# Systems-focused case review tool

This systems-focused case review tool has been developed, based on the London Protocol, to support applying a systems-focused lens in Morbidity and Mortality (M&M) case review meetings.

The tool itself is divided into the London Protocol’s different sociotechnical systems layers to ensure M&M case reviews consider contributing factors in each of the system ‘layers’. It can be used for both Safety-I cases, in which you retrospectively look at what went wrong, or in Safety-II cases (cases with positive outcomes) where you examine what factors contributed to an event having a positive outcome. Safety-II cases can also be used to proactively identify where things could go wrong in the future.

The tool should help staff identify systems contributory factors, rather than individual error and/or blame. Within each system layer there are some trigger questions to drive team discussions. The contributory factors examples in the tables are not exhaustive. If there are systems factors that are not documented, that are considered important to your service/clinical unit, please add these in the free-text area at the end of the section.

There are elements within each layer that can overlap with others. Contributory factors may not necessarily be identified in every case or in every layer of the system. We anticipate that this tool will take approximately 10 minutes per case, providing all the information is available.

**It is recommended that the systems-focused tool is used prior to M&M meetings (during the preparation of the cases), and throughout the meeting to drive discussions:**

* During case presentation preparation

In using this tool prior to the meeting, it is important that either the M&M facilitator, or the presenter reaches out to those involved in each case to obtain the context in which events occurred. This information is often not contained within the patient documentation/medical record. Allow staff involved to tell their account, to give you information about the reality of the work situation at the time.

The goal is to understand why decisions and actions made sense at the time of the event.

* Within a meeting to assist in facilitating systems-focused discussion

Using the tool during the meeting helps facilitate system-focussed discussions which moves the review focus away from individual staff involved in the event. This promotes safety culture prioritising psychological safety for everyone attending, including those in the meeting that may have been involved in the event.

Identifying system contributory factors may be limited if the tool is only used in M&M meetings**. This is particularly critical if staff involved are absent or do not feeling psychologically safe enough to discuss events.**

Using the structured systems focused tool will facilitate the identification of trends in the types of issues occurring at the departmental level. These should be monitored periodically (quarterly, bi-annual or annually). This information can be fed into the M&M Quarterly/Periodic Report template for higher governance committee monitoring.

## Considerations Advice for use:

* Use one tool per case
* Steer away from individual blame, instead think ‘systems’
* Use the question and headings to assist systems-focused discussion
* Use the expand and collapse functions () next to the questions to expose the factors to consider in each system
* Examine what went well and what could be improved in each case reviewed
* Use for cases with both positive and negative outcomes
* Expand on how the factors influenced the situation

Type of review: Safety-II (positive outcome) case  Unexpected death/adverse event/complaint

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reviewer(s):** | | | **M&M Review Date:** | |
| **Type of case review:** Morbidity  Mortality  *(if mortality, complete mortality screening below)* | | | | |
| **Case Review Details**  *(e.g. relevant details and findings from review/chronological outline of events)*  ***Note: A detailed M&M review does not replace more formal review methodologies if a case meets SAPSE or Sentinel Event criteria*** | | | | |
| Significant past medical history/  Co-morbidities |  | | | |
| **Relevant details of case:** |  | | | |
| **Complete for both morbidity/ mortality cases** | ISR classification  1  2  3  4  N/A  SIRS Classification  1  2 | VHIMS/ SIRS (aged care) completed:  Y  N  VHIMS/ SIRs ID: | | If no - person responsible for completion: |
| Meets Sentinel event criteria:  Y  N | Date reported: Select a date  By whom: | | |
| Meets SDC (SAPSE) criteria:  Y  N | Date reported: Select a date  By whom: | | |
| Open disclosure required:  Y  N | Date performed: Select a date  By whom: | | |

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| --- |
| Event summary |
|  |

### Mortality Screening:

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| --- | --- | --- |
|  | | |
|  | **Y/N** | **Comments** |
| Was there a procedure or operation in the 30 days prior to death? |  |  |
| Was the case referred to the coroner? *If no, & should have been, please explain in comments* |  |  |
| Was the case referred to the Office of the Chief Psychiatrist?  *If no, & should have been, please explain in comments* |  |  |
| Were there any issues with Medical Certificate Cause of Death? (e.g. not completed, incorrect cause. Please explain in comments) |  |  |
|  | | |
| Death Category Choose a death category. | | |

## Assessment of contributing system factors:

### Cultural & societal factors:

#### For example: Were there any cultural &/or societal specific factors that contributed to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Eligibility to access Medicare for free/ low- cost care |  | History of family violence |  |
| Difficulty accessing care |  | Family/social network support |  |
| Financial barriers to receive required care |  | Cultural &/or language barriers impacting provision of care |  |
| Living arrangements/homelessness |  | Public/community awareness of risk/disease |  |
| Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Regulations, government & external factors:

