures with intact distal circulation, abdominal pain without shock)
GREEN — Minor (P3)	Walking wounded; can wait or be treated outside ED
BLACK — Deceased / Expectant (P4)	No signs of life; or injuries incompatible with survival given available resources

b) Name the 2 commonly used pre-hospital triage tools. (2 marks)

- **Triage Sieve** — initial primary triage (walking, breathing, capillary refill / pulse, GCS)
- **Triage Sort** — secondary triage using physiological scores (RR, SBP, GCS) at receiving area
- **START / JumpSTART** (paediatric)

c) List 2 ethical principles that may apply if resources are overwhelmed. (2 marks)

- **Utilitarianism** — greatest good for the greatest number; resource allocation favours those most likely to survive with treatment
- **Distributive justice** — fairness in allocation; equal regard for each life
- Transparent decision-making; documentation; senior / ethical oversight

References: Australasian Inter-service Incident Management System (AIIMS) and MIMMS (Major Incident Medical Management and Support) • MIMMS • ACEM clinical policies and statements

Question 17 | Missed Fracture (10 marks)

A 70-year-old woman is recalled after radiology over-read identifies a missed scaphoid fracture from her ED visit 7 days ago. The original ED report described 'no acute fracture'.

a) List 4 immediate actions on identification of the missed fracture. (4 marks)

- Contact the patient promptly to recall for review; explain the finding without speculation **[core]**
- Open disclosure with apology, factual explanation, and what is being done
- Arrange definitive management (immobilisation, hand surgery referral)
- Document all communications and clinical actions
- Notify EM Director, MDO, and treating clinician

b) List 3 ED system features that reduce missed-fracture rates. (3 marks)

- Routine radiology over-read of all ED imaging within 24 hours with closed-loop recall process **[core]**
- Clinical decision rules (Ottawa ankle, Ottawa knee, NEXUS) embedded in pathways
- Senior review of high-risk imaging (paediatric NAI, suspected scaphoid, NOF, cervical spine)
- PACS access at home for after-hours senior review
- Audit of discrepancy rate with feedback to clinicians

c) List 3 quality-improvement actions following this case. (3 marks)

- Audit recent scaphoid imaging discrepancies; quantify rate
- Targeted education on scaphoid fracture pitfalls (occult fractures, presumptive immobilisation)
- Standard discharge pathway: clinical scaphoid → 7–10 day review with repeat imaging or MRI
- Closed-loop EMR alert for over-read discrepancies

References: Australian Commission on Safety and Quality in Health Care national standards (current edition) • Australian Open Disclosure Framework — Australian Commission on Safety and Quality in Health Care 2013 • Tintinalli's Emergency Medicine 9e Ch 269 (Wrist Injuries)

Question 18 | Missed Malignancy on Imaging (10 marks)

A 55-year-old man attended your ED 4 weeks ago with chest pain. The CXR was reported by you as normal. Radiology over-read 7 days later identified a 4 cm right-upper-lobe mass. The patient has not been informed and continues with GP follow-up.

a) List 4 immediate actions. (4 marks)

- Contact patient by telephone to arrange urgent review (and same-day GP / respiratory referral) **[core]**
- Notify GP directly of the finding and ensure follow-up is arranged
- Open disclosure: factual explanation of what happened, sincere apology, and what is being done
- Document all actions; notify EM Director and MDO
- Initiate critical-incident review (SAC1/2) per jurisdictional policy

b) List 3 systemic causes of failed test-result follow-up. (3 marks)

- No closed-loop process for over-read discrepancies (reports filed, not acted on)
- Poor handover between shifts; results returning after discharge fall through gaps
- Patient lost to contact (incorrect demographic data, homelessness)
- EMR limitations — no automated escalation, alert fatigue
- No designated clinician responsible for each test result trail

c) List 3 system improvements to prevent recurrence. (3 marks)

- Mandatory radiologist over-read with structured discrepancy notification within 24 hours
- Designated 'results manager' role with closed-loop follow-up SOP and audit
- EMR alerts for unread / abnormal results; escalation if not actioned within set time
- Patient notification process at point of care: 'we will contact you if anything else is found'

References: Australian Commission on Safety and Quality in Health Care national standards (current edition) • Australian Open Disclosure Framework — Australian Commission on Safety and Quality in Health Care 2013 • National Safety and Quality Health Service Standards (2nd ed, NSQHS)

