Department of Health

PRIME CI Dictionary & Guide for Use

V6.6

PRIME Clinical Incidents is

the Queensland Health Clinical Incident Management Information System

(last major upgrade Nov 2010, last AA release Nov 2013)

PRIME Clinical Incidents (CI) supports the following Health Service Directives:

No 32: Patient Safety, No 19: Data collection and provision of data to the Chief Executive

No 15: Enterprise Architecture.

- *Queensland Health Policies and associated standards ceased to be of effect from 1 July 2013 and were replaced by Health Service Directives.*
- *Clinical Incident Management Policy (CIMP) August 2012*

PRIME Clinical Incident – Dictionary

This document lists all of the data concepts and elements (fields) within the PRIME Clinical Incidents information system. To jump to the underlined references within this document hold the [Ctlr] key (a little hand icon should appear) then click on the underlined word/phrase.

Reporter data fields

Clinical incidents, including near misses, involving patients, clients, residents (ie consumers of the health care service) are to be recorded on PRIME CI.

Incidents involving staff, visitors and others should be recorded using local Workplace Health and Safety incident monitoring processes and systems. If you are unsure of the most appropriate system to record an incident, please contact your line manager for advice.
The majority of mandatory data entry fields are marked with an asterisk (*) and highlighted yellow.

In addition, reporters are encouraged to complete as many non-mandatory fields with facts/knowledge to hand as possible to enable a future risk assessment. This will better enable us to trend data and identify system improvements…any details you can provide would be great!

Listed below are all of the Reporter data fields as they appear in the system along with a guide for use. When developing QHERS reports the grey text refers to the field names and tables within the business view. ● Indicates missing information.

Person Affected Details

Patient Status

Incident.PersonAffectedTypeName

NOTE. This system is for the reporting and management of clinical incidents, ie incidents involving a person receiving health care. (known as patients, clients, consumers, residents)

As per the CIMP, the term patient refers to any recipient of a QH clinical service. Boarders are not patients. Incidents related to staff or visitors are reported via local Workplace Health and Safety procedures.

Client of Community-based service

- A person receiving services delivered in a community setting, for example, school based services, services in dedicated facilities, community based networks of rehabilitation and home care, community based convalescence, respite and palliative care services, and community based mental health services, and outreach services.

Emergency Presentation

- An emergency department patient who does not undergo a facility's formal admission process.

Inpatient: home ward (updated 31/8/2012)

- 'An admitted patient is a patient who undergoes a hospital's formal admission process as either an overnight stay patient or a same-day patient. If in doubt, select "Inpatient : home ward".

Inpatient: outlying ward (updated 31/8/2012)

- For the purposes of PRIME CI, an **Outlier** is defined as "a patient cared for in a clinical area outside of the usual base/ ward of the patient's treating team. It will not include patients cared for in a clinical area appropriate for their needs at the time of the incident (eg Isolation). See table below.

Inpatient on approved leave

- Leave occurs when the patient leaves the hospital during a period of treatment or care for not more than seven days, and intends on return to the hospital to continue the current course of treatment.

Inpatient: Non Queensland Health Facility (introduced 1/3/2013)

- An admitted patient being treated at their own home or a non Queensland Health facility, eg residential aged care facility. Examples include Community Health Interface Program (CHIP), Hospital in the Home, Hospital in the Nursing Home, palliative care.
- This option can also be selected where a patient is in transit between two health care facilities.

Further guidance: A medical/ surgical/ mental health/ maternal/ paediatric patient is cared for in a non-medical/ surgical/ mental health/ maternal/ paediatric ward. A medical/ surgical/ mental health/ maternal/ paediatric patient is admitted under a treating team but cared for in a ward/ location that is not usually the base for that treating team.	Upon **initial presentation to health services** where the patient is still in the receiving area at the time of the incident. For example A&E/ DEM, PEC **Critical care areas** where a patient remains under the care of a treating team but is transferred for specialist interventions or care packages. For example ICU, HDU, CCU **Operative areas** where the patient receives a surgical or radiology guided interventional procedure. For example theatre, recovery, catheterisation lab. **Specialty areas**: where the patient receives short term targeted interventions and is transferred back to the ward for ongoing care. For example dialysis, radiation therapy.

Outpatient

- A person receiving specialist or other services provided to non-admitted patients by a hospital.

Residential / Aged Care Residential

- Refers to persons residing in Acquired Brain Injury facilities.
- Additionally, all people residing in the residential aged care facility who are in receipt of a residential aged care service either subsidised by the Commonwealth or self funded for the purposes of receiving services, excluding respite care and transitional care. Note that the residents may be in receipt of a range of services from low level care to high level care.

UR number	Patient identifier, unique within a facility. Assigned by the facility at first admission/ contact and used at all subsequent admissions/visits. The UR number field allows a maximum of four letters in the first field and seven numbers in the second field. The number field is used to aid any required investigation or further analysis of an identified risk and is mandatory. If the UR number is not known then enter 000001. Incident.PatientURN: String
Surname & First name	Enter the client's name as it appears in the paper-based clinical record. Incident.PatientFirstName:String and Incident.PatientSurname: String
DOB **(Date of birth)**	Used as a means of validating UR number for error checking and also for analysing whether age may be a contributing factor to the incident. If you the date of birth is not known, enter **/**/*** If the DOB is less than 12 months from the date of incident additional fields are displayed. Incident.DOB: DateTime
Gestation Period (weeks)	The gestational age of the infant, (ie the length of their gestation up until delivery), measured in weeks. Range = 12 to 42 Incident.Gestation
Birth Weight (grams)	The birth weight of the infant, measured in grams. (1000g = 1kg, 1 pound = 453.6 g) Allowed range = 400 to 12000
Sex	Used as a means of analysing whether gender may be a contributing factor to the incident. Incident.SexName: String
Pt/family/carer informed of incident?	Incident.RadioButtonOptionName: String
Reason not informed	Incident.ReasonPatientNotInformed: String

Was this person under the care of a Mental Health Team?

Incident.IsMHClient: Boolean

This information is collected to assist in the analysis of incidents related to clients of the mental health service (ie at time of incident).
Scenario: A person is currently a mental health client receiving care via community mental health services, and happens to break their leg playing football on the weekend….. a clinician wishes to report a fall by this patient/client during their treatment for their broken leg in the ortho ward. In answering this question, the reporter would select "No".
Only select yes when the incident occurs to a client directly receiving mental health care eg, either as an inpatient or as an outpatient.

Was the patient/family/carer informed of this incident?

This section allows recording of whether the patient/client had been informed that an incident had occurred. Known as Clinician Disclosure, this is defined as an informal process where the treating clinician informs the patient/client of what has occurred, and expresses their regret (ie including saying sorry) of the harm caused or adverse outcome. This may be all that is required for some incidents, or may be the first step in a formal process.
If "No" is selected, a free text area will be supplied to indicate why the patient had not been informed of the incident.

Possible reasons for selecting no may include –

- Incident was a near miss/ near hit or 'good catch'
- The patient may already be aware of the incident (eg aggression)
- Unable to contact patient post-discharge
- Formal Open Disclosure process underway
- Incident logged from feedback from external body (eg Health Quality and Complaints Commission)

What Happened Details

Date of Incident
Time of Incident

The date/time on which the injury, accident or illness (or near miss) associated with the episode of care occurred. Incident.DateTimeOfIncident

Location

District > Facility > Division > Ward in a hierarchical drop down structure.

Incident.DistrictName, Incident.WardName etc

Place

Incident.PlaceName

The place the incident occurred eg bedside, treatment area etc
This element provides geographical validity for analysis of incident types for common occurrences in common areas.
This field will allow review of incident by specific locations and may identify 'risky' areas…

- Bathroom area
- Bed/ Bedside/Trolley/ treatment chair
- Consumer's Residence
- Correctional Centre
- Corridor
- Designated seclusion / secure room
- Dining / Kitchen areas
- High Dependency Unit
- Hospital Grounds and facilities
- Mobile Staff Clinic
- Nurses Station / ward reception
- Off hospital/ facility grounds
- Other (if other is selected, reporter must provide details)
- Patient communal areas
- School based program
- Stairs
- Treatment / procedure area

What was the outcome to the patient?

Incident.InitialSeverityAssessmentCodeName

Incident.Classification_PatientOutcomeName

Select one of the options below

SAC 1
- Death
- Likely permanent harm (ie where full recovery is not expected, includes physical and psychological harm.)

SAC 2
- Temporary harm (ie full recovery is expected over a period of time, this includes physical and psychological harm. Additional procedure required, increased LOS, increased observations)

SAC 3
- Minimal harm No long term physical effect to patient. First aid provided. Short term pain, distress
- No harm

Harm sustained

If permanent, temporary, or minimal harm is selected, a new mandatory field 'Harm sustained' is displayed. Select all that are appropriate.

Soft tissue: abrasion, infection, pressure sore, **skin tear** (cut/laceration, rash, burn, sharps/puncture, /graze, extravasation, wound dehiscence, pain)

There are three ways that a skin tear can be reported. Select the most appropriate from the following examples:

1. If a skin tear develops as a result of treatment i.e drape tapes in theatre or removal of duoderm etc then it would be reported as a 'patient reaction' under Intervention/Treatment".
2. If the skin tear was as a result of a Patient Accident then it is reported under Patient Incident > Patient accident.
3. If it was not known what the cause was, it is reported under Patient Incident > Harm from unknown cause.

Eye: including loss of vision, infection - conjunctivitis

Oral/dental: including broken or extracted tooth

Skeletal: Sprain/strain, Dislocation, Fracture

Gastrointestinal upset: vomiting, diarrhoea

Respiratory: breathing difficulties, distress, obstruction, aspiration, pneumonia, pneumothorax, pulmonary embolism, respiratory arrest, asthma, use of tracheostomy

Cardiac: cardiac arrest, dysrhythmia, myocardial infarction, chest pain

Neurological: temporary nerve damage/paralysis, CNS : injury (brain or spinal cord), awareness, epidural abscess/ meningitis, post procedural headache, spinal abscess, coma, hearing impairment (replaces head injury)

Circulatory/ Vascular: thrombosis (DVT), PE, damage to vein, embolus, arterial blockage, haemorrhage, shock, clotting disorder

Other Internal injury: includes intraoperative injury, obstetric complication, hysterectomy, caesarean, perforation of organ, hepatic or urinary impairment etc.

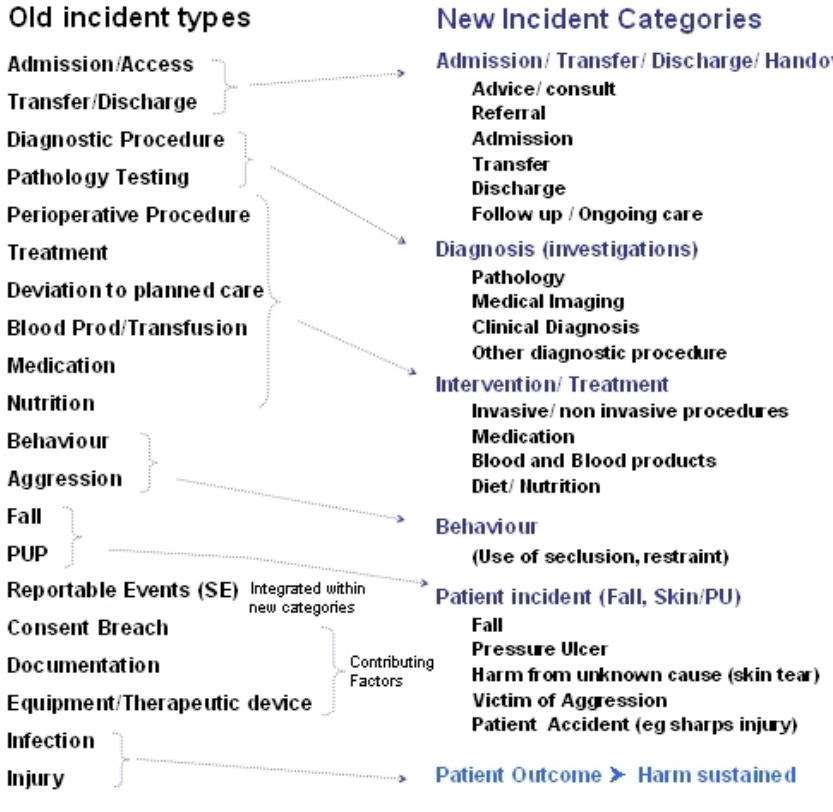
Psychological: anxiety, emotional distress, depression, grief, fear, anger, excessive worrying, loss of confidence resulting in a prolonged impact on function.

None of the above If none of the above are appropriate, reporter can select this option. Please describe the nature of the harm in the "What Happened" field.

Incident category

This diagram compares the pre 2009 release incident classification with the current one.

Incident.IncidentCategory



This list is linked to the area of this document where the definitions can be found. Hold the [control key] and then click on the link.

Admission / Transfer/ Discharge/ Handover

- Admission
- Advice/consult
- Discharge
- Follow up/ongoing care
- Referral
- Transfer

Behavioural
- Self harm, aggression etc leading to the use of seclusion and/or restraint

Diagnosis /Investigation
- Clinical Diagnosis
- Medical Imaging
- Other Diagnostic Procedure
- Pathology

Patient incident
- Fall
- Harm from Unknown cause
- Patient accident (eg skin tear, sharps injury)
- Pressure Ulcer
- Victim of aggression

Treatment/ Intervention
- Blood products Transfusion and Haemovigilance
- Diet/ Nutrition
- Invasive/ non invasive care
- Medication

What happened

Incident.WhatHappened

A narrative of the incident as understood by the person reporting it. Record only facts, use titles and avoid names. When entering a clinical incident in PRIME, imagine that the person reading your report has never been to your ward/service and knows nothing about the patient/client or the environment. The narrative should be a clear and concise summary of the incident ie, who, what, when, where, how. It is an objective description of what actually happened or what was observed. It does not include the author's opinion.

For more information about how completing the free text fields in PRIME refer to the document "Tips on writing narratives" available from the website. Please note: This field appears on PRIME reports as well as on QHERS reports.

Immediate Action(s) taken

Describe what you did for the patient/client following the incident. Don't overlook your duty of care to the patient/client. Incident.ActionTaken

Results of Immediate action(s)

Record what were the results of the immediate actions taken. Incident.ResultsofActions

What stopped the patient from being seriously harmed?

ClassificationStoppedPatientBeingHarmed.StoppedPatientBeningHarmedName

If the reporter selects patient outcome is either 'minimal' or 'no harm' these fields, "Immediate Actions taken" and Results of Immediate Actions", are hidden.

Fortunately most reported incidents (~95%) do not result in harm to patients. Many times it is because the incident is a near miss, ie something or someone intervened, preventing the incident from 'reaching the patient'. (a family member spoke up, or a back up system prevented an error). Other times, a system error will have occurred, eg the patient was given wrong medication; or missed a medication; or fell; or theatre delayed for two hours, but no harm is reported.

Chance: Good Luck, coincidence, it happened that patient wasn't harmed. Eg patient given wrong medication; or missed medication; or fell; or theatre delayed for two hours, but no harm reported.

Staff intervention: eg Ward pharmacist identified and corrected wrong drug order preventing patient harm. Potential effects of incorrect intervention stopped or reversed.

Patient intervention

Family/visitor intervention: eg Family member spoke up, a parent alerted staff to child's allergy

Existing safety system: eg At final pre op check, device/ alarm, allergy armband, equipment alarm sounded, software, designed into process eg: oral syringe, physical incompatibility, Electronic medication station records identify error.

Suggestions to prevent reoccurrence?

Enter a clear and concise summary of the factors that could be addressed to prevent reoccurrence.

Incident.Classification_SuggestionsToPreventReoccurance: String

Risk Factors

Also known as Contributing Factors

Categories

Classification of the circumstances that may have had an impact on the occurrence of the incident. Risk/Contributing factors are additional reasons, not necessarily the most basic reason (ie issue) that an event has occurred. Hold the [control key] and then click on the following link.

Risk/ Contributing factors List

Please select only the contributing factors that directly relate to the incident.

IncidentContributingFactor.ContributingFactorCategoryName: String
IncidentContributingFactor.ContributingFactorName: String

Was a staff member harmed during this incident?

Select either yes, no, or not known. This field will be used to provide information to local Occupational Health and Safety Officers.

IncidentContributingFactor.IncidentContributingDetails_StaffmemberHarmed:String *NB doesn't appear to display consistently*

Current Diagnosis/ problems

Enter details of the patient's, client's, or resident's diagnosis or problems relevant to the incident.