#### For example: How did regulatory & governmental factors as well as external influences contribute to the event? Did the pressures of demand or efficiency contribute to this event? Did local, state or national policies contribute to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Bed availability/access block |  | Weather conditions impacting safe transport |  |
| Consistency of protocols & clinical guidelines across Victorian health services |  | Remote geographic location/length of transfer |  |
| Frequency of training provided by colleges |  | Availability of ambulance/PIPER/NETS |  |
| Impact of COVID 19 |  | Communication between multiple agencies involved |  |
| Public/community awareness of risk/disease |  |
| Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Organisation & management factors:

#### For example: How did organisation & management factors contribute to the event? Did local policies contribute to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational structure |  | Credentialing |  |
| Availability/accessibility of fit for purpose policies, protocols & guidelines |  | Access to interpreters |  |
| Recency of policies, protocols & guidelines |  | Appropriateness of transfer – capability of receiving health services to look after patient |  |
| Time allocated for training & education of staff |  | Just culture/Safety culture (staff feeling safe to speak up for safety & report events without fear of retribution) |  |
| Systems/processes for information sharing between services |  |
| Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Task & Technology factors:

#### For example: How did task & technology factors contribute to the event? Did the usability & availability of the tools used contribute to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Timeliness of procedure |  | Accuracy of test results |  |
| Availability & accessibility of test results |  | Wearing PPE |  |
| Timeliness of emergency response |  | Availability/use of decision-making aids |  |
| IT system related (useability/functionality) |  | Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Environmental factors:

#### For example: How did environmental conditions contribute to this event? Did staffing numbers &/or competing priorities contribute to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Staffing levels |  | Equipment fit for purpose for task |  |
| Availability of senior clinical staff (skill mix appropriate) |  | Accessibility/storage of equipment |  |
| Workload/acuity/competing priorities |  | PPE impacting delivery of care |  |
| Design/layout of equipment (e.g. resus trolley) |  | Design of guidelines/decision-making aids |  |
| Availability of equipment (e.g. resus equipment) |  | Design/layout of work environment |  |
| Equipment functionality & maintenance |  | Administrative & managerial support |  |
| Rostering/shift patterns |  | Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Team factors:

#### For example: How did teamwork factors contribute to the event? What was there capacity of the team to handle this type of event? How did the staff involved function as a team?

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| --- | --- | --- | --- |
| Communication between staff |  | Team leadership |  |
| Seeking help &/or escalation of safety issues |  | Written communication/documentation |  |
| Timeliness of escalation |  | Verbal communication (e.g. handover) |  |
| Supervision |  | Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Staff factors:

#### For example: What were the individual staff goals, plans & expectations at the time? Did the staff involved have the capacity to handle this type of event? What was the staff’s focus of attention & why?

|  |  |  |  |
| --- | --- | --- | --- |
| Knowledge/skills of staff |  | Physical health of staff |  |
| Experience (seniority/competence) of clinical staff |  | Diagnostic decision making |  |
| Mental health of staff |  | Compliance with guidelines/best practice |  |
| Fatigue |  | Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### Patient Factors:

#### For example: How did any patient-specific factors contributed to this event?

|  |  |  |  |
| --- | --- | --- | --- |
| Recognition of complexity/seriousness of condition by patient/parent/caregiver |  | Poor attendance to appointments due to decision to manage own care independently, or preference for alternative therapies |  |
| Mental health of patient/parents/caregiver |  | Unanticipated complications |  |
| Malnutrition (inc. obesity) impacting optimal care |  | Complexity/seriousness of condition |  |
| Substance use (prescription or non-prescription) |  | Other (please describe in box below) |  |
| Please describe in more detail how these systems factors did not work well regardless of the outcome of the event. | | | |
| Please describe in more detail any systems factors that did work well regardless of the outcome of the event. | | | |

### What other important systems issues have been identified?

For example: Systems factors that did not work well but did not directly contribute to the adverse event.

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| --- | --- | --- | --- |
| Systems lessons learned:  Factors that did not go well | Use systems-focused case analysis tool to identify systems factors (positive and negative)  e.g. access block, staff skill mix/shortage  Delete this instruction text before distribution | | |
| Systems lessons learned:  Factors that did go well | Use systems-focused case analysis tool to identify systems factors (positive and negative)  e.g. deterioration recognised in a timely manner, good use of available policies/algorithms  Delete this instruction text before distribution | | |
| Discussion points: |  | | |
| Recommendation/ Action | Delete or add ‘Item’ and ‘Action/Person responsible/Deadline’ rows as required.  Delete this instruction text before distribution | | |
| Person responsible |  | Deadline | Select a date |
| Recommendation/ Action |  | | |
| Person responsible |  | Deadline | Select a date |

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