Victorian Agency for Health Information

Victorian Health Incident Management System Minimum Dataset Manual 2023–24

Edition 2

VICTORIA State Government | Department of Health

Feedback

We welcome your feedback on the Victorian Health Incident Management System Minimum Dataset Manual.

Your input will help us shape future editions of the Manual to ensure it meets your need for accurate and complete information about how to report clinical, Occupational Health and Safety (OH&S) incidents, near misses and hazards in Victorian public health services.

Please provide feedback to:
Consumer Experience, Outcomes and Safety
Victorian Agency for Health Information
Department of Health
Email: vhims2@vahi.vic.gov.au

To receive this document in another format, email the Victorian Agency for Health Information <vahi@vahi.vic.gov.au>.

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Available at the Victorian Department of Health <https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting/vhims-program-of-reforms>
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Contents

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
API	Application Programming Interface
DH	Department of Health (Victoria)
DHHS	Department of Health and Human Services (Victoria) (pre-February 2021)
FMDS	Feedback Minimum Dataset
IMS	Incident Management System
ISR	Incident Severity Rating
MHCC	Mental Health Complaints Commissioner (Victoria)
OH&S	Occupational Health and Safety
SOP	Standard Operating Procedure
SCV	Safer Care Victoria
VAHI	Victorian Agency for Health Information
VAWG	VHIMS Analytics Working Group
VHIMS	Victorian Health Incident Management System
VHIMS CS	Victorian Health Incident Management System Central Solution
VHIMS MDS	Victorian Health Incident Management System Minimum Dataset
VMIA	Victorian Managed Insurance Authority
WHO	World Health Organization

Section 1: Introduction

The Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) is a standardised dataset designed to collect clinical and occupational health and safety (OH&S) incidents and near misses and hazards.

These data must be collected in all Victorian public health services and all services under their governance structure including community health and bush nursing centres services (referred from this point onwards as health services).

The purpose of the VHIMS MDS is to improve quality, safety, and patient experience in Victorian public health services through access to standardised state-wide reporting, supporting the roles of VAHI, the Department of Health (DH) and Safer Care Victoria (SCV).

VHIMS MDS scope

Victorian health services are responsible for ensuring the safety of their patients, residents, clients, and consumers. Funded organisations covered by the Victorian Policy and Funding Guidelines must have robust systems and processes in place to enable timely identification, management, and response to adverse events. These processes address identified gaps, aiming to reduce the risk of such future events.[1]

Victorian public health and community service organisations that provide services on behalf of the department are in scope for capturing the VHIMS MDS through the reporting of patient, resident, client, or consumer safety incidents. These services are also subject to the overarching SCV Adverse Patient Safety Event policy which outlines individual, health service and SCV responsibilities when responding to an adverse event.[2]

The following in scope organisations* for reporting VHIMS MDS are listed below:

- Public health services and all services under their governance structure.
- Registered community health services.
- Ambulance Victoria.
- Bolton Clarke – Royal District Nursing Service.
- Integrated Living (formerly Ballarat District Nursing and Healthcare).
- Bush nursing centres (publicly funded).
- Forensicare (Thomas Embling Hospital).
- Incorporated residential aged care services (publicly funded).

Manual purpose

The VHIMS MDS manual provides incident reporters and users of the data with a complete dataset resource including:

- definitions of data items
- information and business rules for the incident reporter and data users
- how to submit VHIMS MDS data to DH (VAHI)
- contact details for support related to the VHIMS MDS.

Contact details

VHIMS Central Solution users

For health services using the VHIMS Central Solution (VHIMS CS), support is available via your internal VHIMS Central delegate or the VHIMS Central Helpdesk at the Department. Internal VHIMS Central delegates are staff members within your organisation who have been trained by VAHI to support your VHIMS Central reporting. A list of these contacts in your organisation can be found by contacting the VHIMS Central Helpdesk (details below).

For other questions about the VHIMS CS, or to add new users or report system issues, contact:

VHIMS Central Helpdesk
1800 848 900 (if the matter is urgent)
Email: VHIMS@support.vic.gov.au

1. State of Victoria, Department of Health. (2023, July). *Policy and funding guidelines for health services*. Retrieved from https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services
2. State of Victoria, Safer Care Victoria. (2023, July, 13). *Policy: Adverse Patient Safety Events*. Retrieved from https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events

* Please note in Section 3, the 'Reported by' field refers to all the in-scope organisations listed below.

Other Incident Management System (IMS) users

Health Services not using VHIMS CS should contact their incident management system (IMS) vendor to resolve any issues with the functionality of the system including VHIMS MDS submission issues.

Feedback on VHIMS Minimum Data Set and data manual

For questions and feedback related to content of this data manual, or data elements within the VHIMS MDS, contact:

Consumer Experience, Outcomes and Safety Team
Victorian Agency for Health Information
Department of Health

Email: vhims2@vahi.vic.gov.au

VHIMS MDS webpage: https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting/vhims-program-of-reforms

VHIMS reforms: https://vahi.vic.gov.au/ourwork/safety-and-surveillance-reporting/vhims-program-of-reforms

Data quality statement

The data quality statement for the VHIMS MDS covers eight data quality dimensions. These are listed below. This data quality statement is designed to enable the consistent capturing and reporting of data quality across data sets and over time. These associated data quality dimensions are used to briefly summarise any known data quality issues to assist in the use and interpretation of the information asset.

Accuracy

The VHIMS MDS manual is published by VAHI to provide clarity for all health services and information for data users on reporting requirements.

Health service IMS should be configured to report the VHIMS MDS. This manual outlines the pre-defined code sets for the VHIMS MDS.

Incidents transmitted where there is a **Date Closed** present are subject to validations in the VHIMS API. The validations ensure reported data includes only valid codes and complies with VHIMS MDS business rules.

Completeness

All Victorian public health services are required to report the VHIMS MDS. The VHIMS MDS is a standardised dataset within each health service's IMS. Individual health services must have procedures and processes in place to ensure all in-scope incidents are recorded in a timely manner.

Coherence

From July 2023, the Department will implement an annual change process for the VHIMS MDS to ensure the data collection:

- supports the department and Safer Care Victoria in ensuring the quality and safety of care in Victorian health services
- assists planning and policy development
- contains consistent definitions for common data items across different datasets
- incorporates appropriate feedback from data providers on improvements.

Interpretability

The VHIMS MDS manual provides definitions of concepts, data, reporting guides and business rules for health services and data users.

In July 2019, 39 health services began reporting the VHIMS MDS. Between July and April 2023, remaining in-scope services commenced reporting the VHIMS MDS.

All health services are required to report the VHIMS MDS. The VHIMS MDS has replaced the VHIMS interim data collection which operated from July 2017

The requirement to report the interim dataset ceases once reporting the new MDS begins. However, data needs to be supplied to VAHI for the full quarter when the new VHIMS MDS goes live at the health service.

While the interim dataset and the new VHIMS MDS are different, the counts of all incidents, incidents by type, and incident severity rating from the VHIMS interim data collection are directly comparable to the new VHIMS MDS.

Timeliness

From 1 July 2023, health services are required to transmit all new and updated incidents to VAHI daily (near-real-time). The availability of near-real-time incident data supports oversight and monitoring by the department and SCV, including proactive identification of emerging safety risks.

Registered Community Health services that are not using VHIMS CS have been given an exemption from this requirement for 2023–24, but may report near-real-time data if they choose.

Accessibility

The VHIMS MDS is recorded in the Department's Information Asset Register. Requests for VHIMS data can be made through the VAHI Data Request Hub.

VAHI publish state-wide results and topic-specific reports using the VHIMS MDS. Queries about VAHI reports can be directed to the Consumer Experience, Outcomes and Safety Team by emailing vhims2@vahi.vic.gov.au.

Relevance

A set of guiding principles was used to develop the VHIMS MDS, which looked for relevance, utility, collectability, reliability, applicability and being evidence-based.

Feedback from health services is recorded and any suggested updates are considered. See Changes to the VHIMS MDS.

Consistency

The VHIMS MDS manual provides definitions, concepts, data items and reporting guidance to ensure that health services understand and interpret all data elements consistently.

Requests for VHIMS MDS data release

Requests for VHIMS MDS data can be lodged via the VAHI Data Request Hub. VAHI administers data requests in compliance with the Department of Health's privacy policy, and as permitted by the *Privacy and Data Protection Act 2014* (VIC), the *Health Records Act 2001* (VIC) and other relevant legislation.

For more information on making a request, visit the VAHI Data Request Hub.

History and development of the VHIMS Minimum Dataset

VAHI is leading the VHIMS reform program to ensure information collected is better able to inform the quality and safety of health care in Victorian public health services. These reforms are detailed on the VHIMS page of the VAHI portal.

As part of the reforms VAHI developed a new VHIMS MDS in 2018–19, for the collection of clinical, occupational health and safety (OH&S) incidents, near misses and hazards. The new VHIMS MDS comprises the data items that Victorian public health services are required to collect and submit to VAHI to support statewide reporting.

The VHIMS MDS was developed through consultation with SCV, DHHS/DH[†], the Australian Nursing and Midwifery Federation, the Mental Health Complaints Commissioner Victoria (MHCC), the Office of the Chief Psychiatrist Victoria, the Victorian Managed Insurance Authority (VMIA) and WorkSafe Victoria. VAHI also carried out a review of what was collected in other jurisdictions across Australia. The VHIMS Analytics Working Group (VAWG), an advisory group comprising representatives from Victorian public health services, DH and SCV also assisted in the development of the VHIMS MDS.

Based on recommendations from stakeholders and the VAWG, the MDS focuses on data items required to monitor trends and support state-wide reporting, rather than data items required for individual incident investigation and management.

[†] On 1 February 2021, the former Department of Health and Human Services (DHHS) was split into the Department of Health (DH) and the Department of Families, Fairness and Housing (DFFH). We refer to DHHS when discussing actions prior to 2021.

Changes to the VHIMS MDS

VAHI seeks to minimise the changes to the VHIMS MDS while ensuring that the collection maintains its integrity and continues to provide value. An annual change process for the VHIMS MDS will commence from 2023–24 to bring this collection in line with the department's administrative collections. This process will involve a call for proposals for changes to the data set and will follow established governance processes.

Please note that the feedback module (compliments, complaints, and suggestions) is not yet part of the VHIMS MDS. Implementation of the feedback module is being considered as part of the department's consumer voice reforms.

Suggestions for changes to the VHIMS MDS can be made to:

Consumer Experience, Outcomes and Safety Team
Victorian Agency for Health Information
Department of Health
Email: vhims2@vahi.vic.gov.au

Changes in 2022–23

- Removal of the mandatory ISR-2 classification for behaviour incidents related to sexual safety. The ISR for these incidents now aligns with other incident categories.
- Removal of the requirement to obtain new codes for newly established wards. All new wards can be transmitted under the health service's "other code".
- Changes to the transmission of free-text event summary and event details fields. These are now transmitted as N/A.

Section 2: Concepts and derived items

Introduction

This section lists concepts and terms related to incidents and incident management that help data users and reporters to understand the VHIMS MDS data elements.

Incidents reported in the VHIMS MDS cover clinical and OH&S incidents, near misses and hazards in Victorian public health services.

The detailed definitions and specifications of individual data elements that make up the VHIMS MDS are listed in Section 3 of this manual.

Concepts

Clinical incident	An event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a person receiving clinical care. Clinical incidents include adverse events, near misses and hazards in an environment that pose a clinical risk. These may also be referred to as adverse patient safety events.
Feedback (compliment/complaint)	Some incident management systems including the VHIMS CS include the ability to collect details of positive feedback (compliments), negative feedback (complaints) and suggestions from patients/residents/clients/consumers. Functionality may also include the ability to set notifications and monitor actions from the feedback. Currently, the Feedback Minimum Dataset (FMDS) is not in scope. It is envisaged that the FMDS will be considered following the capture of 12 months of stable VHIMS MDS data. The FMDS will be developed in consultation with the VAWG and other key stakeholders.
Harm	Physical or psychological damage or injury to a person. Examples of harm include disease, suffering, impairment (disability) and death: • Disease: a psychological or physiological dysfunction. • Suffering: experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, loss (any negative consequence, including financial) depression, agitation, alarm, fear, or grief. • Impairment (disability): any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present harm.
Hazard	A hazard is a situation or thing that has the potential to cause harm, damage, or injury. For example, uneven tiles in a patient bathroom.
Incidents	An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person and/or a complaint, loss or damage. In their broadest sense, includes clinical incidents, OH&S incidents, near misses and hazards in Victorian public health services.

Incident Severity Rating (ISR)	**Calculating the ISR** ISR calculations are based on a World Health Organization (WHO) algorithm, adapted, and refined by subject matter experts from Victorian public health services to support VHIMS incident classification and reporting. The ISR is derived from the response to three consequence-descriptor category questions defined below. The questions are related to level of harm (previously 'degree of impact'; required level of care (previously 'level of care'), and level of treatment required (previously 'treatment required'). **Level of harm (previously referred to as 'Degree of impact')** • No harm – did not reach person • No harm – did reach person • Harm – Temporary (Minor) • Harm – Temporary (Moderate) • Harm – Permanent • Death **Required level of care (this field was previously 'Level of care')** • Current setting – No change • Current setting – Increased observation or monitoring • Internal/external transfer for diagnostic test or monitoring only • Internal transfer for advanced/specialised care • External transfer for advanced/specialised care **Level of treatment required** Level of intervention required for the incident is measured using the following scale: • No treatment • Minor treatment • Intermediate treatment • Advanced treatment Additional details for the responses to three consequence-descriptor category questions can be found in Section 3: Data definitions.
Near miss	An incident that did not cause harm. A near miss is also an incident that had the potential to cause harm but didn't, due to timely intervention and/or luck and/or chance.
Occupational Health and Safety (OH&S) incident	OH&S incidents are events resulting in harm, or which could have resulted in harm, to any person in the workplace. This includes employees or contractors, casual staff, volunteers, and visitors in workplaces (excluding patients). High consequence and serious OH&S incidents must also be reported to WorkSafe as a notifiable incident. High consequence incidents are those that involve: • the death of a person • a person needing medical treatment within 48 hours of being exposed to a substance • a person needing immediate treatment as an in-patient in a hospital • a person needing immediate medical treatment for one of the following injuries: amputation, serious head injury or serious eye injury, removal of skin (example: de-gloving, scalping), electric shock, spinal injury, loss of a bodily function, serious lacerations (example: requiring stitching or other medical treatment).

