MEASURING HARM AND INFORMING QUALITY IMPROVEMENT LONGITUDINALLY IN THE WELSH NHS

HARM2

(CONFIDENTIAL: DO NOT FILE IN THE MEDICAL RECORD IF FOUND RETURN TO THE CLINICAL GOVERNANCE DEPARTMENT)

UNIQUE IDENTIFYER	
REVIEWERS ID	

SECTION 1: PATIENT INFORMATION AND DOCUMENTATION

PATIENT DETAILS			**DOCUMENTATION ASSESSMENT**	**PRESENT Y/N**		**Specialty at Time of Initial Ward Admission?**	**Please Tick**
Length of stay (DAYS)			Initial medical/surgical notes	Y/N		Older Peoples Medicine	
Age (Years)			Medical/surgical progress notes	Y/N		Rehabilitation	
Gender	M/F		Nursing documentation	Y/N		General Medicine inc Short Stay/Assessment	
Admission status	ACUTE / ELECTIVE		Procedure documentation	Y/N/NA		Medical Subspecialty if known	

Pt admitted from	
Dementia	Y/N
Mental Health diagnosis	Y/N
Learning Disability	Y/N

Laboratory or pathology results	Y/N/NA
Discharge summary	Y/N/NA
Other (give details)	

Psychiatry	
General Surgery including Assessment and Short Stay	
Surgical Subspecialty if known	
Other (give details)	

Does the Patient have any of the following co-morbidities?

Myocardial Infarction (history, not ECG changes only)	Y/N	Hemiplegia	Y/N
Congestive Heart Failure	Y/N	Moderate or Severe Renal Disease	Y/N
Peripheral Vascular Disease (includes aortic aneurysm >6cm)	Y/N	Diabetes with end-organ damage (retinopathy, neuropathy, nephropathy, or brittle diabetes)	Y/N
Cerebrovascular Disease: CVA with mild or no residua or TIA)	Y/N	Tumour without metastases (exclude if >5years from diagnosis)	Y/N
Dementia	Y/N	Leukaemia (acute or chronic)	Y/N
Chronic Pulmonary Disease	Y/N	Lymphoma	Y/N
Connective Tissue Disease	Y/N	Moderate or Severe Liver disease	Y/N
Peptic Ulcer Disease	Y/N	Metastatic Solid Tumour	Y/N
Mild Liver Disease (without portal hypertension, includes chronic hepatitis)	Y/N	AIDS (not just HIV)	Y/N
Diabetes without end-organ damage (excludes diet controlled alone)	Y/N	Other (give details)	

SECTION 2: HARM SCREENING ASSESSMENT

Criteria Number	Criteria	Criteria Present Y/N	Harm Present Y/N
1	Unplanned admission within 30 days prior to index admission as a result of any healthcare management		
2	Unplanned admission to any hospital within 30 days post this discharge		
3	Hospital-incurred accident or injury		
	a) Pressure ulcer		
	b) Fall		
	c) Equipment related accident of injury		
	d) Other not covered above		
4	Adverse drug reaction, side effect or drug error		
5	Unplanned transfer from general care to intensive care/higher dependency		
6	Unplanned transfer to another acute care hospital		
7	Unplanned return to theatre in this admission		
Criteria Number	**Criteria**	**Criteria Present Y/N**	**Harm Present Y/N**
8	Unplanned removal, injury or repair of organ or structure during surgery, invasive procedure or vaginal delivery		
9	Other patient complications to include MI, DVT, CVA		
10	Development of neurological deficit not present on admission		

11	Unexpected death or referral to coroner		
12	Inappropriate discharge home, inadequate discharge plan		
13	Cardiac, respiratory arrest		
14	**Hospital Acquired Infection**		
	a) Wound infection		
	b) Hospital Acquired Pneumonia		
	c) Sepsis		
	d) Other		
15	Patient/family dissatisfaction with care received documented in the medical record and or evidence of complaint lodged		
16	Delays in or cancellation of treatment		
17	Evidence of inappropriate decision making regarding the treatment or intervention the patient received		
18	Problems relating to communication		
19	Problems relating to documentation		
20	Missed, delayed or incorrect diagnosis		
21	Any other undesirable outcomes not covered by any other criteria		

DETERMINATION OF HARM EVENT/PROBLEM IN CARE

	Criteria Number	Harm/Problem in Care Category (See manual- Appendix 5 page 38)	**Severity Code**		Severity Codes E-I	
EVENT:1					E: Contributed or resulted in temporary harm to patient & required intervention	H: Required intervention to sustain life
EVENT:2					F: Contributed or resulted in temporary harm to patient and required initial or prolonged hospitalisation	I: Contributed to the patient's death
EVENT:3					G: Contributed or resulted in permanent patient harm	

CLINICAL SUMMARY

Please provide a brief overview clinical summary of the inpatient episode.

