|  |  |  |
| --- | --- | --- |
| **Reporter/s:­­­­­­­­­­­­­­­­­­­­­­­­­­­** | | |
| **Patient’s Initials:** | **MRN:** | Clinic: |
| **Date Start of Dialysis:** | **Date of Event:** | **Date of Report:** |
| **Referred by: SAS / MEC / Other Service / Voluntary Report / Other (specify):** | | |

**Situation:** (Brief description of event and why it was referred for review)

**Background**: (Explain course leading up to event, i.e. timeline)

**What happened? (Causal actions leading to event)**

**Assessment**: What are the identified issues that contributed to the error/failure?

***Areas of assessment related to the event should address:***

What usually happens? (What does similarly trained staff do in a similar situation?)

What was supposed to happen? (Policies? Procedures? SoC?)

\*What individual factors contributed to event?

\*What system factors contributed to event?

\*Quality Concern Score (QCS)?

What was the staffing at the time? Did it make a contribution to the event?

**Recommendation**: What changes should happen in order to prevent similar failures?

**\*Reference Page**

**Examples of INDIVIDUAL Factors that could have contributed to the event** –

|  |  |  |
| --- | --- | --- |
| * Fatigue * Stress | * Distractibility * Experience * Task tension and engagement | * Motivation |

**Examples of SYSTEM Factors that could have contributed to the event** – (Source – Outcome Engenuity Just Culture)

|  |  |
| --- | --- |
| * Lack of patient information * Lack of product information? * Failure to communicate? * Labeling, packaging, nomenclature problems? * Storage and access? | * Medical device/job aid problem? * Lack of patient education? * Lack of staff education/orientation/supervision? * Environmental, workflow, or staffing? * Culture |

**Quality Concern Score (QCS)©**

QCS is different than the Harm Score used in SAS. The QCS is based on the relationship between *any identified variations in practice, delayed diagnosis or medical error* and the event being reviewed?

* **QCS 0 = (“No Quality of Care Concern Identified”)** - There was no variation from a generally agreed upon standard of care, no delayed diagnosis, and/or no medical error involved?
* **QCS 1 = (Reached patient or near miss - “Low Risk to Patient”)** - Variation in practice, delayed diagnosis or medical error; did not affect patient or wellbeing AND was not associated with clinically significant increased risk to patient.
* **QCS 2 = (Near miss - “High Risk to Patient”)** - Variation in practice, delayed diagnosis or medical error; did not affect patient or wellbeing BUT was associated with a clinically significant increased risk to patient.
* **QCS 3 = (“Event Reached Patient – Additional Care Required”)** - Variation in practice, delayed diagnosis or medical error reached the patient and resulted in escalation of care ( ED visit resulting in admission)
* **QCS 4 = (“Event Reached Patient – Potentially Life Threatening or Disability”)** - Variation in practice, delayed diagnosis or medical error resulted in extended or permanent disability or was potentially life-threatening.
* **QCS 5 = (“Event Reached Patient – Life Threatening or Death”)** - Variation in practice, delayed diagnosis or medical error resulted in death or was life threatening

**Just Culture Algorithms** – Available from Liz McNamara (liz.mcnamara@nwkidney.org)