Clinical incident and APSE flags

Guidance for health services implementing the VHIMS MDS, version 2

OFFICIAL

Contents

Introduction

The revised Victorian Health Incident Management System minimum dataset (VHIMS MDS), version 2 includes a *Clinical Incident flag* and *Adverse Patient Safety Event (APSE) flag.*

These new elements ensure the classification of clinical incidents in the VHIMS MDS aligns with departmental and Safer Care Victoria (SCV) policies and supports Statutory Duty of Candour (SDC) processes by identifying serious adverse patient safety events (SAPSEs). See box 1 for definitions.

Both elements have been tested for interpretability, consistency, accuracy, and coherence with health services, SCV, and relevant policy and program areas in the department, and have been endorsed for implementation in the VHIMS MDS, version 2.

Box 1: VHIMS MDS definitions

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 patient safety events, including near misses, in an environment that poses a clinical risk. For community health services, clinical incidents also include events or circumstances that resulted or could have resulted, in unintended or unnecessary harm to a client during delivery of a non-clinical service (also referred to as client incidents).

Adverse patient safety event

A clinical incident, during which treatment or care **did not** go as intended and expected.

How to use this document

This document provides health services with additional information to support implementation of the new *Clinical incident flag* and *APSE flag*, including further detail on the definition and application of each element.

This document should be read in conjunction with the **VHIMS MDS Manual, 2024−25,** which outlines data definitions, business rules and submission requirements for the VHIMS MDS.

This document uses the term *patient*, which is intended to include patients, clients, residents or consumers, noting different terms are relevant for different parts of the health system.

This document uses the term *adverse patient safety event (APSE),* which encompasses all clinical incidents where treatment or care did not go as expected and intended. This definition of APSE applies to all services regardless of whether they are currently subject to the *Safer Care Victoria APSE policy.*

Clinical Incident Flag

Accurate identification of clinical incidents is imperative to ensure safety learnings can be developed, and to facilitate accurate reporting of clinical incidents via the VHIMS MDS.

Health services use their IMS for a variety of purposes and may collect and store records in their internal systems that do not meet the VHIMS MDS definition of a clinical incident. With health services transmitting records to the department automatically in near-real-time, the *Clinical incident flag* element allows services to identify transmitted records that do not meet the definition of a clinical incident. These records are then excluded from VHIMS analysis and reporting.

The *Clinical incident flag* replaces the *"Is this related to care in this organisation"* element.

Application

The purpose of this element is to indicate whether a record satisfies the VHIMS clinical incident definition. This element is only collected when the incident type is clinical.

The Clinical incident flag refers to the MDS field name. Health services may use a different, appropriate prompt in their local IMS system providing it elicits the required information.

The *'Clinical Incident Flag'* element is mandatory at incident closure, noting it may not be possible to confirm understanding of whether a record satisfies the clinical incident definition until a review is completed.

Clinical incident flag codes and descriptions

Code/Value	Description
Yes	The record satisfies the VHIMS clinical incident definition, i.e. person experienced unintended or unnecessary harm while receiving clinical care, or during a non-clinical service.
No	The record does not satisfy the VHIMS clinical incident definition

Principles for assigning the clinical incident flag

- All clinical records should be considered a clinical incident (i.e. *Clinical incident flag* =yes) unless it can be definitively demonstrated that the record does not meet the VHIMS definition of a clinical incident.

- Harm includes both physical and psychological damage or injury. Harm should be considered unintended and/or unnecessary unless it was a deliberately imposed necessity of treatment or care (e.g. surgical incision).
- A person should be considered as receiving clinical care if they are under the influence of the health service's clinical decision-making at the time of the incident. This is not determined by the location of the person at the time of the incident. Circumstances that lead to unintended and/or unnecessary harm to clients receiving non-clinical services should be considered a clinical incident (see *Box 2* for examples).

Box 2: Examples of circumstances where patients are "receiving clinical care" or "receiving non-clinical services"

It is important to note that the clauses in the clinical incident definition referring to a "person receiving clinical care" or "a client during delivery of a non-clinical service", are not determined by the location of the individual.