Open disclosure	An open discussion with a patient or medical treatment decision maker about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are: • an apology or expression of regret (including the word 'sorry') • a factual explanation of what happened • an opportunity for the patient to relate their experience • an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings and must be appropriately documented.
Patient/Resident/Client/ Consumer	Children, young people, or adults who receive services delivered by Victorian public health services that are funded by the Department. Note: Patient/Resident/Client/Consumer can be used interchangeably dependent on the health care setting.
Sentinel event	Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals. All Victorian health services including Ambulance Victoria, bush nursing centres, Forensicare, public sector residential aged care facilities, private hospitals and day procedure surgeries are required to report adverse patient safety events within three business days, in accordance with the Victorian sentinel event list. In Victoria, sentinel events fall under 11 categories – 10 of which are standard across the country. Health services must report: • surgery or other invasive procedure performed on the wrong site resulting in serious harm or death • surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death • wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death • unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death • haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death • suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward • medication error resulting in serious harm or death • use of physical or mechanical restraint resulting in serious harm or death • discharge or release of an infant or child to an unauthorised person • use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death • all other adverse patient safety events resulting in serious harm or death. For sentinel event reporting requirements please refer to Safer Care Victoria Sentinel Events.
Staff (worker)	An employee, contractor, or volunteer of the organisation. Relevant for reporting OH&S incidents.

Derived items

This section covers a list of the derived items in the VHIMS MDS. Derived items in the VHIMS MDS are data calculated from other information entered by incident reporters or system data from the incident management software.

Incident Severity Rating	The ISR is derived from the response to three consequence-descriptor category questions related to level of harm (previously 'degree of impact'); required level of care (previously 'level of care'), and level of treatment required (previously 'treatment required'). Calculations are based on a WHO algorithm, adapted, and refined by subject matter experts from Victorian public health services to support VHIMS incident classification and reporting. The full description of ISR is available in Section 2: Concepts and derived items.
Age	Age is calculated based on the date of birth and date of incident (for clinical incidents only). Note: date of birth is not transmitted as a data variable in the VHIMS MDS. The purpose of this derived item is to allow for demographic analysis.
Notification type	Relates to the type of incident: Clinical, OH&S or Hazard. This item is calculated based on 'Who was involved?' questions of the VHIMS MDS.
Status of incident	Defines if an incident has been submitted, is under investigation, has outstanding actions or has been closed. Enables monitoring of trends related to the review and management of incidents. Classified into following categories: • **Submitted** – a user has submitted an incident. • **Under investigation** – the incident is under review and investigation. • **Outstanding actions** – one or more actions are open. • **Closed** – the incident has been signed-off. Incidents that have been signed-off, even if there are still outstanding actions, will be marked as 'closed'. For further information see Section 4: Business rule – When is an incident considered closed?

Section 3: Data definitions

Introduction

This section provides specifications for each data element submitted in the VHIMS MDS. Information about each data element is presented in the following structured format:

DATA ELEMENT NAME	
Specification	
Definition	A concise statement that expresses the essential nature of the data element and its differentiation from other data elements.
Form	The format in which the data is recorded. This may include: • code (for pre-determined code sets). May be organisation dependent. • date • free text • system-generated • alpha or numeric character in range A–Z, a–z, 0–9.
Layout	The layout of characters for the data element, expressed by a character string representation, for example: • alpha or numeric character (Range A–Z, a–z, 0–9) • DD numeric characters representing day of the month (Range 01–31) • MM numeric characters representing month (Range 01–12) • YYYY numeric characters representing year • An alpha character (Range A–Z, a–z) • N numeric character (Range 0–9).
Reported by	Criteria for reporting data element.
Reported for	The specific circumstances when this data element must be reported.
Reported when	The stage in the data submission cycle when this data element is reported.
Code set	The set of valid values for the data element.
Reporting guide	Additional comments or advice on reporting the data item.
Validations	A list of validations (validation numbers and titles) that relate to this data element.
Related items	Other data items that relate to this data item.
Administration	
Purpose	The main reason/s for the collection of this data item.
Principal data users	Identifies the primary user/s of the data collected.
Collection start	The year the collection of this data item commenced.
Version history	Provides information regarding modifications made to the data element. Listed are a version number, beginning with 1 and incremented by 1 for each subsequent revision as well as an effective date, describing the date the modification came into effect.
Definition source	Identifies the authority that defined this data item.
Code source	Identifies the authority that developed the code set for this data item.

Data elements model

The data elements in the VHIMS MDS can be grouped into the following broad categories:

- General incident information.
- Who was involved?
- When did it happen?
- Where did it happen?
- What happened?
- Why and how did it happen?
- Actions.

Additional fields are required depending on the notification type: clinical, OH&S, or hazard.

Data elements are only where they have been deemed relevant for that incident.

	Incident/near-miss notification type		
DATA ELEMENT	**Clinical**	**OH&S**	**Hazard**
Data elements applicable to all incidents			
General incident information			
Incident ID	Y	Y	Y
Notification type	Y	Y	Y
Grouping key	Y	Y	Y
Date closed	Y	Y	Y
Status of incident	Y	Y	Y
COVID-19 related?	Y	Y	Y
Who was involved?			
Was a patient/client/resident, staff or visitor harmed either physically or psychologically?	Y	Y	Y
If yes, please indicate who was involved	Y	Y	Y
Was a patient/client/resident, staff or visitor **nearly** harmed either physically or psychologically (i.e., is this a near miss incident)?	Y	Y	Y
If yes, please indicate who was involved (patient/staff/visitor)	Y	Y	Y
Does this relate to a hazard or a non-person related event, e.g., medication discrepancies, hazards, IT system/building issues?	Y	Y	Y
When did it happen?			
Incident date	Y	Y	Y
Incident time	Y	Y	Y
Where did it happen?			
Organisation	Y	Y	Y
Campus	Y	Y	Y
Ward/location	Y	Y	Y
Specialty/unit	Y	Y	Y

DATA ELEMENT	Incident/near-miss notification type		
	Clinical	OH&S	Hazard
What happened?			
Brief summary	Y	Y	Y
Details	Y	Y	Y
Incident type/Event type	Y	Y	Y
Incident type sub-categories. For example: • Type • Process • Problem	Y	Y	Y
Was an emergency response called?	Y	Y	Y
If yes, type of emergency response	Y	Y	Y
Why and how did it happen?			
External notifications	Y	Y	Y
Is this incident related to care provided by this organisation? (this question was previously 'Is this a valid clinical incident?')	Y	Y	Y
Is VMIA notifiable?	Y	Y	Y
Actions			
Review type	Y	Y	Y
Review status	Y	Y	Y
Additional data elements for clinical incidents only			
Client ID/UR Number	Y		
Age	Y		
Gender	Y		
Level of harm sustained (this field was previously 'Degree of impact')	Y		
Required level of care (this field was previously 'Level of care')	Y		
Level of treatment required	Y		
Contributing factors	Y		
Was open disclosure conducted?	Y		
Related National Safety and Quality Health Service Standard	Y		
Is this one of the following sentinel events?	Y		
If other, describe other sentinel event	Y		

DATA ELEMENT	Incident/near-miss notification type		
	Clinical	OH&S	Hazard
Actions			
Additional data elements for OH&S incidents only			
Reporter role		Y	
Where did the incident occur?		Y	
Level of harm sustained (this field was previously 'Degree of impact')		Y	
Required level of care (this field was previously 'Level of care')		Y	
Actions required (this field was previously 'Level of treatment')		Y	
Type of injury		Y	
Body part		Y	
If other body part, specify		Y	
Is this a WorkSafe notifiable event?		Y	
Preventative/corrective action		Y	
Status of preventative/corrective action		Y	
Completion date of preventative/corrective action		Y	
Reason why preventative/corrective action was not achievable		Y	
Additional data elements for hazards (non-clinical/non-OH&S incidents) only			
Level of impact			Y
Level of disruption to services			Y
Level of intervention required			Y

Definitions

INCIDENT ID	
Specification	
Definition	System generated number that is a unique identifier for an incident and allows for the counting and updating of existing incidents.
Form	Numeric (System-generated)
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	N/A
Reporting guide	A system-generated item. Health services are advised not to re-use an Incident ID; an Incident ID must not be re-assigned to another incident. When changing vendors, care must be taken to ensure Incident IDs remain unique.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Unique identifier for each incident. Allows counting of incidents and updating of existing incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

NOTIFICATION TYPE	
Specification	
Definition	System generated code that relates to the type of incident: clinical, OH&S (staff or visitor) or hazard. This item is calculated based on the three 'Who was involved?' questions.
Form	Code (System-generated)
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards
Reported when	Any of the above record types is reported
Code set	Clinical OH&S Hazard

NOTIFICATION TYPE	
Specification	
Reporting guide	It is a system-generated data element to help classify incidents into the three key categories: clinical, OH&S (staff or visitor) or hazard. This item is a derived item that is calculated based on 'Who was involved?' questions, specifically: • Was a patient/client/resident, staff or visitor harmed either physically or psychologically? If yes, please indicate who was involved. • Was a patient/client/resident, staff or visitor nearly harmed either physically or psychologically (i.e., is this a near miss incident)? If yes, please indicate who was involved (patient/staff/visitor). • Does this relate to a hazard or a non-person related event, e.g., medication discrepancies, hazards, IT system/building issues? • Please refer to each data element for specific reporting guides for the questions above.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables clear identification of the type of incident: clinical, OH&S or hazard.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

GROUPING KEY	
Specification	
Definition	System generated key that identifies where multiple reports have been entered about the same incident (e.g., an incident where there are different incident reports related to the staff member affected and for the patient affected by the same incident).
Form	System generated
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	N/A
Reporting guide	A system-generated item that is used to link related incident reports.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables analysis where multiple people are impacted by a single incident.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

STATUS OF INCIDENT	
Specification	
Definition	System generated code that defines if an incident has been submitted, is under investigation, has outstanding actions or has been closed.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Submitted Under investigation Outstanding actions Closed
Reporting guide	System generated data element. Incident status is defined as follows: • **Submitted** – a user has submitted an incident. • **Under investigation** – the incident is under review and investigation. • **Outstanding actions** – one or more actions are open. • **Closed** – the incident has been signed-off. Incidents that have been signed-off even if there are still outstanding actions will be marked as 'closed'. See Section 4: Business rule – When is an incident considered closed?
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Review type Review status Preventative/corrective action (if OH&S incident) Status of preventative/corrective action (if OH&S incident) Completion date of preventative/corrective action (if OH&S incident) Date closed
Administration	
Purpose	Enables monitoring of trends related to the review and management of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

DATE CLOSED	
Specification	
Definition	The date the incident is signed-off and closed.
Form	Date
Layout	YYYY-MM-DD
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is closed.
Code set	N/A
Reporting guide	Date closed cannot be before the incident date. See Section 4: Business rule – When is an incident considered closed?
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident date
Administration	
Purpose	Enables analysis of how long different groups of incidents take to close, potentially identifying areas with incomplete investigations or barriers that prevent investigations being closed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

WAS A PATIENT/CLIENT/RESIDENT, STAFF OR VISITOR HARMED EITHER PHYSICALLY OR PSYCHOLOGICALLY?	
Specification	
Definition	This question is to determine whether this event relates to an incident that resulted in harm. Harm includes disease, injury, suffering, death, and disability.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	This question is to determine whether this event relates to an incident that resulted in harm. Harm includes disease, injury, suffering, death, and disability. For near misses where there was no physical or psychological harm, please select answer **No** to this question. Reporters will be able to provide details of level of harm in a subsequent question.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	If yes, please indicate who was involved (patient/staff/visitor).

