

PRISM 2 Review Form

- A. Date of the review:
- B. Reviewer Name (please print):
- C. Patient unique study number:

'Confidential patient information'

With grateful acknowledgement to Graham Neale, Maria Woloshynowych, Charles Vincent and Frances Healey whose iterations of the format over several research studies formed the basis of this document

ADMINISTRATIVE INFORMATION TO COMPLETE FOR ALL REVIEWED DEATHS

1. Age at death (years)
2. Sex M/F
3. Length of admission (no of days)
4. Month of admission
5. Day of admission (Monday to Sunday)
6. Time of patient's first arrival at hospital (A&E or elsewhere). Please circle.
 - a. Day (08:00-16:59)
 - b. Evening (17:00-21:59)
 - c. Night (22:00-07:59)

7. How many inpatient wards/units was the patient on during this admission?

8. Where was the patient admitted from? Please circle.
 - a. His or her own home
 - b. A nursing or residential care home
 - c. A hospital in another NHS trust
 - d. Other (specify)

9. Type of admission. Please circle
 - a. Emergency
 - b. Planned/elective
 - c. Other (specify)

PART A: Risk Factors

We ask for the following information on all patients who have died. This allows analysis of whether some groups of patients, or some types of wards and units, are disproportionately affected by potentially avoidable deaths, so improvement efforts can be focused there.

1. Did the patient have confusion/memory problems at any point in their hospital stay? Please circle.
 - a. No
 - b. Yes
2. If yes, was a diagnosis of the confusion/memory problems established? Please circle.
 - a. No diagnosis of type of confusion/memory problems apparent
 - b. Dementia alone
 - c. Delirium alone
 - d. Delirium superimposed on dementia
 - e. Other type of confusion/memory problems please specify

3. Did the patient have a significant mental illness (other than confusion/memory problems options above)? Please circle.
 - a. No indications of a significant mental illness
 - b. Clear indications of a significant mental illness
 - c. Some indications of a significant mental illness but records unclear

4. Did the patient have a learning disability? Please circle.
 - a. No indications of a learning disability
 - b. Clear indications of a learning disability
 - c. Some indications of a learning disability but records unclear

5. Did the patient have any of the following comorbidities? This list is based on the Charlson Index of Comorbidity. Other comorbidities can be entered in the last box.

Comorbidity	Yes	No
Myocardial infarct		
Congestive heart failure		
Peripheral vascular disease		
Cerebrovascular disease		
Hemiplegia		
Chronic lung disease		
Connective tissue disease		
Diabetes without end organ damage		
Diabetes with end organ damage		
Ulcer		
Chronic liver disease		
Moderate or severe liver disease		
Moderate or severe kidney disease		
Lymphoma		
Leukemia		
Non-malignant tumor		
Malignant tumor		
Metastasis		
AIDS		
Other		

6. Patient condition immediately prior to the illness that led to this admission. Please circle.
 - a. Fully independent
 - b. Independent in personal care, but needing help with other activities of daily living
 - c. Dependant on others for personal care (washing, dressing, eating, etc.)
 - d. Unable to determine; no relevant information in notes (direct or implied)

7. Was the patient initially assessed in A&E and/or any other short term emergency admission assessment unit? (e.g. Clinical Decision Unit, Medical or Surgical Assessment Unit, etc.). Please circle.

- a. Yes
- b. No
- c. Unable to determine

8. Speciality at time of first ward admission (the first ward/unit where the intention was for them to stay at least one night). Please circle.

- a. Older people's Medicine
- b. Rehabilitation
- c. General medicine (including medical assessment/short stay)
- d. Medical sub-specialities. Specify if can be determined:

- e. General Surgery (including surgical assessment/short stay)
- f. Surgical sub-specialities including gynaecology & orthopaedics. Specify if can be determined.

- g. Other. Specify

9. Was this an appropriate type of ward for their condition? Please circle.

- a. Yes, definitely appropriate
- b. Probably appropriate
- c. No
- d. Unable to determine

10. Speciality at time of death. Please circle.

- a. Older people's Medicine
- b. Rehabilitation
- c. General medicine (including medical assessment/short stay)
- d. Medical sub-specialities. Specify if can be determined:

- e. General Surgery (including surgical assessment/short stay)
- f. Surgical sub-specialities including gynaecology & orthopaedics. Specify if can be determined.

- g. Other. Specify

11. Was this an appropriate type of ward for their condition? Please circle.

- a. Yes, definitely appropriate
- b. Probably appropriate
- c. No
- d. Unable to determine

12. Apparent main diagnosis on admission:

Note you should record the patient's **apparent main diagnosis at the point their initial medical assessment/clerking was completed** (you will have an opportunity later in the form to note if you consider this diagnosis was incorrect). Please circle.