IncidentContributingFactor.CurrentDiagnosis: String

Was an alert related to this incident already in place?

IncidentContributingFactor..AlertAreadyInPlace: Boolean

Check the clinical record and HBCIS to identify whether an alert (related to this type of incident) is in place for this patient, client, customer or resident. Alerts may relate to allergies, aggression, risk factors etc.
This indicator should be monitored closely by Line Managers in order to alert managers and staff that a specific event has happened, or is likely to happen. Predetermined actions should be commenced when an alert indicator signals that the risk of injury, incidence is high.
If no is selected, another field appears **-**
This is intended as a prompt for the reporter, to urge them to use ALERTS as a communication tool to decrease the likelihood of a repeat incident.

Have you now documented or (updated) the alert?

The type of alert is relevant to the area where the incident has occurred and not intended to be rigid or prescriptive. Some examples may be allergy to a medication, relevant if that medication was given, Risk of falling based on admission assessment/criteria, or in a Mental Health setting, it might be risk of absconding, etc. *It is a contextual reference* to alerts that maybe, should have been, or might now (post incident) need to be put in place and communicated to the team.

IncidentContributingFactor..AlertUpdated: Boolean

Incident documented in Clinical Record

Where an incident has been entered on PRIME, the Incident ID number should be noted in the clinical record and any alerts should be noted/ updated.

IncidentContributingFactor.HasClinicalRecordBeenDocumented: Boolean

Reporting Person Details

Surname
First Name

CIMP requires that Line Managers provide feedback to incident reporters. The provision of the reporters name will enable the provision of feedback and further clarification of incident details by the Line Manager. These mandatory fields are free text. Incident.ReportingPersonFirstName:String
Incident.ReportingPersonSurname:String

Staff Category
Position held

Category	Examples
Administrative	Including A&TSI Liaison officers, Pastoral Care
Allied Health	ie Professional Stream (including all Allied Health workers apart from Pharmacy)
Indigenous Health Worker	… ie staff working with indigenous clients
Medical	ie doctors
Non QH staff or external party	… Others, eg carer, visitor, volunteer, students, teaching / research personnel
Nursing	including midwife, pool RNs, ENs, AINs, student

RNs etc.
Operational.....Catering, cleaning, wardspersons, security
Oral Health.....Including Dental technicians
Pathology.....All staff working for Pathology Services
Pharmacy.....All staff providing pharmacy services, including pharmacy assistants, pre-reg pharmacists
Technical.....eg. anaesthetics, urodynamics

Incident.ReportingPersonStaffCategory:String
Incident.ReportingPersonPositionHeld:String

Date incident reported
Time incident reported

These mandatory fields are helpful for the LM who must monitor the incident reporting process.

Incident.DateTimeIncidentReported:DateTime

Witness Details

Any witnesses to the incident?

Patients should be advised, and family or visitors must be asked if they can be noted as a witness. Incident HasAnyWitnesses: Boolean

Witness Surname
Witness First name
Position
Contact Number

Witness.Witness First Name:String

Witness.Witness Surname:String

Witness.Witness Position Held:String

Witness.Witness Contact Number:String

Advice from the Legal and Administrative Law Unit:

Witnesses can be grouped into 2 categories and there are different rules for each group:

1. Patients:
   Patients are to be informed/advised that personal details are recorded on PRIME
   Refer to Privacy brochure “Respecting your privacy”

2. Other 3rd parties, eg family, visitors, staff:
   Family or visitors should be verbally advised that they have been noted as a witness – see guide below.
   A reporter should ask for the witness details, if information is provided, consent for recording/use is implied.
   Potential script:
   We would like to record your name and contact details as a witness to this incident. Is that ok?
   You may be contacted to provide information to reduce the possibility of this occurring again, or to assist with preventing this occurring again.

Staff:
Refer to ‘Information Privacy for QH staff’ on QHEPS - or contact the District Privacy Officer.

If you would like to know more about this process, the please contact your Line Manager or Patient Safety Officer. Privacy brochures are available at: http://qheps.health.qld.gov.au/privacy/home.htm

Of those fields which are mandatory why must you provide details of the witness, but not of the staff reporting or the client?

There MAY be occasions where an anonymous reporter is willing to advise of witness(es) if they do not feel it will reveal their identity. The state-wide PRIME User Group felt this might facilitate investigations where the reporter chose to be anonymous.

Reported to Details

Reported to Surname
Reported to First name
Position

Enter the name and position of the person to whom the clinical incident will be/was initially reported, eg. a line manager or shift coordinator.

Incident.ReportedToSurname:String
Incident.ReportedToFirstName:String

Medical Officer Notification

Medical Officer Notified

Indicates whether a medical officer was notified following the incident. Note, if no is selected it is mandatory to record the rationale for not contacting an MO. Incident.MONotified:Boolean

If no, you must specify a

eg, Nil harm, not required.

reason Incident.ReasonWhyMONotNotified:String

Review requested by Name of the person who asked for the review of the client. Incident.ReviewRequestedBy:String

Medical Officer Surname Incident.MOSurname:String

Date Medical Officer Notified Incident.DateTimeMONotified:DateTime

Time Incident Reported

Line Manager Fields

To enter data relating to the management of a particular incident, a User Identification and Password is required. The level of access granted to PRIME for each user will be determined by the specific role and responsibilities that user has in relation to incident management. For example, a Nurse Unit Manager (NUM) will have access to clinical incident data relating to that NUM's clinical area only. A District Super User (DSU) would be able to view clinical incident data from the entire Health Service.

Important Note:
Passwords are not to be shared - this is to comply with Security Standards for Queensland Health. To ensure that incidents are always managed in a timely fashion, you should nominate a proxy for your ward/area that will monitor incidents in PRIME in the event of your absence. (For example, you might nominate the CN in your area). Please advise your District Super User who this person is and an account will be created for them.

Listed below are all of the Management data fields as they appear in the system along with a guide for use.

Incident

This screen and the Person Affected screen permit the Line Manager to review the details of the incident as entered by the reporter.

Description of Event

(Introduced 1/12/09)

This mandatory, editable field permits a Line Manager to provide a concise synopsis of the event and will be used on all reports rather than the non-editable "What happened" text completed by the Reporter. This is intended to overcome issues with spelling, grammar etc. NOTE: this field is only displayed as mandatory in 'Edit' mode.

The text in the "What Happened" field can be highlighted, copied, and then pasted in to the new field. This text can then be edited, for example to remove names, correct spelling, or acronyms, provide additional details about the event…

Incident.IncidentDiscriptionofEvent:String

Person Affected

This screen permits the Line Manager to review the patient details as entered by the reporter. Eg URN, status, name, DOB, etc. These fields are editable by any Line Manager. To modify fields on this screen, select the [Edit] button.

Mental Health Act Status

These fields are only displayed If a user (eg reporter) has selected that the patient/client is under the care of a MH Team, the Line Manager will be required to record the person's status under the MH Act, eg Involuntary – Absent without permission, Involuntary – Classified Patient, Voluntary, etc. MentalHealthActStatus.MHActStatusName:String

Patient Outcome Review

This screen is mandatory for all incidents. Multiple entries can be created and retained to record the progress over time of the patient following an incident.

Date
PatientOutcomeReview .RiskAssessmentDate

The date and time of the review. Defaults to the current date/time, but may be changed if required.

LM Name and role

These fields are auto-populated and are not editable.
If a Line Manager has more than one role, the highest role is displayed automatically.

Patient outcome

The current patient outcome will be displayed as well as new mandatory patient outcome fields. A line manager must reconfirm the outcome to the patient noting if the outcome has changed.

- **Death**
- **Likely permanent harm** (ie where full recovery is not expected, includes physical and psychological harm.)
- **Temporary harm** (ie full recovery is expected over a period of time, this includes physical and psychological harm.) Includes increased length of stay, additional investigations performed, referral to another clinician, or surgical intervention.
- **Minimal harm** (No long term physical effect to patient, eg first aid provided. Short term pain, distress
- **No harm**

Incident.CurrentPatientOutcome:String

Severity Assessment Code (SAC)

SAC 1 = **Death** or likely **permanent harm** *which is not reasonably expected* (by the treating clinician/s, patient or family) as an outcome of healthcare.
SAC 2 = **Temporary harm** which is *not reasonably expected* as an outcome of healthcare.
SAC 3 = **Minimal** or **no harm**. Includes first aid treatment only.

Incident.CurrentSeverityAssesmentCodeName:String

Risk Assessment rating

Please note, this rating system was replaced by SACs on 13 December 2006. The risk rating codes will still be seen on incidents reported earlier than 13 December 2006.

Risk rating

The risk rating was calculated by the system, based on the Degree of Severity and Likelihood (Probability) of the clinical incident. Refer to the QH Risk Management policy.

Death not related to clinical incident

(Field labelled: Death expected or due to natural cause)

This field is only visible to users with the combined District Line Manager/ District Super User access, eg Patient Safety Officers.

Following an external review, the Coroner may determine that a death has been due to the natural progression of the illness. Rather than delete the incident report (which is no longer classified as a clinical incident) and lose information entered including any learnt lessons from other investigations, this field will be used to flag incidents to be excluded from Reportable Event reports.

DeathDueToNaturalCause: Boolean

Harm sustained

If permanent, temporary, or minimal harm is selected, a new mandatory field 'Harm sustained' is displayed. Select any that is appropriate. Examples available from the drop down list are:

Soft tissue: abrasion, infection, pressure sore, skin tear (cut/laceration, rash, burn, sharps/puncture, /graze, extravasation, wound dehiscence, pain)

There are three ways that a skin tear can be reported. Select the most appropriate from the following examples:

1. If a skin tear develops as a result of treatment i.e drape tapes in theatre or removal of duoderm etc then it would be reported as a 'patient reaction' under Intervention/Treatment".

2. If the skin tear was as a result of a Patient Accident then it is reported under Patient Incident > Patient accident.
3. If it was not known what the cause was, it is reported under Patient Incident > Harm from unknown cause.

Eye: including loss of vision, infection - conjunctivitis

Oral/dental: including broken or extracted tooth

Skeletal: Sprain/strain, Dislocation, Fracture

Gastrointestinal upset: vomiting, diarrhoea

Respiratory: breathing difficulties, distress, obstruction, aspiration, pneumonia, pneumothorax, pulmonary embolism, respiratory arrest, asthma, use of tracheostomy

Cardiac: cardiac arrest, dysrhythmia, myocardial infarction, chest pain

Neurological: temporary nerve damage/paralysis, CNS : injury (brain or spinal cord), awareness, epidural abscess/ meningitis, post procedural headache, spinal abscess, coma, hearing impairment (replaces head injury)

Circulatory/ Vascular: thrombosis (DVT), PE, damage to vein, embolus, arterial blockage, haemorrhage, shock, clotting disorder

Other Internal injury: includes intraoperative injury, obstetric complication, hysterectomy, caesarean, perforation of organ, hepatic or urinary impairment etc.

Psychological: anxiety, emotional distress, depression, grief, fear, anger, excessive worrying, loss of confidence resulting in a prolonged impact on function.

None of the above

Incident.CurrentHarmSustained:String

Clinical Review &

Reviewed by

Timely and appropriate assessment of the patient, resident or customer to identify actual or potential harm (physical, mental, psycho-social) is an essential part of the incident management process. If comments are entered indicate who conducted the review: ie Medical, Nursing, Allied Health or other clinician.

PatientOutcomeReview.ClinicalReview: String
PatientOutcomeReview.Surname: String and …FirstName: String

Acknowledgement of this incident given to reporter?

The Clinical Incident Management Policy requires that Line Managers provide feedback to incident reporters. This field enables Line Mangers to document that they have confirmed to the reporter that they have received the incident report.

PatientOutcomeReview.AcknowledgmentGivenToReporter: Boolean

If yes, 'How was acknowledgement provided?' Select one from list:

- personal verbal message (eg face to face, telephone)
- written (includes email, message book etc)
- ward meeting
- not possible (reporter not identified / not available)
- other

If no is selected, a new free text mandatory field appears, 'Reason no feedback given to reporter'.

PatientOutcomeReview.AcknowledgmentProvidedName: String

Date Feedback Given

PatientOutcomeReview.DateFeedbackGiven: DateTime

Does this incident require a corrective action?

This area allows the Line Manager to record if a Corrective Action is warranted for the incident. If Yes is selected, the Corrective Actions screen will flag as mandatory. Note, this field will be automatically

selected if the incident is classified as a SAC1.

PatientOutcomeReview.CorrectiveActionRequired: Boolean

Does this incident require notification to a higher authority?

This area allows the Line Manager to record if the incident will be escalated to a higher authority (eg, Divisional supervisor, Executive Director Medical Services, CEO, etc).
Depending on the severity rating of the incident this field may already be selected. If Yes is selected, the Higher Authority screen is flagged as mandatory. PatientOutcomeReview.HigherAuthorityRequired: Boolean

Journal Screen

This screen is provided for Line Managers to make notes about the incident for their own reference, eg like an action register. A line manager can view all entries but only edit their own. These fields do not appear in the LM report.

LM Name and role

These fields are auto-populated and are not editable.
If a Line Manager has more than one role, the highest role is selected automatically.

Date review conducted
Time review conducted

The date and time of the review. Defaults to the current date/time, but may be changed if required.
LineManagerReview.DateTimeReviewConducted: DateTime

Notes

This area is provided for Line Managers to make any notes about the incident for their own reference, if required.
LineManagerReview.Notes: String

Higher Authority Notification

Line Manager Name

The line manager / supervisor's name. This is automatically completed from the logged in user's details.

Line Manager Role

The role the line manager has in the PRIME system, as opposed to their position name.

Has authority been notified?

The QH Clinical Incident Management Policy specifies when incidents must be escalated. See Roles and Responsibilities flow chart available on the PRIME website. HigherAuthority.IsAuthorityNotified: Boolean

If yes is selected, the following mandatory fields appear:

Last Name
HigherAuthority.HigherAuthoritySurname: String
First Name
HigherAuthority.HigherAuthorityFirstName: String
Higher Auth. Position
HigherAuthority.HigherAuthorityPosition: String
Notification Date
Date that the higher authority was notified.
HigherAuthority.NotificationDate: DateTime

Has Coroner been notified?

This mandatory field is only displayed if the patient outcome = death.

The question acts as a 'safety net' to ensure the reporting officer confirms that a reportable death has indeed been reported.

If no is selected then a mandatory free text field (250 characters) appears "Reason Coroner not notified". Some cases will fall outside of the categories of reportable death under the Coroners Act 2003, eg, stillbirths. Some other cases also are reportable but will be reported through a different source, eg, community mental health deaths will be reported to the Coroner through the police who visit the scene, and not through the mental health services who may have been providing a service. HigherAuthority.CoronerNotified: Boolean

If yes is selected, the following mandatory fields appear:

Coroner Notification Date

Date that the coroner was notified.
HigherAuthority.CoronerNotificationDate: DateTime

Has a Reportable Incident Brief been sent?

From 1 July 2013 HHS were no longer required to submit RIBs to the Patient Safety Unit. HigherAuthority.IRMTNotified: Boolean

Date RIB sent

HigherAuthority.IRMTNotificationDate: DateTime

Incident Analysis

An essential part of the incident management process is the identification of the individual with overall responsibility for the analysis and investigation of the incident. This analysis and investigation will then lead to corrective action and subsequent resolution of the incident. Depending the on the SAC rating of an incident, Incident Analysis may be mandatory.

Contact Surname
Contact First Name
Contact Position

The name and position of the person assigned to investigate an incident. Note: For Root Cause Analysis (RCA), this person should be the Team Leader.

IncidentAnalysis.ContactSurname: String, etc

Type of Analysis

This field is used to select what type of investigation has been carried out on the incident. Definitions of the type of analysis options:

Aggregated (local) review – These are reviews performed on a selection of similar incidents to determine appropriate actions to take. Predominantly used for Low risk incidents.

Clinical Review – This term encompasses regular multidisciplinary meetings held at a departmental level, eg to examine injuries and deaths that have occurred, and strategies for managing these occurrences.

External review – ie, if an RCA has been stopped, an external review may be commenced.

HEAPS Analysis – Human Error and Patient Safety. This is a tool designed to aid in the analysis of errors that occur within the healthcare system, and to encourage consideration of issues relating to teamwork and open communication. For more information, see http://qheps.health.qld.gov.au/psq/dst/webpages/incident_team.htm

Root Cause Analysis (RCA). A systematic process whereby the underlying factors which contribute to a Reportable (ie Sentinel) Events, or Extreme adverse event are identified. The purpose of an RCA is to identify the root causes and factors that contributed to the incident and to recommend actions to prevent a similar occurrence in Queensland.
As per the Clinical Incident Management Policy (CIMP) an RCA must be commenced for all SAC 1 incidents. The decision whether to conduct an RCA for other incidents, eg SAC 2 or 3, lies with the local executive.