WAS A PATIENT/CLIENT/RESIDENT, STAFF OR VISITOR HARMED EITHER PHYSICALLY OR PSYCHOLOGICALLY?	
Administration	
Purpose	Enables identification of incidents which resulted in harm.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IF YES, PLEASE INDICATE WHO WAS INVOLVED (PATIENT/STAFF/VISITOR)	
Specification	
Definition	Description of person(s) involved in this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Patient Staff Visitor
Reporting guide	To enable identification of who was harmed by the incident: • Report **patient** if the person is a patient/resident/client/consumer of the organisation. • Report **staff** if the person is an employee/contractor/volunteer of the organisation. • Report **visitor** if person involved is neither patient nor staff. Multiple responses allowed.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Was a patient/client/resident, staff or visitor harmed either physically or psychologically?
Administration	
Purpose	Enables monitoring of effect of incidents on patients, staff, and visitors by clear identification of who was injured or harmed by the incident. Enables the identification of trends to see how many incidents involved more than one person.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

WAS A PATIENT/CLIENT/RESIDENT, STAFF OR VISITOR NEARLY HARMED EITHER PHYSICALLY OR PSYCHOLOGICALLY (I.E., IS THIS A NEAR MISS INCIDENT)?	
Specification	
Definition	To identify if the incident was a near miss, i.e., an incident that did not cause harm but had the potential to cause harm.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	Enables identification of near misses. These events were previously referred to as 'non-clinical/non-OHS'. Both an incident/near miss and a hazard/non-person event can be reported, e.g., medication discrepancies, hazards, IT system/building issues. Note: staff includes an employee, contractor, or volunteer of the health service. Visitor is a person that is neither patient nor staff.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	If yes, please indicate who was involved (patient/staff/visitor).
Administration	
Purpose	To determine the rate of incidents where there was a near miss.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IF YES, PLEASE INDICATE WHO WAS INVOLVED (PATIENT/STAFF/VISITOR)	
Specification	
Definition	Type of person(s) involved in the near miss.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Patient Staff Visitor

IF YES, PLEASE INDICATE WHO WAS INVOLVED (PATIENT/STAFF/VISITOR)	
Specification	
Reporting guide	To identify who was nearly injured or harmed by the incident and detect trends about how many incidents involved more than one person. Report **patient** if the person is a patient/resident/client/consumer of the health service. Report **staff** if the person is an employee, contractor, or volunteer of the health service. Report **visitor** if person involved is neither patient nor staff. Multiple responses allowed. See Section 2 – Concepts and derived items for definition of patient/resident/client/consumer.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Was a patient/client/resident, staff or visitor nearly harmed either physically or psychologically (i.e., is this a near miss incident)?
Administration	
Purpose	Enables monitoring of effect of incidents on patient/resident/client/consumer, staff, and visitors
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

DOES THIS RELATE TO A HAZARD OR A NON-PERSON RELATED EVENT, E.G. MEDICATION DISCREPANCIES, HAZARDS, IT SYSTEM/BUILDING ISSUES?	
Specification	
Definition	Determines whether a hazard or non-person related event is being reported. A hazard is an object or situation that has the potential to harm a person, the environment or cause damage to property.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	To enable identification of hazards and non-person related events. These events were previously referred to as 'Non-clinical/non-OHS'. Both an incident/near miss and a hazard/non-person event can be reported, e.g., medication discrepancies, hazards, IT system/building issues.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A

DOES THIS RELATE TO A HAZARD OR A NON-PERSON RELATED EVENT, E.G. MEDICATION DISCREPANCIES, HAZARDS, IT SYSTEM/BUILDING ISSUES?	
Administration	
Purpose	To monitor the prevalence of hazards or non-person related events.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IS THIS INCIDENT RELATED TO A PANDEMIC/EPIDEMIC (E.G. COVID-19)	
Specification	
Definition	This question is to determine whether an incident being reported is related to a pandemic/epidemic such as a COVID-19 hazard or non-person related event.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	Enables analysis of incidents related to a pandemic/epidemic (not specific to COVID-19). Select yes if the incident and contributing factors were related to a pandemic/epidemic (e.g. COVID-19). If the response to this question is Yes, the 'Details field' must outline how the pandemic/epidemic has contributed to the incident. Some examples could be, aggression from a visitor because of visitor restrictions, patient to staff transmission or supplies such as PPE are not available.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	To monitor the prevalence of incidents related to a pandemic/epidemic.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

INCIDENT DATE	
Specification	
Definition	The date on which the incident occurred.
Form	Date
Layout	YYYY-MM-DD
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	N/A
Reporting guide	A valid date must be entered. Incident date cannot be in the future.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables time series reporting and supports analysis of when incidents are occurring.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

INCIDENT TIME	
Specification	
Definition	The time of when the incident occurred.
Form	Time
Layout	HH:MM TT
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	N/A
Reporting guide	This item must be reported in valid 24-hour format. Enter exact time if known. If the time is not known enter an estimated time and select yes to the 'Is the time you entered above an estimated time' question.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Support analysis of what time of day incidents are occurring.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

ORGANISATION	
Specification	
Definition	Unique organisation ID number of the organisation that is submitting the incident report.
Form	Organisation dependent single value.
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code Set	Organisation dependent single value.
Reporting guide	The organisation ID field is reported for each incident that is reported. The organisation ID allows the health service where the incident occurred to be identified.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables identification of the organisation reporting the incident and supports regional analysis of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

CAMPUS	
Specification	
Definition	Campus ID of where the incident occurred at the health service.
Form	Organisation dependent code.
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Organisation dependent code.
Reporting guide	Report the incident under the Campus ID at which the incident occurred.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables identification of the campus where the incident occurred. This will enable analysis at a more granular level for health services with more than one campus/site.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	Organisation dependent

WARD/LOCATION			
Specification			
Definition	Ward/location ID where the incident occurred.		
Form	Organisation dependent code.		
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.		
Reported for	All incidents (clinical and OH&S), near misses, and hazards.		
Reported when	Any of the above record types is reported.		
Code set	Organisation dependent code.		
Reporting guide	Each health service maintains a list of physical locations unique to their campuses. All new wards and locations require a code supplied by VAHI. To lessen the burden on health services, from 1 July 2023 health services requesting new VAHI codes for wards will be given a single "other" ward code that can be used in transmissions to the department. Health services should work with vendors to ensure a unique lists of ward/location codes can be maintained in their system, while transmitting the single code to VAHI.		
Validation	General edits only, see Section 1: Introduction – Data quality statement.		
Related items	N/A		
Administration			
Purpose	Enables assessment of whether there are trends for specific locations in health services.		
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.		
Collection start	2019–20		
Version history	Version 1	Previous name Ward/Location	Effective Date 1/7/2023
Definition source	VAHI		
Code set source	Organisation dependent		

SPECIALTY/UNIT	
Specification	
Definition	The department/specialty/unit ID responsible for following up the incident
Form	Organisation dependent code.
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Organisation dependent code.
Reporting guide	Each health service has a pre-defined list of departments/specialty/unit ID unique to each health service. Report the incident under the department/specialty/unit ID to which the incident is related/who is responsible for taking action to follow up the incident.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A

SPECIALTY/UNIT			
Administration			
Purpose	Allows grouping of specialities across health services to look for trends relating to specialities not apparent in health service analysis, e.g., statewide investigation into mental health services or aged care.		
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.		
Collection start	2019–20		
Definition source	VAHI		
Code set source	Organisation dependent		

BRIEF SUMMARY			
Specification			
Definition	Brief description of the incident.		
Form	Free text		
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.		
Reported for	All incidents (clinical and OH&S), near misses, and hazards.		
Reported when	Any of the above record types is reported.		
Code set	Free text		
Reporting guide	From 1 July 2023 health services are not required to transmit the brief summary of the incident. Health services should work with their vendors to ensure a substitute line of text is transmitted, for example 'Not Applicable' or "N/A". This change has been made to allow the department to review the inclusion of the Brief Summary field within the MDS and to address concerns from health services about the burden of de-identifying data in this field		
Validations	General edits only, see Section 1: Introduction – Data quality statement.		
Related items	N/A		
Administration			
Purpose	Enables thematic analysis of the incident.		
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.		
Collection start	2019–20		
Version history	Version 1	Previous name Brief Summary	Effective Date 1/7/2023
Definition source	VAHI		
Code set source	VAHI		

DETAILS			
Specification			
Definition	Details of the incident.		
Form	Free text		
Layout	Free text		
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.		
Reported for	All incidents (clinical and OH&S), near misses, and hazards.		
Reported when	Any of the above record types is reported.		
Code set	Free text		
Reporting guide	From 1 July 2023 health services are not required to transmit the incident details. Health services should work with their vendors to ensure a substitute line of text is transmitted, for example 'Not Applicable' or "N/A". This change has been made to allow the department to review the inclusion of the Details field within the MDS and to address concerns from health services about the burden of de-identifying data in this field.		
Validations	General edits only, see Section 1: Introduction – Data quality statement.		
Related items	N/A		
Administration			
Purpose	Enables thematic analysis of the incident.		
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.		
Collection start	2019–20		
Version history	Version 1	Previous name Details	Effective Date 1/7/2023
Definition source	VAHI		
Code set source	VAHI		

INCIDENT TYPE/EVENT TYPE	
Specification	
Definition	Type of incident/event (i.e., if it is clinical, OH&S or a non-person or hazard event).
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	The VHIMS2 taxonomy for incident classification will be used. There are three broad categories, further broken down as follows: • 25 clinical incident types. • 13 OH&S incident types. • 79 non-person or hazard event types. See Appendix 1 for full code set for clinical, OH&S, and hazard incident/event types and contributing factors.
Reporting guide	This section allows classification of the event. More than one event type can be selected, in any order (i.e., the order does not indicate which is most relevant or important). The event type selected will determine the additional questions required to be answered. The event types have been 'tagged' with associated key words to improve consistency. Note there is no longer a distinction between primary and related incident types.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident type sub-categories
Administration	
Purpose	Enables more reliable and accurate analysis using incident type.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019-20
Definition source	VAHI
Code set source	VAHI

INCIDENT TYPE SUB-CATEGORIES	
Specification	
Definition	Sub-categories for the incident or event type selected. Sub-categories exist for each of the: • 25 clinical incident types • 13 OH&S incident types • 79 non-person or hazard event types Subcategories capture further details of types, processes or problems related to that incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	See Appendix 1 for full code set for clinical, OH&S, and hazard incident/event types and contributing factors.
Reporting guide	The event type selected in the incident type/event type determines the additional information required to be reported here. This includes further details about the incident/event such as: • the specific type of incident and the problem(s) associated with that incident • a specific process related to the incident and the problem(s) associated to that process • details of the physical items affected in that incident. For example, if the broad category, 'Property' was selected as the Clinical incident type, subcategories that reporters could select include the type of property affected (i.e., Personal belongings) followed up by problems specifically related to personal belongings (i.e., Damaged; inappropriate/unsafe storage etc). Reporting guidelines for some of the sub-categories are included alongside the full code sets.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident type/Event type.
Administration	
Purpose	Enables more detailed investigation of specific incident types.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

WAS AN EMERGENCY RESPONSE CALLED?	
Specification	
Definition	An incident or circumstance that causes the facility's emergency plan to be activated.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	Select Yes if an emergency response was called. Select No if an emergency response was not called.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	If yes, type of emergency response.
Administration	
Purpose	Enables identification of how many incidents resulted in an emergency response.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IF YES, TYPE OF EMERGENCY RESPONSE	
Specification	
Definition	The type of emergency response called for this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	**Code Black** Serious threat and/or involving a weapon **Code Brown** External disaster **Code Grey** Unarmed threat **Code Orange** Evacuation **Code Purple** Bomb threat **Code Red** Fire/smoke **Code Yellow** Internal emergency **MET/Code Blue** Rapid response **Obstetric emergency**
Reporting guide	Applicable only where the value **Yes** is selected for the question **Was an emergency response called?**

IF YES, TYPE OF EMERGENCY RESPONSE	
Specification	
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Was an emergency response called?
Administration	
Purpose	Enables identification of what type of emergency responses are called where there is an incident, e.g., analysis of code greys.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

EXTERNAL NOTIFICATIONS	
Specification	
Definition	Name of external organisation/s that have been notified of this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Aged Care Quality and Safety Commission Australian Health Practitioner Regulation Agency (AHPRA) Child Protection/Child FIRST Clinical council e.g., Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) or Victorian Audit of Surgical Mortality (VASM) Commission for Children and Young People Community and Primary Health Community Health Serious Incident Response Scheme (SIRS) Department of Education and Training Department of Justice and Community Safety DH/Department of Families, Fairness and Housing (DFFH) Dieticians Association of Australia Emergency Management Branch Exercise and Sport Science Australia (ESSA) Health Complaints Commissioner Mental Health Complaints Commissioner (MHCC) NDIS Quality and Safeguards Commission Not required

EXTERNAL NOTIFICATIONS	
Specification	
Code set (continued)	Office of the Australian Information Commissioner (OAIC) Office of the Chief Psychiatrist Radiation Safety Team Safer Care Victoria (SCV) Serious Transfusion Incident Reporting (STIR) Speech Pathology Australia Therapeutic Goods Administration (TGA) Victoria Police Victorian Auditor-General's Office Victorian Managed Insurance Authority (VMIA) WorkSafe Victoria Other Other (e.g., Fire Rescue Victoria (FRV), Environment Protection Authority (EPA) etc.)
Reporting guide	Select an organisation where applicable. Note: This is a question to record external notifications only. Health services are responsible for understanding reporting obligations and completing external notifications, for example for Sentinel events.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables identification of how many incidents resulted in a notification to another organisation and which organisations are being notified.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IS THIS INCIDENT RELATED TO CARE PROVIDED BY THIS ORGANISATION?	
Specification	
Definition	Identifying if this incident is related to the care provided by this organisation.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No

IS THIS INCIDENT RELATED TO CARE PROVIDED BY THIS ORGANISATION?	
Specification	
Reporting guide	Select **Yes** if the incident is related to care provided by this organisation. Select **No** if the incident is not related to care provided by this organisation. For further information on this data element see Section 4: Business Rule – Is this incident related to care provided by this organisation?
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Other data items that relate to this data item.
Administration	
Purpose	Allows services to flag incidents that do not relate to care provided by their organisation. This field will enable these incidents to be excluded from analysis.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IS VMIA NOTIFIABLE?	
Specification	
Definition	Incidents that meet criteria for notification to the Victorian Managed Insurance Authority (VMIA).
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses and hazards.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	Select **Yes** if the incident meets criteria for notification to VMIA. Select **No** if this incident does not meet criteria for notification to VMIA. It is important to notify VMIA of any health care incident, occurrence, complaint, investigation, inquiry, or disciplinary proceeding which may give rise to a medical indemnity claim, or if a request for compensation for personal injury, arising directly out of a health care incident, is received. Contact VMIA: https://www.vmia.vic.gov.au/about-us/contact-us
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A

IS VMIA NOTIFIABLE?	
Administration	
Purpose	Enables identification of how many incidents resulted in a VMIA notifiable event, and aligns with the inclusion of the data item 'Is this a WorkSafe notifiable event?'
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REVIEW TYPE	
Specification	
Definition	Type of review completed following an incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Line Manager Review Aggregate Review In depth case review Root Cause Analysis OHS Review No review process undertaken Other review
Reporting guide	Multiple reviews can be added to an incident.
Validation	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Review status
Administration	
Purpose	Enables monitoring of trends in review and management of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REVIEW STATUS	
Specification	
Definition	Status of a review added to an incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All incidents (clinical and OH&S), near misses, and hazards.
Reported when	Any of the above record types is reported.
Code set	Open Under review Completed
Reporting guide	Review status is reportable if the incident has a review type of anything except 'no review process undertaken'.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Review type
Administration	
Purpose	Enables monitoring of trends in review and management of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

CLIENT ID/UR NUMBER	
Specification	
Definition	The patient's unique identifier from the health service patient administration system.
Form	Alpha-numeric (System-generated).
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.
Code set	Free text
Reporting guide	Clinical incident only.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	For the purposes of linkage to Department of Health administrative data sets if required.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