If a harm event has been identified please proceed to Section 3. If no harm events have been identified please go to section 5 to complete the review.

SECTION 3: ASSESSMENT OF HARM EVENTS

(To be completed for each separate harm identified)

3.1. Journey Stage

(Where did the problem/s in patient management that led to the harm event occur? Please tick as many as apply):

Journey Stage	Event 1	Event 2	Event 3
Before admission (GP, Outpatient clinic, previous admission)			
Early in admission (includes A&E department, admission ward and pre-operative assessment)			
Care during a procedure (including surgery and anaesthesia)			
Post-operative care or post-procedure/HDU or ITU care			
General ward care (after operation or after full assessment and commencement of medical care)			
End of admission assessment and discharge care			
Other			

3.2. Contributory Factors

(What factors do you feel contributed to the harm event? Please tick as many as apply):

Contributory Factors	Event 1	Event 2	Event 3
1. Patient characteristics			
1.1 Barriers to Communication (e.g. hearing impairment, stroke, language difficulties in absence of interpreter or cultural differences)			

1.2 Learning difficulties			
1.3 Social factors			
1.4 Smoker			
1.5 Alcohol			
1.6 Drug addiction			
1.7 Co-morbidity			
1.8 Other (specify)			
2. **Task factors**			
2.1 New, untested or difficult task or procedure			
2.2 Evidence of lack of guidelines/protocols or their use			
2.3 Test results unavailable, difficult to interpret or inaccurate			
2.4 Poor task design/structure			
2.5 Other task factors (specify)			
3. **Individual staff factors**			
3.1 Staff working outside their expertise			
3.2 Lack of knowledge of individuals			
3.3 Lack of skill of individuals			
3.4 Attitude/motivation problem			
3.5 Long shift/under pressure			
3.6 Other individual staff factors (specify)			

4. Team factors			
4.1 Poor teamwork			
4.2 Inadequate supervision			
4.3 Poor verbal communication			
4.4 Inadequate handover			
4.5 Poor written communication (e.g. defects in notes)			
4.6 Other team factors (specify)			
5. Work environment			
5.1 Defective or unavailable equipment			
5.2 Problems with provision or scheduling of services (e.g. theatre list, lab tests, x-rays)			
5.3 Inadequate functioning of hospital support services (e.g. pharmacy, blood bank, housekeeping)			
5.4 Inadequate staffing at the time of the harm event			
5.5 Out of hours (time of day/day of week) factors			
5.6 Other work environmental factors (specify)			
Hospital/ Trust factors			
6.1 Lack of essential resources (e.g. ITU beds)			
6.2 Poor co-ordination of overall services			
6.3 Inadequate senior leadership			
6.4 Other organisational/management factors (specify)			

Please highlight any other key factors contributing to the harm event or any organisational learning.

3.3 ASSESSMENT OF PREVENTABILITY

	AE 1	AE 2	AE 3
Is there some evidence that the harm event was preventable?	Y/N	Y/N	Y/N
If YES rate on a 6 point scale the strength of evidence for preventability (See manual, page 8 for scale)			

If the patient died during the admission please proceed to Section 4, otherwise please complete this form by going to Section 5 overleaf.

SECTION 4 (To be completed for deceased patients only)

	Please circle
Was the patient's death caused by a problem or problems in healthcare?	Y/N
Did a problem or problems in care contribute to the patient's death?	Y/N
If a problem in care contributed to the patient's death, is there some evidence that the patient's death was preventable?	Y/N
If YES rate on a 6 point scale the strength of evidence for preventability	1 2 3 4 5 6

SECTION 5 (To be completed for all patients)

Considering all that you know about this patient's admission, how would you rate the overall quality of healthcare received by this patient from this organisation?
Please enter a tick in the relevant box.

Excellent	
Good	
Adequate	
Poor	
Very Poor	