Question 19 | ED Overcrowding — Real-Time Response (10 marks)

It is 17:00 on a Friday. ED occupancy is 145%. Twelve patients are admitted but boarding in ED. Ambulance ramp delay is 80 minutes. Two ATS-2 patients are unable to be moved into a cubicle.

a) List 5 immediate actions to mitigate the overcrowding. (5 marks)

- Activate the hospital escalation plan (Code Yellow / surge plan) — engage executive, bed manager, ward NUMs [core]
- Senior decision-maker streaming at triage; rapid disposition
- Identify boarders for accelerated transfer (criteria-led discharge, weekend discharge ward)
- Open / re-open additional treatment spaces (corridor monitored care, seated waiting area for stable patients)
- Senior team in ED to keep moving / re-evaluate patients; consider extra senior call-in
- Ambulance offload nurse / standing offload protocol
- Cancel non-time-critical elective theatre / clinics where possible

b) List 5 medium-term actions to reduce recurrence. (5 marks)

- Hospital-wide flow strategy with executive sponsor and shared accountability
- Predictable inpatient discharge before midday; weekend discharge ward
- Short-stay unit and ambulatory care zones
- Demand management — primary care alternatives, urgent care clinics, telehealth
- Aged-care and mental health step-down capacity (system-level)
- Ongoing audit, transparent reporting, executive dashboard

References: *ACEM clinical policies and statements • National Emergency Access Target (NEAT) policy documents • ACEM Statement on Emergency Department Overcrowding*

Question 20 | End-of-Life Care in the ED (12 marks)

An 87-year-old woman with metastatic ovarian cancer presents with progressive dyspnoea and pain. She has an Advance Care Directive (ACD) requesting comfort care only. Her husband is distressed and asks you to 'do everything'.

a) List 4 priorities in the immediate ED management. (4 marks)

- Confirm the ACD is current, applicable, and specific to this clinical situation; verify with the patient if she has capacity **[core]**
- Move to a quiet, private space (single room, family lounge); allow family presence
- Symptom control — opioid for dyspnoea/pain (e.g. morphine 1.25–2.5 mg SC q1h PRN); anti-emetic; benzodiazepine for anxiety
- Honest, empathic communication with patient and husband; engage social work / pastoral care
- Palliative-care service referral and admission planning (palliative-care unit, hospice, home)

b) List 4 components of a goals-of-care discussion with the family. (4 marks)

- Acknowledge their distress and the reality of approaching death
- Clarify what 'do everything' means — specific concerns (comfort, suffering, dignity)
- Frame discussion around what the patient herself wanted (via ACD and prior conversations)
- Explain that comfort care is active care — symptom control, presence, dignity
- Document the discussion and decisions; offer ongoing support and bereavement contacts

c) List 4 medications and doses appropriate for end-of-life symptom control. (4 marks)

Symptom	Drug + dose
Pain / dyspnoea	Morphine 1.25–2.5 mg SC q1h PRN (opioid-naïve); 0.5 mg/h SC infusion via syringe driver if continuous
Agitation / terminal restlessness	Midazolam 1.25–2.5 mg SC q1h PRN; or 0.5–2 mg/h SC infusion
Nausea / vomiting	Haloperidol 0.5–1 mg SC q4h PRN; or metoclopramide 10 mg SC q6h
Respiratory secretions	Hyoscine butylbromide 20 mg SC q6h PRN; or glycopyrrolate 0.2 mg SC q4h PRN

References: ANZICS Statement on Care and Decision-Making at the End of Life • eTG (Therapeutic Guidelines, current): Palliative Care • ACEM clinical policies and statements • Palliative Care Australia standards

Question 21 | Sepsis Protocol Implementation (10 marks)

Following an audit showing 35% compliance with the sepsis 1-hour bundle, you are leading implementation of a department-wide sepsis pathway.

a) List the 5 components of the sepsis 1-hour bundle (Surviving Sepsis Campaign). (5 marks)

- Measure lactate (re-measure if elevated) **[core]**
- Take blood cultures BEFORE antibiotics **[core]**
- Administer broad-spectrum antibiotics (within 1 h of recognition for septic shock; within 3 h for sepsis without shock per current SSC guidance) **[core]**
- Begin fluid resuscitation 30 mL/kg crystalloid for hypotension or lactate ≥ 4 mmol/L
- Apply vasopressors (noradrenaline first-line) if MAP < 65 mmHg after fluid resuscitation

b) List 5 strategies to improve protocol compliance. (5 marks)