GENDER	
Specification	
Definition	How a person describes their gender.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.
Code set	Male Female Other Unknown
Reporting guide	Clinical incidents only.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables demographic analysis of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF HARM SUSTAINED (THIS FIELD WAS PREVIOUSLY 'DEGREE OF IMPACT')	
Specification	
Definition	The level of harm for the person affected by the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical Incidents only.
Reported when	Any of the above record types is reported.
Code set	No harm – did not reach person No harm – did reach person Harm – Temporary (Minor) Harm – Temporary (Moderate) Harm – Permanent Death

LEVEL OF HARM SUSTAINED (THIS FIELD WAS PREVIOUSLY 'DEGREE OF IMPACT')	
Specification	
Reporting guide	Level of harm is defined as follows: • **No harm – Did not reach person:** There was no harm to the subject, that is, the incident did not reach the subject. For example: the incorrect dose or type of medication was prescribed/dispensed but not administered to patient. • **No harm – Did reach person:** The incident reached the subject, but there was no harm caused. For example: Delayed treatment/theatre, absconding, missed medication, vasovagal which does not result in harm or negative consequences for the subject. • **Harm – Temporary (Minor):** One system or component of the subject's body are temporarily unable to operate as they did prior to the incident. The subject is likely to recover from this in the short to medium term. For example: An incident which results in temporary loss or reduction in functioning including hospital acquired infection, laceration, fracture, weight loss, self-harm, pressure injury/skin tear, burn, psychological harm. • **Harm – Temporary (Moderate):** Two or more systems or components of the subject's body are temporarily unable to operate as they did prior to the incident. The subject is likely to recover from this in the short to medium term. For example: An incident which results in temporary loss or reduction in functioning including (two or more of the following) hospital acquired infection, laceration, fracture, malnutrition, significant weight loss, self-harm, pressure injury/skin tear, burn, psychological harm. • **Harm – Permanent:** One or more systems or components of the subject's body are no longer able to operate as they did prior to the incident. The subject is not likely to recover from this loss or reduced functioning. For example: permanent loss or reduction in functioning including complications of surgery/procedure/inpatient admission, hospital acquired infection, medication error, self-harm, pressure injury/skin tear, burn, psychological harm. • **Death:** The subject died unexpectedly at the time or following the incident due to system/process deficiencies and not their underlying condition. For example: misdiagnosis, delay in recognising/responding to deterioration, complications of resuscitation linked to procedural or equipment failures, complications of an inpatient fall, complications of a procedure/surgery.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Required level of care Level of treatment required
Administration	
Purpose	Determine the clinical incident severity rating (ISR). ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REQUIRED LEVEL OF CARE (THIS FIELD WAS PREVIOUSLY 'LEVEL OF CARE')	
Specification	
Definition	The level of care required for the person affected by this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical Incidents only.
Reported when	Any of the above record types is reported.
Code set	Current setting – No change Current setting – Increased observation or monitoring Internal/external transfer for diagnostic test or monitoring only Internal transfer for advanced/specialised care External transfer for advanced/specialised care
Reporting guide	Required level of care is defined as follows: • **Current setting – No change:** The subject did not require additional care or to be moved from their current location as a result of the incident. • **Current setting – Increased observations or monitoring:** The subject required increased observation or monitoring within their current setting. • **Internal/external transfer for diagnostic test or monitoring only:** The subject was transferred for required diagnostic testing or increased monitoring not available in current location. For example: transfer to a facility with x-ray and CT as diagnostic imaging is not on site. • **Internal transfer for advanced/specialised care:** The subject was transferred to another campus within the same health care service for a higher level of care or specialty not available in current location. For example: the patient is in an aged care facility and is transferred to the acute campus of the same health care network for an orthopaedic review of a suspected fracture. • **External transfer for advanced/specialised care:** The subject was transferred externally to another health care service, for a higher level of care or specialty not available in current location. For example: a patient in a regional hospital is transferred to a metropolitan tertiary service following referral to their neurosurgical high dependency unit for surgical treatment of a subarachnoid haemorrhage. Not applicable: The level of care is set to 'not applicable' when the degree of impact was 'death'.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Level of treatment required Level of harm sustained
Administration	
Purpose	Determine the clinical incident severity rating (ISR). ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF TREATMENT REQUIRED	
Specification	
Definition	Level of intervention required for the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.
Code set	No treatment Minor treatment Intermediate treatment Advanced treatment
Reporting guide	Level of treatment is defined as follows: • **No treatment:** Following review, intervention was deemed not required. Review includes: GP, emergency department, MET, VMO. For example: Injury reviewed by medical staff, but no treatment was required. • **Minor treatment:** The subject required a simple or minor intervention or first aid as a result of the incident. For example: blood tests, simple dressings, analgesia. • **Intermediate treatment:** The subject required a referral, a simple procedure, or more advanced diagnostics. For example: CT/MRI, suturing, insertion of nasogastric tube, urinary catheter insertion, evacuation of haematoma, >5 physiotherapy sessions, MET/Code Blue resulting in O2 therapy, administration of anti-arrhythmic or reversal of medications. • **Advanced treatment:** The subject required significant in hospital medical, diagnostic, or surgical intervention as a result of the incident. For example: Surgical intervention to treat life threatening haemorrhage or organ perforation, surgical/ medical referral to treat injury, MET/Code blue resulting in advanced life support (e.g., rescue breathing, cardiac compressions, ventilation, treatment of anaphylaxis) insertion CVC or PICC line, emergency defib, pacemaker insertion, administration of noradrenaline/dopamine, haemofiltration/dialysis, insertion of an intra-aortic balloon pump.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Required level of care Level of harm sustained
Administration	
Purpose	Determine the clinical incident severity rating (ISR). ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

INCIDENT SEVERITY RATING (ISR)	
Specification	
Definition	A system generated data element, the Incident Severity Rating (ISR) is a score between 1 and 4 that measures the severity of impact caused to the person affected following an incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.
Code set	ISR 1 – severe/death ISR 2 – moderate ISR 3 – mild ISR 4 – no harm/near miss
Reporting guide	A system-generated item derived from the response to three consequence-descriptor category questions related to: • **level of harm** (previously 'degree of impact') • **required level of care** (previously 'level of care') • **level of treatment required** (previously 'treatment required'). There are four ISRs used to classify incidents by severity: • ISR 1 – severe/death • ISR 2 – moderate • ISR 3 – mild • ISR 4 – no harm/near miss. Calculations are based on a World Health Organization algorithm, adapted, and refined by subject matter experts from Victorian public health services to support VHIMS incident classification and reporting. The ISR value cannot be changed, however the answers to the three consequence-descriptor category questions can be edited to correct the ISR value. At times there may be limited exceptions where the ISR is predetermined, such as up until 1 July 2023 where a mandatory ISR2 was reported for behavioural incidents related to sexual safety, however any such change will need to gain the approval of the sector via the VHIMS MDS annual change process. The ISR is used to determine who within your health service must be notified of this event. Please refer to the Adverse Patient Safety Events policy on the Better Safer Care website for review of incidents ISR 1 – 4.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Level of treatment required Level of harm sustained Required level of care

INCIDENT SEVERITY RATING (ISR)			
Administration			
Purpose	ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.		
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.		
Collection start	2019–20		
Version history	Version 1	Previous name Incident Severity Rating (ISR)	Effective Date 1/7/2023
Definition source	VAHI		
Code set source	VAHI		

CONTRIBUTING FACTORS	
Specification	
Definition	Factors that contribute to an incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.
Code set	See Appendix 1 for full code set for clinical, OH&S, and hazard incident/event types and contributing factors.
Reporting guide	Select from the list of contributing factors. Multiple contributing factors can be selected. VHIMS MDS only includes contributing factors for ISR 1 and 2 incidents.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables more reliable reporting on contributing factors and to identify insights related to the root causes of incidents. Also enables identification of trends about the possible causes both clinical and OH&S incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

WAS OPEN DISCLOSURE CONDUCTED?	
Specification	
Definition	Identifies if open disclosure was conducted.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	All clinical incidents where there was harm.
Reported when	Clinical incidents only
Code set	Yes No Not applicable
Reporting guide	Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care with the patient, their family, carers, and other support persons. Select **Yes** if open disclosure has been completed. Select **No** if the incident meets criteria but open disclosure has not been completed at time of incident entry. Select **Not applicable** if the incident does not meet open disclosure criteria. See Section 4: Busines Rules – Open Disclosure for additional information on this data element.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	NA
Administration	
Purpose	Enables analysis of open disclosure.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

RELATED NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARD	
Specification	
Definition	Identifies if an incident is related to National Safety and Quality Health Service Standard and which standard it relates to.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	Any of the above record types is reported.

RELATED NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARD	
Specification	
Code set	Standard 1 – Clinical governance Standard 2 – Partnering with consumers Standard 3 – Healthcare-associated infection Standard 4 – Medication safety Standard 5 – Comprehensive care Standard 6 – Communicating for safety Standard 7 – Blood management Standard 8 – Recognising and responding to acute deterioration Not applicable
Reporting guide	Multiple selections allowed. Further information about the National Safety and Quality Health Service Standards is available at: https://www.safetyandquality.gov.au/standards/nsqhs-standards
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables analysis of incidents related to National Safety and Quality Health Service Standards.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IS THIS ONE OF THE FOLLOWING SENTINEL EVENTS?	
Specification	
Definition	Identify if the incident is a type of sentinel event. Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical Incidents only.
Reported when	Any of the above record types is reported.:

IS THIS ONE OF THE FOLLOWING SENTINEL EVENTS?	
Specification	
Code set	Not a sentinel event Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward. Medication error resulting in serious harm or death. Use of physical or mechanical restraint resulting in serious harm or death. Discharge or release of an infant or child to an unauthorised person. Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death. All other adverse patient safety events resulting in serious harm or death.
Reporting guide	Single response only. Select the first appropriate category. The *Victorian sentinel events guide (2019)* is available at: https://www.bettersafercare.vic.gov.au/publications/sentinel-events-guide
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables analysis of sentinel events, for cross referencing with SCV notifications.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IF OTHER, DESCRIBE OTHER SENTINEL EVENT	
Specification	
Definition	Description of the sentinel event if it is of the type 'All other adverse patient safety events resulting in serious harm or death'.
Form	Free text
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Clinical incidents only.
Reported when	'All other adverse patient safety events resulting in serious harm or death' is selected for – Is this one of the following sentinel events?
Code set	Free text

IF OTHER, DESCRIBE OTHER SENTINEL EVENT	
Specification	
Reporting guide	The 'other' category includes all adverse patient safety events resulting in serious harm or death that are not included in the ten national categories. More information on how to report sentinel events including the 'other' category can be found in the *Victorian sentinel events guide (2019)* available at: https://www.bettersafercare.vic.gov.au/publications/sentinel-events-guide
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Is this one of the following sentinel events?
Administration	
Purpose	Enables analysis of sentinel events, for cross referencing with SCV notifications.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REPORTER ROLE	
Specification	
Definition	Role of the staff member reporting the incident.
Form	Free text or Code set (organisation dependent).
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Free text or organisation dependent code.
Reporting guide	Roles are determined by the health service. Enter most appropriate role. This code set can also be predetermined by system permissions and may not be visible to the reporter.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables demographic analysis of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

WHERE DID THE INCIDENT OCCUR?	
Specification	
Definition	Location/Place where the incident took place.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	At the workplace When travelling as part of the job Working away from usual place When travelling to/from work
Reporting guide	Select the location/place that best matches where the incident occurred.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables analysis of where OH&S incidents are occurring, e.g., at the workplace, when travelling as part of the job, etc.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF HARM SUSTAINED (THIS FIELD WAS PREVIOUSLY 'DEGREE OF IMPACT')	
Specification	
Definition	The level of harm for the person affected by this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	No Harm Harm Death
Reporting guide	Level of harm sustained is defined as follows: • **No harm:** There was no harm to the subject either as the incident did not reach the subject, or it did, but did not impact their usual level of health and function. • **Harm:** One or more systems or components of the subject's body are no longer able to operate as they did prior to the incident (impacting their usual level of health and function). • **Death:** The subject died at the time or following the incident.

LEVEL OF HARM SUSTAINED (THIS FIELD WAS PREVIOUSLY 'DEGREE OF IMPACT')	
Specification	
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	To determine the OH&S ISR. ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REQUIRED LEVEL OF CARE (THIS FIELD WAS PREVIOUSLY 'LEVEL OF CARE')	
Specification	
Definition	The level of care required for the person affected by this incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	No care required First Aid Assessment Medical treatment Inpatient hospital admission
Reporting guide	Required level of care is defined as follows: • **No care required:** Following review, intervention was deemed not required. For example: minor cuts, bruises. • **First aid:** The subject required first aid to treat the injury. For example: simple dressings, analgesia. • **Assessment:** The subject required referral for medical, psychological, or physical assessment to ascertain whether an injury has been acquired. For example: diagnostic imaging, psychological assessment, physical assessment to diagnose or rule out injury. • **Medical treatment:** The subject required a clinician, including a GP, specialist, or emergency physician, to treat the injury sustained. For example: minor procedure, sutures, counselling, administration of an anti-arrhythmic. • **Inpatient hospital admission:** The subject required admission to hospital as an inpatient to treat injury. For example: Surgical/medical referral which requires inpatient admission.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A

REQUIRED LEVEL OF CARE (THIS FIELD WAS PREVIOUSLY 'LEVEL OF CARE')	
Administration	
Purpose	To determine the OH&S ISR. ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

ACTIONS REQUIRED (THIS FIELD WAS PREVIOUSLY 'LEVEL OF TREATMENT')	
Specification	
Definition	Level of intervention/treatment required for the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Alternative treatment Paramedic/Ambulance Employee Assistance Program (EAP) Physiotherapy Doctor/Casualty
Reporting guide	OH&S incidents only. **Actions required** is applicable where the value **Medical treatment** is selected for the question **Required level of care**. Actions required are defined as: • **Alternative treatment:** Methods of healing which may not be firmly based on accepted scientific principles and may thereby be of limited known effectiveness e.g., acupuncture, osteopathy, chiropractic, massage etc. • **Paramedic/Ambulance:** Ambulance paramedics are trained to Advanced Life Support (ALS) level and provide sick and injured people care, treatment and transport to further care. • **Employee Assistance Program (EAP):** EAP is a work-based intervention program designed to enhance the emotional, mental, and general psychological wellbeing of all employees and includes services for immediate family members. EAP can help with worker recovery, problem solving and resolution of the issues using current and researched treatment and strategies effective for the workplace. For example, the provision of professional support and counselling from workplace stress, trauma and conflict to personal issues that are impacting performance. This may include individual and group counselling, psychometric testing and psychological, assessment, trauma management, critical incident response, conflict resolution, coaching, out of office hours telephone counselling and outplacement and career transition.