IncidentAnalysis.InvestigationTypeName.String

Actual Date of Commencement

The date the investigation commences. **In the case of an RCA:** The date of the first RCA team meeting..(as opposed to date RCA commissioned).

IncidentAnalysis..ActualCommencmentDate. DateTime

Date Analysis Completed

The actual date the investigation finished, ie reports were tendered to the Commissioning Authority by the team.

IncidentAnalysis..AnalysisCompletedDate. DateTime

Reason RCA not conducted

This is a conditional field that appears when an Analysis Type other than RCA is selected for a SAC 1 incident. Various reasons are presented here for selection. Reporting on this field may allow services to identify issues with policy or resourcing. Options include: Insufficient resourcing; Alternative Analysis selected; DM/CEO decision.

IncidentAnalysis.ReasonRCANotConducted. String

The fields below, related to an RCA, are normally completed by the HHS Patient Safety Officer

Date RCA to be commissioned

This is a non editable (eg system generated field) which indicates the date that signoff from the Commissioning Authority should be received to form an RCA team and begin investigation of the incident. In the case of a Reportable Event, an RCA should be commissioned within 7 (seven) working days of the clinical incident being reported in PRIME CI as a SAC1.

Date RCA Commissioned	IncidentAnalysis.RCACommissionedDate. DateTime
Reason RCA not commissioned within 7 working days	If the "Date RCA Commissioned" is greater than the date calculated for the "Date RCA to be commissioned", then a new mandatory field "Reason not commissioned within 7 working days" is to be displayed. IncidentAnalysis.ReasonReportDelayed: String
RCA Number	Local facility reference number. This is an ID number assigned to the RCA investigation by the Patient Safety Officer. IncidentAnalysis.RCANumber: String
PSC Reference	This is an ID number assigned to the RCA investigation by the PSC Data Analysis team. Known as the RE number. IncidentAnalysis.PSCReference: String Is also at Incident.PSCReference: String
RCA Report Due	The Commissioning Authority must be provided with the RCA Team report within 45 working days of commissioning. (ie note – not of actual date of commencement)… This date is calculated automatically by the system using the date entered for "Actual Date of Commencement".
Date report provided to commissioning authority	The RCA is deemed still in progress until the RCA report and chain of events document is provided to the Commissioning Authority (not the Safety and Quality Review Meeting/Committee). (See 38N of the legislation) Therefore the PSC recommend that the PSO submit these documents as soon as the RCA report has been completed. Meeting with the CA to discuss the report can take place later. IncidentAnalysis.ReportToCommissioningAuthorityDate: DateTime
Reason RCA not completed within 45 days	Conditionally displayed if Date report provided is later than data report due. Eg the report may have been delayed due to external review. IncidentAnalysis.ReasonReportDelayed: String
Date report signed by commissioning authority	The date the commissioning authority signs/endorses the report and either accepts or rejects each recommendation. (this is NOT about implementation of recommendations, simply the decision whether endorsed or not) IncidentAnalysis.ReportSignedByCommissioningAuthorityDate: DateTime
Stop RCA date	The date the Commissioning Authority approves that the RCA cease. **Known Bug:** If an RCA has been commissioned and subsequently stopped, the "Date report provided to Commissioning Authority" and "Date report signed by Commissioning Authority" fields are still required to close the incident, even though these are no longer relevant. (Gemini reference CI7787) It is suggested that the date the Stop RCA memo tendered to the Commissioning Authority be entered for both fields. IncidentAnalysis.RCAStoppedDate: DateTime
Reason for stop RCA	As per the legislation, there are two reasons why an RCA may be stopped: 38P: Stopping conduct of RCA of reportable event – RCA team 38Q: Stopping conduct of RCA of reportable event – commissioning authority IncidentAnalysis.ReasonRCAStopedName: String

RCA Details Screen

(Note – This screen is only visible to users with the combined DSU/DLM role, eg Patient Safety Officers).

Staff Category (RCA team)

Select from one of the list below

- Dr in Training
- Nurse Clinician
- Operational
- Health Practitioner (GFU - incl scientist, AH)
- Consumer Consultant
- Patient Safety Officer
- Snr Doctor
- Nurse Manager
- Admin

IncidentAnalysisRCATeam.StaffCategoryRCATeamName: String

Team Role

Select which role the person is to assume in the team:

Technical Expert
Content Expert
Front line person/worker
Questioner (so what?)

IncidentAnalysisRCATeam.TeamRoleName: String

Has this person received formal RCA training?

Yes or no

Note, this does not refer to 'just-in-time' training

IncidentAnalysisRCATeam.IsPerstonReceivedFormalRCATraining: Boolean

Select if this person is the Team Leader

Select the tick box

IncidentAnalysisRCATeam.IsPerstonTeamLeader: Boolean

Contributing Factors

(Risk Factors)

Contributing factors have been standardized so that regardless of the type of review conducted (HEAPS, RCA) these can be consistently recorded in PRIME CI.

The initial entry will display the Reporter Risk Factors, ie the Risk Factors as entered by the reporter. They can not be edited.

New records are added by authenticated users, ie Line Managers. Multiple page entries are allowed for this item (linked to user, ie one page per user, but multiple allowed for incident).

Note that if a Line Manager creates a new Risk Factors entry from the Contributing Factors screen, this is treated as a separate record, and will be displayed in the list screen as a separate entry. If a user edits their own record, this will overwrite their previous entry.

Please note: the Contributing Factors field was deactivated (Dec 09). Both reporters and LMs are entering risk factors.

LM Name and role

These fields are auto-populated and are not editable.
If a Line Manager has more than one role, the highest role is selected automatically.

Date

The date of the review. Defaults to the current date/time, but may be changed if required.

?? IncidentContributingFactor.CreatedAt: DateTime

Current Diagnosis/ problems

This field allows the reporter to enter additional information regarding the general health of the **patient** which may have influenced the management of the clinical incident or patient outcome.

IncidentContributingFactor.CurrentDiagnosis: String

Description of Device

If a reporter has selected that a medical device issue contributed to the incident, the Line Manager must enter a brief description of the device. This information will be provided to the CASS Medical Device Officer.

IncidentContributingFactor.MedicalDevice_Descriiption: String

Asset number (if known) QH

LM to record the asset number.

IncidentContributingFactor.MedicalDevice_AssetNumber: String

Manufacturer/ Model

LM to record the manufacturer/ model. This data will assist in identifying trends in medical device problems.

IncidentContributingFactor.MedicalDevice_Manufacturer: String

Serial/ Batch Number

LM to record the Serial/ Batch Number

IncidentContributingFactor.MedicalDevice_SerialNumber: String

Corrective Actions

Note: enter one corrective action per screen. Corrective actions relating to a specific clinical incident are identified during the analysis and investigation phase of incident management. Corrective actions are developed to address the underlying cause(s) of the clinical incident. Lower-level (eg low risk rated) incidents may not require corrective actions. These incidents are reported on and often acted on collectively. ALL events of a greater magnitude (eg SAC1) DO REQUIRE corrective actions especially when patient harm has resulted.

Line Manager Name

The line manager / supervisor's name. This is automatically completed from the logged in user's details.

Line Manager Role

The role the line manager has in the PRIME system, as opposed to their position name.

Date proposed

This field auto-populates but can be edited.

CorrectiveAction. ActionProposedDate: DateTime

Source of recommendation

From which type of investigation did this action arise?:

- HEAPS
- RCA - Team
- RCA - Alternative Mngt Action
- RCA - Lessons Learnt
- Aggregated (Local) review eg by Ward/Service line manager
- Clinical Review Eg M&M, clinical expert review (internal or external)
- Other external source Eg HQCC, ministerial, Disability services, QAS
- None of above eg Clinical Governance, Clinical Executive

CorrectiveAction. SourceOfRecommendationName: String

Proposed action description

The recommended action to be taken in response to the incident or "near miss" in order to reduce the risk to patients. Please enter one (1) action per screen. Actions can be strong, intermediate or weak.
Examples of **strong actions** include architectural/ physical plant changes; standardisation of equipment and processes.
Intermediate actions include checklists and eliminating 'look and sound alikes'.
Weak actions include warnings and labels, new policies, procedures or directives and staff training.

CorrectiveAction. ActionTaken: String

Authorised

This field notes whether a specific action was authorised or not. Different screens will be displayed depending on the selection here.

CorrectiveAction. AuthorisedBy: String

Date of Decision

Date the action was either authorised or declined. dd/mm/yyyy.

CorrectiveAction. AuthorisedDate: DateTime

Decided By

The person authorising or declining the action. In general, who authorises the action depends on the impact of that action, and the delegations of the person requesting the action. If an action was restricted to a ward, (eg further training), then the NUM could authorise this. If a change to HHS policy was required, the HHS CEO may have to authorise the action. If decided by a committee, enter the position of the Committee Chair.

- Unit Manager
- Divisional Manager
- EDMS
- EDNS
- CEO/ District Manager
- Commissioning Authority

CorrectiveAction.DecidedByName: String

Is statewide action required?

Yes or No.
This field enables a Line Manager to alert Queensland Health that this action could be applicable as a statewide initiative to address patient harm. CorrectiveAction.IsStatewideActionRequired: Boolean

If Not authorised…

This field is only displayed if an action is not authorised. It allows the user to select a reason why the action had been declined. Several

Reason not authorised (Not authorised only)

common reasons are presented in this area - Drop down options:

- Alternative Action Proposed
- Authorisation Pending
- Insufficient resourcing
- Negative impact to other areas
- Not a current priority
- Not supported by best practice evidence
- Referred to Higher Authority

CorrectiveAction.Reason_Not_Authorised: String

If authorised…
Responsible Person

The Manager must assign a named individual (single point of accountability) who will be responsible for corrective actions AND an expected date for these corrective actions to be in place. Where the manager does not have authority to implement corrective actions, these must be elevated to the next higher level for their actioning.

CorrectiveAction.WhoResponsibleToImplement: String

Responsible person notified

This field is checked to indicate that the person responsible for implementing the corrective action had been informed.

CorrectiveAction.ResponsiblePersonNotified: Boolean

Notification date

The date the responsible person was informed. dd/mm/yyyy.

CorrectiveAction.ResponsiblePersonNotificationDate: DateTime

Action commenced date

The date implementation began (i.e., apply/commence the suggested action). dd/mm/yyyy.

CorrectiveAction.ActionCommencedDate: DateTime

Action due date

The date implementation of the action is scheduled to finish.
Note: Enter a due date for all CAs, if not known, enter a date 2 months from date of entry. dd/mm/yyyy.

CorrectiveAction.ActionDueDate: DateTime

Action Status

Action status remains as 'open' until all mandatory fields related to that action are completed and a user selects 'complete'. There may also be occasions where an action is discontinued.

CorrectiveAction.ActionStatusName: String

Date Completed

The date the action was completed. dd/mm/yyyy.
This field is mandatory when "complete" selected for 'Action Status'.

CorrectiveAction.ActionCompletedDate: DateTime

Reason Action Discontinued

This field is mandatory when "discontinued" selected for 'Action Status'.

CorrectiveAction.ReasonActionDiscontinued: String

Additional Fields for RCA corrective actions:

If the incident is a SAC 1 or the incident type is classified as "reportable" AND the source of the recommendation is either RCA or HEAPS, additional fields are displayed to capture information about the outcome of these corrective actions.

Strength of Action

Low Effect (ie Accept) Redundancy/double checks, Warnings and label, New procedure/ memorandum/ policy, Training, Additional study/analysis

Medium Effect(Control) Increase in staffing/decrease in workload, Read back process, enhanced documentation/communication, Software enhancements/modifications, Eliminate look and sound-a-likes, Eliminate/reduce distractions (sterile medical environment)

High Effect (Eliminate) Architectural/physical plant changes, Tangible involvement & action by leadership in support of patient safety, Simplify the process and remove unnecessary steps, Standardise on equipment or process or care maps, New device with usability testing before purchasing, Checklist/cognitive aid

CorrectiveAction.StrengthOfActionName: String

Effort to implement	Low	One person can do it in a short period of time, eg writing a procedure document.
	Medium	Involves moderate investment in time, resources and implementation, eg A competency based training program is rolled out in the operating theatre.
	High	Implementation and change management associated with a hospital wide initiative, for eg. Electronic order entry system

CorrectiveAction.EffortToImplementName: String

Proposed Evaluation Date	If a date is entered, this corrective action will be included in the To Do list filter AND the following additional mandatory fields displayed: CorrectiveAction.ProposedEvaluationDate: DateTime
Evaluation Completed	If a date is entered in the Proposed Evaluation Date field, this mandatory field appears. CorrectiveAction.EvaluationCompleted: DateTime
Impact of Action on Patient Safety	Must be specific, achievable, realistic and time bound CorrectiveAction…….
How was impact determined?	For measurable changes outline the key indicators used to evaluate the change, and where possible, numerical evidence. Eg Increase of 80% of discharge summaries received by GPs within 24 hours of discharge; 20% improvement in satisfaction of Junior Doctors in Emergency Department shift handover. CorrectiveAction.HowWasImpactDetermined: String

Feedback Status

Staff involved have been notified	This field is used to indicate who has received feedback on the status and outcomes of the incident. Incident.StaffNotified: Boolean

If no, record the **"Reason no feedback given to reporter"**

Incident.Statuses_ReasonForNoFeedback (string)

If yes, identify **Staff Notified**	Entries on a list may be selected to indicate which staff received feedback (eg, Patient Safety Officer, EDMS, etc)

StatusesStaffNotified. StaffNotifiedName: string

Date feedback given	Date feedback has been provided. Note user cannot select a future date.
Comments	
Incident status	**Open** – any incident for which no Management Actions have been entered. **In Process** – any incident that has one or more Management Actions completed. (system assigns) **Closed** – manual selection by the user to close an incident. Note: An incident cannot be closed until all outstanding actions have been completed. Incident.Incident_Status: String
Follow up required	This field indicates whether the user would like to flag the incident for long term follow-up after it has been closed. Selecting this will trigger that this incident will appear on the To Do List #6 Incident.IsFollowupRequired: Boolean
Follow up due	This field is only displayed if "Follow-up required" is selected, and indicates the date the user would like to be reminded to follow up the incident. Once you no longer wish this incident to appear in your Follow Up list, select the field "Followed Up". Incident.FollowupDueDate: DateTime
Followed-up?	Incident.IsFollowedup: Boolean

Formal Disclosure

Note: This screen was introduced 15 November 2007, and updated 1 December 2009. It is only visible for those with District Line Manager access, eg Patient Safety Officers.

Was the patient/family/carer informed of this incident?

This is system populated as per what the reporter entered.

Proceed with Formal Disclosure process?

The decision as to whether formal disclosure is undertaken should be discussed with senior members of the treating team. If yes is selected a number of mandatory fields are displayed.

If no Formal Disclosure is to take place for a SAC 1 incident , the user must select a reason (see below)

OpenDisclosure:ProceedWithFormalDisclosure Boolean

Reason not progressed?

Offer Declined: The Formal Disclosure process requires the patients/families/carers affected by the incident to be actively involved. Some patients/families/carers, for various personal reasons, may not want to commit to this involvement.

Executive Management Override of CIMIP process: The Executive Management of the HHS advise that Formal Open Disclosure is not to progress (As per the CIMP, all SAC 1 incidents should undergo formal open disclosure).

This option should also be selected if managing a legacy incident where the formal open disclosure process was not initiated at the time of the incident and will now not be initiated.

Not SAC1 event: May only be used for incidents involving retained objects.

Unable to contact consumer / next of kin: The patient has been discharged and is unable to be contacted or patient has died, and family members are not able to be contacted.

Incident assessed as not requiring Clinical or Formal Disclosure
This superseded option is still displayed in the drop down list & cannot be removed due to technical issues. It is not a valid reason. Please use one of the options above.

OpenDisclosure:FormalDisclosureNotRequiredName: String

Date Formal Disclosure process initiated

dd/mm/yyyy If date is greater than one week from incident, additional field displayed: OpenDisclosure.ProcessInitiatedDate: DateTime

Reason (FD) process not initiated within one week of incident

- Availability of clinician involved in incident
- Patient/ family/ carer requested delay
- Unable to contact patient/ family/ carer
- Availability of appropriate Open Disclosure consultant
- Availability of Open Disclosure team
- Event not recognised as a clinical incident
- Exec Management advise delay
- QPS/ Coroner/ HQCC recommend delay

OpenDisclosure.ReasonForInitiationDelayName: String

Open Disclosure Consultant involved in the Formal Disclosure process?

