CONFIDENTIAL

NURSE REVIEW FORM (RF1)

MEDICAL RECORD No. ☐☐☐☐☐☐

PATIENT NAME:_____
(Surname) *(Given Names)*

DIRECTIONS:

1. ***For all criteria refer to definitions in RF1 Manual.***

2. ***For all criteria enter the appropriate number in the box.***

3. ***Please print or write response legibly in <u>BLUE</u> pen. <u>RED</u> for corrections or deletions.***

4. ***This page to be <u>removed and destroyed</u> by team leader <u>ONLY</u> after all review elements are completed and prior to removal of review forms from the hospital.***

DO NOT FILE IN THE MEDICAL RECORD

Reviewer ID Number: ☐☐☐

Case Number: ☐☐☐☐☐☐☐

Country code: ☐☐ **Hospital code:** ☐☐

Age: ☐☐☐ **Discharge Status:** ☐

Sex: ☐

1= Home
2= Death
3= Transfer to other hospital
4= Nursing home
5= Community care by family
6= Rehabilitation facility
7= Other_____

Date of Admission: ☐☐☐☐☐☐ *D D M M Y Y*

Date of Discharge: ☐☐☐☐☐☐ *D D M M Y Y*

Date of review: ☐☐☐☐☐☐ **D D M M Y Y**

Time Commenced Review: ☐☐☐☐
(Use 24 hour clock)

Time Review Finished: ☐☐☐☐

Total time spent reviewing in minutes:
(Do not include interruption time off) ☐☐☐☐

Brief clinical summary:

Please indicate below which elements of the medical record were available for review:

1=Yes
2=No
3=N/A

1. **Initial medical assessment:** ☐
2. **Medical progress notes:** ☐
3. **Nursing progress notes:** ☐
4. **Procedure documentation:** ☐
5. **Pathology reports:** ☐
6. **Discharge summary:** ☐
7. **Other (give details):**_____

Was a management plan written on admission ☐ **Yes** ☐ **No**

Is the medical record documentation adequate to support questionnaire: ☐ **Yes**

☐ **No** (***then STOP)***

Demographics:

Diagnosis on admission_____

Name of principal procedure/Operation_____
_____

Was this patient on any regular medication prior to the admission? ☐ **Yes** ☐ **No**

Is there evidence of this patient being HIV positive? ☐ **Yes** ☐ **No**

Is there evidence of this patient having tuberculosis ☐ **Yes** ☐ **No**

Is there evidence of this patient having malaria ☐ **Yes** ☐ **No**

CO-MORBIDITIES

Please tick all of the following co-morbidities that apply to this patient

- ☐ **No co-morbidities**
- ☐ **Not known**

Cardio-vascular

- ☐ **Coronary artery disease**
- ☐ **Peripheral vascular disease**
- ☐ **Cardiac insufficiency or dysrhythmia**
- ☐ **Hypertension**
- ☐ **Other**

Respiratory

- ☐ **Asthma/COPD**
- ☐ **Other serious lung problem (e.g. severe Tuberculous scarring, pneumonectomy) (Specify)_____**

Gastro-intestinal

- ☐ **Chronic or recurrent dyspepsia**
- ☐ **Inflammatory bowel disease Chron's/colitis**
- ☐ **Chronic liver disorder**
- ☐ **Chronic diarrhoea**
- ☐ **Other**

Endocrine

- ☐ **Diabetes**
- ☐ **Other Endocrine disorder (e.g. thyroid, adrenal) (Specify)_____**

Neurological

- ☐ **Epilepsy**
- ☐ **Stroke**
- ☐ **Parkinson's**
- ☐ **Dementia**
- ☐ **Other serious neurological disorders (e.g. MS,MND) (Specify)_____**

Renal

- ☐ **Chronic renal disease**
- ☐ **Other renal diaease**

Haematological

- ☐ **Anaemia**
- ☐ **Malaria**
- ☐ **Haematological cancer**
- ☐ **Other (Specify)_____**

Existing cancer

- ☐ **Specify_____**

Disability

- ☐ **Wheel chair bound**
- ☐ **Blind**
- ☐ **Deaf**
- ☐ **Learning difficulty**
- ☐ **Other (Specify)_____**

Psychiatry

- ☐ **Schizophrenia**
- ☐ **Affective disorder**
- ☐ **Other (Specify)_____**

Psychosocial

- ☐ **Alcoholism**
- ☐ **Drug abuse**
- ☐ **Smoker**
- ☐ **Homeless**
- ☐ **Other (Specify)_____**

Infection

- ☐ **HIV/AIDS**
- ☐ **Chronic infection (e.g. Hep C MRSA) Specify_____**

Nutritional status

- ☐ **Obese**
- ☐ **undernourished**
- ☐ **Other (Specify)_____**

Other co-morbidity

- ☐ **(Specify)_____**

Allergies

- ☐ **(Specify)_____**

CRITERIA

Please indicate for all of the below if the criteria are fulfilled and if so give details.

1. **Unplanned admission (including readmission)as a result of any health care management within 12 months.** ☐ **Yes** ☐ **No**

2. **Unplanned admission to any hospital, post this discharge.** ☐ **Yes** ☐ **No**

3. **Hospital-incurred patient accident or injury.** ☐ **Yes** ☐ **No**

4. **Adverse drug reaction.** ☐ **Yes** ☐ **No**

5. **Unplanned transfer from general care to intensive care/ higher dependency.** ☐ **Yes** ☐ **No**

6. **Unplanned transfer to another acute care hospital.** ☐ **Yes** ☐ **No**

7. Unplanned return to the operating room on the admission. ☐ **Yes** ☐ **No**

8. Unplanned removal, injury or repair of organ or structure during surgery, invasive procedure or vaginal delivery. ☐ **Yes** ☐ **No**

9. Other patient complications to include: AMI, CVA, PE etc. ☐ **Yes** ☐ **No**

10. Development of neurological deficit not present on admission ☐ **Yes** ☐ **No**

11. Unexpected death (i.e. not an expected outcome of disease during this hospitalisation). ☐ **1=Yes** ☐ **No**

12. Inappropriate discharge. ☐ **1=Yes** ☐ **No**

13. Cardiac/respiratory arrest, low Apgar score. ☐ **Yes** ☐ **No**

14. Injury or complications related to abortion or labour and delivery including neonatal complications. ☐ **Yes** ☐ **No**

15. Hospital acquired infection/sepsis. ☐ **Yes** ☐ **No**

16. Patient/family dissatisfaction with care received documented in the medical record and/or evidence of complaint lodged. ☐ **Yes** ☐ **No**

17. Documentation or correspondence indicating litigation, either contemplated or actual (e.g. letter from solicitor etc.) ☐ **Yes** ☐ **No**

18. Any other undesirable outcomes (not covered by any other criteria.) ☐ **Yes** ☐ **No**

Criteria Present: ☐ **Yes** ☐ **No**

ADVERSE EVENT DETERMINATION:

Did the patient sustain an unintended injury resulting in temporary Or permanent disability and/or prolonged length of stay as a Consequence of health care management? ☐ **YES** ☐ **NO**