For clinical services examples of incidents while receiving clinical care include:

- Incidents when a person is receiving medical or therapeutic treatment or supportive care.
- Incidents when a person is using or under the influence of equipment or resources provided by your organisation.
- Incidents when a person under your care is participating in activities for which your organisation has deemed them to be safe to conduct.
- Incidents when a person is harmed by clinician action or decision.

For community health examples of incidents occurring during service delivery of non-clinical services include:

- Incidents when a client is receiving a service.
- Incidents while a client is under a 24-hour service.
- Incidents where a provider action or decision has harmed client.

Adverse Patient Safety Event (APSE) flag

The Adverse Patient Safety Event (APSE) flag has been introduced in the VHIMS MDS, version 2 to enable reporters to indicate if an incident is also an APSE, that is that treatment/care did **not** go as intended and expected.

The APSE flag enables consistent identification of serious adverse patient safety events (SAPSEs) within the VHIMS MDS, in line with Statutory Duty of Candour (SDC) obligations under the Health Legislation Amendment (Quality and Safety) Act 2022.

SAPSEs are primarily characterised as clinical incidents of severe or moderate severity (ISR 1 or 2). However, as established in the Victorian Duty of Candour Framework 2022 "if the treatment or care provided went as intended and as expected, an incident may not qualify as a SAPSE, even if harm occurred".

Identification of incidents that occur despite best practice treatment and care being provided is also important as these events may require different governance and may offer different opportunities for learning and improvement.

Application

The purpose of this element is to indicate whether a record satisfies the VHIMS APSE definition. This element is only collected for records that are confirmed as clinical incidents (i.e. *Clinical incident flag* = yes).

APSE flag refers to the MDS field name. Health services may use a different, appropriate prompt in their local IMS system providing it elicits the required information, i.e. *Is this an APSE?*

The *'APSE Flag'* element is mandatory at incident closure, noting it may not be possible to confirm understanding of whether a record satisfies the APSE definition until a review is completed.

APSE flag codes and descriptions

Code/Value	Description
Yes	Treatment/care **did not** go as intended and expected (i.e. an APSE)
No	Treatment/care **did** go as intended and expected (i.e. not an APSE)

Principles for assigning the APSE flag

- When considering whether treatment or care went as intended and as expected, any treatment or care provided by the organisation that could have influenced the incident occurrence, severity or outcome should be considered.
- Reasoned, professional judgement should be employed when determining if treatment or care went as intended and as expected. If following an appropriate review, the organisation is unable to reach a reasonable and informed belief that treatment or care went as intended and as expected, then a value of "yes" should be assigned. See *Box 3* for further guidance.

Box 3: Guidance for determining if treatment or care went as intended and expected

When determining whether treatment or care went as intended and as expected it may be useful to consider whether any of the following had an influence on the incident occurrence, severity or outcome:

- The existence and appropriateness of the treatment and/or care plan.
- The utilisation of appropriate preventative strategies for known risks.
- The timely identification and uptake of opportunities for mitigation.
- The appropriateness of consent provided.
- The adherence to best practice in the provision of treatment and/or care.
- The currency, availability and implementation of appropriate policies and procedures which align with best practice.
- The scope of practice of staff involved in the provision of treatment and/or care.
- The availability of necessary resources.

Relationship with Incident Severity Rating (ISR)

The APSE flag and ISR are used together to determine if an incident meets the definition of a SAPSE for services under statutory duty of candour (SDC) obligations.

If the following criteria are met and the health service is under SDC obligations, then the record may be considered a SAPSE:

Incident type = "Clinical"
ISR = "1" or "2"
Clinical incident flag = "Yes"
APSE flag = "Yes"

See **figure 1** for further detail.

Please refer to *Clinical Incident Severity Rating (ISR) model: Guidance for health services implementing the VHIMS MDS, version 2* and the *VHIMS manual 2024–25* for further information.

