Recognition and response system retrospective case note review

Introduction

A retrospective case review is recommended after incidents such as cardiac arrests, patient deaths, 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 a random sample of patients who received a rapid response call (for example, every fifth or tenth call). Other prompts for case note reviews may include complaints from patients or family members about failures to recognise or respond to patient deterioration, or patients identified through chart audit activities where recognition, escalation or response did not occur appropriately.

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

Data and themes from case reviews 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 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]

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[1] http://www.ncepod.org.uk/2012report1/toolkit/CAP%20Data%20comparison%20tool.pdf

Case note review template

Event type	
Rapid response call	Tick: □
Cardiorespiratory arrest (required CPR)	Tick: □
Unexpected death (inpatient death in a patient with SGOC A or B)	Tick: □
Unplanned transfer to higher acuity care	Circle: ICU/CCU/HDU/other hospital
Adverse event	Circle: SAC 1/SAC 2/SAC 3
Other	Specify:
Event details	
Date	__/__/__
Time	24h clock: __:__
Day of week	Circle: Mon/Tue/Wed/Thu/Fri/Sat/Sun
Patient demographics	
Age	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 patient speak English as a first language?	Circle: Yes/No
If no, was a translator involved in the 24h before the event?	Circle: Yes/No
Did the patient have documented cognitive impairment?	Circle: Dementia/delirium/mental disability
Did the patient have documented chronic mental illness?	Circle: Yes/No
Was there a valid SGOC form completed before the event?	Circle: Yes/No
Was the patient in a single room?	Circle: Yes/No

Vital signs chart	
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, supplemental oxygen requirement, oxygen saturation, blood pressure, heart rate, level of consciousness and temperature)	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 early warning 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 patient'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, 'not for ICU' or 'not for resuscitation')?
 	
    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

Global review questions	
In your opinion, were there warning signs that the patient was at risk of deterioration in the 24h before the event?	Circle: Yes/No
If yes, were these signs: • recognised? • acted on? • communicated to the appropriate seniority of clinician?	Circle: Yes/No Circle: Yes/No Circle: Yes/No
Did the primary medical team review the patient in the 24h before the event?	Circle: Yes/No
If yes, in your opinion, 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? • documented discussion with patient and whānau?	Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No
Was there documented evidence of patient, family or whānau concern in the 24h before the event?	Circle: Yes/No
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
In your opinion, was there any system, process or clinical issue not identified above that contributed to the event? (For example, equipment failure, communication failure, availability of staff)	Specify:

Abbreviations used in this template

CCU = critical care unit; CPR = cardiopulmonary resuscitation; HDU = high dependency unit; ICU = intensive care unit; NHI = National Health Index; SAC = severity assessment criteria; SGOC = shared goals of care.