1. Trauma-related diagnoses
a. Fractured hip
b. Any other falls-related diagnosis
c. Trauma from other cause (not fall)
2. Cardiovascular diagnoses
a. Stroke
b. Acute coronary syndrome/STEMI/angina
c. Heart failure
d. Arrhythmia
e. DVT/PE
g. Any other cardiovascular condition
3. Infection (with or without sepsis)
a. Chest infection/pneumonia
b. Urinary tract infection
c. Bloodstream infection
d. Gastroenteritis
e. Any other diagnosis of infection
4. Cancer-related diagnosis
5. Acute abdomen
6. Gastrointestinal haemorrhage
7. Exacerbation of Chronic Obstructive Pulmonary Disease
8. Any other diagnosis please specify.....

We recognise the list above is not comprehensive, but it represents the diagnoses most commonly seen in patients who died in hospital in the PRISM 1 study, and will be built on in future phases.

PART B: DECISION TO PROCEED TO DETAILED REVIEW **Clinical reviewer completes for all reviewed deaths**

Before answering the following questions, ensure you have reviewed all available documentation related to the admission in which the patient died, including:

- all inpatient documentation related to the admission in which the patient died, including medical, nursing and therapy records
- any GP referral letters, ambulance summary, A&E summary, etc. related to the admission in which the patient died

Determination of problem in healthcare

13. A problem in healthcare is defined as ‘any point where the patient’s healthcare fell below an acceptable standard and led to harm’. Considering all that you know about this patient’s admission, were there any problems in healthcare (including any problems before admission)? Please circle.

- a. No evidence of any problems in healthcare ⇒ please go straight to Part D
- b. Some evidence of problem/s in healthcare ⇒ please complete the next question

14. In your judgement, is there some evidence that the patient’s death was avoidable if the problem/s in healthcare had not occurred? Please circle.

- a. No, death was definitely not avoidable ⇒ please go straight to Part D
- b. At least slight evidence the death may have been avoidable ⇒ please complete Part C and then Part D

PART C: DETAILED REVIEW OF PROBLEMS IN HEALTHCARE

Clinical reviewers complete this section ONLY if you have answered Question 14 as “At least slight evidence the death may have been avoidable.”

Please summarise in chronological order the background, admission, procedures, and events leading up to the patient’s death and cause of death, including any points where there were problems in healthcare. You will have an opportunity to be more specific about these problems in healthcare and justify your judgements later in the review form.

15. Please complete the following table using the laminated category list that accompanies this review form.

- **A problem in healthcare is defined as ‘any point where the patient’s healthcare fell below an acceptable standard and led to harm’.** To identify the **problems in healthcare**, consider what an acceptable standard of healthcare would be for this patient, and articulate how the healthcare they received fell below this acceptable standard (whether through omission, delay or incorrect actions). Include any problems in healthcare that occurred before the patient’s final admission but were identified during it. **Only one problem should be entered per row.**
- It can be difficult to identify **contributory factors** (i.e. the underlying reasons **why** the problem in healthcare occurred) from case notes alone. If you can clearly identify any factors that contributed to each problem in healthcare please do so, but avoid making assumptions. **Contributory factor should refer to the problem described in the same row.**

Describe each problem in care in your own words. Please articulate what should have happened AND what did happen.	Where did the problem occur?	Sub-type of problem (select one)	Contributory factors (option to select none, one or multiple)
<i>Example: “First dose of IV penicillin should have been given immediately but was not given until three hours after prescribed”</i>	D	B6	c g

Describe each problem in care in your own words. Please articulate what should have happened AND what did happen.	Where did the problem occur?	Sub-type of problem <i>(select one)</i>	Contributory factors <i>(option to select none, one or multiple)</i>

16. Earlier in the case note review, you made a judgement that there was at least slight evidence that death may have been avoidable if the problem/s in healthcare had not occurred. Considering the problems in healthcare you have described above, please rate on the Likert scale the strength of evidence for the avoidability of the death:

- 2 Slight evidence for avoidability
- 3 Possibly avoidable but not very likely, less than 50-50 but close call
- 4 Probably avoidable, more than 50-50 but close call
- 5 Strong evidence for avoidability
- 6 Definitely avoidable

Please record reasons justifying the judgement you have made

- 17. Earlier in the case note review, you made a judgement that there was at least slight evidence that death may have been avoidable if the problem/s in healthcare had not occurred. Considering the problems in healthcare you have described above, please mark on this continuous scale the strength of evidence for the avoidability of the death. Mark with a single line through the scale.**

We appreciate this is an even more difficult judgement call than the decision you made above on Likert Scale (slight/possible/probable/strong evidence for avoidability), but providing your judgement on a continuous scale allows additional analysis.

