**APPENDIX B**

**Table B.1 Characteristics of the participants in the Delphi panel**

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| **Type of professional** | **Number** | **Expert area** | **Employer** |
| Registered nurses | 22 | Home healthcare | Municipal or county council home healthcare |
| Physicians | 6 | Home healthcare | Municipal or county council home healthcare. One of the physicians also represented the Swedish Medical Association |
| Registered nurses | 2 | Patient safety | National Board of Health and Welfare |
| Physician | 1 | Patient safety, RRR methodology and TT design | National Board of Health and Welfare |
| Registered nurse | 1 | Patient safety, RRR methodology and TT design | Swedish Association of Local Authorities and Regions (SALAR) |
| Physician | 1 | Patient safety and RRR methodology | Swedish Association of Local Authorities and Regions (SALAR) |
| Physician | 1 | Patient safety, RRR methodology and TT design | Swedish Association of Local Authorities and Regions (SALAR) |
| Registered nurse | 1 | Patient safety and nursing | Swedish Society of Nursing |
| Registered nurse | 1 | Patient safety and RRR methodology | Region Östergötland |
| Registered nurse | 1 | Home healthcare and patient safety | Royal Institute of Technology and Ersta Sköndal Bräcke University College |
| Registered nurse | 1 | Home healthcare and patient safety | Linnaeus University, Kalmar and Karolinska Institutet, Stockholm |
| Registered nurse | 1 | Patient safety, RRR methodology and TT design | Linnaeus University, Kalmar |
| Registered nurse | 1 | Patient safety, RRR methodology and TT design | Danderyd Hospital and Karolinska Institutet |
| Physician | 1 | Patient safety, RRR methodology and TT design | Linköping University Hospital and Linköping University |

RRR = Retrospective record review; TT = Trigger tool

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| **Table B.2 Example of a trigger definition and description** |
| Adverse drug event/Adverse drug reaction |
| **Definition**  Sign of impairment or harm caused by drug treatment *and/or* anaphylaxis |
| **What to keep in mind and be aware of when reviewing the record and assessing events** Even if the adverse drug reaction is a known side effect, a negative effect on the patient as per the above should be seen as a positive trigger and adverse event.When a certain drug is known to *always* cause a specific reaction (for example, neutropenia following cytostatic treatment), this counts as an adverse event *only* if the negative effect has been unusually strong and caused extraordinary measures and treatment efforts.  Drugs may be double documented in different systems for records and documentation; changes in order entries may fail to be updated if drug review is not performed.  If an anaphylactic reaction requiring treatment should arise, this should be seen as an adverse event, even if the patient has a full recovery after the acute phase.  Be aware of drugs that often cause side effects in the elderly: cardiovascular drugs, anticoagulants, drugs affecting the central nervous system (psychotropic drugs, morphine-like analgesics, anticonvulsants), antibiotics, cytostatic agents, anti-inflammatory or anti-diabetic drugs. Drugs used to ameliorate negative effects of drugs include particular antidotes, such as naloxone (intravenous against overdoses of opiates) and flumazenil (against overdoses of benzodiazepines). Dexrazoxan is an antidote against cytostatic agents of the anthracycline family and used, for example, upon extravasation, to reduce tissue damage. If a drug is given to a patient with known sensitivity, without harm arising, this is to be seen as a no-harm incident.  Are conditions in place for safe drug administration in the home?  Have adequate measures been taken to avoid mix-up of drugs, erroneous administration etc.?Are there routines on delegation and have they been followed?  At delegation - is there a sign-off list in the home?  Is there a correct, up-to-date list of drugs in the home? Experience tells us that multiple drug lists occur and raise a risk for no-harm incidents and/or adverse events.  Have measures been taken to reduce the risk for mix-up of drugs?  Have risky combinations of drugs been used? |
| **Adverse events/no-harm incident that can be identified**  Allergic reactions, skin reactions (blistering, rash, itching), mucous membrane damage in gastrointestinal tract, effect on central nervous system, kidney, liver or other organs, as well as dizziness, hypotension, heart arrhythmia, hypoglycaemia, confusion, kidney failure, altered consciousness, fainting, respiratory insufficiency, apnoea, shock or death. Falls. Life-threatening acute respiratory insufficiency or shock, or death from these causes.  Traceable no-harm incidents:   * wrongly administered drug (dose, administration route, wrong patient) or non-intentional interruption in medication that has not given rise to an adverse event, * an order entry that does not correspond to administration (if changes in the drug list have not been observed), that has not given rise to an adverse event, * the existence of multiple concurrent drug lists in the home is a no-harm incident if no adverse event can be identified. |
| **Preventability**  The event should be seen as preventable if:   * drugs are given despite contraindication or known sensitivity, * impaired function of kidney or liver has not been taken into account, * the risk of an unfavourable effect has not been taken into account and no justification exists for prescription of interaction substances, * the risk of an unfavourable effect from too low or too high concentrations has not been taken into account and no justification exists, * treatment with opiates or benzodiazepines has caused symptoms that mean an antidote must be given (naloxone, flumazenil), * follow-up of drug treatment or drug review has not been performed in an adequate way, with assessments and actions, or * the allergy history has not been reviewed or if a known allergy has not been taken into account. |