- Sepsis-recognition triage tool (qSOFA, NEWS, paed-specific for children) embedded in EMR
- Sepsis order-set with one-click bundle
- 'Sepsis kit' / sepsis trolley with prepared lines, cultures, antibiotics
- Departmental education + simulation; identified clinical champions
- Audit + feedback at individual and team level; visible performance dashboard
- Antimicrobial stewardship review at 24–48 h
- Open recognition: senior nurse / clinician empowered to call sepsis / Code Sepsis

References: *Surviving Sepsis Campaign 2021 (international guideline)* • *ANZICS Statement on Care and Decision-Making at the Sepsis* • *Australian Commission on Safety and Quality in Health Care national standards (current edition)*

Question 22 | Short Stay Unit Governance (10 marks)

You are tasked with redesigning your 12-bed short-stay unit (SSU). Current LOS is creeping (mean 30 hours), and diagnostic / disposition decisions are sometimes deferred to inpatient teams.

a) List 5 admission criteria appropriate for an SSU. (5 marks)

- Anticipated length of stay <24 hours with a clear diagnostic or therapeutic goal **[core]**
- Clinically stable; predictable trajectory
- Common conditions: cellulitis IV antibiotics, low-risk chest pain pathway, asthma observation, alcohol withdrawal, uncomplicated overdose observation, mild head injury
- Hospital-in-Home substitution candidates
- NOT suitable: ICU candidates, undifferentiated illness requiring inpatient workup, palliative-care admissions

b) List 5 governance principles for a high-functioning SSU. (5 marks)

- Admission and discharge criteria with named protocols
- Senior ED clinician medical lead with daily ward round
- Maximum LOS of 24 h with automatic escalation and inpatient transfer if exceeded
- Allied health, social work, and pharmacy presence
- Clear governance — KPIs (LOS, re-presentation, mortality), M&M, complaints
- Robust handover process at change of shift

References: *ACEM clinical policies and statements • ACEM Statement on Short Stay Units in Australasian Emergency Departments • National Safety and Quality Health Service Standards (2nd ed, NSQHS)*

Question 23 | Simulation-Based Education (10 marks)

You wish to introduce regular in-situ simulation in your ED to improve team performance in resuscitation.

a) List 4 components of an effective simulation program. (4 marks)

- Pre-brief — psychological safety, learning objectives, fiction contract
- Scenario design — relevant to actual cases, calibrated to learner level
- Debrief — structured (e.g. PEARLS, Plus/Delta) by trained facilitator; focus on team behaviours
- Multidisciplinary participation (medical, nursing, allied health) reflecting real teams
- Feedback loop into clinical practice — action items, M&M;., equipment / system fixes

b) List 3 latent safety threats simulation may identify. (3 marks)

- Equipment availability / familiarity (e.g. paed's airway trolley, MTP boxes)
- Spatial / environmental issues (cubicle layout, oxygen supply, phones)
- Communication gaps (closed-loop, role allocation, mental model sharing)
- Cognitive aids — accessibility and use of WETFLAG, anaphylaxis card, RSI checklist

c) List 3 risks of simulation done poorly. (3 marks)

- Psychological harm / shame from poor debrief
- Reinforcement of incorrect technique if facilitator untrained
- Disruption to patient care if in-situ scenario underprepared
- Resource cost without measured improvement; loss of engagement

References: *ACEM clinical policies and statements • Society for Simulation in Healthcare standards*

Question 24 | Trainee in Difficulty (12 marks)

A senior advanced trainee has had two missed STEMI diagnoses in the past 3 months and several complaints from nurses about communication. They appear withdrawn and have missed two scheduled assessments.

a) List 4 early warning signs of a trainee in difficulty. (4 marks)

- Failure to progress (repeated competency / assessment failures, delayed milestones)
- Avoidance behaviour (missed shifts, late, swapped duties, missed assessments)
- Interpersonal difficulties (conflict with nursing / colleagues; failure to escalate)
- Clinical errors / near-misses
- Poor time management or organisation
- Signs of physical / psychological distress (presenteeism, appearance change, irritability)

b) List 4 components of a structured response. (4 marks)