ACTIONS REQUIRED (THIS FIELD WAS PREVIOUSLY 'LEVEL OF TREATMENT')	
Specification	
Reporting guide (continued)	• **Physiotherapy:** Physiotherapy is a healthcare profession that assesses, diagnoses, treats, and works to prevent disease and disability through physical means. For example: exercise programs to improve mobility and strengthen muscles; joint manipulation and mobilisation to reduce pain and stiffness; muscle re-education to improve control; airway clearance techniques and breathing exercises; soft tissue mobilisation (massage); hydrotherapy; and assistance with the use of aids, splints, crutches, walking sticks and wheelchairs. • **Doctor/casualty:** Includes GPs and emergency medicine physicians.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Required level of care (this field was previously 'Level of care').
Administration	
Purpose	To determine the OH&S ISR. ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

TYPE OF INJURY	
Specification	
Definition	Type of injuries sustained from the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Abrasion/Cut/Laceration/Puncture Allergy/Infection Bruise/Contusion Burn/Scald Dislocation/Fracture/Crushing Emotional/Psychological Skin disorder Sprains/strains Toxic effects/Poisoning Redness/Swelling

TYPE OF INJURY	
Specification	
Reporting guide	OH&S incidents only. **Type of injury** is applicable where the value **Harm** or **Death** is selected for the question **Level of harm sustained**. Multiple selections allowed.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Level of harm sustained.
Administration	
Purpose	To enable analysis of the type and location of injury, where someone was harmed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

BODY PART				
Specification				
Definition	Description of body part/s injured.			
Form	Code			
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.			
Reported for	OH&S incidents only.			
Reported when	Any of the above record types is reported.			
Code set	Head	Trunk	Abdomen	Heel
	Face	Arm	Back	Toe
	Eye	Elbow	Pelvis	Greater trochanter
	Ear	Wrist	Buttocks	Iliac crest
	Nose	Hand	Groin area	Ischium/buttocks
	Mouth/lips	Palm	Leg	Malleolus
	Cheek	Little finger	Hip	Occiput
	Chin	Fore finger	Thigh	Sacrum coccyx
	Neck	Middle Finger	Knee	Scapula
	Shoulder	Ring finger	Ankle	Spinous process
	Chest	Thumb	Foot	Other

BODY PART		
Specification		
Reporting guide	This data element is applicable where the value **Type of Injury** is one of the following:	
	Abrasion	Crushing
	Cut	Loss of Consciousness (LOC)
	Laceration	Concussion
	Puncture	Fainting
	Allergy	Skin Disorder
	Infection	Sprains
	Bruise	Strains
	Contusion	Toxic effects
	Burn	Poisoning
	Scald	Redness
	Dislocation	Swelling
	Fracture	Multiple selections allowed.
Validations	General edits only, see Section 1: Introduction – Data quality statement.	
Related items	Type of Injury.	
Administration		
Purpose	Where someone was harmed, enables analysis of the type and location of injury.	
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.	
Collection start	2019–20	
Definition source	VAHI	
Code set source	VAHI	

IF OTHER BODY PART, SPECIFY	
Specification	
Definition	Description of body part/s injured that are not covered in the list above or selected 'other'.
Form	Free text
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Free text
Reporting guide	**If other body part, specify** is applicable when the value **Other** is selected for the question **Injured body parts**.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Injured body parts.

IF OTHER BODY PART, SPECIFY	
Administration	
Purpose	Where someone was harmed, enables analysis of the type and location of injury.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

IS THIS A WORKSAFE NOTIFIABLE EVENT?	
Specification	
Definition	Confirm if this incident is a WorkSafe notifiable event.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Yes No
Reporting guide	Under the Occupational Health and Safety Act 2004, employers must notify WorkSafe immediately after becoming aware that a notifiable incident has occurred. Notifiable incidents include but are not limited to incidents that result in death; needing medical treatment within 48 hours of being exposed to a substance; immediate treatment as an in-patient in a hospital; and/or immediate medical treatment for injuries, including for example amputation, serious head or eye injury, electric shock, serious lacerations. Please refer to the WorkSafe Victoria https://www.worksafe.vic.gov.au/report-incident-criteria-notifiable-incidents or contact your organisation's occupational health and safety team.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables identification of how many incidents resulted in a WorkSafe notifiable event.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

PREVENTATIVE/CORRECTIVE ACTION	
Specification	
Definition	Information about preventative/corrective actions associated to the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Develop safe work procedure/SOPs Review/reinstruct on existing safe work procedure Provide training Replace/repair equipment/source new equipment Improve housekeeping Improve layout/access of work site Develop/review behaviour support plan Appropriate personal protective equipment Complete risk assessment Review work process Review client risk profile Other – please specify
Reporting guide	Multiple selections from code set allowed. Note: SOP stands for Standard Operating Procedure/s
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	N/A
Administration	
Purpose	Enables monitoring of trends in review and management of incidents.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

STATUS OF PREVENTATIVE/CORRECTIVE ACTION	
Specification	
Definition	Status of preventative/corrective actions associated to the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.

STATUS OF PREVENTATIVE/CORRECTIVE ACTION	
Specification	
Code set	Not Implemented Implemented Not achievable
Reporting guide	**Status of preventative/corrective action** is applicable when a preventative/corrective action has been recorded.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Preventative/corrective action.
Administration	
Purpose	Monitors the extent to which health services have implemented their intended strategies.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

COMPLETION DATE OF PREVENTATIVE/CORRECTIVE ACTION	
Specification	
Definition	Completion date of preventative/correction action.
Form	Date
Layout	YYYY-MM-DD
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	N/A
Reporting guide	**Completion date of preventative/corrective action** is applicable when a preventative/corrective action has been recorded and completed. Date entered must be the day of or after the incident date.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Preventative/corrective action.
Administration	
Purpose	Monitors the extent to which health services have implemented their intended strategies.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

REASON WHY PREVENTATIVE/CORRECTIVE ACTION WAS NOT ACHIEVABLE	
Specification	
Definition	Text explaining why the preventative/correction action was not achievable.
Form	Free text
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	OH&S incidents only.
Reported when	Any of the above record types is reported.
Code set	Free text
Reporting guide	OH&S incidents only. **Reason why preventative/correction action was not achievable** is applicable when the value **Not achievable** is selected for the question **Status of preventative/corrective action**.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Status of preventative/corrective action.
Administration	
Purpose	Monitors the extent to which health services have implemented their intended strategies.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF IMPACT	
Specification	
Definition	Level of impact of the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Hazards (non-clinical/non-OH&S incidents) only.
Reported when	Any of the above record types is reported.
Code set	No impact – Could have happened No impact – Did happen Minor impact – Local area Moderate impact – Local campus Major impact – More than one campus/organisation wide

LEVEL OF IMPACT	
Specification	
Reporting guide	Level of impact is defined as follows: • **No impact – Could have happened:** A condition within the workplace which has the potential to cause harm. For example: Potential for manual handling injury due to staff moving heavy boxes, frayed electrical lead attached to the bed, wheelchair wheels jamming. • **No impact – Did happen:** A condition within the workplace which had the potential to cause harm but didn't. For example: Exposure to pest infestation in staff tearoom, frayed carpet results staff tripping without injury, poor ventilation, poor lighting, glare from windows. • **Minor impact – Local areas:** A condition within the workplace which had a minor impact on the local area. For example: exposure of staff to pharmaceutical waste especially cytotoxic agents. • **Moderate impact – Local campus:** A condition within the workplace which had a moderate impact on the campus. For example: presence of asbestos throughout campus, radioactive waste from nuclear medicine, presence of ligature points in mental health unit. • **Major impact – More than one campus/organisation wide:** A condition within the workplace which had a major impact across the organisation. For example: Biological waste from clinical areas is not disposed of safely.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident Severity Rating (ISR).
Administration	
Purpose	This field determines the hazard ISR. ISR is used to group hazards with similar levels of impact and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF DISRUPTION TO SERVICES	
Specification	
Definition	Level of disruption caused by the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Hazards (non-clinical/non-OH&S incidents) only.
Reported when	Any of the above record types is reported.
Code set	No or Minimal disruption <1 hr Minor disruption <24 hrs Moderate disruption >24 hrs Major shutdown of unit or site

LEVEL OF DISRUPTION TO SERVICES	
Specification	
Reporting guide	Level of disruption is defined as follows: • **No or minimal disruption <1 hr:** For example: inappropriate storage of medication, emergency exit light not illuminated, air conditioning not working properly. • **Minor disruption >1 hr and <24 hrs:** For example, lifts not opening on level requiring lift company to decommission lift until it can be fixed. • **Moderate disruption >24 hrs:** For example: poorly maintained equipment which takes more than a day to repair. • **Major shutdown of unit or site:** For example: site is shut down due to flooding.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident Severity Rating (ISR).
Administration	
Purpose	This field determines the hazard ISR. ISR is used to group hazards with similar levels of impact and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

LEVEL OF INTERVENTION REQUIRED	
Specification	
Definition	Level of intervention required for the incident.
Form	Code
Reported by	All Victorian public health services and all services under their governance structure including community health and bush nursing centres. For a complete list of in-scope organisations see Section 1: Introduction – VHIMS MDS Scope.
Reported for	Hazards (non-clinical/non-OH&S incidents) only.
Reported when	Any of the above record types is reported.
Code set	**No intervention required** **Minor** – Local area intervention required to resolve issue. **Moderate** – Local division intervention required to resolve the incident. **Major** – Group wide intervention required to resolve issue.
Reporting guide	Select the first appropriate category.
Validations	General edits only, see Section 1: Introduction – Data quality statement.
Related items	Incident Severity Rating (ISR).
Administration	
Purpose	This field determines the hazard ISR. ISR is used to group hazards with similar levels of impact and to assess the degree of investigation needed.
Principal data users	Victorian Agency for Health Information, Department of Health, Safer Care Victoria.
Collection start	2019–20
Definition source	VAHI
Code set source	VAHI

Section 4: Business rules

This section provides business rules that support consistent entry of incident data across all health services. These are data elements within the VHIMS MDS, or functions within the health service incident management system, that can impact on data quality and reporting. The expectation is that all health services will include these business rules in local policy, procedures, and guidelines. These policies, procedures and guidelines must be supported with a workforce communication and education strategy to support successful uptake and implementation of the business rules.

Timing of incident notification

Reporting of an incident in a health service's local incident and reporting management system must occur as soon as is practicable, preferably by the end of the notifier's workday. Best practice identifies that:

- Incidents are reported by the staff member who witnessed the event.
- Reporting must occur as soon as possible following the adverse event to support timely and accurate recall and reporting.
- Reporting as soon as possible minimises the introduction of biases such as cognitive bias, primacy and recency and group think.
- Timely submission of the incident also ensures incidents are notified and actioned appropriately at a local level and escalated as required. Note: For sentinel events, notify Safer Care Victoria within three business days of a health service becoming aware of the incident's status.

Timing of incident transmission

From 1 July 2023 all health services, (except Registered Community Health Services) are required to report all incidents in near-real-time. Health services should work with their IMS vendor to ensure that this reporting timeline is achieved.

From 1 July 2024. Community Health Services will be required to report in near real time. Until this change Community Health services must follow the Critical Incident Pathway.

- Refer to Section 5 for guidance on transmission via the Application Programming Interface.
- Reporting in near real time has been authorised by SCV and is required to facilitate development of an early warning system that support proactive identification of emerging safety risks.

Incidents submitted to the department will be updated in real time reflecting changes made by health services throughout the incident lifecycle. Health services should work with vendors to ensure near-real-time reporting is available via their IMS.

Is this incident related to care provided by this organisation?

This data element allows health services to identify incidents that do not relate to care provided in their organisation.

Health services may also use incident management systems to collect data for reporting purposes. For example, identification of pressure areas that did not occur as a result of care at the health service.

'No' must be selected in this field in this instance to enable these clinical incidents to be excluded from data analysis.

In the event that an incident relates to care at another health service:

- The receiving health service must notify the transferring health service of the incident and patient outcome (if known) to enable the reporting of the incident in the transferring health service incident management system.
- This provides the transferring health service with the necessary information to undertake the appropriate reviews and provide feedback to staff.

Selection of linked versus clone incidents

Incidents can be cloned and linked to indicate a relationship between incidents, and often both are required. The difference between cloning and linking can be described as follows:

- **Cloning:** copies all the elements of an incident to enable the reporter to submit a second incident under another event type (clinical, OHS or hazard), or to create multiple incident reports if more than one person is affected.
- **Linking:** groups two or more incident reports together to identify when a patient has multiple adverse events, or when there is an issue affecting multiple people or occurring on multiple occasions.

When would I clone an incident?

When you need to report that more than one person or property have been affected by the same event, that is when the event date and time is the same. For example, a patient trips on a table leg while walking and grabs on to a nurse resulting in both the patient and nurse falling against the table. This results in the nurse reporting a back injury and the table being damaged in the fall. There is nil harm to the patient.

In this scenario three reports will be submitted for the one event:

- Patient fall (Clinical incident)
- Nurse back injury (OH&S)
- Property damage (table) Non-clinical/non-OHS

Likewise, if the incident involves two or more residents, as in the case of a resident-to-resident aggression event, two reports would be submitted and classified as Clinical for each resident.

When would I link an incident?

