Themed Review (TV) template

What is this for?

A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g. individual datix incidents or previous investigations).

What may benefit a themed review?

Grouped incidents, for example from the same portfolio like pressure ulcers, falls or deteriorating patient, may benefit from a themed review because they take the same safety concern and identify different reference cases and contexts. This helps the organisation make sense of the safety concern at different points of the system and with different aspects of variability e.g. staffing issues, high volume of acute patients. This is important, because safety incidents may occur when systems are 'pushed' or 'pressurised' and therefore our view of safety needs to be flexible to the variability around the context.

What should the output of a themed review be?

Themed reviews may identify fallibilities of the components of a safety system. For example, it may be that across all the reference cases a risk assessment was completed but the preventative measures were not actioned. Outputs of themed reviews can highlight these problems and identify safety recommendations. Themed reviews may provoke more questions than answers, and therefore may be best placed to link in to a quality improvement project for ongoing monitoring and PDSA-style improvement cycles. A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and therefore doing a themed review should **always** result in some improvement efforts after this diagnosis.

What are the stages of a thematic review?

Stage 1: Description of the reference cases
Stage 2: Description of the safety system
Stage 3: Relevant context to each reference case and key problems
Stage 4: Common themes across the reference cases – narrative analysis
Stage 5: Safety recommendations and future work

Stage 1: Description of the reference cases

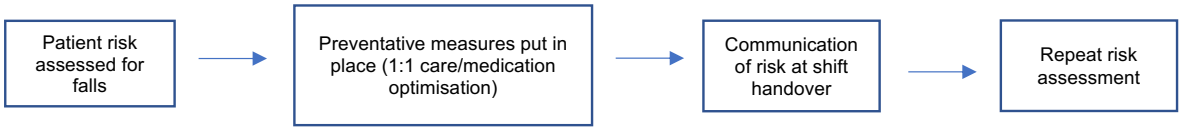
(In this stage, use the table below to list the reference cases using the headings. Remember, reference cases are the different incidents you are including in the themed review)

Date	Datix number	Harm	Description	Investigation level	Actions taken
Date of reference case	*Datix number for reference case*	*Harm level for reference case*	*Description of incident and findings of investigation (if applicable)*	*Level of investigation done (e.g. local investigation/RCA)*	*Actions taken as a result of individual incidents e.g. any recommendations/action plans from RCAs*

Stage 2: Description of safety system

(In this stage, describe the system of safety for the problem. That is, what safeguarding is in place to ensure patients' safety? This could be a list or a diagrammatic flow chart. Where there may be different systems in place (e.g. different processes for different locations or multiple safety risks), break them down in the box below.

E.g. A system of safety for falls below:



E.g. System of safety for deteriorating patient:

- Patient identified as being at risk of deterioration (clinical notes/observations)
- Clinical task of collecting observation data and calculating (NEWS2 score)
- Preventative/clinical measures put in place (e.g. increased observations/sepsis bundle)
- Senior review of deteriorating patient

System of safety for specific safety risk:

What is the difference between the incidents and the expected safety system? Use the template below to help identify across the different reference cases.

E.g. Safety barrier 1: Risk assessment for VTE

What is supposed to happen? *Risk assessment done within X hours*
What did happen? *Risk assessment delayed by Y hours*
Why did this happen? *Junior doctor not aware of need to do risk assessment before prescribing enoxaparin and is used to prescribing it for all patients. Limited time to do assessment before prescription given volume of patients in the ED department and pressure to reconcile medications*
What can we learn from this? Importance of risk assessments prior to prescription was not clear to this prescriber. Need to identify why this is. Tendency to prescribe enoxaparin as a departmental norm.