- Confidential conversation in a safe space; listen first; explore underlying causes (health, mental health, family, financial, learning needs) **[core]**
- Document concerns with specific evidence
- Engage DEMENT, EM Director, ACEM Education Committee; ensure trainee aware of formal processes and supports
- Consider patient-safety implications — ensure adequate supervision in interim
- Refer to EAP / Doctors4Doctors / GP / mental health support
- If health concerns affect practice — consider AHPRA mandatory notification thresholds

c) List 4 elements of a structured performance plan. (4 marks)

- Clear, evidenced concerns documented with specific examples
- Achievable SMART goals with defined timelines
- Regular formal check-ins / progress reviews (frequency stated)
- Defined support structures (DEMENT, ES, mentor, EAP)
- Agreed outcomes if targets not met (further review, extension, escalation, fitness-to-practise pathway)
- Notification to College / training supervisor as required

References: ACEM clinical policies and statements • AHPRA / Medical Board of Australia mandatory notification guidelines • Good Medical Practice — A Code of Conduct for Doctors in Australia • ACEM Trainee Wellbeing and Performance Guidance

Question 25 | Australasian Triage Scale (10 marks)

You are educating new triage nurses in your department on the Australasian Triage Scale (ATS).

a) Complete the table for the 5 ATS categories — clinical descriptor and target time to treatment. (5 marks)

Category	Descriptor	Time to treatment
ATS 1 — Resuscitation	Immediate threat to life (cardiac arrest, obstructed airway, severe shock, GCS <9)	Immediate (0 min)
ATS 2 — Emergency	Imminent threat to life or function (chest pain ischaemic, severe respiratory distress, haemodynamic instability)	≤10 minutes
ATS 3 — Urgent	Potentially life-threatening (moderate dehydration, moderate asthma, severe pain)	≤30 minutes
ATS 4 — Semi-urgent	Potentially serious (mild bleeding, sprain, minor head injury)	≤60 minutes
ATS 5 — Non-urgent	Less urgent (minor symptoms, dressing changes, results review)	≤120 minutes

b) List 5 challenges of accurate triage in real-time. (5 marks)

- Limited time (target ≤10 min from presentation)
- Cognitive bias (anchoring on presenting complaint; age / appearance bias)
- Atypical presentations (silent MI in elderly / diabetic; sepsis in older adult)
- Mental health / behavioural disturbance — risk of under-triaging
- Cultural / language barriers without adequate interpreter
- Vital-sign reliance (vitals lag clinical deterioration)
- Triage in overcrowded waiting room (re-triage capacity)

References: *ACEM Australasian Triage Scale Implementation Guidelines • ACEM clinical policies and statements*

Question 26 | Triage — Behavioural Disturbance (10 marks)

A 26-year-old man presents to triage, brought by police after public intoxication and threats of self-harm. He is agitated, smells of alcohol, and refuses to engage. Police wish to leave.

a) State the appropriate ATS category for this patient. (2 marks)

ATS 2 — Emergency (≤ 10 min). Threats of self-harm with intoxication and behavioural disturbance constitute imminent threat to life. Should NOT be triaged as ATS 4 purely on the basis of intoxication.

b) List 4 immediate priorities in management. (4 marks)

- Place in observed area with line-of-sight; remove access to ligature points; security present **[core]**
- Senior medical and mental-health team review (medical before psychiatric review)
- Police remain or hand over formally — assess capacity / voluntary status before they leave; consider Mental Health Order if criteria met
- Investigations — bedside glucose, ECG, BAC if relevant; exclude head injury, infection, intoxication-mimicking metabolic causes
- De-escalation; offer food, comfort; minimise stimulation

c) List 4 strategies for managing acute behavioural disturbance per ACEM guidance. (4 marks)

- Verbal de-escalation as first-line (calm voice, respectful posture, offer choices) **[core]**
- Environmental — quiet space, minimise stimuli, safe staffing ratio
- Oral medication preferred if accepted (olanzapine 10 mg PO or diazepam 10 mg PO)
- Parenteral if required: droperidol 10 mg IM (repeat at 15 min if needed); ketamine 4–5 mg/kg IM if dangerous behaviour and other measures failed
- Continuous monitoring (airway, sedation depth, SpO₂, BP) post-medication
- Restraint as last resort — least restrictive, time-limited, documented; review every 15 minutes

References: ACEM Australasian Triage Scale Implementation Guidelines • ACEM clinical policies and statements • ACEM Acute Behavioural Disturbance Position Statement