The following example demonstrates how incidents are linked to capture the relevant themes.

A resident in an aged care facility is suffering a delirium and is involved in separate altercations with three other residents over a period of several days. Each day there are incident reports submitted to reflect the altercations. While occurring on different days and times to a number of people, these incident reports can be linked to demonstrate a common cause as outlined below.

On day one, the resident with delirium has two separate altercations with two residents and the following incidents reports are submitted:

- **Incident 1:** for the resident with delirium classified as behavioural problem 'verbal aggression' and behaviour related to 'Cognitively impaired/ Dementia'.
- **Incident 2:** for the second resident who is struck by resident one and classified as behavioural problem 'physical aggression' and behaviour related to 'Cognitively impaired/Dementia'.

On day two, the resident with delirium has further altercations with another resident and a staff member with the following incidents reports submitted:

- **Incident 3:** for the third resident who was struck and fell over during the altercation, classified as behavioural problem 'physical aggression' behaviour related to 'Cognitively impaired/ Dementia' and 'Patient/Client/Resident fall'.
- **Incident 4:** for the staff member who the resident yelled at when coming to the aid of resident three can be as classified as 'Aggression/Behaviour', 'Behaviour problem – verbal aggression' and 'Stress Mental (W) Exposure to occupational violence and aggression'. The instigator role is identified as Resident.

De-identification of information

De-identification maintains confidentiality and privacy standards as outlined in relevant Commonwealth and State law. This protects health service staff and patients from having personal information collected and reported to additional parties which do not have access to this information.

De-identification of information in the incident report allows for honest reporting without fear of retribution, preventing the identification of individual people, areas, or health services. Within the incident description, the reporter must use role or position titles, not the names of the staff involved in the incident under review. 'Just culture' looks beyond human error as a root cause, rather looking for contributing factors to address and improve system-based issues. Therefore, incident reports are de-identified, preventing the identification of individual people, areas, or health services. Within the incident description,

the reporter must use role or position titles, not the names of the staff involved in the incident under review.

When completing an incident report, do not use identifying information in the following fields of the incident management system:

- Brief Summary
- Details

Incident management systems do contain identifying information in some data fields, for example name of reporter and Client ID/UR. These fields are required so the health service can identify the reporter and person/patient involved for the purpose of incident review and follow up.

Examples of the correct and incorrect identification of information is provided below:

Example 1: Incident containing *de-identified* information:

The patient was walking to the bathroom with **Nurse A** when the patient stumbled and fell to the ground. **Nurse A** called **Nurse B** for assistance and the patient was returned to bed. The patient identified that she had felt dizzy while walking. Primary survey identified nil injuries and the patient was neurologically stable. Patient was tachycardic and diaphoretic and complained of jaw pain. **Doctor 1** – Resident Medical Officer (RMO) attended with pathology and an ECG showing ST elevation, was obtained. Code STEMI was called with **Doctor 2** attending. The patient was taken to the Catheterisation Laboratory for management of the acute STEMI.

A legend identifying staff is to be included in the incident management system section not transmitted to VAHI as follows: Nurse A = Susan Smith, Nurse B = Hilda O'Brien, Doctor 1 = Will Bailey (RMO), Doctor 2 = Michael Chan (Cardiology registrar).

Example 2: Incident containing *identifiable* information

Claudia Edwards was walking to the bathroom with Susan when Claudia stumbled and fell to the ground. Susan called Hilda for assistance and Claudia was returned to bed. Claudia identified that she had felt dizzy while walking. Primary survey identified nil injuries and the patient was neurologically stable. Patient was tachycardic and diaphoretic, complaining of jaw pain. Dr Will Bailey attended with pathology and an ECG showing ST elevation, was obtained. Code STEMI was called with Dr Michael Chan attending. Claudia was taken to the Catheterisation Laboratory for management of the acute STEMI.

Incident report documentation

An incident report contains factual and objective information that does not include an individual's assumptions, or personal opinions of what occurred. Throughout the incident report, make sure the documentation is based on what was observed and is supported by evidence. Be clear, objective, and non-emotive. All notes and documents are to be system focused and must not attribute blame to individuals. For further information refer to Incident Review Documentation.

When is an incident considered closed?

- The incident has been reviewed by a manager to:
  - remove any identifying information from the free text
  - ensure description of the event is accurate and objective.
- Where required, open disclosure has been undertaken and recorded.
- A review has occurred appropriate for the confirmed Incident Severity Rating (ISR) in line with health service policy. This includes discussion with staff involved by a manager, or where local policy dictates, a quality-and-safety manager or similar.
- The findings of that review (line manager review, in-depth case review or root cause analysis etc.) and associated recommendations have been documented as per local policy.
- A recommendation monitoring report (or equivalent plan) has been formulated, endorsed as per local policy, and allocated to appropriate staff. This plan must identify responsibilities and a due date for completion of recommendations.
- Incident notifications are made to appropriate bodies including (but not limited to) Safer Care Victoria (SCV), WorkSafe, Victorian Managed Insurance Authority (VMIA) or the Department. This includes notification to SCV for sentinel events as per the Adverse patient safety events policy.

- Feedback is provided to the incident reporter to assure the report has been reviewed and actioned, thereby 'closing the loop'.
- Following feedback to the reporter the incident can be closed. A process to monitor and close the loop on outstanding recommendations must be in place prior to the incident closure. These processes are to be incorporated into local policy, procedures, and guidelines, supporting lessons learned and quality improvement to address identified gaps.

Open Disclosure

It is critical that open disclosure be implemented according to the Australian Open Disclosure Framework and as part of any incident management process.

Reporters must answer the question about open disclosure if it has occurred, so this can be monitored on a state-wide level. The Open Disclosure framework is to be incorporated into local policies, procedures, and guidelines. Identified gaps in this process will guide the need for increased resources or training at a health service level.

VAHI is working with Safer Care Victoria to ensure that VHIMS MDS reporting aligns with the changes to the Health Legislation Amendment Quality and Safety Act 2022.

Timing of VHIMS MDS transmission via Application Programming Interface (API)

The VHIMS MDS must be transmitted **daily** to the department via API transmission. This is an automatic process for users of the VHIMS CS and has been in place since 2019-20.

Daily transmission has been authorised by SCV and is required to:

- provide close to real time data
- prevent batching of incidents and delayed transmission
- facilitate development of an early warning system.

Data transmitted through the API will be refreshed daily and as such will update VHIMS MDS information sent through the previous day. This allows for timely transmission of data and does not require the incident to be closed before transmission occurs.

Incident management system functionality and local policies, procedures, and guidelines to implement this rule are to be addressed at the local level with the system administrator and incident management system vendor.

ISR classification of sexual safety incidents (mental health)

Prior to 1 July 2023 behavioural incidents related to sexual safety were rated as a minimum ISR2. This business rule was included following consultation with the Office of the Chief Psychiatrist (OCP) and was intended to ensure escalation of all sexual safety incidents in bed based mental health services to senior management for timely review and response, as well as oversight and monitoring.

Elevating sexual safety incidents to have a minimum ISR-2 rating for this period of time enabled mental health services to develop local protocols ensuring incidents are reviewed and responded to appropriately.

With all health services now reporting the VHIMS MDS, in consultation with the OCP, we have agreed to remove the manual ISR-2 override from 1 July 2023. The review considered the impact on data quality as well as the burden on health services to manage the artificially increased number of ISR-2 incidents. All vendors have been made aware of this change.

VAHI will work with the OCP to implement notification reports for sexual safety incidents in bed-based mental health services as required to support oversight and monitoring. Health services are encouraged to work with their incident management system vendor to create local notifications to enable appropriate escalation of sexual safety incidents.

Section 5: VHIMS MDS Transmission

This section provides a highlevel overview of how the incident data are transmitted to VAHI. A copy of the detailed technical specifications for the Incident Management System Application Programming Interface (IMS API) can be requested at vhims2@vahi.vic.gov.au.

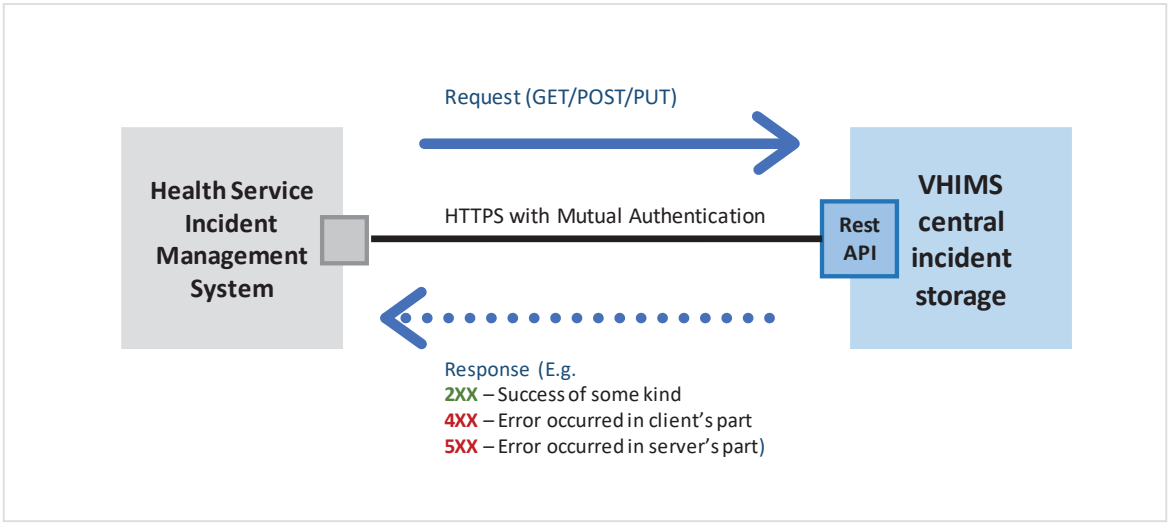
Incident data from health services using the VHIMS CS will be automatically transmitted on a daily basis to the VHIMS central incident storage. The central incident storage holds data from all health services and allows VAHI to analyse the VHIMS MDS to identify areas of improvement and safety.

Health services that are not using VHIMS CS are required to source and maintain an incident management system (IMS) from a vendor of their choice. Data from their chosen IMS is to be stored then submitted to VAHI using an IMS API. The IMS API will allow for health services to continue to use their own IT systems to record and submit incidents to the VHIMS central incident storage.

The diagram below illustrates how the relevant health services will transmit the VHIMS MDS to VAHI through an API. Health services need a client application on their system to interface to the VHIMS IMS API. The interface allows for the health services' chosen systems to submit incident data to the VHIMS central incident storage. The interface will also allow health services to re-submit incidents whenever they are updated.

Health services are required to submit incident data (new incident reports as well as updates to existing incident reports) electronically via the API on a daily basis. Incident management system functionality and local policies, procedures, and guidelines to implement this rule are to be addressed at the local level with the system administrator and incident management system vendor.

Figure 1 – API interface architecture for health services not using VHIMS CS



Appendix 1

Code set: Clinical, OH&S, and hazard incident/event types and contributing factors

