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# Paediatric recognition and response system ‒ retrospective case review tool

Introduction

A retrospective case review is recommended after incidents such as unplanned transfers to higher acuity care, or other reported events (SAC 1, 2 and 3) related to failures to recognise or respond to clinical deterioration. Routine case reviews are recommended for tamariki:

* about whom a rapid response or clinical emergency call was made
* identified in the routine audit tool to have a paediatric early warning score (PEWS) of 8+
* identified through routine chart audit activities where recognition, escalation or response did not occur appropriately
* where there were complaints from whānau about failures to recognise or respond to their tamariki’s deterioration.

Documentation from case notes and paediatric vital sign charts should be reviewed for at least the 24 hours before the event occurred. The reviewer needs sufficient clinical expertise and seniority to interpret the appropriateness of the clinical care provided to the patient.

Data and themes from case reviews should be about system and not individual performance. The summary of the case reviewed should be reported for discussion and action by groups such as local quality improvement teams, the recognition and response system clinical governance committee, education and training providers, specialty morbidity and mortality meetings or grand rounds. Individual cases may be useful as stories to engage clinicians in understanding their role in the recognition and response system, or as teaching tools in scenario-based education. If the cases are used for learning opportunities, they must be presented in a way that ensures psychological safety and promotes a no-blame culture.

If case review identifies adverse events that have not been previously reported and/or where an open disclosure process is warranted, the usual organisational reporting guidelines must be followed. If individual performance issues are identified, these must be referred to the appropriate clinical leader for follow up.

This template was informed by the National Confidential Enquiry into Patient Outcome and Death *Time to Intervene* review tool.[[1]](#footnote-2)

Case note review template

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| **Event type** | |
| Rapid response/clinical emergency call | Tick: |
| PEW score of 8+ on routine audit | Tick: |
| Routine chart audit activities where recognition, escalation or response did not occur appropriately | Tick: |
| Unplanned transfer to higher acuity care | Circle: ICU/HDU/other hospital |
| Adverse event | Circle: SAC 1/SAC 2/SAC 3 |
| Complaint from whānau | Tick: |
| Other | Specify: |
| **Event details** | |
| Date | \_\_/\_\_/\_\_ |
| Time | 24h clock: \_\_:\_\_ |
| Day of week | Circle: Mon/Tue/Wed/Thu/Fri/Sat/Sun |
| **Patient demographics** | |
| Age | Months: Years: |
| Ethnicity  (Record all identified ethnicities as per front sheet or NHI database) | Write: |
| Were cultural services involved in the 24h before the event (for example, a kaumātua)? | Circle: Yes/No |
| Did the tamariki and/or parent(s)/legal guardian speak English as a first language? | Circle: Yes/No |
| If no, was a translator involved in the 24h before the event? | Circle: Yes/No |
| Was the tamariki’s parent/legal guardian present? | Circle: Yes/No |
| **Paediatric vital signs chart** | |
| What paediatric vital signs chart was used? | Circle:   * 0‒11 months * 1‒4 years * 5‒11 years * 12+ years |
| How many sets of vital signs were documented in the 24h before the event? | Number: |
| Was the core vital sign set documented every time?  (Core vital sign set includes respiratory rate, respiratory distress, supplemental oxygen requirement, oxygen saturation, central capillary refill, heart rate, blood pressure) | Circle: Yes/No |
| Was the early warning score calculated correctly (with or without modification) with every set of vital signs?  If no – how many sets of vital signs had an incorrectly calculated early warning score? | Circle: Yes/No  Number: |
| What was the highest early warning score in the 24h period? | Number: |
| Were any modifications to the PEW score made?   * Was clinical justification provided? * Did modification delay or prevent timely escalation? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |
| Was care escalated in accordance with the escalation pathway every time an early warning score trigger was reached?  If no – was there a documented reason for not following the escalation pathway? | Circle: Yes/No  Circle: Yes/No |
| If care was escalated in the 24h before the event, was the response:   * timely (per the escalation pathway)? * appropriate (the right responder)? * effective (the interventions, treatments and ongoing plan met the tamariki’s immediate clinical needs and any necessary follow-up was provided)? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |
| **Limitations of medical treatment** | |
| Were any limitations of medical treatment documented prior to the event, for example, if the tamariki was on an end-of-life pathway?  If yes, did care at the time of the event align with the documented limitations?  If no, were new limitations of medical treatment documented as a result of the event? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |

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| **Global review questions** | |
| In your opinion, were there warning signs that the tamariki was at risk of deterioration in the 24h before the event?  If yes, were these signs:   * recognised? * acted on? * communicated to the appropriate seniority of clinician? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |
| Did the primary medical team review the patient in the 24h before the event?  If yes, in your opinion, did the plan of care demonstrate:   * appropriate recognition of the severity of illness? * documented discussion with tamariki, parent/legal guardian? * an appropriate plan for monitoring the patient? * a clear plan for required interventions and treatments? * appropriate indications for further review? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No  Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |
| Was there documented evidence of patient (this may be an older tamariki who is able to express concern), family or whānau concern in the 24h before the event?  If yes, in your opinion, was this concern:   * recognised? * acted on? * communicated to the appropriate seniority of clinician? | Circle: Yes/No  Circle: Yes/No  Circle: Yes/No  Circle: Yes/No |
| In your opinion, was there any system not identified above that contributed to the event?  (For example, equipment failure, communication failure, availability of staff) | Specify: |

**Abbreviations used in this template**

HDU = high dependency unit; ICU = intensive care unit; NHI = National Health Index;   
PEW score = paediatric early warning score; SAC = severity assessment criteria.

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1. <http://www.ncepod.org.uk/2012report1/toolkit/CAP%20Data%20comparison%20tool.pdf> [↑](#footnote-ref-2)