Yes or no

OpenDisclosure.IsConsultantInvolved: Boolean

Was the clinician involved in the incident included in the Formal Disclosure discussion?

If no, please advise who was involved... (next question)

OpenDisclosure.ClinicianInvolved: Boolean

Which staff member was involved in the Formal Disclosure discussion?	○ Director Unit / Division ○ District Manager ○ EDMS ○ EDNS ○ Non-treating clinician ○ Treating clinician OpenDisclosure.DisclosurePerformedByName: String
Date of first meeting with patient/ family/ carer	dd/mm/yyyy. OpenDisclosure.FirstMeetingDate: DateTime
Were out-of-pocket expenses offered to the patient/ family/ carer?	Yes or No – this refers to ex gratis payments not compensation. OpenDisclosure.ExpensesOffered: Boolean
Date analysis report signed off	System generated.
When was the report discussed with the patient/ family/ carer?	dd/mm/yyyy OpenDisclosure.ReportDiscussedDate: DateTime If no further contact is required by the patient/family/carer, enter **/**/****
Report provided to the patient/family/ carer?	In some cases a HHS may feel it is appropriate to provide a copy of the investigation report but this is not mandatory
Further follow-up with patient/family/carer required?	If 'Yes' is selected this incident will appears on the To Do List #11. Note, this action item is only visible to users with combined DSU/DLM access eg Patient Safety Officers. OpenDisclosure.FurtherFollowUpWithPatientFamilyCarerRequired:String
Reason for No Follow-up required	If 'No', select reason from following list: ○ Consumer requests no further follow up ○ Consumer satisfied with Formal Disclosure ○ Referred to Complaints Coordinator OpenDisclosure.ReasonForNoFollowName: String
Follow-up Due	dd/mm/yyyy. Note this field triggers Item 6 on the To Do List. OpenDisclosure.FollowUpDueDate: DateTime
Followed- Up?	Yes or No. To remove incident from To Do List select 'Yes' OpenDisclosure.IsFollowedUp: Boolean
Comments	

Trouble shooting

Changing or deleting a clinical incident record	A LM is required to provide a reason for making the change and seek authorisation from the appropriate Divisional or Executive Director before submitting the change form to the District Super User (DSU). Note, it is not possible to delete Line Manager Reviews, or Corrective Actions once they have been saved.

To Do List rules

Outstanding incidents by SAC Rating	The coloured bar displays all outstanding incidents for the user sorted by the current severity assessment code (SAC) assigned to the incident. Clicking on any of the displayed numbers will take the user to a Search screen displaying all outstanding incidents for the Severity Assessment Code selected. Date - Outstanding incidents will be displayed according to the date selected. Default is the current date, but this may be changed by the user by clicking on the Calendar icon, and selecting a date.
Select Role -	Role of the Line Manager in the PRIME system – for example, Ward Line Manager, Facility Line Manager, District Line Manager. If the user has one role, this will be selected automatically.
Select Incident Location-	Shows the Location (eg ward, facility) assigned to the Line Manager. If the user is associated with a single location, this will be selected automatically. If the user has responsibility for multiple locations (eg, relieving in another ward), then they may select a location for review from this area.
Due Date -	Sets the date for outstanding actions, ie, users can see what actions are currently due, or what currently logged items will be due on a future date. This area defaults to the current date.
1. Incidents requiring urgent review and notification	This prompts the urgent review of SAC 1 incidents. Incidents are displayed until a Patient Outcome review OR a Journal Entry has been added. Incidents are displayed as 'Due' once reported (excludes incomplete incidents), and 'Overdue' after 18 hours.
2. Other Incidents requiring review	All other incidents (ie SAC2 and SAC3) where the Patient Outcome review has not been added. Incidents are displayed as 'Due' once reported, and 'Overdue' after 7 days.
3. Incidents requiring other follow-up actions	Incidents that have had a Patient Outcome Review added, but other required items are outstanding. Incidents move to Overdue after 90 days (ie from the date the Patient Outcome Review was entered).
4. Incidents with outstanding Corrective Actions	Any incidents with a Corrective Action that has not been completed, and where the "Source of Recommendation" is not RCA. Items will appear as Due one week prior to the entered "Action Due Date", and Overdue once this date has passed. Incidents are removed from the list once Action Status is set to "Complete" or "Discontinued". Incidents with corrective actions with a status of "Not Authorised" should not be displayed. Note, If an incident has 2 corrective actions, an RCA one as well as a Local Review one, this incident will appear in Action item 4 (as well as Item 12 for PSOs). Once the Local Review CA has been closed it will no longer appear here.
5. Incidents requiring feedback and closure	Incidents are displayed as 'Due' once all required actions have been completed but the incident has not yet been closed. Incidents flag as 'Overdue' 7 days after the initial 'Due' flag. Removed when "followed up" radio button is set to "Yes"
6. Incidents requiring Post-closure follow-up	Incidents that have been flagged for follow-up at a later date on the Feedback screen by a user. These will flag as Due 7 days prior to the specified date, and Overdue once that date has passed.
7. Incidents logged in the previous day	All incidents logged in the day before the date displayed in the Due Date field. (Note, this is not the previous 24 hours to current time, but until midnight the day before)

8. Incidents closed in the previous day	All incidents closed in the day before the date displayed in the Due Date field.
9. Incomplete incidents	All incomplete incidents logged in the day before the date displayed in the Due Date field.
10. Incidents requiring Formal Disclosure (PSO only)	Any incident flagged as “Proceed with Formal Disclosure” = Yes and Incident status = “Open” or “In Process”.
11. Incidents requiring Formal Disclosure follow up (PSO only)	Any incident with a Formal Disclosure that has a date in the “Follow-up Due” field. Due = one week prior to the date specified in the “Follow-up Due” field. Overdue = once this date has passed Removed = when “followed up” radio button is set to “Yes”.
12. Incidents with pending RCA recommendations.	Incidents with a Corrective Action that has not been completed, and where the “Source of Recommendation” is RCA. Incidents will appear as ‘Due’ one week prior to the entered “Action Due Date”, and ‘Overdue’ once this date has passed. Incidents are removed from the list once Action Status is set to “Closed” or “Discontinued”. Incidents where the status of the recommendation is “Not approved” should not be displayed in this section at all.
13. Corrective Actions requiring evaluation.	Incidents with a Corrective Action that has a date in the “Proposed Evaluation date” field. Items will appear as Due one week prior to the entered “Proposed Evaluation date”, and Overdue once this date has passed. Items are removed from the list once the “Evaluation Completed” field has been updated.. Note, as these fields are only displayed for SAC1 incidents with actions arising out of HEAPS or RCA.

Incident Category	Incident. PrimaryIncident TypeCategaryName. String
Incident Type.....	PrimaryIncidentSubtypeCategory. PrimaryIncidentSubtypeName. String
Incident Stage	Incident. Classification_IncidentStageName: String
Incident Issue.....	ClassificationIncidentIssue. IncidentIssueName: String
Complication	ClassificationIncidentComplication. IncidentComplicationName: String

Incident Classification

Admission/ Transfer/ Discharge/ Handover

1. Type	**Admission**	refers to access and entry into the service
	Advice/consult	eg advice provided by GP, Health Contact Centre, Pharmacy etc.
	Discharge	Refers to discharge planning process and patient returns to normal place of residence.
	Follow up/ongoing care	Midwifery, cardiac, diabetes, oncology
	Referral	Refers to the referral processes
	Transfer	Refers to transfer between wards/ services. Also may refer to the transport of patient/client by RFDS or QAS
2. Stage	Between team members	Clinical Handover between shifts within the same ward
	Between wards	Between wards/services within the same facility
	Between QH facilities.....	Between two QLD Health hospitals or inpatient service providers
	Between QH facility & community	Between a QLD Health hospital or inpatient service provider, and a QH community or other outpatient provider
	Between QH facility & external service provider	Between a QLD Health hospital or inpatient service provider, and an external healthcare provider, eg Private, Non-QH aged care facility, GP, Correctional facility, city council funded school health program, domiciliary services, alternate health providers.
	Between QH facility & retrieval authority	Between a QLD Health hospital or inpatient service provider (PTQC), and a service dedicated to providing transport of patients (eg RFDS, QAS)
	Between QH & patient/ family/ carer	Between a QLD Health hospital or service provider, and a consumer of healthcare services
3. Issue	Delay.....	**Admission -** Delay in admission. For example, long waits in Emergency Department or waiting rooms. (Excludes 'unreasonable wait for elective surgery'). **Transfer -** Delay in transferring patient at any level of the transfer process. For example, RFDS/ QAS unavailable asap. **Discharge -** ie unable to return to home due to lack of community support. **Referral -** Eg referral made but not actioned. **Advice -** caller unable to get urgent advice due to call load.
	Inappropriate.....	**Admission -** Patient has been admitted to a ward or area that is unable or not appropriate to deliver the care required. For example, lack of available beds required the patient to wait in A&E department for an extended period, or a Mental Health patient. **Advice** provided was incorrect. **Transfer** eg patient brought to hospital via taxi, private transport. Pt inappropriately restrained or medicated in order to transfer. **Discharge** eg self discharge against medical advice, discharge leads to inappropriate admission. See Also Infant discharged to wrong family

Unable to perform.....	**Admission -** Patient not able to be admitted to hospital or service, eg - unable to admit patient to community MHS due to staffing levels. **Transfer -** Unit / ward / facility unable to accept patient transfer
Unexpected.....	**Admission -** (unexpected admission due to inappropriate discharge planning. **Transfer -** Patient is transferred without the receiving ward, service or facility being advised in advance of the patient's arrival. Due to unexpected deterioration, patient transferred eg to ICU.
Responsibility for continuity of care unclear.....	**Transfer** - eg patient sent to another facility (eg Aged Care facility) without confirming who is responsible for ongoing care eg no discharge summary provided, therefore no ongoing care or follow-up. **Discharge -** eg patient sent home without confirming who is responsible for ongoing care eg no discharge summary. Summary sent to GP, therefore no ongoing care or follow-up. **Referral -** Eg Client referred to a community service but information not received or followed up.
Deterioration not observed or recorded	Select where there has been a failure to observe or record the deterioration in the patient's status, ie - any changes were not perceived)
Deterioration observed and recorded but not interpreted	Select where there has been a recorded change in the status of the patient, but that change has not been comprehended as an indicator of deterioration, ie - any changes were not understood)
Deterioration interpreted but response inappropriate	Select where a clinician observed and interpreted patient's deterioration, or was advised of a patient's deterioration, but did not anticipate the consequences of this deterioration. Therefore intervention or escalation was not undertaken or was inappropriate or the response to that escalation was not appropriate.
Infant discharged to the wrong family member. ...	Re-introduced 2/4/2012 to better comply with national reporting. Note, this issue triggers the SAC1 rules.

Comment [WD]: Information provided by Yvonne Wilkinson.

Behavioural

Refers to actions to/by the client/patient…. *Clarification provided 28/2/2011*
A clinical incident is usually one that ends up in restraint or seclusion.

Please note, although it is noted that PRN is a chemical restraint, when a PRN is offered and taken by the patient voluntarily it is part of clinical care - ie the patient is complying with the treatment plan which includes extra medication. (Compare this with a patient who is in pain post op - when offered analgesia they take it - all part of normal care).

When a patient is forced to take PRN (usually by injection) with a number of staff ensuring that the medication is taken then it is a clinical incident. (This includes similar events outside of a mental health situation - it is psychological harm)

Almost all seclusions should be considered a clinical incident. There are some exceptions where seclusion may be written into a treatment plan as a strategy to manage clinical deterioration - these are rare and most often relate to high security environments. I suggest that these are considered on a case by case basis.

Environmental Destimulation (which includes "time out" where the person is simply removed from the environment – ie asked to lie down on their bed or stay in a quiet room and not locked into that situation) is not seclusion and is not a clinical incident - no PRIME report needed.

1. Issue	Attempted to abscond	Select this if a patient was attempting to leave the ward, hospital or unit without permission, against medical advice or without medical consent.
	Absconded / missing.....	Select if a patient was away from the ward, hospital or unit without permission. (eg absent from clinical setting against medical advice, or without medical consent)
	Aggressive behaviour	Definition revised 30/4/10 If there is a management plan which addresses the behaviour, then the aggressive behaviour is not necessarily an incident. Ie a PRIME incident report need not be completed just because a patient is yelling (eg at staff). If the clinician has a strong feeling, or can reasonably predict that the patient may suffer harm, or where an action is required for the patient, eg an intervention, change in management plan, then log in incident report in PRIME. See guide for use on pg 35. **Important note** – Whether a staff member is threatened by a patient, (eg physically or verbally) is not relevant when deciding whether to report an incident in PRIME CI. This behaviour towards staff should be reported via the WH&S reporting process.
	Sexually inappropriate behaviour	Sexual behaviour that is likely to lead to significant health risks to the individual and/or others. Select this if the individual involved in the incident exhibited unacceptable sexually orientated behaviour. Examples include sexual contact with another
	Self harm.....	Added 30/4/10 Select this if the individual involved in the incident self harms, regardless of the severity (NB to record severity of harm, refer to SAC ratings).For example, attention seeking behaviours like a patient cutting his or her legs and then informing staff.
	Attempted suicide	Added 30/4/10 If the individual involved in the incident indicated intent to suicide, but not actually carrying it through or being successful. Lacks value of their life. Examples include a person obtaining a rope, making a noose, but not actually carrying the event
	Suspected suicide.....	Added 30/4/10 See MH mortality report data set Reportable/Sentinel event references: SE #7 a, b, c, d and #8. – 7a. Suspected suicide of a patient receiving inpatient health care - in a mental health facility 7b. Suspected suicide of a patient receiving inpatient health care - in other QH facility 7c. Suspected suicide of a patient receiving inpatient health care - during approved leave 7d. Suspected suicide of a patient receiving inpatient health care - after absconding
	Risk taking behaviour.	added 26/5/10 Actions arising out of altered mental state, due to psychosis or dementia/ lack of insight where the person does intend self harm. Eg: · Walking/running with scissors/sharps · Playing in traffic, ignoring road rules · Climbing trees, jumping out of them · Hiding dangerous objects · Wandering off, getting lost · Cutting fly screens from windows Note, these incidents are different to a temporary lapse

		of attention, which results in accidental harm, in this case classify incident as Patient Accident under the Patient Incident Category.
	Suspected substance misuse	Added 30/4/10 Evidence of illicit drug/ and or alcohol use by the client/patient.
2. Immediate Intervention attempted	BehaviourImmediateIntervention.ImmediateIntervention_Description: String	
	Clinical Intervention...	Commence CPR, administer first aid eg wound management etc
	De-escalation	Use of verbal / non verbal techniques such as approaching the client in a non-threatening, calm manner to decrease the client's level of distress / agitation / aggression.
	Distraction	Distraction is the strategy of focusing attention on stimuli other than pain or the accompanying negative emotions.
	Environmental de-stimulation.....	This is a calming strategy involving the removal of specific stimuli from the consumer's immediate environment in order to prevent or reduce agitation or aggression.
	Increase frequency of observation	
	Initiate search.....	Search grounds, contact family, alert police/ security etc.
	N/A	
	None	
	PRN (medication as required).....	Select one of: Oral, IM, IV, or PR BehaviourImmediateIntervention.PRNAdministered_Description: String
	Removal to restrictive area	Removal to a High Dependency Unit / Acute Observation Area / Psychiatric Intensive Care Unit. These are defined as locked acute inpatient treatment areas that provide high levels of supervision (higher staff to patient ratio) and security for a reasonably short period of time for people with an acute mental health exacerbation posing a serious risk to themselves or others. People with a variety of mental health problems may use this treatment environment.
	Sensory intervention	Multi-sensory therapy is an activity which usually takes place in a dedicated room where patients experience a range of visual, auditory, olfactory, tactile and proprioceptive stimuli. These rooms can be used to create a feeling of comfort and safety, where the individual can relax, explore and enjoy the surroundings.
	Voluntary time out.....	Practice where a patient is requested to seek voluntary social isolation for a minimum period of time.
3. Restrictive Intervention applied	a. None (default)	BehaviourRestrictiveIntervention.RestrictiveIntervention_Description: String
	b. Restraint.....	Restraint is a restrictive intervention that relies on external controls to limit the movement or response of a person. **Mechanical** refers to the restraint of a person by the use of a mechanical appliance (including belt, harness, manacle, sheet, strap and handcuffs) preventing the free movement of the person's body or a limb of the person. **Physical** refers to the use of physical force to prevent a person from placing themselves in a dangerous situation or harming themselves or others. (see Level of Physical Restraint)
	c. Seclusion.....	Seclusion is the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented. Seclusion should not be confused with the practice of "time out" where a patient is requested to seek voluntary social isolation for a minimum period of time.