Clinical event – list values

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
	Process	*Problem*	*Problem* is dependent on *Process*
Assessment & Care Planning	Access/admission/appointment	Delayed	
		Inappropriate cancellation	
		Incorrect scheduling	
		Not booked	
		Not registered	
		Refused	
		Request to reschedule denied	
	Assessment/diagnosis	Assessment incomplete	
		Delayed	
		Inappropriate monitoring	
		Incorrect diagnosis	
		No diagnosis made	
		No referral made	
		Not assessed	
		Not monitored	
		Not performed when indicated	
		Pathway/care plan not followed	
		Risk assessment not completed/updated	
	Care planning	Basic care not attended	
		Condition not reviewed	
		Delayed	
		Dispatched to incorrect address	
		Inappropriate pathway/care plan	
		Inappropriate restraint	
		Inappropriate seclusion	
		No pathway/care plan	
		Readmission to ICU	
		Refused	
		Unplanned admission to ICU	
		Unplanned readmission	
		Unplanned return to theatre	
		Unsatisfactory pain control	
	Dispatch/attendance	Delayed	
		Dispatched to incorrect address	
		Inappropriate cancellation	
		Refused	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Behaviour	Behaviour problem	Verbal aggression	
		Uncooperative/obstructive	
		Intimidating behaviour	
		Physical aggression	
		Damage to property	
		Sexual aggression	
		Sexual inappropriateness	
		Homicide	
		Attempt to abscond	
		Absconded	
		Discharged against medical advice	
		Absent without leave (AWOL)	
		Self Harm	
		Suicide attempt	
		Suicide	
		Wandering/loitering	
		Stalking	
		Drug/alcohol use/possession	
		Possession of dangerous/illegal item	
	Behaviour related to	Cognitively impaired/Dementia	
		Medications	
		Mental health	
		Substance use/Abuse	
		Unknown	
	Instigator Role	Affected person (above)	
		Unknown	
		Resident	
		Client	
		Patient admitted	
		Patient not admitted	
		Carer	
		Non health emergency services	
		Other member of the public	
		Relative	
		Visitor	
		Administrative/Clerical	
		Allied Health	
		Ambulance/Transport	
		Complementary Therapist	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Behaviour	Instigator Role	Dentist/Dental	
		Doctor/Medic	
		Environment/Infrastructure/Non Clinical	
		Medical support	
		Nurse	
		Pharmacist/Pharmacy	
		Student	
		Volunteer	
Restraint	Was restraint required?	Yes	
		No	
	Type of restraint used	Mechanical restraint - Hard	*Type of restraint used'* is applicable when the value 'Yes' is selected for the question *'Was restraint required'*
		Mechanical restraint - Soft	
		Physical restraint	
		Chemical restraint	
Blood Products	Blood Product Type	Albumin/plasma protein	
		Anti-D	
		Cord blood	
		Cryoprecipitate	
		Fresh Frozen Plasma-FFP	
		Immunoglobulin	
		Platelets	
		Recombinant products rVIIa, VIII, and IX	
		Red cells	
	Process	Administration	
		Blood preparation	
		Delivery/transportation	
		Dispensing	
		Ordering	
		Prescribing	
		Storage	
		Wastage	
	Problem	Contamination	
		Contraindicated	
		Delayed	
		Expired	
		Given not signed for	
		Omitted	
		Signed and not given	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Blood Products	Problem	Transfusion reaction	
		Transfusion without indication	
		Wrong administration set used	
		Wrong amount	
		Wrong blood/blood product	
		Wrong rate	
		Wrong storage	
		Wrong time	
Communication/ Documentation	*Process*	*Problem*	*Problem* is dependent on *Process*
	Documentation	Breach of privacy	
		Damaged	
		Delay or unable to access	
		Illegible	
		Inadequate	
		Incomplete	
		Missing/Unavailable	
		Unclear/Ambiguous	
	Languages other than English	Information not available in required language	
		Interpreter not offered	
		Interpreter not provided	
		Unable to provide interpreter service	
	Verbal communication	Breach of privacy	
		Delayed	
		Inaccurate information communicated	
		Inappropriate	
		Incomplete	
		Not concluded	
Consent	Related to	Admission	
		Blood products	
		Medical records	
		Treatment/Procedure/Agent	
	Problem	Inappropriately obtained	
		Incomplete	
		Incorrect procedure/agent	
		Incorrect side/site	
		Not obtained	
		Obtained outside required timeframe	
		Subject not fully informed	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Deteriorating patient	Process	End of life care	
		Escalation of care	
		Observations	
		Response	
	Problem	Failure to recognise significance	
		Advanced care directive not followed	
		Failure to withdraw care	
		NFR order not followed	
		NFR order not in place	
		Over treatment	
		Delayed escalation	
		Failure to escalate	
		Not performed	
		Not reviewed	
		Delayed response	
		Failure to respond	
		Inappropriate response	
Equipment	Type	Bed	
		Engineering related	
		Medical device/equipment	
		Patient lifting equipment	
		Other furniture	
	Problem	Contraindicated	
		Damaged	
		Failure/malfunction	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Not available	
		Recall	
		Reused inappropriately	
		Stolen	
		Supply error	
		Unclean/contaminated	
		Unsterile	
		Used incorrectly	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Fall	Activity at the time	Dressing/undressing	
		During procedure/therapy	
		During transport	
		Getting in/out of bed	
		Getting in/out of chair	
		Going up/down stairs	
		Playing	
		Reaching	
		Re-positioning	
		Showering/bathing	
		Standing/stationary	
		Toileting including getting on/off toilet	
		Transferring	
		Walking	
	Was the fall witnessed	Yes	
		No	
	Type of fall	Collapse	
		Loss of balance	
		Slip	
		Trip/Stumble	
		Unknown	
Handover / Transfer	*Process*	*Problem*	*Problem* is dependent on *Process*
	Clinical handover	Breach of privacy	
		Delayed	
		Inaccurate information communicated	
		Inadequate planning	
		Inappropriate	
		Incomplete	
		Not conducted	
		Not enough time allocated	
	Transfer	Delayed	
		Inaccurate information communicated	
		Inadequate planning	
		Inappropriate	
		Incomplete	
		Not conducted	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Infection	When was the infection detected?	30 days post original admission	
Infection	When was the infection detected?	During admission	
		On discharge	
		Acquired in other facility	
		Present on admission	
		Present on transfer	
		Within 365 days for implantable surgeries	
	Type of infection	Bloodstream	
		Bone or joint	
		Communicable infectious disease	
		Device related	
		Gastrointestinal	
		Other non surgical infection	
		Respiratory	
		Surgical site	
		Urinary tract	
		Wound (non surgical)	
Investigation(s)	Which service was this incident related to?	Pathology	
		Radiology	
	Process	*Problem*	*Problem* is dependent on *Process*
	Orders	Delayed	
		Inaccurate	
		Lost/missing	
		Not actioned	
		Not received	
		Not sent	
	Results	Delayed	
		Different received than ordered	
		Inaccurate	
		Lost/missing	
		Not actioned	
		Not received	
		Not reviewed	
		Not sent to appropriate care provider	
		Sent to incorrect address	
	Testing/Sampling	Contraindicated	
		Different taken than ordered	
		Expired sample	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Investigation(s)	Testing/Sampling	Inadequate	
		Lost/missing	
		Multiple failed attempts	
		No/inadequate preparation	
		Not taken	
		Testing/imaging not performed	
		Unnecessary tests/imaging	
		Wrong blood in tube (WBIT)	
Maternity / Neonatal Complications	*Type*	*Problem*	Problem is dependent on Type
	Maternal	Amniotic Embolus	
		Cord Prolapse/Knot/Around neck	
		Deterioration	
		Fourth degree tear	
		Haemorrhage (Antepartum)	
		Haemorrhage (Intrapartum)	
		Haemorrhage (Post partum)	
		Hysterectomy Post Delivery	
		Preeclampsia	
		Preterm labour	
		Ruptured Uterus	
		Third degree tear	
		Other	
	Neonatal	Apgar < 7 @ 5 minutes	
		Birth Asphyxia	
		Deterioration	
		Hypoxic Ischaemic Encephalopathy	
		Perinatal/Neonatal Death	
		Seizure/s	
		Shoulder Dystocia	
		Stillbirth	
		Other	
Medication and IV fluids	Did this involve a high risk (PINCH) medication?	Yes	
		No	
	Process	*Problem*	*Problem* is dependent on *Process*
	Prescribing/charting	Wrong patient	
		Wrong medicine/fluid	
		Wrong route/site	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Medication and IV fluids	Prescribing/charting	Wrong dose/strength/concentration	
		Wrong frequency/rate/time	
		Wrong formulation/presentation	
		Wrong quantity/duration	
		Illegible/ambiguous/conflicting	
		Incomplete prescription/order	
		Not signed	
		Not prescribed	
		Duplicate	
		Delayed prescribing	
		Prescribed a medicine to which a patient has a known allergy/ADR	
		Known allergy/ADR	
		Contraindicated	
		Medicine interaction	
		Not indicated	
		Other	
	Dispensing/Supply	Wrong patient	
		Wrong medicine/fluid	
		Wrong route/site	
		Wrong dose/strength/concentration	
		Wrong frequency/rate/time	
		Wrong formulation/presentation	
		Wrong quantity/duration	
		Wrong instruction/label	
		Not dispensed/supplied	
		Delayed dispensing/supply	
		Dispensed a medicine to which a patient has a known allergy/ADR	
		Known allergy/ADR	
		Contraindicated	
		Medicine interaction	
		Not indicated	
		Incompatibility	
		Expired/Expiry date missing	
		Other	
	Administration	Wrong patient	
		Wrong medicine/fluid	
		Wrong route/site	
		Wrong dose/strength/concentration	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Medication and IV fluids	Administration	Wrong frequency/rate/time	
		Wrong formulation/presentation	
		Wrong instruction/label	
		Not signed	
		Administered without order/prescription	
		Ceased/withheld dose administered	
		Delayed administration	
		Extra dose	
		Not administered	
		Incompatibility	
		Administered a medicine to which a patient has a known allergy/ADR	
		Known allergy/ADR	
		Contraindicated	
		Medicine interaction	
		Not indicated	
		Extravasation	
		Expired/expiry date missing	
		Other	
	Monitoring	Wrong timing	
		Not monitored	
		Allergy/adverse drug reaction	
		Delay or failure to act on results	
		Other	
	Storage/handling/disposal	Wrong medicine/fluid	
		Wrong dose/strength/concentration	
		Wrong formulation/presentation	
		Wrong disposal	
		Wrong handling	
		Wrong storage temperature	
		Wrong storage location/security	
		Not available	
		Damaged	
		Lost/missing/theft	
		Incorrect count/balance	
		Expired/Expiry date missing	
		Other	
	Clinician Communication/Handover	Incomplete/Inaccurate Information	
		Not communicated/handed over	
		Other	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Medication and IV fluids	Provision of Information to Patients	Incomplete/Inaccurate Information	
		Not provided	
		Other	
Medication details	Generic name		*Generic name* ' is dependent on other medication details
	Brand name		*Brand name*' is dependent on other medication details
	Medication Class		*Medication class*' is dependent on other medication details
Nutrition	Nutrition involved	General diets	
		Special diets	
		Enteral feeding	
		Total parenteral nutrition (TPN)	
	Process	Administration	
		Cooking	
		Delivery	
		Dispensing/allocation	
		Inadequate monitoring	
		Manufacturing	
		Preparation	
		Prescribing/requesting	
		Presentation	
		Storage/wastage	
		Supply/ordering	
	Problem	Allergy/reaction/anaphylaxis	
		Assistance not provided when required	
		Ceased/withheld/fasting	
		Contamination/foreign material	
		Delayed order	
		Expired/out of date	
		Known allergy	
		Malnutrition	
		Not available	
		Not ordered	
		Unsafe temperature	
		Weight loss	
		Wrong consistency	
		Wrong food/nutrition/diet	
		Wrong frequency	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Nutrition	Problem	Wrong quantity	
		Wrong route	
		Wrong storage	
		Wrong strength/formulation/volume	
		Wrong time	
Organisation and Management	Problem	**Accounts**	
		Amount charged/cost	
		Financial circumstances disregarded	
		Ineligible/overseas patient	
		Insurance/claims mis-handled	
		Public/private classification error	
		Questionable billing practice	
		Unreasonable late fee	
		Availability	
		Bed not available	
		Exit/entry block	
		Service not available	
		Unnecessary delay to service	
		Decisions	
		Identified issue not corrected	
		No/Inadequate change management plan	
		No/Inadequate risk assessment plan	
		Non compliance with regulations/Standards	
		Poor audit/quality control	
		Freedom of Information	
		Application not processed in timely or effective manner	
		Application process error	
		Exemptions applied	
		External review error	
		Internal review error	
		Unreasonable timeframe	
		Health Record Management	
		Access refused	
		Delayed delivery	
		Inappropriate storage/filing	
		Not available/missing	
		Sent to wrong address/location	
		Unauthorised destruction/deletion	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Organisation and Management	Problem	Unauthorised removal	
		Unlawful collection	
		Human Resources	
		Human Resources - Communication	
		Competency	
		Not qualified to perform task	
		Human resources - Skill mix	
		Staffing	
		Supervision	
		Training	
		Policies Protocols SWP	
		Ambiguous	
		Non compliance	
		Not available	
		Not communicated	
		Not used	
		Out of date	
		Teamwork	
		Teamwork - Communication	
		Conflict	
		Continuity	
		Responsibility overlap	
		Workload	
		Fatigue	
		Insufficient resources for workload	
		Planning/Rostering	
		Workload - Skill mix	
		Staff absence	
Patient ID and Procedure Matching	Process	Access/admission	
		Assessment/diagnosis	
		Blood product	
		Consent	
		Investigation(s)	
		Medical records/charts/assessments	
		Medication	
		Nutrition	
		Patient Identification label	
		Results/specimen	
		Treatment/procedure	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Patient ID and Procedure Matching	Problem	No ID	
		Identification process not performed	
		Patient/carer not involved in ID process	
		Three unique identifiers not present	
		Wrong patient	
		Wrong procedure/treatment	
		Wrong side/site	
Property	*Type*	*Affected*	*Affected* is dependent on *Type* .
	Personal Belongings	Cash/credit cards	
		Denture/dental plate	
		Documents	
		Glasses	
		Handbag/backpack	
		Mobile/electronic devices	
		Multiple items	
		Personal effects	
	Vehicles	Ambulance	
		Bus/coach	
		Health service owned/fleet vehicle(s)	
		Hospital or community patient transport	
		Personal vehicle	
		Truck	
	Other	Other	
	Type	*Problem*	*Problem* is dependent on *Type* .
	Personal Belongings	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	
		Stolen	
	Vehicles	Damaged	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Maintenance not attended	
		Not available	
		Stolen	
		Unclean/contaminated	
	Other	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Property	Other	Stolen	
Radiation / Radiation Oncology Events	Radiation Source	Computerised Tomography (CT)	
		Fluoroscopy	
		General radiography	
		Linear accelerator	
		Radiation oncology	
		Sealed radioactive source	
		Superficial unit	
		Unsealed radioactive source (includes nuclear medicine)	
		Other	
Seclusion	Was seclusion required?	Yes	*'Was seclusion required'* is applicable for behaviour incidents. If seclusion is entered as an event type, this question is not-applicable.
		No	
	Were injuries sustained	Yes	*'Were injuries sustained'* is applicable is the value 'Yes' is selected for the question *'Was seclusion required'* for the event type behaviour, or where seclusion has been selected as the event type.
		No	
Security	Was personal security affected?	Yes	
		No	
	How was personal security affected?	Abduction/attempted	*How was personal security affected* ' is applicable when the value 'Yes' is selected for the question *'How was personal security affected'*
		Assault	
		Attempted assault	
		Duress alarm activated	
	Was the problem with security services?	Yes	
		No	
	Security service Problem	Delayed response/attendance	*Security service problem'* is applicable when the value 'Yes' is selected for the question *'Was the problem with security services?'*
		Doors being left unlocked	
		Failed to attend	
		Inadequate security	
		Lost ID cards	
		Patrols not being performed	
		PIN/password disclosed	
Skin Integrity	Type of Injury	Skin tear	
		Pressure injury	
Skin Integrity	Type of Injury	Wound	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
	Process	*Problem*	*Problem is dependent on Process*
Treatment / Procedure	Incorrect count	Accountable item	
		Gauze/packing/swab	
		Instrument or part thereof	
		Stitch/staple/clip	
	Orders/decisions	Contraindicated	
		Delayed	
		No order/decision for treatment/procedure	
		Unnecessary treatment/procedure ordered	
		Without appropriate reconciliation	
		Wrong/missing subject details	
	Retained items	Accountable item	
		Gauze/packing/swab	
		Guidewire	
		Instrument or part thereof	
		IV cannula	
		Stitch/staple/clip	
	Treatment/procedure	Delayed	
		Inadequate/no preparation	
		Inappropriate	
		Inappropriate method used	
		Multiple failed attempts	
		Not completed	
		Unnecessary	
		Wrong time	
		Wrong treatment/procedure	
Unexpected outcome	Type of unexpected outcome	Amputation	
		Broken teeth/implant	
		Coma	
		Concussion/amnesia	
		Choking	
		Death - Cause unknown	
		Death - Reportable	
		Death (unexpected)	
		Deep Vein Thrombosis (DVT)	
		Exacerbation of existing condition	

