

## Appendix B. CASE REPORT FORM used by reviewers for medical record review

Date medical record review (dd-mm-yyyy)

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Name reviewer

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### 1. SUMMARY OF PATIENT

Give a short summary of the patient in this medical record .

Example: A 75-year old male with an extensive medical history and polypharmacy is admitted to hospital with a myocardial infarction. After discharge, he is checked at the outpatient clinic.  
Example 2: A 69-year old female is referred to the gastroenterologist with rectal bleeding. She is diagnosed with haemorrhoids and treated accordingly.


### 2. TRANSITIONAL MEDICAL RECORD REVIEW

**Definition of a transitional safety incident:** Any unintended or unexpected event in patient care between different healthcare organisations which could have led or did lead to harm for one or more patients receiving care. In the TIPP study, we chose to focus on transitional incidents between primary care and hospital instead of all levels of care. If an unintentional event occurs in primary care and the results of the incident are noticed in the hospital or vice versa, this also counts as a transitional safety incident.

In this medical record, we use a broad definition of “incident”. The following incidents are included:

- **Adverse event:** Any injury caused by medical care.
- **Near miss:** An act of commission or omission that could have harmed the patient but did not do so as a result of chance, prevention or mitigation.<sup>1</sup>
- **Unsafe situation:** Circumstances or events occurred that had the capacity to cause error.<sup>2</sup>

#### 2a) IDENTIFICATION OF THE TRANSITIONAL SAFETY INCIDENT

<sup>(1)</sup> Aspden P, Corrigan JM, Wolcott J, Erickson SM, editors for the Committee for Data Standards for Patient Safety, Institute of Medicine. Washington, D.C.: The National Academic Press; 2004.

<sup>(2)</sup> National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). Medication Errors Council revises and expands index for categorizing errors. Definitions of medication errors broadened [Internet]. June 12, 2001. Available from: <http://www.nccmerp.org/press/press2001-06-12.html>.

**Check the following transitions and risks for TSIs. Did something go wrong in one of the following processes?**

- Information from GP to hospital (referral information).** This information can be delayed, incomplete or incorrect. Even if this information is present in hospital, it can be ignored or missing. Pay attention, in this pilot the referral letters cannot be found in the medical record.
- Information from hospital to GP (discharge letters, letters from the outpatient clinic).** This information can be delayed, incomplete or incorrect. Even if this information is present at the GP, it can be ignored or missing.
- Diagnostic research.** Diagnostic research can be performed twice (by GP and hospital) within a short period, or cannot be performed. Also, the incorrect diagnostic research can be performed.
- Medication or other prescription (e.g. wound care, stoma care, material for incontinence)**
- Most responsible physician.** The most responsible physician should be appointed to every patient; sometimes this is not done, or there is obscurity in who is the most responsible physician.
- Communication and collaboration.** This comprises of all communication or collaboration, except communication by mail (discharge letters, referral letters and letters from the outpatient clinic).
- Triage**
- Diagnosis**
- Self-care advise**
- Accessibility**
- Care in out-of-office hours**
- Discharge from the outpatient clinic.**
- Discharge after hospital admission.** Concerning the discharge process, excluding the discharge letter.
- Referral to outpatient clinic.** Concerning the referral process itself, excluding the referral letter.
- Referral to the emergency department.**
- Record keeping in medical record**
- Other, namely.....**

**Have you identified a transitional safety incident?**

- Yes
- Possibly
- No

**You need to fill in part 3 and 4 for every individual transitional safety incident you have identified.**

### **3 THE TRANSITIONAL SAFETY INCIDENT**

**Summarize the TSI**

Example 1: A week after discharge a patient visits his GP, who has not received a discharge letter yet.

Example 2: A patient is known with heart failure and uses diuretic medication (Bumetanide) prescribed by the cardiologist. Because of swollen ankles, the GP prescribes Furosemide (another diuretic medicine) because he is ignorant of the use of Bumetanide. Three months later the nurse at the heart failure outpatient clinic discovers the double medication.

