# Critical Systems Analysis (CSA)

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# Critical Systems Analysis (CSA)

- Developed  due to recognised gap in critical analysis / thinking
- 2019 introduced, Late 2020 re-introduced
- CSA designed to enable aged care services to;
  - critically analyse serious incidents
  - understand causation, contributing factors and
  - Target and implement improvements to reduce future harm

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# Critical Systems Analysis (CSA)

- SIRS reporting commenced 1 April 2021
- The intent of SIRS;
  - strengthen aged care systems (Royal Commission & substandard care)
  - reduce risk
  - build skills to better understand causation of serious incidents
  - drive improvements and reduce recurrence.

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# Critical Systems Analysis (CSA)

- Co-designer
- The CSA tool designed using internationally recognised incident review methodologies
  - Root Cause Analysis (RCA), London Protocol (LP) and Human Error & Patient Safety (HEAPS) principles
- Typically RCA & LP applied in the acute healthcare setting for Sentinel events/reporting
- Aged care needed something less resource intensive, more user-friendly and applicable to both complex and lower level incidents

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# Critical Systems Analysis (CSA)

VALUE-ADD OF CSA;

- looks at 'what went wrong' but also '<u>what went right</u>'.
- Can assist providers improve their awareness of and response to serious incidents
- Demonstrate to Commission how the service manages serious incidents
- Improve staff education and training opportunities, and
- Use information gained to change processes/systems, apply open disclosure and provide a level of transparency needed in our industry

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# Critical Systems Analysis (CSA)

KEY ELEMENTS OF CSA;

1. What happened and associated timeline
2. Identification of contributing factors (consumer, staff, equipment, environment, documentation, communication, policy/procedure, coordination of care)
3. Identification of main issues / concerns
4. What improvements can be made?
5. How improvements will be measured?

# Critical Systems Analysis (CSA)

| Critical Systems Analysis (CSA) | | |
|---|---|---|
| Date of Event: | Date Review Commenced: | Date Review Completed: |
| Identification number allocated by facility: | | |

| Describe what happened |
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| Document a timeline of events leading up to and including the outcome | |
|---|---|
| Key Date / Time | Description of events |
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# Critical Systems Analysis (CSA)

| System Headings | Possible factors contributing to the problem | Positive outcomes identified during the review |
|---|---|---|
| **Consumer Assessment**<br>(covers initial assessment and ongoing monitoring of physical and mental state for evaluation of risk) | • | |
| **Consumer Factors**<br>(covers any other pre-existing morbidities that may cause the consumer to have a high risk of an adverse outcome) | • | |
| **Staff Factors**<br>(covers HR matters, including inadequacies of knowledge or skills to undertake required duties or to deal with a situation that might be expected to arise, includes training and education) | • | |
| **Equipment Factors**<br>(covers factors that relate to facility equipment including design or operating faults, maintenance or calibration deficiencies, or suitability for purpose for which the equipment is provided) | • | |
| **Work Environment**<br>(covers factors arising from any aspect of the environment in which the service is provided, including design and security, including management of external factors such as contracted services e.g. pathology, maintenance or IT) | • | • |
| **Information / Documentation**<br>(covers all factors relating to documentation of information about care, including medical records and ambiguous or illegible documentation) | • | • |
| **Communication**<br>(covers issues arising from lack of effective communication between staff, across disciplines, units or facilities, and between staff and consumers or their family, carer or advocate) | • | • |
| **Rules / Policies / Procedures**<br>(covers policies, procedure, work instructions and all other governance systems) | • | • |
| **Coordination**<br>(covers factors associated with coordination of consumer care arrangements, whether immediate e.g. transportation between sites, or longer term e.g. a coordinated care plan involving community based services) | • | • |

# Critical Systems Analysis (CSA)

| What were the main issues / concerns identified? |
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| What Improvements are required? | How will you measure these improvements? | Accountability | Timeframe |
| --- | --- | --- | --- |
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| Other lessons learnt | Accountability |
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# Critical Systems Analysis (CSA)

RESULTS

- Over the past six (6) months, eight (8) CSA's have been completed.
- CSA reviews explored themes/classifications around
  - unexpected death, unactioned clinical deterioration, fracture following a fall and infection outbreak management.
- Main contributing factors were identified as
  - Staff knowledge and education, followed by communication and information gaps.
- Improvements focused on
  - education and training for staff, Communication, collaboration with GP's and improved processes to identify and manage deterioration.

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# Critical Systems Analysis (CSA)

Summary

- The CSA approach has proven invaluable in unpacking serious incidents to;
  - Create a space for conversation and learning, change the narrative specific to harm in age care and find innovative solutions to issues that have been normalise.
- The outcomes provide a platform for case study education and application of open disclosure.
- Focus on systems and less on people
- My hope…
  - to make what seems Impossible (that is.. to do no harm) Possible