1. **HES DATA EXTRACTED BY PROJECT TEAM BEFORE CASE RECORD REVIEW (not made available to reviewers)**	
Sex M/F	
Age at hospital admission	
Date and Time of patient's first arrival at hospital (ED or other primary receiving ward).	
Duration of stay in ED (interval between arrival at hospital and time of admission, hrs & mins)	
Time, date and day of admission	
Length of hospital stay (days)	
Primary admitting diagnosis	
Comorbid disease (Charlson)	
Hospital Outcome: death or survival	

2. CLINICAL DATA EXTRACTED BY CASE RECORD REVIEWER (independently for duplicate reviews)	
1. **PRE-ADMISSION PHASE INCLUDING EMERGENCY DEPARTMENT**	
Source of admission: • Own home • Nursing or residential care home • Another hospital • No fixed abode • No information available	
Patient condition immediately before the illness that led to this admission. • Independent • Needing help with some activities of daily living (ADLs) • Dependant on others for most/all ADLs including personal hygiene • Unable to determine; no relevant information in notes	
Referral mechanism: • Self-presentation to ED (walk-in/own transport) • 999/ambulance transfer to ED • GP or deputising service referral • Unable to determine	
Admission pathway: Was the patient initially assessed in ED or any other short term emergency pre-admission assessment unit (e.g. Clinical Decision Unit, Ambulatory care, Medical or Surgical Assessment Unit, etc.), or was the patient admitted directly to an acute ward (AMU, general or specialty ward)? • ED/pre-admission area • Direct admission to acute ward • Unable to determine	
2. **POST-ADMISSION PHASE**	
Location immediately following admission:	

• Clinical Decision Unit or short stay ward • Acute Medical Unit [AMU/MAU (medical assessment unit)] • General medical ward • Medical sub-specialities including high care (eg: Coronary Care Unit, Renal Unit, Respiratory, Haematology, Oncology) • Older People's Medicine/Elderly Care Unit • Rehabilitation • Critical Care Unit / Intensive Care Unit (including High Dependency) • General Surgery (including surgical assessment/operating theatre) • Other (please specify): • Unable to determine ward type	
Was this an appropriate type of ward for the patient's condition? • Yes, definitely appropriate • Probably appropriate • No • Unable to determine	
Were vital signs recorded for calculation of a National Early Warning Score in the first 12 hours following admission? • Yes, full vital signs and a NEWS recorded • Full vital signs, but NEWS not documented • Some vital signs not documented, no NEWS • No evidence of vital signs or NEWS	
Initial Consultant Review in the first 24 hours following admission: • Consultant review documented [REVIEWER TO RECORD TIME AND DATE] • Probable consultant review but status of doctor uncertain [REVIEWER TO RECORD TIME AND DATE] • Consultant review, time not documented, but case record suggests < 14 hrs after admission • Consultant review, time not documented, but case record suggests > 14 hrs after admission • Unlikely that consultant review occurred during first 24 hours • No evidence for consultant review in first 24 hours	

Palliative and end-of-life care (within first 7 days): were discussions held or decisions made to limit treatment, forego resuscitation (DNACPR), or refer to palliative care?
• No: not required, patient appropriately for full treatment
• No, but would probably have been appropriate to consider some form of treatment limitation
• No, but would definitely have been appropriate to limit treatment.
• Yes: time and date of discussion or decision to limit treatment
  ○ Yes, appropriate decision
  ○ Yes, but patient might have benefited from escalation
  ○ Yes, but likely inappropriate decision, patient should have been considered for full escalation	

• If referral to palliative care, time and date referral made:	
Admission avoidance: Could admission to hospital have been avoided given optimal care in the community (eg: primary care, Hospital at Home, palliative care etc)? • Yes • Possibly • No	
Free Text Comments: Anything else you want to mention about this case?	
3. ASSESSMENT OF CARE QUALITY	
Errors in care: Does the case record contain evidence of one or more errors in care defined as '*the failure of a planned action to be completed as intended or use of a wrong, inappropriate, or incorrect plan to achieve an aim*' (This may include events identified above). If Yes, please complete next table, errors in healthcare: • Description of event • Where did the event occur? • When did the event occur? • Category of event • Associated with adverse event? • If yes, grade preventability	
Proceed to next table, errors in care	

