In-depth case review tool template

This tool has been designed to assist with the review of adverse patient safety events (APSE), including Serious Adverse Patient Safety Events (SAPSE) that do not meet sentinel event criteria. Please refer to the [Adverse Patient Safety Event policy and guideline](https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events) for more information on when to use this tool and how to complete an adverse event review. The guideline provides detailed information on how to complete each step of the review process.

If you are unsure if your event meets sentinel event criteria, more information can be found here [Sentinel events | Safer Care Victoria](https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events) or email sentinel.events@safercare.vic.gov.au.

### Background

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| **Patient/Resident/Client/Consumer details** |
| **Patient identifier (e.g. UR, name)** |  | **Date of birth** | DD/MM/YYYY | **Date of death (if applicable)** | DD/MM/YYYY |
| **Gender** | [ ]  Female | [ ]  Male | [ ]  Non-binary / gender diverse | [ ]  Prefer not to say or not provided |
| **Identifies as Aboriginal and/or Torres Strait Islander?** | [ ]  Aboriginal | [ ]  Torres Strait Islander | [ ]  Both Aboriginal and Torres Strait Islander | [ ]  Neither Aboriginal or Torres Strait Islander  | [ ]  Unknown/did not say |
| **Past medical history**  |  |
| **Diagnosis/ reason for admission**  |  |

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| **Health Service- event details**  |
| **Date of Admission**  | DD/MM/YYYY | **Date of adverse event** | DD/MM/YYYY | **Date adverse event identified** | DD/MM/YYYY |
| **Treating specialty team/s** |  |
| **How was this adverse event identified?**  | [ ]  Incident Reporting System  | [ ]  Morbidity and Mortality meeting | [ ]  Consumer feedback  |
| [ ]  Team discussion/Safety huddle | [ ]  Coroner’s findings  | [ ]  Other (specify): |
| **Was this adverse event reported in VHIMS (RiskMan) or an equivalent system?** | [ ]  Yes Incident ID: | [ ]  No | If yes, Incident Severity Rating (ISR)?If this event is a sentinel event, please notify SCV, discontinue using the tool and commence a review in line with sentinel event requirements.  | [ ]  1 | [ ]  2 | [ ]  3 | [ ]  4 |
| **Did this adverse event occur in a residential aged care facility governed by the health service?**  | [ ]  Yes | [ ]  No | If yes, was it reported to the Serious Incident Response Scheme (SIRS)?  | [ ]  Yes – Priority 1 | [ ]  Yes – Priority 2 | [ ]  No |
| **Was this adverse event a serious adverse patient safety event (SAPSE)?** | [ ]  Yes | [ ]  No | ☐ Unsure If the registered health practitioner cannot adequately determine if the event is a SAPSE, please see these [examples](https://www.safercare.vic.gov.au/sites/default/files/2023-05/SAPSE%20-%20Hospital%20Acquired%20Complications%20examples.docx), or contact SCV at sentinel.events@safercare.vic.gov.au  |
| **Has Statutory Duty of Candour (SDC) or Open Disclosure (OD) commenced?****[Note: SDC is a legal requirement for a SAPSE]** | [ ]  Yes – SDC[ ]  Yes – OD  | Date SDC commenced:By whom: | [ ]  No | If no - why not? | [ ]  N/A |
| Date OD commenced:By whom: |
| **Was the SDC or OD response recorded in the medical record?**  | [ ]  Yes | [ ]  No  | If no - why not? | [ ]  N/A |
| **Is this review being undertaken as a protected review?**  | [ ]  Yes | [ ]  No  | ☐ Unsure See [Statutory Duty of Candour and protections for SAPSE reviews](https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour) for more information  |
| **Was this adverse event notified to any external agencies?**  | [ ]  Coroner | [ ]  WorkSafe  | [ ]  Therapeutic Goods Administration (TGA) |
| [ ]  Victorian Managed Insurance Authority (VMIA) | [ ]  Aged Care Quality and Safety Commission | [ ]  National Disability Insurance Scheme (NDIS) |
| [ ]  Office of the Chief Psychiatrist  | [ ]  Safer Care Victoria/Department of Health | [ ]  Other (specify):  |
| **Are other specialty teams (internal or external) involved in the care of this patient?** | [ ]  YesPlease specify:  | [ ]  No |
| **What other health service entities (if any) were involved in the adverse event?**  | [ ]  Ambulance Victoria (AV) | [ ]  Newborn & Paediatric Emergency Transport (NETS) | [ ]  Paediatric Infant Perinatal Emergency Retrieval (PIPER) |
| [ ]  Adult Retrieval Victoria (ARV) | ☐ Non-Emergency Patient Transport (NEPT) | [ ]  N/A |
| [ ]  Other health service (specify) | [ ]  Other e.g. primary care, community service (specify) |  |
| **If other health services are involved in this adverse event, please describe how they will be engaged in the review** |  |