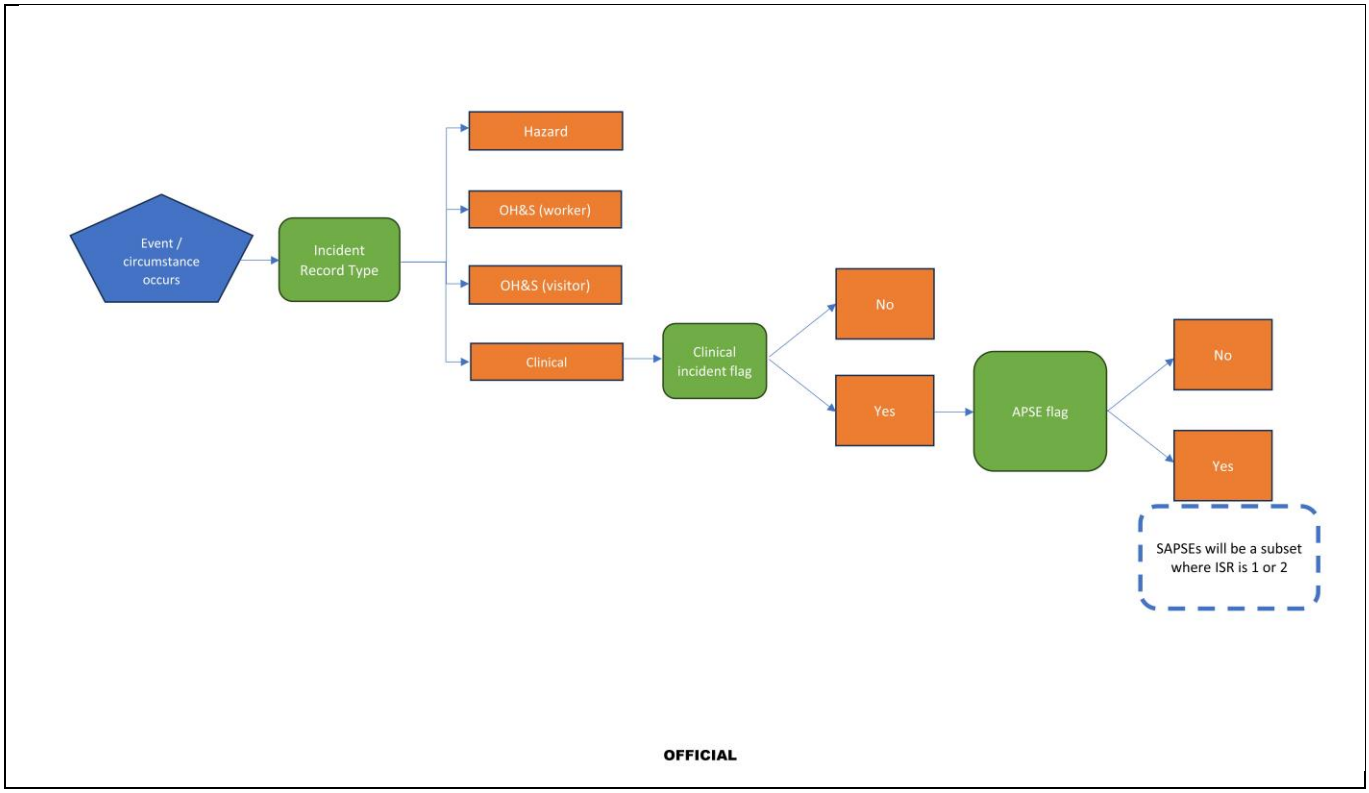

Figure 1. Clinical incident flag, APSE flag and SAPSE logic

Case examples

The following cases are presented to demonstrate the application of the *Clinical incident flag* and *APSE flag.*

Case: Graham

Graham (67 years old) attends his local community health clinic for general practice and dental care. Graham's last appointment with the clinic was five months ago for a general check-up where all appropriate checks were conducted, and Graham's results were within normal ranges.

Graham begins experiencing chest pain. His partner decides he requires medical attention and drives Graham to the local community health clinic. During the drive, Graham's chest pain continues and he experiences shortness of breath and high levels of distress and anxiety. Upon arriving at the clinic car park Graham feels unable to exit the car, so his partner runs into the clinic to seek help.

Nurses from the clinic urgently attend to Graham in the car park and immediately identify that Graham is exhibiting signs of a heart attack. An ambulance is called and doctors and nurses from the clinic provide Graham appropriate care and support until the ambulance arrives. Graham is transferred to the nearest hospital where it is confirmed that he is suffering a heart attack, and he is treated with a coronary angioplasty.