BehaviourRestrictive Intervention. Sedation_Description: String	d. Acute sedation	'Acute Sedation' in these guidelines refers to the emergency administration of psychotropic medication to a patient in a mental health inpatient setting: • to relieve distress; • to bring severe behavioural disturbance under control to protect the person or other people from immediate or imminent risk to their safety; • to facilitate comprehensive diagnostic assessment and management. Select one of: Oral, IM, IV, PR
Restraint: additional information	Date commenced Time commenced Date ended Time ended	If time ended cannot be completed at time of logging incident, leave blank, and do an incomplete save. The Line Manager will be required to complete this field, then "save final" in order to manage the incident. Behaviour. DateTimeRestraintCommenced: DateTime
Type of Restraint	Mechanical	refers to the restraint of a person by the use of a mechanical appliance (including belt, harness, manacle, sheet, strap and handcuffs) preventing the free movement of the person's body or a limb of the person.
	Physical	refers to the use of physical force to prevent a person from placing themselves in a dangerous situation or harming themselves or others. (see Level of Physical Restraint)
	BehaviourRestraintType. RestraintType_Description: String	
Level of Physical restraint	1: Escort, verbal convincing	E.g. show of force, getting extra staff to take medication or move to another part of the unit.
	2: Escort, verbal and physical coercion.	E.g. escorted without pain compliance, guiding, supporting.
	3: Escort, physical coercion and pain compliance.	E.g. using wrist locks, escort holds.
	4: Physical restraint to the ground, 3 people "hands on"	Description updated 01/11/2013. Rational: Mental health services are the only health speciality that have the legal powers to hold individuals who are mentally unwell against their will for their safety and the safety of others. The unfortunate use of the term "take down" within Mental health is very sensitive. It is important for us to promote the spirit of support and protection for the patient and others and the use of language reflects this.
	5: Physical restraint, other.	E.g. restraint using more or less than 3 people "hands on".
	BehaviourRestraintType. LevelofRestraint_Description: String	
Persons Involved	Default = 0. Enter the number of staff of each type involved in managing this incident. ▪ Allied Health ▪ Nursing ▪ Police ▪ Medical ▪ Other ▪ Security BehaviourSeclusionNumber of persons: Number of personsCategory_Description: String	
Seclusion: additional information	Date commenced Time commenced Date ended Time ended	As above Behaviour. DateTimeSeclusionCommenced: DateTime Behaviour. DateTimeSeclusionEnded: DateTime
Persons Involved	As above BehaviourSeclusionNumber of persons. Number: Number	

Diagnosis / Investigation

Incident Category ..... Incident..PrimaryIncident TypeCategaryName. String
Incident Type..... PrimaryIncidentSubtypeCategory. PrimaryIncidentSubtypeName. String
Incident Stage ..... Incident.Classification_IncidentStageName: String
Incident Issue..... ClassificationIncidentIssue.IncidentIssueName: String
Complication ..... ClassificationIncidentComplication.IncidentComplicationName: String

1. Type	**Clinical Diagnosis**	Clinical assessment of signs and symptoms, leading to a management plan.
	Medical Imaging	Diagnostic procedures involving the use of radiation (such as x-rays) or other imaging technologies (such as ultrasound and magnetic resonance imaging) to diagnose disease. **Note** – this does not include radiological procedures used to treat disease (see Intervention / Treatment)
	Other Diagnostic procedure	Use where the patient is undergoing a specific activity related to clinical diagnosis, including surgical procedure eg, Cardiac stress test, ECGs, glucose tolerance test, cystoscopy, bronchoscopy, colonoscopy.
	Pathology	Diagnostic procedures involving pathological analysis of patient specimens. Includes biochemistry, microbiology, haematology, transfusion, serology, virology, anatomical pathology, cytology. Specimens may include blood, urine, sputum, CSF, bone or tissue
2. Stage	Request	The stage at which the diagnostic procedure is requested, eg referral of patient for X ray or MRI, filling out of laboratory test request form
	Specimen Collection	The stage at which any required samples are collected from the patient (where applicable). Blood, tissue, biopsy, other biological sample,
	Transport	Courier issues, software issues, Air tube (Lampson), temperature, time, damage
	Performance of test/ procedure.....	The stage at which the diagnostic test is performed, eg testing of specimens, conduct x-ray, tracing, cystoscopy, other surgical diagnostic procedure
	Interpretation of test results	The stage at which the results of the diagnostic procedure are interpreted, eg review of X rays, comparison of results against known reference ranges, and diagnosis made where appropriate.
	Reporting of test results	The stage at which the results of the diagnostic procedure are committed to a formal report, eg transcription of dictated review, provision of report to clinical area. Reporting critical results, display and delivery of reports eg software issues = results not available
	Verification/ Review of test results	Acknowledgement of receipt by requesting clinician.
2. Stage - Clinical diagnosis	History.....	History obtained by the clinician when communicating with the patient/ and or care team.
	Examination	physical and/or mental health examination
	Interpretation.....	provisional diagnostic formulation based on history and assessment

3. Issue	Delay.....	Select this if a procedure was not performed within an appropriate timeframe. Eg delayed assessment from other allied health services (for example, physiotherapists, speech pathologists, occupational therapists). Also includes STAT tests
	Failure to.....	Select this if a procedure was not ordered or performed (for example, glucose omitted from a urea & electrolytes test).
	Inappropriate / Unsuitable.....	Select this if a procedure was performed inappropriately (eg faecal fat ordered on patient with constipation) or the procedure or sample provided was unsuitable (eg EDTA supplied for urea and electrolytes). Incorrect assessment tool used, not following assessment procedure.
	Inadequate/ No Labelling	Only displayed for Pathology > Request, Specimen Collection, and Transport. See Reporting a Pathology Incident info sheet.
	Additional intervention required.....	Eg xray; recollect blood, sample; surgical procedure
	Deterioration not observed or recorded	Select where there has been a failure to observe or record the deterioration in the patient's status, ie - any changes were not perceived)
	Deterioration observed and recorded but not interpreted	Select where there has been a recorded change in the status of the patient, but that change has not been comprehended as an indicator of deterioration, ie - any changes were not understood)
	Deterioration interpreted but response inappropriate	Select where a clinician observed and interpreted patient's deterioration, or was advised of a patient's deterioration, but did not anticipate the consequences of this deterioration. Therefore intervention or escalation was not undertaken or was inappropriate or the response to that escalation was not appropriate.
	Wrong body part / side / site (SE #4).....	Select where diagnostic test or procedure has been performed on the wrong site of the correct patient (For example - left arm X-rayed instead of right).
	Wrong patient	Select where diagnostic test or procedure has been performed on the wrong patient
	Patient reaction.....	The patient reaction (physical or psychological) impacted on the progression or outcome of the diagnosis/investigation type (eg allergic reaction or anxiety/ emotional distress or patient underwent MRI with nicotine patch and subsequent burns; contrast reaction;
	Wrong procedure.....	Select this if a procedure was performed incorrectly Eg - one diagnostic procedure ordered, but another performed (eg MRI not CT)
	Retained object / instrument (SE #5).....	Select where an instrument or medical device has not been removed from the patient (by error)
4a. Patient reaction/ Complication – Clinical Diagnosis		
	None……..	Note, the user will **not** be provided a free text box
	Other unexpected clinical outcome……	
4b. Patient reaction/ Complication - Medical Imaging		Ie clinical reaction, not patient's psychological response to the incident. MRI, Ultrasound, Xray/ CT scan
	Contrast reaction	Adverse reactions to contrast agents (eg Iodine based contrast) range from a mild inconvenience, such as

		itching associated with hives, to a life-threatening emergency. Renal toxicity is a well known adverse reaction associated with the use of intravenous contrast material. Other forms of adverse reactions include delayed allergic reactions, anaphylactic reactions, and local tissue damage.
	Inadvertent perforation	Delamination, dissection of a vessel. Eg during angiogram
	Unintended exposure	Unintended exposures arising from radiotherapy, incidents can be divided into the following categories: (a) radiotherapy treatment delivered with a dose or dose fractionation differing substantially from the values prescribed by the oncologist; (b) radiotherapy treatment delivered to either the wrong patient or the wrong tissue and (c) accidental exposure of patient due to equipment failure or equipment malfunction.
	Overexposure	Wrong exposure was set for the body part x-rayed.
	Reaction with foreign body	eg During an MRI the presence of metallic objects can harm the patient, ECG patches, pacemaker, jewellery.
	Other / None	Note, the user will **not** be provided a free text box
4c. Patient reaction/ Complication - Other diagnostic procedure		
	None……..	Note, the user will **not** be provided a free text box
	Unexpected clinical outcome……	
4d. Patient reaction/ Complication -Pathology		Ie clinical reaction, not patient's psychological response to the incident
	Excessive bleeding	Eg haemorrhage, excessive bleeding from heel prick
	Thrombophlebitis	Venous inflammation with thrombus formation.
	Haematoma	(May be included with thrombophlebitis) is a collection of blood outside the blood vessels,[1] generally the result of haemorrhage, or more specifically, internal bleeding.
	Fainting	a sudden, usually temporary, loss of consciousness
	Peripheral nerve damage	eg caused by a needle
	Allergic reaction	
	Unexpected clinical outcome	perforation, cardiac arrest

Patient Incident (Fall, Skin/PU

Fall

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or lower level (eg from chair, bed, cot, therapeutic equipment, in shower)

Patient being assisted by staff to perform a task?	**Yes/ No**	To compare the incidence of patient falls with and without staff supervision/ assistance. Fall. IsAssistedbyStaff: Boolean
Type of fall as reported by patient	Unknown	This is not a user selectable option but is displayed for legacy falls incidents Fall. FallTypeName: String
	Dizziness	Loss of equilibrium, for example, a spinning sensation, or light-headedness, or a feeling you are about to fall
	Faint	Loss of consciousness
	Legs gave way	Involuntary loss of mechanical support in the leg or legs

	Overbalance	Movement of the body beyond its base of support
	Patient unable to report	eg pt loss of memory, unconscious at time etc.
	Slip	fall or loss of balance occurring from Loss of traction on surface
	Trip	Loss of balance usually while walking resulting from portion of foot or lower limb contacting an obstacle.
Activity at time of fall	ie related to activities of daily living *Reference: Australian Commission on Safety and Quality in Healthcare. Preventing falls and harm from falls in older people. 2009*	Fall. ActivityName: String
	Unknown	This is not a user selectable option but is displayed for legacy falls incidents
	Patient unable to report	eg pt loss of memory, unconscious at time etc.
	Reaching for object while seated	
	Reaching for object while standing	
	Rolling out of bed	Rolling out of bed onto the floor
	Seating to seating	Transferring from one seated position to another, eg chair or toilet to wheelchair
	Sitting	Sitting without other activity
	Sitting to standing	Moving from a sitting position to a standing position, eg rising from a bed or chair, or toilet.
	Standing	Standing without other activity
	Standing from lying position	Moving from a lying to a standing position, eg, getting out of bed
	Standing to lying position	Moving from a standing to a lying position , eg getting into bed
	Standing to sitting	Moving from a standing to a sitting position, eg lowering to a bed, chair or toilet.
	Walking/running	Eg, child playing during physiotherapy
Function attempted by patient at time of fall	ie related to allied health activities	Fall. FunctionName: String
	Bathing/ showering	All activities involved in bathing or showering, including getting to shower
	Exercising	Activity undertaken for therapeutic or recreational purposes, eg, going for a walk, or a part of treatment program
	Grooming or dressing	Includes activities such as brushing hair or teeth, dressing, etc
	Patient unable to recollect	eg pt loss of memory, unconscious at time etc.
	Resting	Includes movement to location of rest
	Toileting	All activities involved in getting to and using toilet
	Use of entertainment	Includes activities such as picking up a book or turning on the TV
Information for activity/function obtained from	Patient reported	Ie, details of how incident occurred provided by the patient.
	Staff observation	Incident witnessed by staff
	Other person	Ie reported by parent, carer, visitor etc
	Not witnessed	FallInformationForActivity…. Name: String
Post fall management	Falls reassessment Increased frequency of observation Diagnostic procedures Therapeutic treatment Fall prevention strategies implemented None	PostFallManagement …Name: String

Was a falls risk identified prior to incident? as "at increased risk" Yes or No
Fall. PatientIdentifieddAsIncreasedRisk: Boolean

If yes, Was the patient identified as being" at increased risk" Yes or No
Fall. PatientIdentifieddAsIncreasedRisk: Boolean

If no, reason risk not established Free Text
Fall. ReasonNotEstablished: String

Pressure Injury (Ulcer)

A pressure injury is localised injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure in combination with shear and/or friction.

Assessment tool used & Score (numeric)

Incident.Assessment ToolNusedName

	Name of Tool	*Range*	
1	(Modified) **Braden Q** *[paeds]*	**[7 – 28]**	
2	**Glamorgan** *[paeds]*	**[0 – 42]**	**(New 2/4/12)**
3	**Waterlow** (Revised)	**[2 – 55]**	
4	**RBWH** RBWH staff only are to select the RBWH tool	**0 = No risk** **1 = At risk**	

Present on Admission

Patients admitted with existing pressure ulcers (ie. community acquired or present on transfer), should be reported as patient outcome rating of 'NO HARM' (ie. SAC 3). The outcome of 'No Harm' must only be used for pressure ulcers present on admission. The stage should be accurately reported for all incidents. Refer also to the Pressure Injury Info Sheet

.....PressureUlcer. PressureAreaAtAdmissionStatusName: String

No, acquired during admission .....

ie, acquired in your Queensland Health (QH) facility during the current episode of care..
If you are receiving a patient who has been transferred to your ward/ unit from another ward/unit **within** your facility, it is expected that the pressure injury would already have been identified and logged in PRIME CI. You can confirm this by checking documentation within the record (for e.g. PRIME Clinical Incident report; PI notification sticker; progress notes; assessment tool).

If there is no documented evidence in the medical record that the PI has been reported in PRIME CI then it is your responsibility to log this incident.

When assessing whether the PI was "present on admission" *(ie. to your facility/hospital NOT referring to internal transfers to your ward/unit)*, check whether it was recorded in the medical record within 24 hours of admission. If not, it should be presumed that the PI is a HAPI and should be recorded as acquired during the current admission. interventional strategies implemented.

KNOWN Bug:
Although this is a mandatory field, it is not being enforced prior to selecting [Save final].

This has been noted for the 'site' field as well.

Yes, present on admission from non QH location

Yes, admitted from non QH location eg. acquired in private facility (nursing home), in private residential setting or at person's home (community-acquired).
Note: this must be documented in medical record within 24 hours of admission.

When reporting a pressure injury "present on admission", select that the "patient outcome" rating of "no harm". It is possible to exclude those pressure injuries "present on admission" from QHERS reports. The circumstances related to where the pressure injury was acquired may influence the type of analysis commissioned. It will be possible to distinguish (and exclude) those pressure injuries "present on admission" when running QHERS reports.

	Yes, present on admission from QH facility	**Yes, present on admission from a QH facility** eg. transfer from QH residential care facility, other QH hospital, QH Multi Purpose Health Service, QH clinic, etc. NOTE: This also includes where treatment had been provided as a non admitted patient, *eg. Where transferred from another QH Emergency Department (DEM) or Outpatients clinic (OPD) this must be documented in medical record within 24 hours of admission.* If the documentation does not support that an initial skin assessment was done within 24 hours of the patient being transferred/admitted to your facility, it should be presumed that the PI was acquired during the current admission at your facility and recorded as hospital-acquired.
Stage PressureUlcer. PressureStageName : String	**Mucosal Membrane**	New 2/4/12. The staging system for PI of the skin cannot be used to stage mucosal PIs. The reasons for this is that nonblanchable erythema cannot be seen in mucous membranes, as shallow open ulcers indicating superficial tissue loss of the non-keratinized epithelium are so shallow that they are visually indistinguishable from deeper, full thickness ulcers. Soft coagulum seen in mucosal PIs, which resembles slough in Stage III PIs, is actually soft blood clot. Exposed muscle would seldom be seen and bone is not present in mucosa.
	1	Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area.
	2	Partial thickness skin loss of dermis presenting as a shallow open ulcer with pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister
	3	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunnelling
	4	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling
	Suspected Deep Tissue Injury.....	New 2/4/12. Purple or maroon localised area of discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, or warmer or cooler than adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with treatment.
	Unstageable	New 2/4/12. Pressure injury presenting as full thickness tissue loss in which the base of the PI is covered by slough preventing the determination of the true depth, and therefore the stage.