CLASSIFICATIONS OF ERRORS, ADVERSE EVENT PREVENTABILITY AND GLOBAL QUALITY OF CARE

1.1 Location Of Error: Where did the error occur?
A. Outside hospital (primary care, ambulance, etc.)
B. In the ED or linked area before admission
C. AMU or equivalent area
D. Acute ward (other than AMU)
E. Specialty ward [ICU/HDU (high dependency unit), coronary care, renal, respiratory, elderly care, rehab]
F. Diagnostic area, radiology

1.2 Error Typology	***Examples only (not exhaustive – not for recording)***
A. Assessment, investigation or diagnosis	Physical examination and history taking incomplete Pressure ulcer risk not assessed/incorrectly assessed VTE (venous thromboembolism) risk assessment not completed/ incorrectly completed Falls history/vulnerability to falls not identified Swallowing safety not assessed/incorrectly assessed Tests and investigations missed/delayed/wrong Diagnosis missed/delayed/wrong Failure to assess comorbidities or frailty
B. Medication	Over- or under-hydration Oxygen supply wrong/delayed/omitted Allergic/anaphylactic reaction to any medication Anticoagulants/antiplatelets wrong/delayed/omitted Antibiotics wrong/delayed/omitted Insulin or other diabetes medication wrong/delayed/omitted Opiates wrong/delayed/omitted Sedatives/hypnotics/antipsychotics wrong/delayed/omitted Steroids wrong/delayed/omitted NSAID (non-steroidal anti-inflammatory drug) wrong/delayed/ omitted Diuretics wrong/delayed/omitted Antihypertensives wrong/delayed/omitted Cardiovascular medications wrong/delayed/omitted Chemotherapy wrong/delayed/omitted
C. Treatment and management plan	Appropriate medical/surgical treatment not planned Avoidable delay/omission of planned medical/surgical treatment Inappropriate/unnecessary medical/surgical treatment given Inappropriate ceiling of care Omitted/delayed/wrong treatment from AHPs (allied health professional) Acquired pressure ulcer: prevention below acceptable standard Acquired pressure ulcer despite apparently acceptable standard of prevention Slip/trip/fall: prevention plan below acceptable standard Slip/trip/fall despite apparently acceptable standard of falls prevention Developed VTE: prophylaxis below acceptable standard Developed VTE despite apparently acceptable standard of VTE prophylaxis

D. Infection control	Surgical wound infection Infection from invasive procedure other than surgery Other healthcare associated wound infection *(e.g. infected ulcer)* Infection from indwelling device *(catheter, central lines, etc.)* Healthcare associated clostridium difficile Healthcare- /device-associated MRSA (methicillin-resistant *Staphylococcus aureus*) bloodstream infection Other bloodstream infection (not MRSA) Healthcare associated pneumonia/chest infection (including aspiration) Healthcare associated norovirus/D&V (diarrhoea and vomiting)
E. Invasive procedures	Avoidable delay in undertaking procedure Inadequate pre-procedure assessment/preparation Complication of anaesthesia/sedation including airway management Complication of operative procedure *(e.g. perforation, haemorrhage)* Complication of invasive procedure *(e.g. perforation, haemorrhage)*
F. Monitoring	Vital signs monitoring. Fluid intake/output. Nutritional intake. Delay in initiating resuscitation
G. Cardiopulmonary resuscitation	Delay in initiating cardiopulmonary resuscitation Inappropriate resuscitation Airway management Resuscitation equipment
H. Other problem	Describe in free text

1.3: Grading Of Preventability Of Adverse Event:
1. Virtually no evidence for preventability.
2. Slight to modest evidence of preventability.
3. Possibly preventable, but not very likely (less than 50–50, but close call).
4. Probably preventable (more than 50–50, but close call).
5. Strong evidence for preventability.
6. Virtually certain evidence of preventability.

1.4: Global assessment of quality of care
To what extent did this patient receive best practice care? (select one only)
• Completely
• Substantially
• Partially
• Very little
• Not at all