Death
definitely
not avoidable

Death
definitely
avoidable

- 18. If death was considered avoidable had the problem/s in healthcare had not occurred, by how many days/months/years do you estimate the patient's life was shortened? Please circle.**
- a. By one week or less
 - b. By more than a week but less than a month
 - c. By more than a month but less than three months
 - d. By more than three months but less than a year
 - e. Byyears

We appreciate this is difficult judgement call, but even estimates are helpful in prioritising future improvement efforts. In arriving at an estimate, you may wish to consider expected prognosis for a patient presenting with this condition and comorbidities who received an acceptable standard of healthcare, and/or average life expectancy alongside consideration of whether the patient had better or worse general health and capacity to recover than average.

- 19. If death was considered avoidable had the problem/s in healthcare not occurred, please indicate when you believe the BEST opportunity of avoiding the death occurred:**
- a. Outside hospital care (primary care, ambulance, etc.)
 - b. In a prior admission/attendance (this trust)
 - c. In a prior admission/attendance (another secondary healthcare provider)
 - d. In an initial assessment unit (e.g. A&E department, or any other short term emergency assessment unit such as a Clinical Decision Unit, Medical Assessment Unit, Surgical Assessment Unit, etc.)
 - e. During an invasive procedure (including surgery and anaesthesia)
 - f. During post-operative care or post-procedure care (except HDU/ITU)

- g. During High Dependency or ITU care (not including decision to refer to HDU/ITU)
- h. During inpatient care on a ward/unit designated as:
 - i. Older people's Medicine
 - ii. Rehabilitation
 - iii. General medicine
 - iv. Medical sub-specialities
 - v. General Surgery
 - vi. Surgical sub-specialities including gynaecology & orthopaedics
 - vii. Other (specify)

20. Avoiding future deaths

Although case note review in isolation cannot be a substitute for a full root cause analysis investigation, please indicate any specific improvements you believe might decrease the likelihood of similar deaths occurring in future. Areas you might consider are better design of equipment or procedures, interventions to limit human error or organisational changes.

PART D: GENERAL QUALITY OF CARE AND END OF LIFE CARE

Compete for ALL reviewed deaths

Overall Quality of Care

21. Considering all that you know about this patient's admission, how would you rate the OVERALL quality of healthcare received by the patient from this trust? This question recognises that a problem in care causing patient harm can occur against a backdrop of overall good quality care, and the converse, a patient may experience poor overall quality of care without obvious harm. For this question, do not consider healthcare prior to the admission that ended in the patient's death or give detail of a specific problem in care causing harm, which were entered in Part C.

- a. Excellent
- b. Good
- c. Adequate
- d. Poor
- e. Very poor

Please add any detail on overall quality of healthcare that can be used for learning (positive or negative):

End of Life Care

Questions 22 and 23 focus on care EITHER from the point where the patient was recognised at high risk of dying (whether this was days or hours before death) OR, for patients who were not recognised as at high risk of dying, the last 48 hours of their life

- 22.** Was the patient subject to any intrusive or invasive procedures that were **not** in their best interests at the end of life (including inappropriate attempts at CPR)?
- a. Yes
 - b. No
 - c. Unable to determine
- 23.** Was there evidence of discussion of end of life care with family/friends? Please circle.
- a. Yes, evidence of discussion
 - b. No, discussion appeared appropriate and feasible, but no evidence it took place
 - c. Not appropriate/not feasible to discuss with family/friends

Please add any detail on overall quality of end of life healthcare that can be used for learning (positive or negative) including pain and symptom control:

PART E: REVIEW PROCESS INFORMATION

Complete for ALL reviewed deaths

24. Were your judgements limited or hampered by lack of subspecialty knowledge?

- a. No
- b. Yes

25. If so was a second specialist opinion sought?

- a. No
- b. Yes

26. What was your question/s for the specialist?

27. What was the answer/s from the specialist?

28. Did the answer/s change your opinion and how?

29. How adequate were the records in providing information to enable judgements of problems in care? Please circle.

- a. Medical records were adequate to make a reasonable judgement
- b. Some deficiencies in the records (specify)
- c. Major deficiencies (specify)
- d. Severe deficiencies, impossible to make judgements about problems in care

Please use this space to specify any deficiencies in the medical record

30. Total time taken to complete review (minutes)?