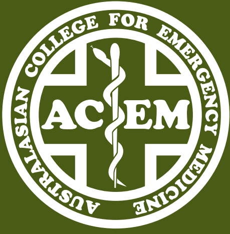

Australasian College
for Emergency Medicine

Guidelines on Case Review Meetings

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Document review

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v1	Nov-22	Approved by CAPP

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1. Purpose and Scope

Learning from clinical cases is an essential part of emergency medicine (EM). There are particular challenges that are inherent in EM, including undifferentiated patients, clinical uncertainty, disease evolution/progression, high risk procedures, overcrowding and access block. Case Review Meetings (CRMs), a subset of which is Morbidity and Mortality (M&M) meetings, are an essential opportunity to develop reflective practice, audit clinical outcomes, learn from incidents, effect change, and learn from excellence in practice. Reflective practice should also acknowledge that some poor outcomes are unavoidable, despite the correct and diligent decisions and actions of staff.

This guideline should be used in conjunction with hospital and jurisdictional advice. It provides recommendations on establishing regular CRM programs for analysing and discussing emergency department (ED) cases. In doing so it complements broader sources of advice, such as the Australian Commission on Safety and Quality in Health Care *Incident Management Guide* (which includes links to all Australian state and territory policies).[1]

The purpose of an CRM meeting is to reflect on systemic issues, and how they interface with patient safety in the ED. Opportunities for system improvement should be sought and recurrent ED 'error traps' identified (for example diagnosis-related, procedure-related, and/or medication-related). CRMs are not an opportunity to review or manage issues of performance or competence. The key aims are to:

- identify key events resulting in adverse patient outcomes;
- foster open and honest discussion of those events;
- identify and disseminate information and insights about patient care that are drawn from individual and collective experience;
- reinforce system level and individual accountability for providing high quality care;
- create open and honest discussion with a just, patient-centred culture; and
- contribute to clinical governance processes

CRM meetings often focus on adverse clinical incidents and deaths. However, there is a shift within patient safety literature towards exemplifying the high levels of clinical success achieved within complex healthcare systems. Case review meetings should therefore also include cases with excellent clinical outcomes, with a similarly in-depth analysis of why those positive outcomes have occurred. In patient safety literature, such outcomes have been referred to as 'Epic Saves', 'Safety and Success', 'Marvellous and Magnificent' or 'Awesome and Amazing' cases.[2]

This guideline applies to all Australian and Aotearoa New Zealand EDs. It is of relevance to ED medical, nursing, and allied health staff, and will support trainees who choose a CRM review to fulfil the FACEM training program requirement (quality improvement activity).

Other health practitioners may also be invited to contribute to relevant cases, such as inpatient teams, ambulance services, primary care services, and the patient liaison team. The theory and practice of CRM in the ED is applicable to hospital-wide CRM meetings.

2. Definitions

Psychological Safety. Feeling able to speak up with ideas, questions, concerns, or mistakes without fear of being punished, humiliated, or sustaining negative consequences to one's self-image, status or career

Second Victim. The psychological distress and trauma experienced by a healthcare provider who is involved in an unanticipated adverse patient event

Safety I. Traditional definition of safety as the absence of adverse outcomes. Focuses on adverse outcomes and presumes they occur because of identifiable failures, such as human error. It means learning from what goes wrong, but noting that human error should be the start of an investigation not its conclusion.

Safety II. Safety defined as excellent patient outcomes despite varying work conditions. Focuses on learning from what goes right (90 per cent of work), not what is exceptional (<5 per cent). It presumes staff perform safely because they are able to adjust what they do to match the conditions of work.

Systems Improvement. Strategic oversight and evaluation of the healthcare system with the aim of improving clinical practice, applying evidence-based models and methods of health care, reducing unwarranted clinical variation, and supporting a safety culture

Hindsight Bias. The tendency, after an event has occurred, to overestimate the extent to which the outcome could have been foreseen. Hindsight bias stems from (a) cognitive inputs — people selectively recall information consistent with what they now know to be true; (b) metacognitive inputs — people may misattribute their ease of understanding an outcome to its assumed prior likelihood; and (c) motivational inputs — people have a need to see the world as orderly and predictable.

Cultural Safety. The Cultural Safety is determined by Aboriginal, Torres Strait Islander and Māori individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

3. Background

These CRM guidelines reflect contemporary safety and quality principles. They are guided by human factors science to improve learning and system improvement, and are based on the NSW Government and Clinical Excellence Commission (CEC) guidelines[3] for conducting and reporting CRM meetings. Six core principles underline the methodology developed by the CEC:

1. **Safety.** Providing a safe space for learning through discussions that are blame-free, and education focused.
2. **Multidisciplinary.** Enhancing active participation across disciplines.
3. **Methodology.** Undertaking root cause analysis of patient factors, department process factors, and hospital systems factors.
4. **Open Discussion.** Generating actionable learning and/or system improvement.
5. **Lessons Learned.** Documenting outcomes and disseminating recommendations to ensure action.
6. **Governance.** Opening pathways for reporting to support learning and recommendations.

4. Procedures and Actions

CRM meetings should focus on opportunities for system improvement. This aim should be stated explicitly, both in the invite and at the commencement of the meeting itself.