### Review team

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| **Remember:** * Team members completing this tool should represent the skills, knowledge, and experience of staff involved in the event, or provide additional relevant subject matter expertise. While formation of a review panel is not a requirement for the review of adverse patient safety events that are not sentinel events, it is considered best practice to have several team members with different perspectives completing the tool. You may also consider including a consumer and external expert. At a minimum, this in-depth case review tool should be completed by a team of two, with oversight by a senior manager.
* Team members must be independent of the event itself i.e. must not include staff and consumers directly involved in or impacted by the adverse event.
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| **Review team members** | **Name (optional)** | **Position** |
| **Review chair** |  |  |
| **Review lead/facilitator**  |  |  |
| **Review team member/s** |  |  |
| **External expert (if required)** |  |  |
| **Consumer (if required)** |  |  |

### Gather the evidence

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| **Remember:** * Interviews should be conducted with everyone who was involved in the adverse event, including staff and the impacted consumer/family/carers (upon obtaining consent from the patient where possible).
* Be mindful of the impact on interviewees and reassure them that interviewing is not a blame-focused exercise but instead aims to identify the systems issues that contributed to the event, in line with the principles of a Just Culture.
* Interviewing is a skill that requires practice.
* There are many information sources that should be considered to obtain an understanding of what happened and why. It is important that information sought is systems-focused to obtain a comprehensive understanding of what happened.

**The examples below are not exhaustive and may not be applicable to every review.** |

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| **Identify who needs to be interviewed to inform this review**  |
| **Frontline staff** |
| [ ]  Specialty teams – nurses  | [ ]  Specialty teams – doctors  | [ ]  Cross specialty clinical staff | [ ]  Allied health staff | [ ]  Pharmacy | [ ]  Non-clinical | [ ]  Other (specify): |
| **Operational management** |
| [ ]  NUMs/ANUMs | [ ]  Medical heads of specialty | [ ]  Infection Prevention | [ ]  Quality, Safety & Risk | [ ]  Equipment Manager | [ ]  Facilities Manager | [ ]  IT support services |
|  [ ]  Other:  |
| **External** |
| [ ]  Patient/Family and/or carers  | [ ]  Pathology provider  | [ ]  Ambulance | [ ]  GPs | [ ]  Other (specify): |

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| **Identify the data sources which will inform this review (systems and process information collection)**  |
| **Patient systems** | **Staff systems** | **Governance and administration** |
| [ ]  Electronic Medical Record (EMR)[ ]  Physical health records/patient files[ ]  Referral letters[ ]  Other (specify):  | [ ]  Rosters[ ]  Training records[ ]  Other (specify): | [ ]  Internal policies, procedures and guidelines[ ]  Safety Climate surveys (e.g. People Matter Surveys)[ ]  Credentialing and competency processes[ ]  Equipment maintenance records[ ]  Consumer feedback (e.g. complaints/compliments, Victorian Health Experience Survey)[ ]  Adverse event data[ ]  Audit results[ ]  Meeting minutes[ ]  Existing action plans/improvement work[ ]  Other (specify): |
| **Government, regulatory, and external information**  | **Work environment**  | **Task and technology**  |
| [ ]  (Pre)hospital policies, procedures, and guidelines[ ]  Patient transfer information[ ]  State-wide/national guidelines and frameworks [ ]  Government policies and procedures[ ]  Accreditation standards [ ]  Equipment suppliers, manuals, and information[ ]  Other (specify):  | [ ]  Layout of clinical area/patient room/transport vehicle (e.g. photos, videos or floor plan) [ ]  Decision-making aids/checklists [ ]  Rosters[ ]  Other (specify): | [ ]  Photos of technology used to identify potential design inefficiencies [ ]  Workflow to achieve (complex) tasks[ ]  Other (specify): |

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### Event description and timeline

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| **Remember:** * The description should be succinct (no more than one page).
* A visual timeline diagram can be used to support the description.
* The event description needs to set the scene with de-identified, factual, evidence-based information. It should not be a clinical summary of the patient journey but should include relevant past medical and social history and needs to include the patient outcome.
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| **What happened in this event? Provide a chronological description of what happened, including the outcomes.** |
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### Analyse data

