Clinical Case Review

The aim of this review is to identify any gaps in systems and processes that have contributed to significant unanticipated patient harm, including cardiopulmonary arrest on a ward, in order to inform quality improvement activities to close those gaps.

NHI	Datix Number:	SAC score
Date of event	Date review commenced: Date review completed:	
Names & disciplines of people conducting review *(Representative of multidisciplinary team and clinical services. Does not include anyone involved in the event)*		
What was the source of review information? *(Staff interviewed / Patient/Family/Whanāu Interviewed/Documents Reviewed/Best Practice Reviewed) [NB identify staff by position not name (e.g. RN, HO)]*		

Situation
Patient Demographics: Age Gender Ethnicity
What happened? *Brief description of occurrence including sequence of event, management of event and patient outcome*

Background
Pertinent clinical information *(medical history)*

Timeline *(patient course, procedures, results)*

Date	Time	Action	Issue/Point to note. What was different this time? What works well?

Assessment	**Yes**	**Maybe**	**No**	**Comment**
Situational Factors:				
Did the staff involved function as a team?				
Was fatigue/stress/distraction/ inexperience a concern for any team member?				
Was there an unfamiliar/difficult/monotonous task involved?				

Was there any reason this event was more likely to happen to this particular patient?				
Local working conditions:				
Was there sufficient staff to match the expected workload?				
Did everyone understand their role?				
Was all equipment, consumables and medicine available and functional?				
Latent Organisational factors:				
Did the environment hinder the work in any way?				
Was there a delay in investigations/ results/ diagnosis/treatment?				
Was there a delay in transfer to or within the hospital?				
Did all team members have the appropriate knowledge and skills?				
Was there inadequate recognition or response to a change in the child's condition?				
Did local policies and guidelines help or hinder?				
Latent external factors				
Is there any characteristic about the equipment, consumables or medicines used that was unhelpful?				
General factors:				
Was documentation legible/ unambiguous / complete?				
Were there any communication issues within a service?				
Were there any communication issues between services?				
Were any individuals that require further support identified?				

For ward cardiopulmonary arrest	Yes	No	Comments
How many sets of vital signs were documented in the preceding 24 hours?			
Were all PEWS parameters documented every time?			
Were all PEWS scores calculated every time?			
If care was escalated in the 24hours before death was the response: • Timely? (per the escalation pathway) • Appropriate? (the right responder) • Effective? (the interventions, treatments and ongoing plan met the patient's immediate clinical needs and any necessary follow up was provided)			
Did the primary medical team review the patient in the 24 hours before the death? If yes, did the plan of care demonstrate: • Appropriate recognition of the severity of illness? • An appropriate plan for monitoring the patient? • A clear plan for required interventions and treatments? • Appropriate indications for further review?			
Did the patient speak English as a first language? If no, was a translator involved in the 24hours before death?			
Was there documented evidence of patient, family or whanau concern in the 24 hours before death? If yes, was this concern: • Recognised?			

• Acted on? • Communicated to the appropriate seniority of clinician?			
Were there documented issues of care or documented family or whanau concern **earlier** than 24hr before the death? If yes, was this concern: • Recognised? • Acted upon? • Communicated to the appropriate seniority of clinician?			

Any other issues noted that are not covered by the above.

Summary of contributing factors *(system vulnerabilities written as cause, effect and event).*	
1.	
2.	
3.	

Recommendations				
	Action	Responsibility	By when	Date Completed
1.				
2.				
3.				

Add recommendations to the service clinical excellence action register

Organisational learning. *If there is learning for the wider Child Health Directorate, please note below and email a copy of this report to the Leader, Safe Care Programme.*

Please complete electronically, attach a copy to the safety management system (Datix) record (if applicable) and save to a local Service Clinical Excellence folder.