Draft

proforma 4 version 1.3 13/10/03

PROFORMA 4 ADVERSE EVENTS

FORM SHOULD BE COMPLETED FOR;
1.all audit patients who have an unplanned readmission within 30 days of their ERCP regardless of cause.
2.Any audit patient who has had an adverse event within 30 days of their ERCP which you think may be attributable to the procedure.
3.Any deaths within 30days of ERCP being performed
GUIDANCE ON COMPLETING FORM CAN BE FOUND ON LAST PAGE

1.Date form Completed ☐☐ / ☐☐ / ☐☐

2.PATIENT DETAILS - IMPORTANT ;PLEASE COMPLETE AS FULLY AS YOU CAN

When was ERCP performed ☐☐ / ☐☐ / ☐☐

Name of Hospital where ERCP performed

Hospital Number (if known) ☐☐☐☐☐☐☐☐☐☐

Name of Hospital where patient admitted/treated following ERCP(if different to above)

Patients Date Of Birth ☐☐ / ☐☐ / ☐☐

Patients Sex ☐ Male ☐ Female

3.Your Details (these will be kept confidential)

Name

Contact Address

Telephone

Contact email

4.On basis of patient's history when did the presenting symptoms relating to readmission/ adverse event first start?

☐ Before ERCP
☐ During ERCP
☐ During Early recovery (ie less than 4 hours after ERCP)
☐ During Late Recovery (ie 4hours to 3 days after procedure)
☐ Following Recovery (ie didn't start until 4-30 days after ERCP)

5a. Was the patient diagnosed by endoscopist or supervising medical team as having an adverse reaction to medication given at the time of ERCP?

☐ yes
☐ no

If yes: according to definitions on page 4 which of the following adverse reactions occurred:

☐ generalised allergic reaction
☐ wheezing
☐ hypoxia
☐ hypertension
☐ hypotension
☐ neuropsychiatric reaction
☐ Reaction at IV Site

5b. According to definitions given on page 4 was patient diagnosed with one of the following conditions?

☐ duodenal perforation,
  ☐ suspected
  ☐ proven
☐ upper GI bleed.
  If gastroscopy (OGD) performed during/ following bleed indicate the diagnosis / findings documented on endoscopy report:
☐ Basket impaction
☐ Other Equipment failure reported at time of ERCP,specify:
☐ Pancreatitis,specify if:
  ☐ haemorrhagic
  ☐ complicated by pseudocyst
☐ Cholangitis
  ☐ Septic shock present
  ☐ shock not present

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5c.Indicate if any other new diagnoses were made by the supervising medical team or doctor:

- ☐ Jaundice secondary to biliary obstruction
- ☐ Abdominal pain of uncertain origin
- ☐ Chest pain of uncertain origin
- ☐ Unstable coronary syndrome/Myocardial infarct
- ☐ Cardiac arrythmia
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary Embolus
- ☐ Cerebro-Vascular Accident/Stroke
- ☐ Pneumonia/Chest infection
- ☐ Urinary Tract Infection
- ☐ Other, specify

6.Following ERCP indicate if:

☐ patient required unplanned consultation(s) eg clinic,GP's, A+E

☐ Patient remained in hospital for at least 2 nights ie.was not discharged next day

DateDischarged* ☐☐ / ☐☐ / ☐☐

Date medically fit for discharge (if different from above) ☐☐ / ☐☐ / ☐☐

☐ Patient required unplanned re-admission following discharge

Date of readmission ☐☐ / ☐☐ / ☐☐

DateDischarged* ☐☐ / ☐☐ / ☐☐

Date medically fit for discharge (if different from above) ☐☐ / ☐☐ / ☐☐

*if death leave blank and ensure question5 completed
If still inpatient at time of completing form leave blank and tick here: ☐

IF MORE THAN ONE UNPLANNED ADMISSION WITHIN 30 DAYS OF ERCP or DELAYED DISCHARGE FOLLOWED BY RE-ADMISSION COMPLETE ONE PROFORMA 4 FOR EACH EPISODE

7.Did the patient require admission to ITU during period of hospitalisation reported in question 6?

☐ yes ☐ no

8a.During period of hospitalisation reported in question 6 did the patient require any of the following medical treatments?

- ☐ reversal agents, ie naloxone or flumazanil
- ☐ atropine
- ☐ oxygen
- ☐ transfusion (less than 5 units)
- ☐ transfusion (5units or more)
- ☐ ventilatory assistance without intubation eg bag and mask
- ☐ tracheal intubation
- ☐ crash call/cardiac arrest call

8b.Additional (invasive) treatment required

Endoscopic,Specify Procedure Performed

Date Performed ☐☐ / ☐☐ / ☐☐

Radiological,Specify Procedure Performed

Date Performed ☐☐ / ☐☐ / ☐☐

Surgery,Specify Procedure Performed

Date Performed ☐☐ / ☐☐ / ☐☐

Other Procedure,Specify

Date Performed ☐☐ / ☐☐ / ☐☐

9.Outcome (cross one box)

☐ full recovery

☐ permanent disability/loss of function expected, specify

☐ Death

Date of Death ☐☐ / ☐☐ / ☐☐

Cause of death certified as:

Ia

Ib

II

10.Does the supervising clinical team/doctor think event (s) reported are attributable to ERCP

☐ Yes ☐ Probably ☐ No ☐ Uncertain

IF YOU NEED TO ENTER ANY FURTHER INFORMATION USE BOX BELOW:

THANKYOU FOR YOUR ASSISTANCE - PLEASE SEND COMPLETED FORM TO:

DR EARL WILLIAMS,
BSG RESEARCH FELLOW,
DEPARTMENT OF CLINICAL INFORMATION,
4TH FLOOR LINDA MCCARTNEY CENTRE,
ROYAL LIVERPOOL HOSPITAL
LIVERPOOL
L7 8XP

IN EVENT OF QUERY:
TEL. EARL WILLIAMS ON 0151 706 3794/3137 OR
EMAIL earl.williams@rlbuht.nhs.uk