Safety barrier 1:

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Safety barrier 2:

What was supposed to happen	**What did happen**
Why was there a difference?	**What can we learn from this?**

Safety barrier 3:

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Safety barrier 4:

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Safety barrier 5:

What was supposed to happen?	**What did happen?**
Why was there a difference?	**What can we learn from this?**

Stage 3: Relevant context to each reference case and key problems

This stage refers to contributory factors (as classified by the contributory and mitigating factors classification here: https://www.england.nhs.uk/wp-content/uploads/2020/08/PSII_Contributory_and_Mitigation_Factors_Classification.pdf)

For each incident, mark down the external context factors, organisational and strategic, workplace, equipment, and task factors that affected the safety incident. All components that fall under each group can be seen below.

External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Operational management factors	Components
Safety focus	• Rule compliance • Dealing with risks from past incidents • Awareness of current practice • Adherence to current practice • Empowerment of staff to act
Work planning and delivery	• Risk management plans • Scheduling • Incentive schemes • Contingency planning
Staffing levels and skill mix	• Skill mix • Staff to patient ratio • Workload/weighting/dependency • Temporary staff • Staff turnover
Workload, shift patterns, hours of work	• Working hours • Work breaks • Workload (under/over/balanced) • Extraneous tasks • Social relaxation, rest and recuperation
Training design	• Training needs analysis • Training design • Training/education content • Targeted training • Style of delivery • Time of day provided
Training availability/accessibility	• Training availability/accessibility • Core skills training • On the job training • Emergency scenario training (skills drills) • Team training • Refresher training
Staff supervision	• Orientation • Personal supervision • Monitoring of supervision (assessment) • Mentorship
Staff competence	• Knowledge • Skill • Experience • Familiarity with task • Competence testing and assessment

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information Interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

Team and social factors	Components
Culture	• Approach to newcomers • Approach to adverse events • Approach to conflict • Approach to rules/regulations • Approach to seeking support • Approach to interprofessional challenge • Interpersonal relationships • Power relationships
Team structure and consistency	• Shared understanding • Familiarity • Mutual respect • Clarity of roles and responsibilities • Congruence of roles and responsibilities • Informal support networks
Leadership	• Clinical leadership • Managerial leadership • Leadership impact • Leadership decision-making • Timeliness of leadership action • Respect for leadership • Formal support networks for staff
Communication management	• Communication strategy and policy documents • Involvement of patient/family/carers in treatment and decisions • Communication of risks to patient/family/carers • Communication of risks to staff • Communication of risks to the board • Information from patient/family/carers • Communication flow to staff up, down and across • Communication with other agencies (partnership working) • Measuring effectiveness of communication
Verbal communication	• Tone of voice • Style of verbal communication delivery • Use of language • Specificity • Direction • Channel/route • Verbal communication aids/equipment
Written communication	• Readability • Accessibility/availability • Collated • Completeness • Contemporaneous • Accuracy • Currency • Circulation of written information • Patient identification • Information to patients
Non-verbal communication	• Body language/gestures/facial expression

Task factors	Components
Clinical condition	• Pre-existing co-morbidities • Complexity of condition • Seriousness of condition • Options available to treat condition
Plans, guidelines, policies, procedures and protocols	• Informative • Instructional • Representative • Routine use • Usability • Currency • Accuracy • Availability • Accessibility (ambiguous, complex, irrelevant, incorrect) • Monitoring • Review • Targeting/focus (ie audience)
Decision-making aids (information/results/ tools/machines, etc)	• Available • Accessible • Working • Accurate • For prioritisation of tasks • Access to specialist advice • Access to technical information, flow charts and diagrams
Procedural or task design and clarity	• Task complexity • Task memorability • Understandable • Agreed with staff (feasibility) • Time allocation • Task sequencing/stage sequencing • Workload (under/over/balanced) • Compatibility of tasks/task stages • Competing task demands • Feedback from the task • Transferability to/from other situations • Influence on task/outcome • Automation • Audit, quality control, quality assurance

Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

Mark the factors that affected each reference case based on the description above:

