



Systems Analysis Review Report Template

Confidential

Date of Incident:

NIMS Number:

Hospital Group/CHO/NAS/Other:

Commissioner of the Review:

Chair of Review:

Date Report Completed:

Note: Guidance is provided throughout the template in *italicised* text- please ensure that this is deleted before finalising the report.

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1.0 Executive Summary

To include: Details of the incident type, the circumstances of the incident and the impact on the service user/relevant person(s) (use codes i.e. do not use names)

Purpose of the review

Timeframe taken to conduct the review.

That the Review Team was independent of the matters under review i.e. not directly involved in the incident.

A summary of the key findings and that recommendations have been made to address the factors that contributed to these.

Consider writing this summary in a manner that it can be adapted as the basis for sharing learning with other services.

2.0 Acknowledgement

Acknowledgement - to the persons affected e.g. service user, relevant person(s), staff and service for their participation in the process.

3.0 Overview of the Review Process

How was the review commissioned and by whom? What was the remit of the review (consider including the terms of reference as an appendix). Include detail of how the service user/relevant person(s) was involved in the process e.g. was there a meeting with them to outline the plan for review and to ask them if they had any particular questions that they would like to see the review address? Consider providing detail of the questions identified by the service user/relevant person(s) here.

Document the approach used and what information/material was considered e.g. documented reviewed (incident report, review of health records (medical case notes, nursing records, laboratory and radiological reports), site visits, use of written recollection of events from staff, interviews with staff (if any), duty rotas, PM/Coroner reports, equipment reports including serial number, relevant local or national PPPGs.

Outline that an analysis of this was conducted to identify the findings and the relevant systems analysis tools were used to identify any factors that contributed to the findings.

Outline that the outcome of this analysis has resulted in the identification of a number of recommendations to reduce the risk of recurrence. Make reference to the process used to ensure natural justice and fair procedures was guaranteed for all parties.

4.0 Persons involved in the conduct of the Review

Name and title of lead reviewer and others who assisted in the process, including any subject matter experts (if involved)

5.0 Background

Provide brief detail relating to the background of the service user and relevant detail of their care episode leading up to the incident e.g. the service user was an elderly person with a history of multiple admissions for treatment of chronic respiratory problems. S/He was admitted 5 days prior to the incident for ... and outline what happened.



6.0 High Level Chronology of Events

Though the Review Team will have developed a detailed chronology of events the inclusion of this within the report is not required as many chronologies are lengthy and serve to interrupt the flow of the report. Consider therefore outlining here a high level chronology which focuses on key events leading up to the event. The more detailed chronology may be held as part of the review file or included in an appendix to the report.

7.0 Aftermath of the incident

Outline what happened following identification of the incident and provide detail of the immediate management of the incident to include how persons affected (service user/relevant person(s)/staff) were cared for/supported, whether and when open disclosure occurred, what steps were taken to identify and address any immediate risks that may have affected others.

8.0 Analysis and Findings of the Review Team

To include:

*Statement(s) of Findings and the Factors that contributed to each of these (see **Systems Analysis Guidance (IMF Guidance Section 13)**)*

Incidental Findings (note anything that requires attention but which had no real impact on the event e.g. illegible/untimed records, procedures not followed)

Good/Notable Practice – Highlight any good practice identified e.g. good record keeping, the service's immediate response to the incident, the support for persons affected etc.

9.0 Review Outcome

Indicate which **ONE** of the following outcomes best applies and **delete all** others:

- Appropriate care and/or service – well planned and delivered, unavoidable outcome and no findings identified.
- Indirect system of care/service issues – no findings identified but Incidental Findings were identified i.e. improvement lessons can be learned but these were unlikely to have affected the outcome.
- Minor system of care/service issues – a different plan and/or delivery of care may have resulted in a different outcome, for example systemic factors were identified although there was uncertainty regarding the degree to which these impacted on the outcome.
- Major system of care/service issues – a different plan and/or delivery of care would, on the balance of probability, have been expected to result in a more favourable outcome, for example systemic factors were considered to have an adverse and causal influence on the outcome

10.0 Other issues raised by the service user/relevant person(s) not addressed by the systems analysis

Cross check to see the extent to which the questions posed by the service user/relevant person(s) at the outset have been covered in the report to this point and if the answers to some or all have not been explicitly covered provide detail here.

11.0 Recommendations

What is recommended to address the findings and contributory factors? **Guidance on Developing Recommendations (IMF Guidance Section 14)**

- 1.
- 2.
- 3.



12.0 Learning

Consideration should be given to the inclusion of learning from the review of the incident that may indicate an opportunity for service improvement with a potential for application in other services. This can act as a prompt for other services to ask the question; 'What controls (systems and processes) do we have in place to reduce the risk of a similar incident occurring here and how assured are we that these are effective?' **Guidance on Developing Recommendations** (IMF Guidance Section 14)

Appendix 1: Terms of Reference

<Include a copy of the terms of reference here>

Appendix 2: Definitions and Abbreviations used in the report

Definitions

<Enter definitions used in the report here>

Abbreviations

<Enter the abbreviations used in the report here>