Wound description

Briefly describe the wound in this free text field. Note, detailed information should be documented on a "Wound Assessment Chart" and utilised.

PressureUlcer. WoundDescription: String

Site
PressureUlcer. SiteName: String

Achilles Tendon	Hand (New 2/4/12)	Sacrum
Anal Region	Head	Scapula
Anterior Superior Iliac Spine	Heel	Scrotum
Arm	Iliac Crest	Shin
Back	Ischium /Trochanter (hip)	Shoulder

Breast	Knee	Spinous Process
Buttock	Leg	Thigh
Coccyx	Lips	Toe
Ear	Malleolus (ankle)	Tongue
Elbow	Mouth	Tracheostomy
Finger (New 2/4/12)	Nose	Wrist
Foot	Occipital Bone	
Genitalia	Ribs	
Gluteal Fold		

Site location
PressureUlcer.SiteLocationName: String

Back	Front	Lower	Proximal (New 2/4/12)
Central / middle	Lateral	Medial	Right
Distal (New 2/4/12)	Left	Plantar (New 2/4/12)	Upper
Dorsal (New 2/4/12)			

Pressure equipment in use
PressureEquipment…Name: String

Ear pads	Mattress – Standard pressure reducing-foam
Elbow pads	Mattress – static air mattress
Foam device	Mouth protection
Gel filled pad	Nose pads
Heel wedge	Other (please specify)
Leg gutters	Pressure reducing cushion
Mattress – alternating air mattress	
Mattress – low air loss	

Interventional strategies implemented
Interventional Strategy…Name: String

1. Dressing regime implemented	Ensure suitable dressing is applied.
2. Reduce pressure	Use of appropriate pressure relieving devices
3. Nutritional assessment	Determine whether client is malnourished, ie dehydration, oedema, protein insufficiency, unintended weight loss, weight gain, poor intake due to reduced appetite.
4. Maintenance of skin integrity	Prevention of excessive moisture (drainage: fistulae, wounds; incontinence: urine, faeces; perspiration. Prevention of excessive dryness of skin. Monitoring for clients/patients with frail/ fragile skin.
5. Eliminate shear and friction	Shear: skin trauma can be caused by tissue layers sliding on one another, resulting in disruption or angulation of blood vessels. Friction: A force created by two surfaces in contact moving across one another.
6. Positioning and turning	Client must be positioned and repositioned on individualised regime to minimise pressure.
7. Promote activity and mobility	Educate and partner with patient and family to encourage mobility.
8. Care Plan Commenced	Ulcer details are documented and a care plan is documented, communicated and implemented.
9. Specialist advice sought	Eg. Specialist nurse, medical officer, stomal therapist, dietician, occupational therapy, physiotherapist, podiatry, etc, notified
10. Discharge planning intra facility, between facility and/or home	Handover occurs to the community health professionals/ or receiving facility, and/or family, to support ongoing care, monitoring and planned follow up. Consideration should be given regarding supply of dressings or other resources (as per local guidelines).

- Qld Health. Pressure Ulcer prevention and management resource guidelines. 2009 Available electronically at http://www.health.qld.gov.au/psq/pip/docs/pup_guidelines.pdf

There are no additional data fields to complete for the following incident types:

Victim of aggression	This option is selected for incidents where the patient/client was the subject of verbal abuse or intimidation, or physical or sexual assault.
Harm from unknown cause	This option is available for the reporter to select when unable to determine the cause of harm or injury. For example, bruises or skin tears.
Patient Accident	Harm/injury resulting from a non clinical event/ incident. Includes motor vehicle accidents, exposure to hazardous chemicals, contact with sharps/ other objects.

Treatment/ Intervention

Incident Category ..... Incident. PrimaryIncidentTypeCategaryName. String
Incident Type..... PrimaryIncidentSubtypeCategory. PrimaryIncidentSubtypeName. String
Incident Stage ..... Incident. Classification_IncidentStageName: String
Incident Issue..... ClassificationIncidentIssue. IncidentIssueName: String
Complication ..... ClassificationIncidentComplication. IncidentComplicationName: String

1. Type	**Blood Products, Transfusion and Haemovigilance**	Haemovigilance consists of the detection, gathering and analysis of information regarding untoward and unexpected effects of blood transfusion.
	Diet / Nutrition	
	Invasive / non-invasive care	Invasive procedure / Non invasive procedure , taking bp, surgical procedure
	Medication	

Blood Products, Transfusion & Haemovigilance

Haemovigilance consists of the detection, gathering and analysis of information regarding untoward and unexpected effects of blood transfusion.

Product / Component (Blood) Incident. BloodProductsComponentName	Cryodepleted plasma (CPP)	This is plasma left after cryoprecipitate has been removed from FFP by controlled thawing. It contains most coagulation factors other than Factor VIII, fibrinogen, von Willebrand factor, Factor XIII and fibronectin (which are found in cryoprecipitate).
	Cryoprecipitate	Prepared by thawing FFP and recovering the precipitate. This component is used mainly for its high fibrinogen content.
	Fresh frozen plasma (FFP)	Produced from whole blood donations and by apheresis. FFP contains all coagulation factors.
	Other blood products	Albumin (4% and 20%). Anti-D (Rh D immunoglobulin & WinRho SDF) Autologous eye drops.
	Plasma derived factor concentrates -	Concentrate of vitamin K dependent coagulation factors (except Factor VII) produced from plasma. Belongs to group of concentrates termed ‘prothrombin complex

	Prothrombinex VF	concentrates' due to content of vitamin K dependent clotting factors. Main use is for reversal of warfarin and other vitamin K antagonists in situation of overdose with significant bleeding.
	Plasma derived factor concentrates - other	These products include other plasma derived clotting factor concentrates fractionated from plasma. Examples include Factor VIII (Biostate), Factor IX (Monofix VF), FEIBA, Fibrogamin (Factor XIII), Thrombotrol-VF, Protein C (Ceprotin), Factor XI etc.
	Platelets	An adult dose of platelets are produced by apheresis or by separation from a whole blood donation. Both products are leucodepleted (white cells removed during production). Also available are PAEDIATRIC apheresis leucodepleted platelets.
	Red cell concentrates	Majority are red cells from which plasma and white cells (leucocytes) are removed during processing of a whole blood donation. The red cells are suspended in an additive solution to preserve the red cell function. Also, can refer to WASHED red cells, PAEDIATRIC red cell component, whole blood and emergency donor panel whole blood donations.
	Stem Cells - Haemopoietic (HSC)	Haemopoietic stem cells may be obtained from bone marrow, peripheral blood or cord blood. HSCs are used to facilitate bone marrow recovery following a bone marrow, umbilical cord blood or peripheral blood stem cell transplant.
2. Stage	**Prior to administration** **During administration** **After administration**	
3. Issue	Incorrect blood component transfused (IBCT) - wrong patient ..	Select when a blood component or plasma component was administered to the wrong patient and there was no harm to the patient. (QiiT Haemovigilance)
	Incorrect blood component transfused (IBCT) - not suitable	Appropriate product / requirement not met, ie select when a blood component or plasma component ordered or administered did not meet the appropriate requirements (expired, irradiated, CMV negative, leucodepleted etc) for the intended recipient. (QiiT Haemovigilance). Also includes contaminated component.
	Transfusion time outside of prescribed rate, without circulatory overload	This category should be selected when, as per best practice, transfusion of a blood product bag was either not completed in 4 hours, or was significantly different from the prescribed rate and without evidence of circulatory overload. If the incident results in circulatory overload, reporter should select "Transfusion associated cardiac overload (TACO)". *(revised definition 1/7/08)*
	Wrong dose / volume.....	This category should be selected when either the dose or volume transfused is outside the prescribed dose or volume and without evidence of circulatory overload. If the incident results in circulatory overload, reporter should select "Transfusion associated cardiac overload (TACO)".
	Administered with contraindicated substance	Administration of an incompatible substance through the same intravenous route and at the same time as the blood component is being infused.

	Patient reaction Product not administered	
4. Patient Reaction/ Complication	None	
	ABO haemolytic transfusion reaction……..	Haemolytic transfusion reaction due to ABO incompatibility. (QiiT Haemovigilance) See DHTR above for features of a haemolytic transfusion reaction.
	Febrile non haemolytic transfusion reaction (FNHTR)	Select when the transfusion of a blood product has caused a febrile non haemolytic transfusion reaction – defined as one or more of following within 4 hours of transfusion without any other cause (e.g. haemolytic transfusion reaction or infection) - rise in temperature during transfusion of 1 ^{O}C or temp. ≥ 38.0 ^{O}C; chills; sensation of cold; rigors. (QiiT Haemovigilance)
	Transfusion associated cardiac overload (TACO)	Select when volume overload led to congestive cardiac failure within 12 hours of transfusion. Defined as featuring any 4 of the following: respiratory distress; tachycardia; increased blood pressure; acute or worsening pulmonary oedema (typical signs of cardiogenic lung oedema in the chest X-ray); evidence of a positive fluid balance and/or a known compromised cardiac status. (QiiT Haemovigilance)
	Severe Allergic reaction.	Severe allergic reaction defined as one or more of rash, dyspnoea (wheezing, stridor, cyanosis), angioedema, generalised pruritus, and/or urticaria during or within 24 hours of a transfusion of a blood component or a plasma component that requires **pharmacological treatment**. (QiiT Haemovigilance)
	Anaphylaxis	Allergic reaction (one or more of rash, wheezing, dyspnoea, stridor, angioedema, generalised pruritus, and/or urticaria) with hypotension **(drop in systolic blood pressure of equal to or more than 30 mmHg**) during or within 24 hours of a transfusion of a blood component or plasma component. (QiiT Haemovigilance)
	Transfusion related Acute Lung Injury (TRALI)	Occurrence of acute respiratory distress and bilateral pulmonary infiltrates on chest X-ray with no evidence of circulatory overload or other potential cause within 6 hours of transfusion of a blood component or plasma component. (QiiT Haemovigilance)
	Post Transfusion Purpura (PTP)…… ….	An acute episode of thrombocytopenia occurring within 12 days of a transfusion (red cells or plasma) and confirmed by the presence of platelet specific alloantibodies (usually anti-HPA1a) in recipient's blood and presence of the antithetical antigen on donor platelets, or by positive platelet cross match. (QiiT Haemovigilance)
	Delayed Haemolytic Transfusion Reaction (DHTR) …… .....……	Haemolytic transfusion reaction occurring more than 24 hours after the transfusion. (QiiT Haemovigilance) Features that suggest a haemolytic transfusion reaction are one or more of: • Fever and other symptoms/signs of haemolysis (e.g. jaundice, dyspnoea, flank or back pain, tachycardia, hypotension, haemoglobinuria) • Inadequate rise in post-transfusion Hb • Fall in Hb level • Rise in LDH level • Rise in bilirubin, decreased haptoglobin And confirmed by a positive direct antiglobulin test

		(DAT) and positive cross match not detectable pre-transfusion.
	Acute non-ABO Haemolytic Transfusion reaction…….....……	Haemolytic transfusion reaction (not due to ABO incompatibility) occurring within 24 hours of a transfusion. (QiiT Haemovigilance) See DHTR for features of a haemolytic transfusion reaction.
	Transfusion Associated Acute Graft versus Host Disease (TaGVHD).....	Development of symptoms and signs (fever, erythematous skin rash, hepatic dysfunction, diarrhoea and bone marrow hypoplasia/pancytopenia) 1-6 weeks following transfusion with no other apparent cause. The diagnosis is confirmed by skin and/or bone marrow biopsy appearances and/or the demonstration of genetic chimerism in the recipient's peripheral blood lymphocytes. (QiiT Haemovigilance)
	Transfusion Transmitted Infection (including bacterial contamination of blood component)	A post-transfusion infection (viral, bacterial or parasitic) not present in the recipient before transfusion of a blood component or plasma component and present in either one of the components transfused or the donor of one of the transfused components. (QiiT Haemovigilance) Includes bacterial contamination of blood component - Detection and confirmation of bacteria in a blood component or plasma component, which has either not been transfused to the intended patient or was transfused but no bacteria was detected in cultures of the recipient's blood. (QiiT Haemovigilance)
Diet/ Nutrition	Malnutrition, referring to protein-energy malnutrition or undernutrition, develops as a result of inadequate dietary intake, increased nutritional requirements and/or increased nutrient losses. The nutritional status of a significant number of patients/residents declines over the course of admission to hospital or residential care. The prevalence of malnutrition in adults in Queensland Health hospitals is around 30% and up to 50% in residential care facilities. The impact of malnutrition is increased length of stay, convalescence and healthcare costs and poorer patient outcomes, including pressure injuries. *Changed introduced 2/4/2012*	
2. Stage	**Ordering**.....	Identification and ordering of food, fluids and/or nutrition support including diets for food allergies and intolerances, texture modified diets and thickened fluids.
	Preparation.....	Includes preparation of food and fluids including special diets, formula, etc. Also the appropriate storage, e.g. refrigeration, maintaining constant temperature.
	Feeding.....	At point where nutrition provided to patient.
3. Issue	Contamination of food / fluid	The meal or feed was affected by an impurity. This includes foreign bodies, pathogens or airborne matter. Examples include food left out of the fridge for greater than 2 hours after plating and still served to patients.
	Fed when NBM	(New 2/4/12) Food and/or fluids consumed when a fasting or a Nil by Mouth order applied.
	Inadequate screening	(New 2/4/12) Nutrition screening refers to the process of identifying patients/residents with characteristics commonly associated with nutrition problems who may require comprehensive nutrition assessment and may benefit from nutrition intervention. Includes screening for a ability to eat and drink safely. Includes referral to the healthcare team where required. *Introduced in PRIME April 2012*

	Inappropriate diet/ nutrition	Food, fluid or nutrition support was inappropriate or unsafe for the individual, special dietary requirements not met, incorrect texture, inappropriate food or fluid. For example · provided ordinary fluids (given jug of water) when prescribed thick fluids. · Food/fluid provided does not meet the cultural, religious, or ethnic needs of the patient.
	Inappropriate fasting	Select if the subject was fasted when not required (e.g., operation rescheduled or cancelled, but order to fast not rescinded).
	Incorrect route	Nasogastric tube used when oral route indicated or vice versa, tube placed incorrectly.
	Insufficient food intake	(New 2/4/12) Intake of nutrition does not meet the patient's nutritional requirements.
	Lack of assistance	(New 2/4/12) Inadequate assistance and/or supervision of food and fluid intake including positioning of meal, opening packages, cutting up food, monitoring safety of eating and drinking, prompting, and feeding patients who are unable to self-feed.
	Missed/delayed meal	Patient misses meal e.g. no meal provided, off ward.
	Wrong breast milk	Expressed breast milk given was incorrect for the individual.
	Wrong patient	Meal was given to wrong patient (e.g. special dietary requirement).
	Patient reaction……..	
4. Patient Reaction/ Complication	Aspiration	The entry of secretions or foreign material into the trachea and lungs.
	Allergic reaction/ anaphylaxis	Hypersensitivity reaction to a particular allergen.
	Dehydration	An abnormal depletion of body fluid with symptoms including tachycardia, increased respiratory rate, lethargy, irritability.
	Choking	(New 2/4/12) The mechanical obstruction of the flow of air into the lungs.
	Hypoglycaemia	Low blood sugar. Symptoms include drowsy, headache, delirium, seizure.
	Unplanned weight loss	(New 2/4/12) A decrease in body weight that occurs during the admission that is not planned or desired.
	Expected weight gain not met	(New 2/4/12) Unexpected variation in weight gain during a child's admission with a deviation of one percentile or more on standardised growth charts.
	None	No patient reaction/complication
	Food borne illness	(New 2/4/12) Symptoms associated with eating contaminated food that may include diarrhoea, nausea, vomiting, abdominal cramps, fever and headaches. * In a healthcare setting, following the identification of two or more cases of food borne illness, reporting to the Executive Officer is mandatory.