### 3a) TIMING OF THE TRANSITIONAL SAFETY INCIDENT

#### Timing of TSI:

- At referral
- During hospital admission
- At or after discharge
- At/ after visit to the outpatient clinic
- At/ after visit to the GP

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#### In which part of the healthcare process the TSI occurred?

- Information from GP to hospital (referral information)
  - No referral information received
  - Delayed
  - Incomplete
  - Incorrect
  - Present, but ignored at the hospital
  
- Information from hospital to GP (discharge letters, letters from the outpatient clinic)
  - No information received
  - Delayed
  - Incomplete
  - Incorrect
  - Present, but ignored at the GP
  
- Diagnostic research
  - Not performed
  - Doubly performed at GP and hospital
  - Wrong diagnostic test

- Medication or other prescription (e.g. wound care, stoma care, material for incontinence)
  - Absent
  - Double medication
  - Incorrect
  
- Most responsible physician
  - Obscurity
  - None appointed
  
- Communication and collaboration
- Triage
- Diagnosis
- Self-care advice
- Accessibility
- Out-of-office hours
- Discharge from the outpatient clinic
- Discharge after hospital admission
- Referral to the outpatient clinic
- Referral to hospital (either admittance or emergency department)
- Record keeping in medical record
- Other, namely.....

**During which shift did the TSI occur?**

- Day shift (8:00 – 17:00 mon-fri)
- Evening shift (17:00 – 23:00 mon-fri)
- Night shift (23:00 – 8:00 mon-fri)
- Weekend day shift (8:00 – 17:00 sat-sun)
- Weekend evening shift (17:00 – 23:00 sat-sun)
- Weekend night shift (23:00 – 8:00 sat-sun)

**3b PREVENTABILITY OF THE TRANSITIONAL INCIDENT**

**What factors contributed to the TSI?**

- Out-of-office service
- Time constraints
- Complex patient
- Language barrier
- Emergency
- Known complication
- Referral within hospital
- Multiple departments involved within the hospital
- Multiple hospitals involved
- Multiple GPs involved
- Other, namely.....

**Was the TSI (potentially) preventable?**

- (Nearly) no evidence for preventability
- Slight evidence for preventability
- Possibly preventable but not very likely, less than 50-50 but close call
- Probably preventable, more than 50-50 but close call
- Strong evidence for preventability
- (Definitely) evidence for preventability

*Did you answer “Probably preventable, more than 50-50 but close call”, “Strong evidence for preventability” or “(definitely) evidence for preventability”, please answer the following question:*

**Describe how the TSI could have been prevented:**

**3c SEVERITY OF THE TRANSITIONAL INCIDENT**

**What was the severity if the TSI?**

**Did the TSI cause hospital admission or lengthening of hospital stay?**

- No
- Yes: hospital admission
- Yes: readmission
- Yes, lengthening of hospital stay of ..... days
- Not possible to assess

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**What harm did the TSI cause the patient?**

- A Unsafe situation: “Circumstances or events occurred that had the capacity to cause error”
- B Near miss: “Error occurred but did not reach the patient”
- C Near miss: “Error occurred that reached the patient but did not cause patient harm”
- D Near miss: “Error occurred that reached the patient and required monitoring to preclude harm or confirm that it caused no harm”, namely.....
- E Adverse event: “Error occurred that may have contributed to or resulted in temporary (mental or physical) harm or prolonged suffering from curable symptoms and required intervention”, namely.....
- F Adverse event: “Error occurred that may have contributed to or resulted in (mental or physical) harm and required an initial or prolonged hospital stay”, namely.....
- G Adverse event: “Error occurred that contributed to or resulted in permanent patient harm”, namely.....
- H Adverse event: “Error occurred that required intervention to sustain patient’s life”, namely.....
- I Adverse event: “Error occurred that may have contributed to or resulted in patient death”