Clinical event – list values continued

Clinical event types (patient/client/resident)			Business rule
	Process / Type	*Problem*	*Problem* is dependent on *Process*
Unexpected outcome	Type of unexpected outcome	Eye injury	
		Faint/dizziness	
		Fracture/dislocation	
		Head injury	
		Intracranial haemorrhage	
		Intravascular gas embolism	
		Loss of consciousness	
		Nerve damage	
		Pulmonary emboli (PE)	
		Seizure	
		Soft tissue/sprain/strain	
		Spinal injury	
		Stress	
		Outcome not specified	

OHS event – list values

OHS event types (Staff/Visitor)			Business Rule
Aggression / behaviour	Behaviour problem	Verbal aggression	
		Intimidating behaviour	
		Physical aggression	
		Damage to property	
		Sexual aggression	
		Sexual inappropriateness	
		Bullying	
		Harassment	
		Discrimination/prejudice	
		Inappropriate/inconsiderate	
		Rude/swearing	
		Uncooperative/obstructive	
		Drug/alcohol use/possession	
		Possession of dangerous/illegal item	
		Stalking	
	Instigator Role	Affected person (above)	
		Unknown	
		Resident	
		Client	
		Patient admitted	
		Patient not admitted	
		Carer	
		Non health emergency services	
		Other member of the public	
		Relative	
		Visitor	
		Administrative/Clerical	
		Allied Health	
		Ambulance/Transport	
		Complementary Therapist	
		Dentist/Dental	
		Doctor/Medic	
		Environment/Infrastructure/Non Clinical	
		Medical support	
		Nurse	
		Pharmacist/Pharmacy	
		Student	

OHS event – list values continued

OHS event types (Staff/Visitor)			Business Rule
Aggression / behaviour	Instigator Role	Volunteer	
Equipment	Type	Bed	
		Engineering related	
		Medical device/equipment	
		Patient lifting equipment	
		Other furniture	
	Problem	Contraindicated	
		Damaged	
		Failure/malfunction	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Not available	
		Recall	
		Reused inappropriately	
		Stolen	
		Supply error	
		Unclean/contaminated	
		Unsterile	
		Used incorrectly	
Exposure	Exposure	Ingestion	
		Inhalation	
		Skin/Body Contact	
		Other	
	Type	*Sub-type*	*Sub-type* is dependent on *Type*
	Biological	Animals	
		Blood/bodily fluid	
		Infectious material	
		Insects	
		Plants	
		Other	
	Chemical	Gas/fumes/vapours	
		Liquids	
		Medication	
		Solids	
		Toxin/poison	
		Other	

OHS event – list values continued

OHS event types (Staff/Visitor)			Business Rule
Exposure	Physical environment	Asbestos	
		Dust/dirt	
		Electrical	
		Heat/smoke/cold	
		Noise/sound	
		Pressure	
		Radiation	
		Vibration	
		Other	
Fall, Slip, Trip	Slip/trip/fall type	Fall from height (excluding stairs)	
		Fall from same level	
		Fall from stairs	
		Slips/Trips/Stumbles (No fall)	
Manual Handling	Category	Patient/client/resident	
		Object/material	
		Other person (e.g. non-patient/resident)	
	Type	Awkward posture	
		Bending	
		Lifting/carrying/holding	
		Prolonged unchanged standing	
		Pushing/pulling	
		Repetitive movement	
		Throwing/reaching out	
		Twisting	
		Unknown	
Property	*Type*	*Affected*	*Affected* is dependent on *Type*
	Personal Belongings	Cash/credit cards	
		Denture/dental plate	
		Documents	
		Glasses	
		Handbag/backpack	
		Mobile/electronic devices	
		Multiple items	
		Personal effects	
	Vehicles	Ambulance	
		Bus/coach	
		Health service owned/fleet vehicle(s)	

OHS event – list values continued

OHS event types (Staff/Visitor)			Business Rule
Property	vehicles	Hospital or community patient transport	
		Personal vehicle	
		Truck	
	Other	Other	
	Type	*Problem*	*Problem* is dependent on *Type*
	Personal Belongings	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	
		Stolen	
	Vehicles	Damaged	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Maintenance not attended	
		Not available	
		Stolen	
		Unclean/contaminated	
	Other	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	
		Stolen	
Security	Was personal security affected?	Yes	
		No	
	How was personal security affected?	Abduction/attempted	*How was personal security affected* ' is applicable when the value 'Yes' is selected for the question *'How was personal security affected'*
		Assault	
		Attempted assault	
		Duress alarm activated	
	Was the problem with security services?	Yes	
		No	
	Problem	Delayed response/attendance	*Security service problem'* is applicable when the value 'Yes' is selected for the question *'Was the problem with security services?'*
		Doors being left unlocked	
		Failed to attend	
		Inadequate security	
		Lost ID cards	
		Patrols not being performed	
		PIN/password disclosed	

OHS event – list values continued

OHS event types (Staff/Visitor)			Business Rule
	Process	*Problem*	*Problem* is dependent on *Process*
Struck by / against	Hit by object	Bitten by animal/insect	
		Falling object	
		Hit by animal	
		Hit by person	
		Hit by vehicle	
		Moving object	
		Trapped between objects	
		Trapped by machinery/equipment	
		Trapped by/between vehicle	
	I hit object	Hit moving object	
		Hit stationary object	
		Rubbing and chafing	
		Vehicle incident	

Hazard event – list values

Hazard event types			Business Rule
Critical/IT Systems	Affected	Alarm systems	
		CCTV	
		Duress & emergency systems	
		IT and communications systems	
		Nurse call system	
		Phone/PBAX	
	Problem	Asbestos	
		Damaged	
		Exposed wiring	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Maintenance not attended	
		Not available	
		Pest infestation	
		Stolen	
		Subject to biological agents	
		Unclean/contaminated	
Equipment (N)	Type	Bed	
		Engineering related	
		Medical device/equipment	
		Patient lifting equipment	
		Other furniture	
	Problem	Contraindicated	
		Damaged	
		Failure/malfunction	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Not available	
		Recall	
		Reused inappropriately	
		Stolen	
		Supply error	
		Unclean/contaminated	
		Unsterile	
		Used incorrectly	

Hazard event – list values continued

Hazard event types			Business Rule
Medication Management	Problem	Expired/expiry date missing	
		Wrong disposal	
		Wrong handling	
		Wrong storage - Temperature	
		Wrong storage - Location/security	
		Not available	
		Damaged	
		Lost/missing/theft	
		Incorrect count/balance	
		Expired/expiry date missing	
		Other	
Medication details	Generic name		*Generic name* ' is dependent on other medication details
	Brand name		*Brand name*' is dependent on other medication details
	Medication Class		*Medication class*' is dependent on other medication details
Organisation and Management (N)	Problem	**Accounts**	
		Amount charged/cost	
		Financial circumstances disregarded	
		Ineligible/overseas patient	
		Insurance/claims mis-handled	
		Public/private classification error	
		Questionable billing practice	
		Unreasonable late fee	
		Availability	
		Bed not available	
		Exit/entry block	
		Service not available	
		Unnecessary delay to service	
		Decisions	
		Identified issue not corrected	
		No/Inadequate change management plan	
		No/Inadequate risk assessment plan	
		Non compliance with regulations/Standards	
		Poor audit/quality control	
		Freedom of Information	
		Application not processed in timely or effective manner	
		Application process error	
		Exemptions applied	

Hazard event – list values continued

Hazard event types			Business Rule
Organisation and Management (N)	Problem	External review error	
		Internal review error	
		Unreasonable timeframe	
		Health Record Management	
		Access refused	
		Delayed delivery	
		Inappropriate storage/filing	
		Not available/missing	
		Sent to wrong address/location	
		Unauthorised destruction/deletion	
		Unauthorised removal	
		Unlawful collection	
		Human Resources	
		Human Resources - Communication	
		Competency	
		Not qualified to perform task	
		Human resources - Skill mix	
		Staffing	
		Supervision	
		Training	
		Policies Protocols SWP	
		Ambiguous	
		Non compliance	
		Not available	
		Not communicated	
		Not used	
		Out of date	
		Teamwork	
		Teamwork - Communication	
		Conflict	
		Continuity	
		Responsibility overlap	
		Workload	
		Fatigue	
		Insufficient resources for workload	
		Planning/Rostering	
		Workload - Skill mix	
		Staff absence	

Hazard event – list values continued

Hazard event types			Business Rule
Plant & Facilities	Problem	Asbestos	
		Damaged	
		Exposed wiring	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Maintenance not attended	
		Not available	
		Pest infestation	
		Stolen	
		Subject to biological agents	
		Unclean/contaminated	
	Type	*Affected*	*Affected* is dependent on *Type*
	Building(s)	Ceilings	
		Doorways	
		Floor	
		Foundations	
		Stairs	
		Walls	
		Window frames	
		Window glass	
	Car Park(s)	Bollards	
		CCTV	
		Entry Booms	
		Humps	
		Lighting	
		Parking meters	
		Road Surface	
		Stairs	
		Ticket machines	
		Walkway(s)	
	External surrounds	Ambulance bays	
		Gardens & surrounds	
		Hazardous chemical storage area	
		Helipads	
		Outside lighting	
		Pedestrian areas	
		Refrigeration infrastructure	

Hazard event – list values continued

Hazard event types			Business Rule
Plant & Facilities	External surrounds	Road Surface	
		Walkway(s)	
		Water system/drainage	
	Fittings & fixtures	Cooling	
		Door and locks	
		Electrical supply	
		Floor coverings	
		Gas systems	
		Hazardous chemical storage area	
		Heating	
		Lifts	
		Lighting	
		Patient fixtures	
		Pharmaceuticals storage	
		Plumbing	
		Refrigeration	
		Ventilation	
Property (N)	*Type*	*Affected*	*Affected* is dependent on *Type* .
	Personal Belongings	Cash/credit cards	
		Denture/dental plate	
		Documents	
		Glasses	
		Handbag/backpack	
		Mobile/electronic devices	
		Multiple items	
		Personal effects	
	Vehicles	Ambulance	
		Bus/coach	
		Health service owned/fleet vehicle(s)	
		Hospital or community patient transport	
		Personal vehicle	
		Truck	
	Other	Other	
	Type	*Problem*	*Problem* is dependent on *Type* .
	Personal Belongings	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	

Hazard event – list values continued

Hazard event types			Business Rule
Property (N)	Personal Belongings	Stolen	
	Vehicles	Damaged	
		Fault/defect	
		Inappropriate/unsafe storage	
		Lost/missing	
		Maintenance not attended	
		Not available	
		Stolen	
		Unclean/contaminated	
	Other	Damaged	
		Inappropriate/unsafe storage	
		Lost/missing	
		Stolen	
Radiation / Radiation Oncology Events (N)	Radiation Source	Computerised Tomography (CT)	
		Fluoroscopy	
		General radiography	
		Linear accelerator	
		Radiation oncology	
		Sealed radioactive source	
		Superficial unit	
		Unsealed radioactive source (includes nuclear medicine)	
		Other	

Contributing factors

Contributing Factors
Communication
Communication delayed
Communication not conducted
Inaccurate information communicated
Inappropriate communication
Incomplete communication
Documentation
Breach of privacy
Delay in accessing a document
Illegible
Inadequate documentation
Incomplete documentation
Missing/Unavailable documentation
Unclear/Ambiguous
Equipment
Equipment failed
Equipment not used when indicated
Equipment not working
Equipment suitability for purpose
Equipment unavailable/inaccessible
Equipment unfamiliar
Equipment usability
Patient Factors
Patient factors - co-morbidities
Patient factors - inattention/distraction
Patient factors - language
Patient factors - literacy/comprehension
Patient factors - physical condition
Patient factors - social history

Contributing factors continued

Contributing Factors
Physical Environment
Environment not matched to task or patient/client/resident
Lighting
Noise
Overcrowding
Temperature
Unsafe floor
Policies/Decision Support
Could not locate policy/guideline
Decision support not used
Decision support unavailable
No relevant policy/guideline to follow
Policy/guideline availability unknown
Policy/guideline not current best practice
Policy/guideline not followed
Policy/guideline not yet implemented
Policy/guideline used but not useful
Relative/Visitor Factors
Relative/Visitor factors - inattention/distraction
Relative/Visitor factors - language
Relative/Visitor factors - literacy/comprehension
Relative/Visitor factors - physical condition
Relative/Visitor factors - social history
Teamwork
No identified leader
No senior/specialist support sought
Responsibilities not clear
Staff not supervised
Supervision inadequate
Team structure inappropriate
Team structure unclear

Contributing factors continued

Contributing Factors
Treatment & Procedures
Assessment not completed
Diagnosis delayed
Diagnosis missed
Diagnosis not established
Diagnosis wrong
Inappropriate care plan
Incomplete care plan
Not followed post-discharge
Screening not completed
Test delay
Test order delay
Test results not accurate
Test results not available
Test results not communicated
Test results not reviewed/actioned
Tests inappropriate/outmoded
Unable to access appropriate level
Unable to access at a time required
Unable to access service
Worker factors
Alarm fatigue
Worker factors - co-morbidities
Worker factors - inattention/distraction
Knowledge/skills
Worker factors - language
Worker factors - literacy/comprehension
Worker factors - physical condition
Worker factors - social history

Contributing factors continued

Contributing Factors
Worker factors
Fatigue
Workforce
Inappropriate staff levels
Induction not adequate
Rostering/shift patterns
Skill gap not recognised
Skill mix
Time pressure
Training inadequate
Working beyond skill level
Working outside expertise
Workload

References

1 State of Victoria, Department of Health. (2023, July). *Policy and funding guidelines for health services*. Retrieved from https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services.

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Victorian Agency for **Health Information**

Department of Health

GPO Box 4057, Melbourne VIC 3001
bettersafercare.vic.gov.au