

Patient Safety Case Conference Worksheet

Use this card to organize and document the Case Conference or M&M process.

What Happened?* (Brief notes or flow chart)

Why Did it Happen? (Circle relevant questions)

Information Systems

- Patient correctly identified?
- Documentation provides a clear picture?
- Training Issues? Communication issues?
- Level of automation appropriate?
- Other? _____

Equipment

- Displays & controls understandable?
- Equipment detects & displays problems?
- Standardized or several different models?
- Maintenance/upgrades up to date?
- Warnings/labels understandable?
- Other? _____

Environment

- Noise levels interferes with voices/alarms?
- Lighting adequate for tasks?
- Adequate air, water, surface temperature?
- Other? _____

Architecture

- Area adequate for people & equipment?
- Clutter or inadequate stowage?
- People flow adequate, optimal?
- Work areas, tools, etc. located correctly?
- Other? _____

Policies and Processes

- Audit/quality control for process?
- Do people work around official policy?
- Standardized process, or order set?
- Use of checklists or other tools?
- Other? _____

Safety Mechanisms

- Did anything stop or decrease harm?
- Equipment safety mechanisms functional?
- System designed to be fault tolerant?
- Other? _____

*Note

This is a Quality Improvement document. Do not include patient or healthcare provider identifiers!

Why Did it Happen?

(Root cause/contributing factor statements)

How to prevent it?

Standardize/Simplify

- * Standardize equipment
- * Standardize protocol
- * Remove unneeded step(s)

Automation/Computerization

- * Automatic calculations
- * Provide reminders
- * Assist decision making

Improve or New Devices

- * Better controls/displays
- * Better integration
- * More fault tolerant

Improve Architecture

- * Improve flow of personnel
- * Better lighting, noise, clutter
- * Better stowage, signage, etc.

Your Specific Solutions:

Evaluating Effectiveness

What outcome will be measured?

Date of measurement? _____