**Can the health status of the patient return to his/her health status before the TSI?**

**Daily activities**

- Yes
- No
- Patient is deceased
- Not applicable

**Independence**

- Yes
- No
- Patient is deceased
- Not applicable

**3d) CAUSE OF THE TRANSITIONAL INCIDENT**

**Can you identify a possible cause for the TSI?**

- No
- Yes, namely.....
- Technical factors—equipment, software, forms
- Organizational factors—policies, procedures, and protocols
- Human factors—knowledge-based (familiar procedures applied to frequent decision-making situations), rule-based (routine tasks requiring little conscious effort), and skill-based (problem solving activities often in new situations)
- Patient related: Failures related to patient characteristics or conditions, which are beyond the control of staff and influence treatment.
- Other, not possible to classify further in the categories mentioned above, namely
- Not possible to identify a probable cause because of missing data

**4 CONSULTATION OF AN EXPERT/ SPECIALIST**

**Do you wish an expert opinion in this case?**

- Yes
- No

**What medical specialty:**

- Gastroenterology
- Cardiology
- General practitioner

**Question to the expert**

**Answer specialist:**

**Has the reviewer's opinion changed?**

- Yes, namely.....
- No

**Are there any other doubts in answering CRF? These doubts will be addressed in the reviewers' group meetings**

- Yes, about question.....
- No

If you answered yes, what is the obscurity or doubt?

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**Are there any other TSIs you have not addressed yet in the CRF?**

- Yes -> a new TSI CRF (part 3 and 4) opens
- No -> go to part 5

**5 MEDICAL RECORD QUALITY**

**Medical record of the GP**

	Poor	Moderate	Adequate	Good	Not applicable
Medical history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resuscitation code	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult registration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnostics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Correspondence/ handoff from hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, namely...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**What is the overall quality of the GP's medical record?**

- Poor
- Moderate
- Adequate
- Good

Did you answer “poor” or “moderate”? Was the medical record:

- Incomplete, namely .....(What part; please describe in short)
- Inadequate, namely .....(What part; please describe in short)
- Poor, namely .....(What part; please describe in short)
- Other, namely .....(What part; please describe in short)

**Did you have enough information to assess the TSI?**

- Yes
- Partly, namely ..... (What part of the medical record did you miss end for which review question?)
- No, namely..... (What part of the medical record did you miss end for which review question?)

**Hospital medical record**

	Poor	Moderate	Adequate	Good	Not applicable
Medical history	○	○	○	○	
Medication	○	○	○	○	
Resuscitation code	○	○	○	○	
Allergies	○	○	○	○	○
Consult registration	○	○	○	○	○
Diagnostics	○	○	○	○	○
Admission registration	○	○	○	○	○
Nurses report	○	○	○	○	○
Inter-collegial consultations within the hospital	○	○	○	○	○
Correspondence to GP (e.g. discharge letter or letter from out-patient clinic)	○	○	○	○	○
Other, namely....	○	○	○	○	○

**What was the overall quality of the hospital medical record?**

- Poor
- Moderate
- Adequate
- Good



**Did you answer “poor” or “moderate”? Was the medical record:**

- Incomplete, namely .....(What part; please describe in short)
- Inadequate, namely .....(What part; please describe in short)
- Poor, namely .....(What part; please describe in short)
- Other, namely .....(What part; please describe in short)

**Is the correspondence between hospital and GP in any way inadequate?** E.g. Is important information missing in the referral letter, such as relevant history of medical treatment? Or is important information missing in hospital correspondence to the GP, like further planned medical policy?

- Yes
- No
- Too little information in medical record, correspondence was missing

**Did you answer yes: What correspondence was inadequate?** (type, location in the medical record and date)

**Direction of the correspondence:**

- GP to hospital
- Hospital to GP
- Other, namely...

**What information was missing?**

**Did you have enough information to assess the TSI?**

- Yes
- Partly, namely.....(what did you miss and what part of the review did it affect?)
- No, namely.....(what did you miss and what part of the review did it affect?)

**Do you have other observations regarding the medical record (of either the GP or the hospital)?**

- Yes, namely.....
- No