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| **Describe systems contributing factors identified in the relevant table sections below.** A contributing systems factor is a systems factor that contributed to the adverse event occurring, as evidenced by the information collected during the review. To ensure that all systems contributing factors have been considered, please review the people and systems selected under ‘who and what needs to inform the review’ and consider their role in this event.Each contributing factor identified below needs to be able to be linked to the information you collected (i.e. supported by evidence). |
| **System layers** | **Which systems factors contributed to the adverse event (which systems didn’t work well)?***Please identify systems factors that contributed to the adverse event as evidenced by the information collected* | **Which systems factors were working well?***Please describe any systems factors that were working well, despite the adverse outcome of this event.* |
| **Cultural and societal factors** *e.g. cultural background, gender, disability, age, sexuality, socioeconomic background* |
| How did cultural and societal factors contribute to the event?  |  |  |
| **Regulations, government, and external influences** *e.g. Economic, and regulatory context; legislation; links with external organisations (e.g. ambulance services, other health services, medical colleges); other external influences (e.g. geographic location).* |
| How did regulatory and government factors and external influences contribute to the event? |  |  |
| **Organisation and management** *e.g. financial resources & constraints, organisation structure; policy, standards, and goals; safety culture/just culture* |
| How did organisation and management factors contribute to the event? |  |  |
| **Task and technology** *e.g. task design and clarity of structure; availability and use of protocols; availability and accuracy of test results; decision-making aids.* |
| How did task and technology factors contribute to the event? |  |  |
| **Work environment** *e.g. staffing levels and skills mix; workload and shift patterns; design, availability, and maintenance of equipment; administrative and managerial support; physical environment.* |
| How did work environment factors contribute to the event? |  |  |
| **Team** *e.g. verbal communication; written communication, supervision and seeking help; team structure (congruence, consistency, leadership, etc).* |
| How did team factors contribute to the event? |  |  |
| **Staff** *e.g. knowledge and skills, physical and mental health.* |
| How did staff factors contribute to the event? |  |  |
| **Patient** *e.g. condition (complexity & seriousness); other pre-existing conditions (physical, cognitive, sensory impairments etc); living conditions (alone, extended household, shared accommodation etc); sole carer; unsafe home environment.* |
| How did patient factors contribute to the event?  |  |  |

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### Develop findings

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| **Remember:*** Findings should identify what happened and why it happened.
* Finding statements describe how the system factors identified during data analysis contributed to the adverse event.
* The output of the data analysis determines the content of the findings statement.
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| **Translate the contributing factors identified in the data analysis into written finding statements.**Contributing factors across different levels of the system can be connected in the written finding statement to identify how they impact each other. Make sure that all selected contributing factors from above have been covered in the finding statements. |
| Finding 1 |  |
| Finding 2 |  |
| Finding 3 |  |
| Finding 4 |  |
| Finding 5 |  |
| Finding 6 |  |
| Finding 7 |  |

**Safety lessons learnt**

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| **Are there any other related safety lessons learnt that were identified but did not directly contribute to the event?** A safety lesson learnt describes a system issue that did not work well, but where there is no evidence that it directly contributed to the adverse event under review. |
| Lesson 1 |  |
| Lesson 2 |  |
| Lesson 3 |  |
| Lesson 4 |  |
| Lesson 5 |  |

### Recommendations and action plans

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| **Remember:*** Each finding should be addressed by a recommendation.
* Recommendations for lessons learnt should be developed as required, e.g. if a risk is identified.
* Recommendations can address multiple findings, i.e. there may be more findings than recommendations.

Consider the following:* Are the recommendations achievable on face value?
* Are the majority (at least 50%) of recommendations rated as moderate or strong? See the [SCV Developing recommendations fact sheet](https://www.safercare.vic.gov.au/sites/default/files/2023-06/Developing%20recommendations.pdf) for examples and the strength of recommendations hierarchy.
* Have the staff responsible for implementing the recommendation been consulted in their development?
* Are recommendations SMART (specific, measurable, assignable, realistic and time-bound)?
* Have potential unintended consequences of implementation been assessed?
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| **Recommendation action plan**Develop systems-based recommendations to mitigate the reoccurrence of the same event in the future and/or reduce harm if the event were to reoccur.   |
| **ID** | **Recommendation**  | **Strength of action -** *weak, moderate, strong* | **Which finding/lessons learnt will this address?** | **Describe the actions required to implement the recommendation** | **Who is responsible for implementation?** | **When will it be implemented by?***DD/MM/YYYY* | **How will success be evaluated?** *Consider outcome, process and balancing measures* | **Status of action implementation***Completed, in-progress* |
| 1 |  |  |  |  |  |  |  |  |
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### Governance

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| **Endorsement of the review and recommendation actions by relevant review committee/ exec sponsor** | **Name of Committee/ Exec Sponsor** | **Date** | **Signature of Committee Chair/ Exec Sponsor**  |
| **Relevant review and authorisation committee** |  | DD/MM/YYYY  |  |