Application of clinical incident flag element

Graham's experience would not be considered a clinical incident. While Graham is a client of the community health service, he was not receiving clinical care when the event occurred. The care Graham was receiving before the event was appropriate and did not contribute to the event occurring. The care the clinic doctors and nurses provided Graham in response to the event was also delivered appropriately and did not expose Graham to unintended or unnecessary harm.

If the community health service chooses to record this event in their incident management system, the clinical incident flag should be reported as "no".

Case: Pamela

Pamela (42 years old) undergoes a knee reconstruction at her local hospital following an ACL rupture. Before being discharged home from hospital, Pamlea is assessed by an occupational therapist who determines Pamela requires a shower stool to safely shower at home while recovering from her procedure.

Pamela is provided with a shower stool from third-party equipment provider contracted by the hospital. Pamela's partner assembles the stool according to the instructions provided by Pamela's occupational therapist and the equipment company. The day after her discharge home, Pamela attempts to sit on the shower stool but it collapses causing Pamela to fall and hit her head and shoulder on the shower wall. Pamela experiences dizziness and pain in her shoulder following the fall. On inspection, it can be seen that a screw has dislodged from the stool causing it to collapse.

Pamela's son calls 000 and an ambulance transports Pamela to the hospital emergency department (ED). A CT brain is conducted which shows that Pamela does not have any intracranial bleeding and upon examination her shoulder injury is superficial. Pamela is prescribed paracetamol and non-steroidal anti-inflammatory medication. An occupational therapist reviews Pamela in ED and arranges for the broken shower stool to be removed and a replacement shower chair delivered.

Application of clinical incident flag element

In this case Pamela's fall constitutes unintended and unnecessary harm. This harm occurred as a result of Pamela using equipment provided to by the hospital her as part of her post-operative care. Therefore, this case is a clinical incident, and the *Clinical incident flag* should be reported as 'yes'.

Application of adverse patient safety event flag element

The shower chair provided to Pamela did not function as intended and caused Pamela's fall. Pamela's care did not go as intended or as expected, and the *APSE flag* should be reported as 'yes'.

Case: Helen

Helen (49 years old) has a history of Psoriatic arthritis. She has been experiencing increasing restriction of movement in her right hand in the last 6 months. To support diagnosis and treatment Helen is advised that she requires an MRI of her hand with contrast.

Helen has a history of severe allergic reactions to various medications and foods and has been under the care of an immunologist. Upon booking her MRI Helen is advised that given her allergy history, she should consult with her immunologist before undertaking the procedure. Helen consults her immunologist who arranges for Helen to have prophylactic medication before her MRI. At the time of her MRI Helen is counselled on the risks involved in the procedure, with specific emphasis on the risks she faces in having contrast given her allergy history. Helen provides her informed consent.

Shortly after Helen undergoes the MRI, she begins experiencing lip and tongue swelling with difficulty breathing. A medical team is called, and Helen receives a dose of 0.5 mg IM adrenaline which improves her symptoms. Helen is transferred to the emergency department (ED) for further monitoring. In the ED Helen continues to have some ongoing stridor but this resolves after a short time. Helen is observed in ED overnight and discharged home the following day. An urgent referral is made for Helen to be reviewed by her immunologist.

Application of clinical incident flag element

The harm Helen experienced by way of her anaphylactic reaction was not a necessary or intended part of her care. Therefore, this case is a clinical incident, and the *Clinical incident flag* should be reported as ‘yes’.

Application of adverse patient safety event flag element

Helen’s risk of allergic reaction was correctly identified before she underwent the MRI. Clinicians with the appropriate expertise were consulted and appropriate preventative strategies were incorporated into Helen’s treatment plan. Helen was fully informed of the risks of undertaking the procedure. When harm occurred it was immediately identified, and Helen received appropriate treatment and care for her condition. Treatment and care were provided as intended and as expected; therefore, the *APSE flag* should be reported as ‘no’.

To receive this document in another format email the Consumer Experience, Outcomes, and Safety team <vhims2@vahi.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.