Invasive / noninvasive care

2. Stage	**Before commencement of intervention**	Includes prior to admission or during planning phase of treatment, eg includes 3 Cs protocol
	During intervention	During the performance of the intervention/treatment. Ie once procedure is underway.
	After intervention	During the recovery phase

3. Issue	Deterioration not observed or recorded.....	Select where there has been a failure to observe or record the deterioration in the patient's status, ie - any changes were not perceived)
	Deterioration observed and recorded but not interpreted	Select where there has been a recorded change in the status of the patient, but that change has not been comprehended as an indicator of deterioration, ie - any changes were not understood)
	Deterioration interpreted but response inappropriate	Select where a clinician observed and interpreted patient's deterioration, or was advised of a patient's deterioration, but did not anticipate the consequences of this deterioration. Therefore intervention or escalation was not undertaken or was inappropriate or the response to that escalation was not appropriate.
	Additional intervention required.....	Eg xray; wound management following wound dehiscence; administer antibiotics; surgical procedure
	Unplanned readmission	Ie following discharge from unit/ward or facility.
	Delay.....	Delays in treatment, or any other delay, including delay in provider attending or treatment provision in a timely manner. Eg, unreasonable delay for elective surgery.
	Not performed / inadequate	Assertion that reasonable care was not provided, based on what would be expected in a given clinical scenario. Eg Claim that provider did not provide treatment that a reasonable professional, in their capacity, would deem as adequate. (Excludes 'Negligence) Responsibility for the patient's ongoing care unclear.
	Inappropriate.....	The incorrect or inappropriate choice of therapy has been made but not where proper therapies are performed wrongly. Not clinically indicated, eg caesarean delivery or contraindicated / conflicting treatment regime Radiotherapy treatment delivered with a dose or dose fractionation differing substantially from the values prescribed by the oncologist; either because of human error or equipment malfunction.
	Incorrectly performed.....	Select this if a procedure or treatment was performed incorrectly. Procedures or treatments include removal of sutures and drains, wound dressings, IVP, Lumbar punctures, indicated observations etc.
	Not ceased when indicated	Treatment or service not ceased or removed when clinically appropriate, eg sutures or drains not removed when indicated, pain management maintained beyond requirements.
	Withdrawn.....	Removal of treatment; or denial of additional treatment or service perceived to have a therapeutic benefit.
SE # refers to the items on the retired Sentinel Event list. Used for National SE reporting.	Wrong body part / side / site (SE #4).....	Procedure was performed on the wrong part of the body (eg, arm operated on instead of leg), wrong side of the body (eg, left arm instead of right), or wrong operative site (eg, wrong mole removed from correct location of left arm)
	Wrong patient (SE #4) ...	Procedure was performed on the wrong patient
	Incorrect count	Select when there has been a count discrepancy leading to a delay or additional procedure but was resolved prior to completion of the surgery or procedure. (*introduced 30/4/10)*

Retained object / instrument (SE #5)	Retained instruments or other materials after surgery requiring re-operation or further surgical procedure.
Device compromised	This issue can be selected by the reporter when a device (eg IV, cannula) has been dislodged or become blocked. (*introduced 30/4/10)*
Non consented procedure performed	Select when an additional procedure has been performed for which consent is not documented.
Entrapment by bedrail and/or in bed accessories.....	Entrapment by bedrail and/or in bed accessories can cause significant levels of patient harm, even death. Queensland Health has defined a target of zero for death and/or permanent harm for this event. (Issue introduced 2/4/12)
Unexpected clinical event.....	Eg cardiac arrest

4. Patient Reaction/ Complication

An accidental condition or second disease occurring in the course of a primary process. An additional medical problem that develops following a procedure, treatment or illness
A condition that was not present at the time the episode of care commenced. A complication may be:¨ A condition resulting from misadventure during surgical or medical care¨ An abnormal reaction to, or later complication of, surgical or medical care, or ¨A condition which arose during the episode of care (that is, the condition was not present at the start of the episode or care).31;
An adverse patient event related to medical intervention, especially an event that is an expected consequence of, or that sometimes occurs in relation to, the patient's disease or its treatment.47;
None .....

Unexpected clinical outcome….	
Inadvertent perforation/ extravasation……..	Includes organ, vessel, duct or viscus
Infection……..	
Excessive Bleeding…..	
Complications of delivery – maternal	+ SAC1 = SE #1
Complications of delivery – foetal.....	+ death = SE #9
Intravascular gas embolism	+ SAC1 or 2 = SE #3

SE # refers to the items on the retired Sentinel Event list

Medication

2. Stage

This classification system is not descriptive of individual professional roles rather reflects the steps within the medication management system. It is possible to report more than one medication stage per incident.

1. Prescribing / Ordering	Any error that occurs at the time of prescribing the medication, including the initial decision to prescribe.
2. Dispensing / Supply	Any error that occurs during the dispensing, supply, distribution or storage of a medication, whether in a pharmacy, or a ward.
3. Transcribing.....	Any error that occurs when the prescription is transcribed, either to an order sheet, or into the patient's chart.
4. Administration	Any error directly involved in the administration of a medication to a patient.
5. Monitoring	Any specific observation taken post administration which monitors the effect of the medication on the patient.

3.1 Issue - Prescribing/ Ordering	Wrong patient	Medication is prescribed for the wrong patient. Note, if the medication is given to the wrong patient, also record that wrong medication has been administered
	Wrong medication.....	The medication being prescribed to a patient is wrong, inappropriate or not required. eg patient had known allergy.
	Wrong dose – overdose.	The dose of medication prescribed exceeds the recommended does. Eg. 10mg instead of 1mg, or normal dose prescribed 3x daily instead of 1x.
	Wrong dose – underdose.....	The dose of medication prescribed is below the recommended dose, eg 100mcg instead of 100mg, or nal dose prescribed 1x3 days, instead of 3x daily.
	Drug omission.....	Where a medication has not been prescribed when ongoing therapy should occur.
	Wrong formulation	Medication not prescribed in correct form eg tablet vs suspension, or spray vs cream
	Wrong rate	Medication is prescribed at wrong rate. Med written as twice per day (BD) when should have been once per day (Daily); or incorrect infusion rate.
	Wrong route	Medication is prescribed via the wrong route, eg intrathecal rather than intravenous.
	Wrong time……..	New 2/4/12. Medication that should be given nocte is prescribed mane. Eg. Sleeping tablet prescribed for the morning.
	Duplicate Order.....	New 2/4/12. Prescribed twice, 2 active orders.
3.2. Issue - Dispensing/ Supply	Wrong patient	Medication dispensed to wrong patient, eg orders mixed up.
	Wrong medication.....	The medication being supplied does not match what is prescribed. Eg. Contents of bedside medication drawer given to patient at discharge without review, ie ‘bag and go’.
	Wrong dose – extra quantity	(‘quantity’ added 2/4/12) Incorrect quantity of a drug is dispensed, eg two tablets, not one; 10 pack instead of 20.
	Wrong dose – overdose.	The dose of medication supplied exceeds the prescribed dose, eg 10mg instead of 1mg.
	Wrong dose – underdose.....	The dose of medication supplied is below the prescribed dose, eg 100mcg instead of 100mg.
	Drug omission.....	Patient has missed a dose of their medication, eg not available in pharmacy, or inadvertently not dispensed.
	Wrong formulation	The form of medication dispensed is incorrect.
	Unauthorised drug substitution	(‘substitution added 2/4/12) Where a medication has been substituted e.g. bendrofluazide for hydrochlorthiazide or Marevan brand for Coumarin, without appropriate authorisation processes being followed.
	Duplicate Order.....	New 2/4/12. Prescribed twice, 2 active orders.
	Wrong Directions…….	New 2/4/12. Documentation error on a label. Eg label says administer over 30 minutes but should have been over 60 minutes. Label indicates tablet should be taken 1 hour before meals when should be 2 hours after meal.
3.3. Issue - Transcribing	Wrong patient record	New 2/4/12. Medication details were transcribed into the wrong order or chart, or medications for one patient transcribed into another’s chart.
	Wrong medication.....	The wrong medication has been transcribed

	Wrong quantity.....	Wrong concentration or quantity was transcribed into the order or chart, eg 100mg instead of 100mcg.
	Drug omission.....	Prescribed medication has been omitted from the order during transcription.
	Wrong formulation	New 2/4/12. The form of medication transcribed is incorrect eg SL not ticked.
	Wrong route	New 2/4/12. Medication is transcribed via the wrong route, eg intrathecal rather than intravenous.
3.4. Issue - Administration	Wrong patient	The medication was administered to the wrong patient.
	Wrong medication……..	Patient administered wrong medication.
	Wrong dose – extra quantity	('quantity' added 2/4/12) Incorrect quantity of a drug is administered, eg two tablets given instead of one, duplication of dose by different staff members.
	Wrong dose – overdose.	The drug prescribed was correct but the dose administered exceeds the prescribed dose ie too much.
	Wrong dose – underdose.....	The dose of medication received by the patient is below the prescribed dose ie too little.
	Not received by patient	The patient has missed a dose of their medication, eg person not present in ward or discharged, medication expired or not available. OR if it is unable to be confirmed either way that the patient received the medication.
	Wrong formulation	The form of medication administered to a patient is incorrect e.g. controlled release tablet crushed for NG tube administration.
	Wrong rate	Medication is not administered at the prescribed rate.
	Wrong route	The medication is administered via the wrong route eg intrathecal, not intravenous.
	Wrong administration method.....	('administration' added 2/4/12). Where the prescribed method of administration is not followed eg where drugs where required to be given with food but no food provided when administered.
	Wrong frequency	The frequency of dose administration is incorrect, eg given 1 tablet daily, rather than 1 tablet every two days. (vs "Wrong Time" - ie when medication is given at wrong time of day).
	Wrong time	Medication was given at wrong time of day or night, eg ordered at 0800 hours and given at 2000 hrs. Do not confuse with "wrong frequency".
	Administered but not signed	Select when a patient receives medication but this has not been signed/documented. (ie it is confirmed that the patient received the prescribed medication).
	Unauthorised drug substitution.....	('substitution added 2/4/12) Where a medication has been substituted and administered without authorisation e.g. bendrofluazide for hydrochlorthiazide or Marevan brand for Coumarin.
	Unauthorised administrator	Select when a medication was administered by a clinician acting outside of their scope of practice. Eg, panadeine given without an order.
	Patient reaction.....	Patient experiences an adverse reaction to an appropriately administered medication.
3.5. Issue - Monitoring	Inadequate.....	The monitoring practices used for a specific medication do not meet the recommended standards of practice (e.g. insufficient monitoring of BGLs, blood levels not taken after the administration of gentamicin.)
	Patient reaction.....	

4. Patient reaction/ Complication	ADR new.....	Select when an adverse reaction to the medication administered is observed during patient monitoring, and this reaction had not been previously documented in the clinical record, or known of by the patient.
	ADR previously known	
	Drug interaction	A physicochemical interaction between 2 or more medications, eg interactions between anticoagulants and aspirin. A physicochemical interaction between a medication and a food or nutrient.
	Other unexpected clinical outcome	Eg, the medication did not have the expected therapeutic effect.
	None	

5. Route of administration	Intravenous	Intramuscular/ subcutaneous
	Eye/ ear/ nose	Enteral
	Oral	Peritoneal
	Topical	Aerosol / inhalation / nebulisation
	Rectal	Sublingual / buccal
	Vaginal	Intra-arterial
	Epidural/ Intrathecal	Intra-vesical
	Interosseous (2/4/12)	Medication.Administered_RouteofAdministrationName: string OR Intended_RouteofAdministrationName: string

6. Medication details	Brand Name.....	Brand or common name of the medication
See Medication table	Generic Name.....	Proper chemical designation of the medication, the representation of the active ingredient(s) within a medication
	Strength	Strength or concentration of active ingredient(s)
	Form	Medication type, eg Tablet, Injection, Syrup etc
	CDS Pack	Number or volume of medication dispensed
	SHPA Code	Unique ID required - currently QHPIMS product ID
	Risk Score	Risk score for OMI calculation NB -NOT IN USE

Risk Factors/ Contributing Factors

Classification of the circumstances that may have had an impact on the occurrence of the incident.
Contributing/Risk factors are additional reasons, not necessarily the most basic reason (ie issue) that an event has occurred.
Please select only the contributing/risk factors that directly relate to the incident.
Bracketed references are to the RCA cognitive aid booklet.
IncidentContributingFactor.ContributingFactorCategoryName: String
IncidentContributingFactor.ContributingFactorName: String

Factor	Description/Definition - Guide for Use
Barriers	Eg: An improvement you can put in place that will prevent the problem from happening again.
Barriers and controls were involved	Barriers (ie obstructions) and controls (ie mechanisms to direct operation) were involved in the adverse event/near miss. (B1)
Barriers designed were not effective	Barriers may be designed to protect patients, staff, equipment and the environment. (B2)
Barriers/controls not evaluated for reliability	Eg Barriers implemented without the necessary checks to check that they are meet best practise guidelines. (B5)
Barriers/controls not in place before the event/ near miss	Eg a policy/procedure was not in place to correctly identify a patient before an error involving patient misidentification occurred. (B4)
Barriers/ controls not monitored	Relevant barriers and controls were not maintained or checked on a routine basis by designated staff. For example, a review to ensure the crash trolley was being checked as per the local procedure (B8)

Concept of "fault tolerance" not applied to system design	Eg the equipment design allowed staff to disable critical alarms on a cardiac monitor (B7)
No method for identifying impact of system changes pre implementation	Management did not have a method for identifying what the results of the system changes would be before implementation. For example, an impact analysis was not completed and/or the change was not trialled in a representative setting/situation prior to it being introduced. (B12)
Other barriers/controls did not exist	Eg There appeared to be nothing in place to have prevented this incident from happening. (B6)
Patient risk was not considered in barrier/ control design	Eg Workplace designed solely around staff and the risk for patients not considered. A specific example might be: Fracture clinic on 2nd floor but no lift in place. (B3)
Review of barriers excluded adequate evaluation	Audits/reviews related to barriers did not include evaluation of plans, designs, installation, maintenance and process changes (B11)
Systems/ processes not tested prior to implementation	Similar to B5 Eg New systems and process implemented without the necessary checks to check that they are meet best practise guidelines and/or will actually work. (B10)
Communication Factors	
Communication across organisational boundaries inadequate	Communication across organisational boundaries was problematic. For example, between facilities, between Queensland Health and other sectors. (HF-C14)
Communication between multidisciplinary team members inadequate	Verbal and or written communication between the staff treating the team was inadequate or incomplete. Authority gradients within the team impacted communication (for example a junior staff member unable to challenge a more experienced staff member). Includes irregular team, eg Agency staff, staff returned from leave, new staff etc unfamiliar with each other's role (HF-C5)
Communication between supervisors and staff inadequate	Communication between management/supervisors and frontline staff was inadequate. For example it was not accurate, incomplete, did not use standardised vocabulary or was ambiguous). The authority gradient impacted communication (for example the junior staff member unable to challenge a more experienced staff member). Team member not able to be contacted/ does not respond (HF-C4)
Communication of policies / procedures inadequate	Policies, procedures and guidelines were not communicated adequately amongst staff. For example information was inaccurate, incomplete or ambiguous (HF-C6)
Communication of product alert/advisory inadequate	A manufacturer's recall/alert/bulletin on file for equipment, medication, or transfusion related elements was in place at the time of the event or close call. Relevant staff members were un/aware of the recall/alert/bulletin (HF-C10)
Communication of risk factors impeded adequate care	Barriers or obstacles to the communication of risk factors existed (eg related to falls risk, alerts, allergies etc) (HF-C9)
Communication with patient/significant others inadequate	If relevant, the patient and their family/significant others were not actively included in the assessment and treatment planning. (HF-C11)
Documentation insufficient	Existing documentation did not provide a clear picture of the work-up, the treatment plan and the patient's response to treatment. These could include: assessments consultations, orders, treatment team's notes, progress notes, medication charts, x-ray reports, laboratory reports etc) (HF-C3)
Information sharing was not timely	Information from various patient assessments was not shared/used by members of the treatment team on a timely basis. Delay in receipt of information required for clinical care. (HF-C2)