Causal Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES and STRENGTHS									
Incident numbers			1	2	3	4	5	6	7	8	9	10
CONTRIBUTORY and MITIGATING FACTORS Described as they relate to the **PROBLEMS/WEAKNESSES and STRENGTHS** identified (NB: There may be none, one or more CF/MF in each category)	**External Contextual Factors**	*National guidelines and policies*										
		Economic and regulatory context										
		Societal factors										
	Total											
	Organisational Strategic Factors	*Structure*										
		Priorities/resource										
		Safety culture										
		Policies, standards, and goals										
	Total											
	Operational Management Factors	*Safety focus*										
		Workplanning and delivering										
		Staffing levels and skill mix										
		Workload, shift pattern, hours of work										
		Training										
		Staff supervision										
		Staff competence										
	Total											
	Workplace Factors	*Environmement factors*										
		Design of physical environment										
		Administrative factors										
	Total											
	Equipment & Technology Factors	*Display*										
		Integrity and maintenance										
		Positioning and availability										

		Usability/design										
	Total											
	Team & Social Factors	*Culture*										
		Team structure and consistency										
		Leadership										
		Communication management										
		Verbal communication										
		Written communication										
		Non-verbal communication										
	Total											
	Task Factors	*Clinical condition*										
		Plans/policies/procedures in place for task										
		Decision making aids										
		Procedual or task design and clarity										
	Total											
	Individual Patient Factors	*Physical factors*										
		Social factors										
		Psychological factors										
	Total											
	Individual Staff Factors	*Physical health*										
		Psychological factors										
		Social/domestic factors										
		Personality factors										
		Social factors										
		Cognitive factors										
Incident numbers			**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Stage 4: Narrative analysis

Use the space below to compile narrative data surrounding the above sections. For example, if 2 or more incidents have a X by the group, then clarify the similarities/differences in the boxes below:

External Contextual Factors	*E.g., How did national guidelines affect the reference cases?*
Organisational Strategic Factors	*E.g., How did local guidelines/organisational resource affect the reference cases?*
Operational Management Factors	*E.g., How did local organisational level factorsl (e.g. staffing, skill mix, training, and staff supervision) affect the reference cases?*
Workplace Factors	*E.g., How did environment factors/design of workplace affect the reference cases?*
Equipment & Technology Factors	*E.g., How did equipment/technology affect the reference cases?*
Team & Social Factors	*E.g., How did local team dynamics/team culture/leadership/communication affect the reference cases?*
Task Factors	*E.g., How did task clarity/decision-making prompts affect the reference cases?*

Individual Patient Factors	*E.g. How did individual patient factors (e.g. acuity/clinical/psychological) affect the reference cases?*
Individual Staff Factors	*E.g. How did individual staff factors (e.g. social/psychological) affect the reference cases?*

Stage 5: Safety recommendations

In this section, linking to the sections above, list the safety recommendations based on this thematic review.

Different types of safety recommendations:

Category	Definition	Example
Fix	Resolve problems in reliably doing what we said we would do. These were usually issues that could be resolved with rapid operational changes.	Linear or more 'simple' things you can do to help the process. E.g., if you identify that there are conflicting local policies which meant a clinician was confused with the task, then the **fix** would be to resolve the confusion by rewriting the policy
Improvements	Find better ways of delivering standard care; improve what is currently being done.	Where improvement need to be made in an already defined process. This may be linked to a Quality Improvement (QI) project and should involve metrics to measure improvements.
Changes	Significant changes in clinical or operational practice.	Where a system, process, or pathway needs to change. N.b. this should be based on multiple cases of evidence, rather than being linked to one case. Where change is needed, an output may be a task and finish group, and this will involve multiple stakeholders.
Further insight	Where investigations have resulted in more questions relating to a safety issue, it may be appropriate for a safety recommendation to involve gaining more insight	If you do an investigation for a particular safety risk but are not sure of the scale of the problem or the mechanism of action then collecting further data may then help identify safety recommendations later.

Safety recommendation	**Category** (Fix/improvement/change/further insight)	**Date Due**	**Evidence**	**Owner**