Focus should be on identifying the phenomena (system/process) that led to the death or incident, and not on individuals who provided care. These issues should be divided into a standard framework, for example: patient factors, department process factors, hospital system factors. Cases should be de-identified, describing only the facts of the case in an objective manner, including any confounding factors such as hindsight bias, ED overcrowding, length of wait time, triage score and location in department.

Discussions should be used for educational purposes and not for apportioning blame to individuals. The content should focus on measures that can be implemented to improve outcomes or prevent a similar incident or adverse outcome.

The methodology used to analyse and reflect upon a case should be consistent, whether the clinical outcome of the case was favourable or not. CRM meetings should therefore also include cases with excellent clinical outcomes, with a similarly in-depth analysis.

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4.1 Roles

4.1.1 Presenter

May be a staff member involved in the case, or an impartial, unconflicted staff member. Presenters are responsible for describing and analysing the case. The case is usually presented in a chronological order and should include objective details that contextualise the patient's journey. This might include the state of the department at the time (for example, staff off sick, other clinical priorities, and/or organisational changes).

In analysing the case, the presenter should identify key points, critical decisions or events that could have contributed to the outcome. This includes talking to staff involved to gain their perspective. The presenter should use a structured approach to identify issues and/or positives raised by the case, such as system factors, department factors, and patient factors (be aware of hindsight bias). Analysis should include a review of best practice.

The presenter should conclude with learning points and/or recommendations for improvement. The presenter must be aware of and avoid hindsight bias/ outcome bias and counterfactual definitions of error. The presenter must also be supported because of the risk of psychological harm to staff (themselves and other staff members) to avoid second victimisation.

4.1.2 Chair

An unbiased and impartial person to facilitate and focus discussions on meeting aims. This person should be carefully chosen and trained, for instance RCA training, difficult debrief training, and second victim training. For reasons of impartiality, it is preferable that the Chair does not present cases, although this may be more challenging in smaller EDs. The chair must recognise and shut down blame especially when it comes from the organisational hierarchy such as the director or quality and safety department.

4.1.3 Note-keeper

A nominated person, who may be the Chair, and should be responsible for documenting and disseminating outcomes from the meeting, particularly for staff who may be unable to attend. A deidentified record of the meeting's cases, discussions and lessons learned should be kept in a confidential but accessible database (for example, hospital intranet) as part of department clinical governance. A database should also be kept of all cases referred to a CRM Committee.

4.1.4 CRM Committee

A multidisciplinary committee should be formed to lead the CRM process in the department. Ideally this would consist of at least one senior medical officer, one trainee and one ED nurse. The committee should meet regularly to review cases referred for CRM, decide on relevance and necessity for presentation, liaise with potential presenters, promote attendance, appoint a Chair and note-keeper, maintain a database and log of action items, and follow-up on implementation.

4.2 Frequency

Meetings should be held regularly. These may be monthly, bimonthly, or quarterly. All ED staff should be invited to attend.

4.3 Choice of cases

Cases can be selected for presentation at departmental CRM meetings from a range of sources including:

- Deaths which occur in the ED and within 24 hours of admission.
- Cases referred by a clinician.
- Cases referred via the organisation's clinical risk management platforms, patient safety committee or complaints officer.

It has become more common to also present cases where the outcome was positive, such as 'near misses' or 'good saves'. These have been termed 'Safety and Success', 'Marvellous and Magnificent' or 'Awesome and Amazing'.[1] These cases highlight the 'Safety II' features defined above.

4.4 Psychological safety

Although patients are the first and most obvious victims of unanticipated adverse events, healthcare providers are also profoundly affected, and may suffer severe emotional distress when bad outcomes occur – a concept termed the 'second victim'.

Those involved in a case should be notified ahead of time that it will be presented at a CRM meeting, and that a summary of the case and discussion will be distributed in time. To avoid re-traumatisation, it is imperative to speak to all parties involved in the case and understand why their decisions made sense to them at the time (context). They should also be invited to attend and/or present, without pressure to do so. On occasions individuals may be further traumatised by being re-exposed to those events.

At a later date, a summary of the case and discussion should be conveyed to individuals directly involved, if they desire. Ideally these individuals would be given the opportunity to review the summary prior to distribution, and be invited to be involved if open disclosure with the patient or family occurs after the meeting.

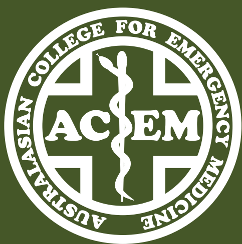
Certain cases (for example the death of a child) can be very distressing for staff involved, as well as CRM meeting attendees, and this should be openly acknowledged. It is also important to identify when a poor outcome was probably unavoidable, despite the correct decisions and actions of staff.

5. References

1. Australian Commission on Safety and Quality in Health Care. *Incident Management Guide*. Sydney (AU): ACSQHC; 2021.

2. Purdy E, Roseby R, Brinkmann M, Blackmore E, Meyer C, Cabrera D. *Education as Culture: The Amazing and Awesome Case Conference*. J Grad Med Educ. 2021 Feb;13(1):18-21. doi: 10.4300/JGME-D-20-00407.1. Epub 2021 Feb 13.

3. NSW Government and Clinical Excellence Commission. *Guidelines for Conducting and Reporting Morbidity and Mortality/Clinical Review Meetings September 2020*. Sydney (AU), NSW Government 2021.



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