Methods to optimise communication not used	Methods for monitoring the adequacy of staff communication were not utilised. For example, "read back", confirmation messages, debriefs. (HF-C8)
Methods / processes used to share information inadequate	The methods and processes used by management to establish easy and timely access to information by staff were inadequate. Information/documentation was not received. Eg sent email but did not follow up that read and understood. (HF-C12)
Organisational culture impeded communication	The overall culture of the facility did not encourage or welcome observation, suggestions, or "early warnings" from staff about risky situations and risk reduction. (HF-C13)
Other (Free Will)	Individual choice of staff member to deviate from defined practice
Patient identification incorrect	The patient was not identified correctly. For example, patients with similar names lead to a patient receiving incorrect medication, pt receiving surgery planned for another patient. (HF-C1)
Sharing of technical information inadequate	The correct technical information was not communicated to the care team when they needed it (HF-C7)
Social/cultural factors impeded communication	For example, family problems, language barriers, religious beliefs and/or authority gradients with staff. Relates to both patients and staff. *(not in cognitive aid)*

Consent Factors	
Consent form absent - emergency patient	Rationale: Patient health status may not permit a timely consenting process or appropriate person not available eg parent for a child emergency.
Consent form absent - private patient	Rationale: Data from PRIME suggests that private patients admitted to public hospitals may not always have a Consent Form (of any description) in the medical record therefore compromising the ensuring intended surgery.
Consent form absent at time of need	Select when Consent Form was not available in the medical record. eg missing at pre-op check at ward level or missing during operating room peri operative check or at any crucial stage of system checking as per organisational policy. If this relates to a private pt, select option 2. If it relates to a patient transferred from emergency dept, select option 3. Rationale: Consent is obtained for all invasive investigations, treatments or procedures in accordance with Queensland Health Informed Consent for Invasive Procedures Policy.
Consent form expired / lapsed	Select when form indicates that it is over 12 months since the doctor/patient/parent/guardian/substitute decision maker signature has been signed/dated. or when there has been a significant change in the patient's health status or the patient/parent/guardian/substitute decision maker signatory cannot recall the comprehensive information required for an informed consent Rationale: To address the possibility of long waiting lists. Consent is only valid for a period of 12 months.
Consent form not signed by relevant person	Select if Consent Form not signed by relevant person or if signed by an inappropriate person. Rationale: Relevant person to the patient to sign for the Informed Consent ie parent/ guardian (if a child) or substitute decision maker.
Consent form undated	Select when the date has not been entered on the form.
Incorrect/ missing pt ID label or incorrect/ missing pt ID documented on the Consent form	Select if Incorrect/missing patient ID label on Consent Form or Incorrect/missing patient identification data documented on the Consent Form, eg High risk situation leading to incorrect surgery to patient.
Side/ site of treatment not	Select if laterality not documented on the Consent Form.

documented on consent form	
Environmental Factors	
Environment stress levels inappropriate	Eg physical or psychological stress levels were too high (EE3)
Environmental codes/ specifications/ regulations not met	Eg, safety standards, design standards etc (EE7)
Environmental conditions were inappropriate	Eg the level of noise, vibration or lighting was inappropriate (moved from fatigue/scheduling factors)
Environmental distractions	Eg Major renovations happening outside the area where a procedure has to take place and staff cannot concentrate. (HF-F6) *(moved from fatigue/scheduling factors)*
Environmental stressors were not adequately anticipated	Eg A new location is chosen to carry out a procedure as all other locations are busy or full. The new location is too small and the procedure has to be stopped or is compromised in some way. (moved from fatigue/scheduling factors)
Inability for patient to access treatment	Patients unable to easily enter the facility
Inappropriate location	
Risk assessment/audit not completed	An environmental risk assessment (for example a safety audit) of the area had not been conducted or completed (EE2)
Safety audits/disaster drills not conducted	Eg, fire evacuations, management of chemical spills, safety evaluations (EE4)
Security problem	
Unfamiliar task	Eg having to perform resus at a community clinic, complex outlier in your ward, unusual or complex task, task completed out of sequence, sudden emergency
Work area design not fit for purpose	The work area or environment design did not support the function it was being used for. For example, the design of the ward did not support patient flow, appropriate monitoring, unable to easily access emergency equipment or call bell etc. Co-location of unrelated services, admission of outlier. Insufficient security measures in place for a high risk area (EE1).
Fatigue / Scheduling Factors	
Fatigue was not anticipated	(HF-F5)
Level of automation was inappropriate – too high	Either too much (HF-F8)
Level of automation was inappropriate – too low	Either not enough (HF-F8)
Personnel experiencing emotional/ personal distractions	Eg family member sick, etc (not in cognitive aid)
Personnel experiencing time pressure to complete task	Eg There is an influx of patients, or perhaps staff are suddenly called to another area. This leads to tasks being hurried in order to get them done. (not in cognitive aid)
Personnel had inadequate sleep – personal factors	Eg. New baby at home, construction noises (HF-F3)
Personnel had inadequate sleep – scheduling factors	Ie. Rostering (HF-F4)
Personnel missed meal break	Eg Ward was so busy that staff member was not able to get away for their scheduled break. (not in cognitive aid)
Staffing inadequate for the workload	Eg the workload was too high, too low, or the wrong mix of staff. Insufficient staffing allocation for client demand (HF-F7)
Medical Device Factors	If Risk factor involves fixtures, fittings or plant, select one of the Environmental Factors. If non clinical equipment contributed to the incident (eg phones down, call bell not working), please describe in the "Description of the Device".

Backup equipment/emergency systems unavailable	Emergency provisions and backup systems were not available in case of equipment failure (EE14)
Corrective actions for known equipment problems not actioned/ effective	(EE11)
Design specifications not adhered to	EG: Company provides directions for how to set up/use equipment and staff do not adhere to these guidelines. (EE17)
Device reused inappropriately	Eg a single use device was re-used (EE23)
Equipment codes/ specifications/ regulations not met	Eg safety standards, design standards etc (includes equipment brought in by patient) (EE5)
Equipment design hindered implementation of corrective actions	Equipment designed so that corrective actions could not be accomplished. For example, software on an infusion pump could not be modified by specified staff to reflect the facility protocol (EE21)
Equipment design hindered timely recognition of error	The design of the equipment did not enable early detection of the problem and make it obvious to the operator in a timely fashion (EE20)
Equipment displays not working/ interpretable	Equipment displays or controls are not working properly or are unable to be interpreted correctly (EE22)
Equipment inadequate to perform the task	(EE13)
Equipment is known to have failed in the past	(EE15)
Equipment maintenance program not in place	A maintenance program was not in place to maintain the equipment A safety review of the equipment was not performed or not documented. The review was not conducted when it should have been. (EE9)
Equipment used in a manner it was not designed to	Equipment was produced to specification but operated in a manner it was not designed or intended to satisfy (EE18)
Poor product design	Equipment was not designed properly to accomplish its intended purpose. For example, poor user interface, difficult to use etc. (EE6)
Previous maintenance checks indicated a problem	Maintenance previously conducted on the equipment had indicated the equipment was not working properly (EE10)
Sterilisation Breach	Select if the sterilisation process was not performed, was inadequately performed or if the equipment or device was contaminated post-sterilisation. *(Not in cognitive aid, but required for CHRISP)*
Time/ resources inadequate to conduct equipment upgrades	Adequate time and resources were not allowed for physical plant and equipment upgrades if problems were identified. (EE12)
Patient Factors	
Other (free will)	Uncooperative/ instructions not followed eg self discharge against medical advice.
Physical status compromised	Patient's physical status contributed to the incident g diagnosis/ effects of substances/ age/ co morbidities/speech
Psychological status impaired	IQ/ personality/distraction etc
Product/sample Factors	
Calculation / concentration error	Eg There was a mistake made when calculating the strength/concentration of the drug required.
Duplication	
Incorrect product used or sample provided	Select when testing was not performed because an incorrect sample was provided. Eg. Wrong tube or wrong sample provided for test requested.

No administration access	Eg It was not possible to administer the drug in the required manner as there not the appropriate access
Not signed for	Eg The administration of the drug has not been documented.
Not usable/ unsatisfactory (ie damaged, expired)	**Product:** Select when product to be administered to patient was damaged or were not able to be used / transfused, eg broken, reconstituted incorrectly, spiked **Sample:** Select when sample of incorrect volume, contaminated, degraded, or clotted.(eg short sample for coagulation specimen (citrate tube)
Unavailable product/result (lost specimen)	Select when a product (eg blood/blood product) or test results were not available when required to assist with patient management.
Wrong diluent	Eg The drug is mixed with the wrong fluid recommended for administration.

Rules/ Policies/ Procedures	
Care required outside scope of facility service capability	This may include staff expertise and availability, technical and support services resources (RPP5)
Lack of incentive for staff to use policy/ procedure	Incentives could be positive or negative. Eg authority gradients, or culture: “We’ve always done things this way” (RPP13)
Not adhered to by staff	Policies and procedures are available, but not adhered to routinely by staff (RPP11)
Not clear, understandable and/or accessible to staff	The relevant policies/procedures were not clear or understandable by staff (for example, used language which was ambiguous). Policies/procedures were not accessible to staff (Eg, were kept in location not easily accessible to staff).(RPP10)
Not consistent with Federal or state policies, standards or regulations	Eg A Workplace instruction is developed that might suit the local area but does not take into account existing Federal or QH policies standards or regulations. (RPP9)
Obstacles prevented their use by staff	Eg - Procedures stored on PC but limited access to PC meant staff could not access them (RPP12)
Policies/procedures not documented and/or up-to-date	(RPP8)
Problem not identified/corrected despite audit/review	This problem may have gone unidentified or uncorrected after an audit or review. (RPP4)
Quality system not in place to inform risks	Management did not have an audit or quality system in place to inform them how key processes related to adverse events functioned (RPP2)
Risk management plan not in place	An overall risk management plan for addressing risk and assigning responsibility for risk was not in place (RPP1)
Staff not qualified or adequately trained to perform function	Includes not credentialed to perform task (RPP6)
Staff not orientated to job/facility/unit policies	Staff were not orientated adequately to the job, facility and unit policies regarding: safety, security, hazardous material management, emergency preparedness, personal protection, medical equipment and utilities management (RPP7)

Training Factors	
Inadequate training in the use of barriers/controls	(HF-T7)
Procedures/equipment did not align with staff and their tasks	Procedures and equipment had not been reviewed to ensure there was a good match between people and the task they did; or people and the equipment they used. For example, human factors engineering principles were not used. Staff working outside scope of practice (HF-T6)
Program to identify training needs absent	A program was not in place to identify what was actually needed for training of staff (HF-T1)

Training not provided prior to work commencing	Staff were not trained prior to starting the work process (HF-T2)
Training programs not focused on error prevention	Training programs for staff were not designed up-front with the intent of helping staff perform their tasks without errors. (HF-T5)
Training results not adequately monitored	The results of training were not reviewed or monitored over time to evaluate effectiveness or compliance (HF-T3)
Training was not sufficient	Length, content did not address skills, knowledge needed. Consider the following factors: supervisory responsibility, procedure omission, flawed training, and flawed rules/policies/procedures. (HF-T5)

History of changes

1 Oct 2008 release – main changes:

- New subcategory under "transfer/discharge' called "Delay in Retrieval"
- Two new subcategories under "Deviation to Planned Care":
  - "Procedures involving the wrong patient or body part" (Note not involving permanent harm or death) This will permit the collation of the SAC 2 and 3 incidents for this type of incident
  - "Development of VTE"
- Pressure Ulcer changes to drop down lists

Please note, references to SEs within PRIME CI cannot be removed until the next major release due to underlying system rules linked to the Sentinel Event Primary Incident type.

1 Mar 2009 release – main changes:

- New subcategory under "Deviation to Planned Care called "Respiratory Related" (this includes 'self extubation')
- Two new subcategories under "Injury List":
  - Nares (nose)
  - Respiratory
- Revisions to the 'Equipment' Risk / Contributing Factors List
- Infections and fall injuries are reported via the Harm sustained field
- Consent and documentation issues are recorded as Risk/Contributing factors.

1 Dec 2009 release – Key changes:

- an express process to report incidents that result in minimal or no harm to the patient. This will reduce the time required to report the majority of incidents reported in PRIME CI;
- introduction of a minimum data set for most incident types;
- the integration of reportable sentinel events into the new classification model;
- the primary incident types have been consolidated under 5 incident categories
- the capability to print a one page PRIME CI incident summary report;
- mandatory LM actions for SAC 1 & 2.

30 April 2010 – AA release

5 Aug 2010 – Warranty release (No. 1)
Addressed and resolved issues arising out of 1 Dec 2009 release.

1 Dec 2010 - Warranty release (No. 2)
Addressed and resolved issues arising out of 1 Dec 2009 release.

7 Dec 2011 – PRIME Location Project implementation (Phase One)

Implementation of a new district location structure in PRIME to reflects the QH location structure as at 1 July 2011.

7 Mar 2012 – PRIME Location Project implementation (Phase Two)

Implementation of changes to the district location structure to tidy up records that were unable to be migrated in Phase One of the project due to corrupt locations. Opportunity has also been provided to the districts to propose location structure changes that are required, for varying reasons, since Phase One was completed.

2 April 2012 – AA release
A minor, non-development release (ie Application Administrator changes only) introduces changes

requested by a number of statewide reference groups and steering committees.

- Changes to Pressure Injury (Ulcer) data set:
  - Addition of stages: Mucosal membrane; Suspected deep tissue injury; and Unstageable.
  - Addition of Glamorgan (paediatrics) Range 0 – 42 as an 'Assessment Tool'
  - Additions of sites: Tongue, Tracheostomy, Hand, Finger
  - Removal of sites: calcaneal; edge of foot; sole of foot; ankle, trochanter, and "other".
  - Additions of site locations: Dorsal, Plantar, Distal, Proximal
  - Addition of interventional strategy implemented: Care Plan Commenced
  - Removal of interventional strategy implemented: Wound chart commenced
  - Rewording of 'present on admission' to 'Yes, present on admission from non QH location'
- Addition of new discharge issue 'Infant discharged to wrong family member'.
- Changes to the nutrition data set to support the introduction of the QH Nutrition Screening, Assessment and Support Policy and Implementation Standard (2011).
- Addition of issue 'Entrapment by bedrail and/or in bed accessories'
- Changes to medication data set:
  - Some issue definitions have been reviewed to reduce confusion.
  - Addition of new route of administration: interosseus.
  - A number of additions and changes have been made to issues displayed for the Stages.
  - Removal of issue from 'Prescribing / Ordering': "Wrong dose – extra quantity".
- Addition to 'Activity at time of fall' list: Staff transferring patient
- Change of Patient Reaction (Blood): Haemolytic blood transfusion reaction resulting from ABO incompatibility will be reworded to read "ABO haemolytic transfusion reaction"

31 Aug 2012 – AA release

- Addition: Patient Status Inpatient – home ward, and Inpatient – Outlier

1 Mar 2013 – AA release

- Addition: Patient Status Inpatient: Non Queensland Health Facility

1 Nov 2013 – AA release

- Amended: Behaviour > Physical Restraint (see pg

Document Revision History

Version	Date	Prepared By	Comments
0.1	2005	W Duffield	First draft – (html format)
1.0		PRIME Team	Review & Update to reflect Dec 05 release
2.0		PRIME Team	Review & Update to reflect July 06 release
2.1		PRIME Team	Update to reflect changes to staff category, injury list
3.0		PRIME Team	Review & Update to reflect Dec 06 release
3.1		PRIME Team	Review & Update to reflect Jul 07 release
4.0	16/08/2007	W Duffield	Review & Update to reflect November 07 release
4.1	18/04/2008	W Duffield	Document format changed to MS Word.
4.2	12/05/2008	W Duffield	Added Medication sub cat definitions
4.3	12/06/2008	W Duffield	Added 1 July 08 release changes
4.4	1/10/2008	W Duffield	Added 1 October 09 release changes
4.5	2/3/2009	PRIME Team	Minor changes introduced for NICU/ICU reporting
5.1	16/12/2009	W Duffield	Updated for CI 09 Release (1/12/09)
5.2	18/2/2010	W Duffield	Add: Definition of aggressive behaviour, pg 34
5.3	22/10/10		Reformatted as per Patient Safety & Quality Improvement Service branding
5.4	05/11/2010	PRIME Team	Review and Update
5.5	25/02/2011	Y Wilkinson	Added Behaviour incident clarification.
5.6	26/03/2012	PRIME Team	AA Changes 02/04/2012 See Release notes
5.7	4/07/2012	PRIME Team	To Do List update, branding updated, OD lookup
5.8	31/8/2012	PRIME Team	Amended Pt Status list
6.0	13/03/2013	PRIME Team	Added QHER Business View field names, rebranded.
6.4	01/07/2013	Patient Safety Reporting	Updated. 6.5 (Nov 2013) Updated Physical Restraint term.
6.6	01/08/2014	PRS	Contact details updated, rebranded

Acknowledgement

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